

# **Dorset Safeguarding Adults Board**

**Serious case review in respect of female adult  
JT**

**Died May 2012**

**Overview Report**

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# 1 Background

**1.1** Mrs JT died on 29 May 2012 as a result of a stroke. She had, in January 2012, been admitted to a care home. This was an emergency measure because her husband, who was her main carer, had suffered a stroke and was admitted to hospital. In March 2012 JT transferred to a nursing home, where she died. The move was in order that she could be nearer to her husband who had then returned to their family home in Weymouth.

**1.2** JT had been known to an increasing range of agencies since suffering a first stroke in 1990. Ultimately she was well known to the following agencies: Dorset County Council Adult and Community Services (DCCACS); Dorset Healthcare University Foundation Trust (DHUFT); NHS Bournemouth and Poole/Dorset Cluster (NHSBPDC); Dorset County Hospital NHS Foundation Trust (DCHNHSFT); Synergy Housing (SH); Care South (CS); South West Ambulance Service NHS Foundation Trust (SWAST); a care home and a nursing home.

**1.3** JT's general condition and health on admission to the care home in January 2012 gave rise to significant concerns as a result of which a safeguarding alert was raised and an investigation ensued. This subsequently gave rise to questions about the way in which local professionals and services had worked together in this situation.

**1.4** The period scrutinised by the serious case review panel was the period from 01.01.1990 to JT's death on 29.05.2012.

## 2 Purpose, terms of reference and methodology

**2.1** A formal decision to conduct a SCR was made by the SCR Panel of Dorset Safeguarding Adults Board on 27 June 2012, in accordance with the Inter-agency Safeguarding Procedures on the following grounds (as set out in that procedure):

- *An adult at risk dies and neglect is suspected to be a factor in his or her death.*
- *An adult at risk has sustained serious and permanent impairment of health or development through neglect and the case gives rise to concerns about the way in which local professionals and services work together to safeguarding adults in vulnerable situations.*

**2.2** The key purpose for undertaking an SCR is to enable lessons to be learned from serious injury, death or from homicides where a person is killed as a result of domestic violence. In order for these lessons to be learned as widely and thoroughly as possible, professionals need to be able to understand fully what happened in each [situation], and most importantly, what needs to change in order to reduce the risk of such tragedies happening in the future.

## 2.3 Terms of Reference

The Terms of Reference for an SCR are set by the SCR Panel as follows:

- i. To establish the events and circumstances relating to the injuries, neglect or other serious issues sustained by JT, and review information known to Dorset Safeguarding Adults Board agencies, and actions taken by them, to include the period 1.1.1990 to 29.5.2012.
- ii. To establish the involvement of agencies with JT in order to understand the circumstances.
- iii. To take account of findings of each agency's Internal Management Review, and review how inter-agency working accorded with the Bournemouth, Dorset & Poole Safeguarding Adults Board Multi-Agency Safeguarding Procedures.
- iv. To request that the authors of the Internal Management Reviews obtain further information or make other enquiries within their own agency as necessary within the remit of this case review, in order to properly review the circumstances of the case.
- v. To ascertain as far as possible the facts of the case indicating the source of information. In situations where it is indicated that events other than those recorded took place, the Panel should include this information, but clarify that there was no written evidence. Where these relate to important issues or incidents, the Panel should attempt to establish any corroboration. Where conflicting accounts are given, areas of consensus and dispute about events should be detailed.
- vi. To obtain further information or make other enquiries within these terms of reference as necessary to properly undertake the case review. In particular, information relating to the adult's history which should be included as part of the review, regardless of the time frame.
- vii. To provide feedback to a senior manager of a specific agency about any important issues which arise from the overview process, which may not have been known or addressed in the individual agency review report.
- viii. To establish whether the inter-agency safeguarding procedures were adhered to, and whether any changes are necessary in relation to these, or in the guidance or training associated with them.
- ix. To consider, in liaison with police if criminal proceedings are pending, how to seek the views of family/carers of (adult's initials) on services provided by agencies, for consideration within the case review.

- x. To prepare a report outlining the circumstances, key issues and conclusions of this case in accordance with the Serious Case Review protocol and make recommendations to the Bournemouth & Poole Safeguarding Adult Board.
- xi. To make other recommendations as appropriate to this review and commission/identify the author of the Overview Report.
- xii. The author of the Overview Report to prepare an Executive Summary.

The SCR panel identified that in the case of JT the most important issues to be addressed were:

- a) The reason why JT's health and condition deteriorated to such an extent
- b) The use of and understanding of the Mental Capacity Act and JT and MT's ability to understand and make decisions in the light of the complexity of JT's health needs
- c) The quality and extent of the assessment, review and communication between the different agencies

**2.4** The emphasis in this review is on the lessons and implications for multiagency working.

Individual Management Reports (IMRs) have been prepared by all agencies involved with JT and deal in detail with the actions required within each individual agency. The Safeguarding Adults Board will provide a scrutiny role in relation to single agency action plans but those individual actions/recommendations will only be included in the SCR recommendations

- Where they have significant implications across agencies
- Where they underline highly pertinent matters which may have received tepid attention in the IMR recommendations - and the Safeguarding Adults Board needs to be alert to them

## **2.5 Panel Membership**

Panel members were senior managers who had been nominated by their organisation to participate in the Serious Case Review. Their role was to analyse the information from the Internal Management Reviews and to produce a report of their findings and make recommendations for future practice, as well as to highlight any good practice.

The SCR Panel comprised:

- Jane Ashman (Independent Chair)
- Glen Gocoul (Head of Specialist Adult Services, Adult & Community Services, Directorate, Dorset County Council)
- David Vitty (Head of Adult Social Care Services, Borough of Poole)

- Eileen Dunnachie (Service Director, Adult & Community Support, Bournemouth Borough Council)
- Sally Shead (Interim Director of Quality & Lead Director of Safeguarding, NHS Bournemouth & Poole, NHS Dorset)
- Mary Smeaton (Safeguarding Manager, South Western Ambulance Service)
- Jan Sayers (Policy and Performance Officer, Bournemouth and Poole Safeguarding Adults Board)
- Michelle Hopkins (Head of Patient Safety and Risk, DUHFT)
- David Buggins (Safeguarding Partnership Officer, Adult Social Care Services, Borough of Poole)

Jane Lawson, an independent report author was commissioned to produce the report and was a member of the panel from the time of the meeting on September 12 2012.

**2.6 Independent Management Reviews (IMRs) were commissioned from agencies that had had contact with JT during the period defined by the review for analysis:**

Dorset CC Adult Social Care Services  
 Care South  
 DHUFT for Community District Nurses and Specialist Services (specialist tissue viability service, continence advisory service).  
 Dorchester County Hospital (community dieticians)  
 NHS Bournemouth, Dorset & Poole for GP  
 SW Ambulance Services  
 Emergency Duty Team, Borough of Poole  
 Synergy Sheltered Housing Provider

The following organisations were contacted about the SCR and produced written reports / information relating to JT over the specified review period:

Cheverell's Care Home  
 Queen Charlotte Nursing Home, Weymouth  
 Dorset Police re any criminal investigations.

The Coroner was not involved in this case.

**2.7 Methodology**

- Records were collected from all agencies that had significant involvement with JT during the period under consideration. These were collated into an integrated chronology.
- Internal management reports were requested from organisations outlined in 2.6
- These documents were presented by the IMR authors to a SCR panel discussion on 12 September
- A meeting between the Chair of the panel, the independent overview report writer and Mr MT took place on September 28. MT's neighbor and a friend were present

- An independent overview report writer was commissioned to work with the SCR panel to prepare a report informed by their work. The independent person provided external objectivity to the process. Additional records were requested from organisations who had been involved with JT to inform the analysis and report
- Where issues were identified these were subject to further analysis with reference to relevant existing policies and literature. The review report was submitted to chief executives of those organisations involved with JT
- The review report was submitted to the Safeguarding Adults Board in December 2012.

### **3 JT and family background**

**3.1** JT was born in late 1942. She lived for the duration of the period under consideration with her husband MT who was her main carer. They lived in 3 different tenancies and for the last 13 years at a warden controlled bungalow. At the time of JT's death they had been married for 47 years. JT enjoyed watching "soaps" on TV, listening to Wessex FM and was a keen "Elvis" fan.

**3.2** They had three sons but tragically during the period covered by this review two of these sons died. Their son, PT was murdered in 1997 and another son, JT(ii), died of pneumonia in 2007. JT's husband told us that the death of the second son "hit her hard and she was very down as a result". Local press entries on the internet indicate an ongoing attention to these deaths by the family who year by year recorded them in the family announcements section of the local newspaper. A third son, MT (ii), was in and out of prison throughout the period reviewed. A care manager recorded in 1995 that JT refers to this son as "the worry of my life...always in trouble".

**3.3** JT's husband also referred to his brother in law who came to their bungalow on the day MT was admitted to hospital with a stroke. In an assessment by Dorset CC Care Manager in July 1995 it is recorded that, during the early part of the period under scrutiny, JT was visiting her mother on 6 afternoons each week where she also saw her widowed sister. It is not clear for how long this continued. The DCCACS IMR informs that proximity to JT's mother was the reason for the move to the bungalow as this was the Close where her mother lived too. There is no record of whether her mother continued to live there or for how long.

**3.4** It is striking that few of the professionals who supported JT were aware of this family background and especially so that they were seemingly unaware of the death from pneumonia of JT (ii) (son) in 2007. This does not appear in any records despite a discussion in the records in September of that year as to whether, following concerns raised by an OT, JT might be depressed. The GP record states: "discussed with JT, does not feel low, no crying, sleep ok, eating ok, able to concentrate. Just had 43<sup>rd</sup> wedding anniversary and son coming out of prison this week."

**3.5** JT's health was a dominant feature throughout the period of this review. A significant part of the chronology is given over to discussion of health conditions, concerns and treatments/support with those issues. These included: right cerebro vascular accidents (CVA); bronchitis; gastric erosion; Urinary Tract Infections (UTI's); possible depression; anxiety; panic attacks. These health issues were persistent and recurrent and became increasingly restrictive and isolating for both JT and her husband. JT was known to have suffered three strokes; one on 24 July 1990 and the other on 12 August 1998. Then a third was the cause of her death in May 2012. On 2 March 2007 MT believed that JT had suffered a further stroke, but this episode is recorded in the GP notes as probably due to a UTI.

## **4 Case Outline**

**4.1** The integrated chronology, showing contacts of a range of agencies with JT and her husband over the period from 01.01.1990 to JT's death on 29.05.2012 is too lengthy to reproduce here. A synopsis of the most significant involvements and events is provided below. This is taken from the chronologies; IMRs and from a conversation with Mr. MT.

### **4.2 Key events and service interventions**

#### **4.2.1 1990-1991**

JT suffered a dense right CVA on 24 July 1990. She was 47 years old. She was referred for Speech and Language Therapy (SLT); occupational therapy (OT) and Physiotherapy. Even at this early stage it was noted that JT had been a "poor outpatient attender in the past" and there were concerns that she may not attend for outpatient appointments on discharge from hospital. At this stage JT needed minimal help with daily living and walked independently. By December 1990 JT had "DNA'd" (did not attend) three times and was as a result discharged from physiotherapy. She attended a review with her consultant physician on 26 March 1991 (this review was late; 7 months rather than 3 months following the stroke) who noted that she had been discharged from therapy but that she was aware of exercises to reduce spasticity.

A challenge running through this review period is that of the extent to which JT and MT were in control of what they would or would not accept in terms of care, treatment and support and the extent to which their decisions might have been ill informed through lack of insight or understanding of the consequences. Professionals went along with their decisions not to engage or not to accept support irrespective of the implications in terms of level of risk to health and wellbeing. There was little or no evidence of attempts to support that decision making with information/ discussion.

#### **4.2.2 1991-March 1994**

There was a range of contacts with the GP during this period. He prescribed medication as well as supporting an application for a move to more suitable accommodation (JT and MT at this time lived in a flat with three flights of stairs to enter the flat and two flights down to access the toilet). In October 1992 there is a first reference in the GP records to depression in JT and then

in September 1993 a first reference to muscle spasm on being touched on the stroke side of her body. This presented an ongoing barrier to care staff carrying out essential care tasks and yet, except for prescribing medication, there was little evidence of sustained attempts to support JT in coping with this issue. MT did, when interviewed, refer to the DCCACS home carers using diversionary tactics such as singing with JT. These were to some extent successful. These issues were never discussed across professional groups or agencies and therefore no other staff benefitted from this knowledge.

During this period a social worker was involved with input in relation to rehousing/benefits advice.

A request for a shower was made in March 1994. Otherwise all recorded contacts in 1994 related to the GP prescribing for JT (14 in all) or adaptations to the bathroom. This pattern continued into the first half of 1995

#### **4.2.3 1995-1996**

In June 1995 there is a first reference in the records to MT experiencing difficulties in his role as primary carer for JT and it is noted that he requested respite care.

On **10 July 1995** a care manager visited JT and MT and planned a care package for one day per month to give MT a day off. However, one month later "Mrs JT cancelled carer and not willing to accept"

The assessment on 10 July states that for JT the worst problem associated with the effects of the stroke was "muscle spasms-occur about one a month 'all nerves seize up'- cannot bear to be touched...lasts about 20 mins, but very frightening and painful". The assessment indicates that JT felt guilty and concerned that her husband had to do everything.

JT indicated that she did not want to mix with other disabled people.

**20 July 1995** This was the only time in 17 years of involvement that a carers' assessment was carried out with MT. The record of the assessment indicates an extensive caring role even at this early stage but that, at this time, when JT visited her mother each afternoon, MT was able to do other things. It is recorded that he feels as though "he is just left to get on with it. He gets days when he "just feels like going off for the day" and "worries about leaving JT alone" but that he "enjoys making JT's life more comfortable". He is recorded to have a heart problem with 2 valves needing replacing. The assessment records that he travels to the surgery every other morning for injections. He was to try tablets instead of injections but the outcome of this is not recorded anywhere. MT requests a few hours off perhaps alternate Mondays as well as: information on holidays for people with disabilities; general information for carers and service users ; information about a piper line phone and to register JT as disabled.

In July JT was registered disabled.

In August the bathroom adaptations were completed and support with rehousing resumed.

There is very little of significance recorded in **1996**.

#### **4.2.4 1997-1998**

In January 1997 JT and MT's son (PT) was murdered.

There is little recorded contact with any professionals during this year other than four entries in GP records.

In **August 1998** JT suffered a second stroke which is recorded in the record of a home visit by the GP. JT was still only 55 years old at this point. The record gives no details of the effects of the stroke or of any assessments/actions in response to it (other than a review of medication). JT was not admitted to hospital. Mr MT referred to this occasion when interviewed as part of this SCR. He said that the GP felt JT would be better with MT.

It is surprising in view of this second stroke that there are only 4 entries in the chronology over the following 16 months. These relate to adaptations and to the need for alternative housing. Where is the review of the needs assessment or carers assessment? There is activity only in respect of isolated practical issues rather than a holistic assessment.

#### **4.2.5 2000-2001**

On **6 January 2000** JT attended A&E by ambulance. She had collapsed probably due to diazepam intake.

JT was discharged from hospital on 12 January and the DCHNHSFT record states "Feels bright. Going home today. XXXX House doing follow up from physiotherapy point of view. OTs providing new wheelchair. Social workers setting up daily input at home, starting Monday. Husband happy to care for her until then" There is no evidence in the records that daily input of care is set up and nothing on the chronology of DCC (or indeed of any other agency) to suggest that there was social work involvement.

A gradual withdrawal from diazepam was advised following this hospital admission and followed this incident. In March 2000 the GP recorded that JT was "much more mobile now less sedated"

Right at the end of 2000 there were three contacts in respect of a new tenancy.

The move to the bungalow where MT still lives took place in **December 2000**. **During 2000 and 2001** contacts recorded with JT were largely through GP contacts in respect of miscellaneous medical issues. These are a combination of prescribing; home visits; surgery attendance and telephone contacts in relation to: gastro enteritis; spasms; anxiety and depression; frequent urination; diarrhoea; constipation; UTIs; gastric erosion; issues relating to the CVA; diazepam prescribing.

#### **4.2.6 2002**

In **February 2002** there were issues in relation to the son, MT(ii) and the tenancy agreement. The son, who had been released from prison, was living at the property and this was prohibited.

In **April 2002** the GP referred Mr and Mrs MT/JT situation to a social worker for assessment for respite care. MT was having difficulty coping and was exhausted, partly due to night disturbances.

JT refused suggestions of placement at a day centre or rehabilitation centre. She would only accept a referral to OT for assessment regarding difficulties in the bathroom and standing in the kitchen. The Community Care Officer was concerned about how JT was dealing with the murder of her son in 1997 but JT refused offers of referral for counselling. She is reported to have said that she was unable to bear anyone touching her.

In **October 2002** a GP record following examination of JT refers to anxiety, insomnia and depression. In relation to this the record states "Might be expected with age and lack of capacity to exercise" In fact JT was at this point only 60 years old. This degree of resignation to the state of affairs does not seem to be warranted.

December, the bathroom and kitchen refurbishment was completed.

#### **4.2.7 2003-2005**

Records refer at intervals to MT/JT's son, MT (ii), as he was in and out of prison during this period and there were occasional problems with his presence at the bungalow occupied by MT/JT.

On 12 September **2003** JT was admitted to hospital and then discharged. She was suffering with left sided pain. JT refused to be examined because she said this would set off spasms. There was liaison between the hospital and GP with the GP reporting to the hospital that the "situation unchanged for many years". Following discharge home JT declined a suggestion by the GP of respite or admission to care.

There is a clear repetitive pattern of professionals being complicit with JT's wishes even though this may present risks to potential recovery/improvement. There is no record of any attempt to challenge "refusals" or to offer insight into the implications of such decisions. Indeed there may also have been questions as to JT's capacity to make the decisions in view of the cognitive deficits which must have resulted from the strokes. There is no record to suggest that those deficits were ever assessed. This issue is again reflected in February 2005 (below)

Between **December 2004 and February 2005** there were a number of GP contacts with JT in respect of miscellaneous medical issues/medication. There were also references to her son (MT)

On **23 February 2005** JT fell going to the toilet. MT called an ambulance as JT was on the floor. JT refused to go to hospital. The GP records record a telephone contact as follows: "Frequency and tachycardia. Going to pass urine all the time, some breathlessness, previous CVA (stroke). Husband requested admission, ambulance paramedic willing to take her in but patient refuses. Requests visit."

When interviewed as part of this SCR process JT's husband referred to this pattern of JT needing to go to pass urine frequently. He said that there were times when [JT] might ask to go onto the commode 20/30 times a day but often not needing to go to the toilet once she was on the commode. This was very demanding.

A GP record on 16 August 2005 states "Micturition frequency. Ongoing keep sitting on toilet but nothing happening. Mid stream urine – nothing as diagnosed."

**In August 2005** there is an initial housing related support plan. Alarm monitoring and low level support is agreed and it is recorded that MT is meeting JT's care and support needs. This took place at this point because it was in 2005 that Supporting People funding was introduced.

August 2005 to March 2006 there are a number of GP contacts again in respect of medication and miscellaneous medical issues. During this time too

there were two entries in housing support records regarding JT's son (MT) and one routine visit.

#### **4.2.8 2006-2007**

Throughout 2006/2007 there were medication and housing support reviews as well as GP contacts particularly in relation to UTIs.

In **June 2006** a Housing related support review records that MT "is coping well with caring role" and in July and August routine visits were carried out and help given by providing clothing and bedding.

In **December 2006** incontinence of urine (in respect of JT) is recorded for the first time in GP records.

**During 2007** there is a significant heightening of awareness and concern in individual professionals, all the indications were that more care and support was needed but there was no drawing together of those concerns into an integrated multi agency assessment.

In **March 2007** MT was recorded in GP records as thinking that JT had suffered a further stroke. He called the GP who recorded that this was probably a UTI. JT had been unable to transfer and MT had had a bad night and was struggling again to cope with the care of JT. The GP records state: "Patient states she feels well in self but husband at end of ability to care. Hasn't been able to get her washed in last few days". GP concludes there is no indication for an acute admission. The records state that MT wanted JT to be admitted. The GP requested urgent assessment by DCCACS for respite placement today." Respite was refused by JT but the Community Care Officer referred JT to the Community Rehabilitation Team (CRT).

There is no carers assessment recorded despite the recurrent theme of sleep disturbance and increasing dependency of JT on MT. There is no attempt to support JT/MT in their decision making.

On **14 March 2007** the DCCACS records state that they plan to introduce personal care twice a week with a plan to work towards long term care (although there is no indication that this longer term plan is mentioned to or discussed with JT and MT). That long term plan is never discussed again or pursued until an emergency arises almost five years later. The record on 12 April states that JT has accepted this care. No record of this care appears in the chronology but it is referred to in the DCCACS IMR.

In March 2007 a district nurse became involved due to JT having an infected hand. The nurse also cut JT's nails which were reported to be 1 ½ inches long.

On **3 April 2007** the support worker reviewed the action plan for housing related support and recorded no change in the level of support required. In view of the context provided by the review there is a question as to expectations of housing support officers around multiagency discussions to inform the reviews.

In **May 2007** there was an assessment by a district nurse for incontinence products. The nurse was also asked to check necrotic wound on right hip with red broken skin. This is the first reference in the records to skin break down. Although the records state that this nurse is to return to JT on 1 June the records indicate that the return visit did not take place until 8 June. MT recalled the first occurrence of a pressure ulcer which had clearly been a

source of anxiety. There is no evidence that this source of anxiety is ever discussed with MT so that he can be a part of the “team” monitoring and acting upon this and future concerns about pressure ulcers.

On **8 June** a catheter was fitted.

In **June 2007** health concerns accumulated and there were recurrent references in records to pressure ulcers and concerns regarding JT’s low weight.

A Waterlow assessment was undertaken on 14 June 2007 The score card records a score of 23 (over 20 constitutes a “very high risk”) . It appears that there is no scoring entered in respect of weight loss, the score for which would be at least 2 (this is the score if “unsure”) but probably greater than two given the marked weight loss in JT. The only actions recorded in response to the assessment are provision of alphaxcell mattress and hospital bed. There are a range of other possibilities none of which are recorded: nutrition assessment/advice; taking care in lifting technique and in hygiene; sheepskin/bed cradle. There is an absence of any reference to discussing these issues and techniques of care with MT.

**14 June 2007** a hospital bed and alphaxcell mattress were recorded as being in place. The sore area on the right hip was recorded as improving but a small superficial area on the sacrum was developing as well as a pressure area on the right ear lobe. The record states that JT “generally doesn’t look well”

**21 June 2007** records state that the GP “refers to dietician for “advice on the right kind of diet to help maintain her weight and skin condition ....”

**23 June** the district nurse records indicate that left toe and bunion area are breaking down too.

On the **24 June** a bed bath is given “as far as JT would tolerate”. Again JT is controlling the level of care and it is unclear as to the extent to which this is challenged and whether the consequences of this are explained to or understood by her. There is no record of such challenge taking place.

**29 June** DCCACS record that district nurses were visiting daily regarding pressure ulcers.

**10 July 2007** Daily carers began to attend JT.

**14 July** a dietician makes a home visit (“I chatted to husband then met patient at end. She was lying in bed watching TV” ) in which dietary supplements are provided and contact details given to MT. Following this on 30 July JT was discharged from the dietician service with a note to GP stating: “Mr T is doing a sterling job to provide and prepare a nutritious diet. He had received some written information from the district nurse about food fortification and has followed this well. It was impossible to weigh Mrs T but her husband felt she had lost a little weight but reported that she had always been very slim”

**14 September 2007** the GP visited for a “follow up psychiatric assessment” as the OT had queried depression in JT. The GP seems to conclude that this is not an issue: “discussed with JT, does not feel low, no crying, sleep ok, eating ok, able to concentrate. Just had 43<sup>rd</sup> wedding anniversary and son coming out of prison this week.”

**On 28 September** JT declined physio for chestiness.

By **mid October** the DCCACS home care officer records increased confidence in JT since having home care and it was agreed that in accordance with JT's wishes home care could be reduced to 30 minutes.

When interviewed as part of this SCR process MT advised of a third son JT(ii) who died in 2007 from pneumonia. There is no mention of this anywhere in the chronologies of agencies involved with JT. MT states that the effect on JT of her son's (JT's) death was considerable such that he reports she suffered a second stroke in 2007 and stopped being able to get out of bed. This may have been in March when records relating to a GP home visit state that MT felt JT had had another stroke but the GP felt this was a UTI.

By this point there was a wide range of professionals going in to JT including: nurses; GP; Housing Support Officers; Community Rehabilitation Team (CRT) OT and Physiotherapists; DCC Community Care Officer; Social Worker; Dietician; Chiropodist.

#### **4.2.9 2008**

**November 2007 to March 2008** there were a number of calls to the GP out of hours service regarding catheter issues.

Throughout 2008 there was a range of references in records from health professionals relating to issues regarding: catheter; chest infection; nails; chiropody; hand care; pressure ulcers; eye infection; hand infection.

On **14 May 2008** the Housing Support Plan was reviewed and updated to reflect the assistance being provided by other agencies. However the housing provider IMR acknowledges that their own records did not indicate which agency provided the care. There were no details on record. There was seemingly no communication with those other agencies.

On **5 November 2008** the support worker undertook an annual review of housing related support needs. The support worker offered to help MT access support with domestic tasks but this was declined. There was no challenge recorded and no reference made to any other agency.

#### **4.2.10 2009**

OT involvement was recorded and district nurses record **22 June 2009 to 31 May 2010** "Weekly visits continued. Regular visits to undertake continence care, hand care including nail cutting and pressure area care including care to right ear"

Housing Support worker annual review on **8 June 2009** records no additional housing related support needs. A new pendant alarm is issued. Later in June and in July that support worker records concerns about JT not eating or drinking properly. She intends to speak to the district nurse but there is no record of a conversation. JT developed bronchitis and a UTI but stayed at home as, the GP records, she was "not keen to go to hospital". During the following four months there were recurrences of UTI; chest infection and hallucinations with associated GP involvement.

On **20 July 2009** the GP records "confused-not sleeping, irritable with husband"

The burden of caring on MT is clearly increasing and yet there is no record of a carer's assessment

On **31 August 2009** weekly welfare checks from the Supporting People provider began following a review in July where JT/MT opt for “option 2” for support which is a basic alarm (24 hour response) and a weekly welfare check. Total of 20-23 minutes per week provided including related administrative tasks

In **December 2009** the GP records a home visit and states that JT “is not losing weight apparently, eating well.” Tests in hospital are suggested to look at possible underlying problems, but “At present they say they would like to wait and see how she does, for bloods in a month to check not worsening.”

In January 2010 the SLT discharged JT from the service, due to two appointments being cancelled. This recurrent theme of service refusal becomes more significant as JT’s condition deteriorates. The decision making of JT and MT needs to be supported by appraising them of the likely consequences of their decisions.

#### **4.2.11 2010**

In **February 2010** it is recorded that MT believed JT had a slight stroke at the weekend. This was not confirmed in GP notes.

In **March 2010** there were concerns because pressure areas were beginning to break down and that JT’s general condition was deteriorating. The social worker was approached to increase care to assist with turning JT; a nimbus mattress was ordered. At the same time there was a report from the DCHNHSFT Infection Prevention and Control Team stating: “We have isolated MRSA from your patient. These resistant strains usually spread more easily than sensitive Staph. Aureus and can persist for long periods. Should your patient require nursing or clinical care in the community, nursing or rest homes, clinics or hospital outpatients, would you please notify the professionals concerned so that they can take appropriate precautions to minimise the risk of spread to other patients. In addition, if the patient requires admission to any hospital it is very important to inform the admitting doctor”. This communication to carers and care settings is not recorded/evidenced anywhere.

**March to September 2010** The IMR provided by the Supporting People provider states that during this period “the majority of visits took place on the doorstep...only saw JT when went into the property to carry out pull cord checks.”

In **May 2010** there was a telephone call to the social worker from the home carer to report that JT was increasingly asking for fluids and food. It was agreed that the home carer would phone the district nurse for information. There is no record on the chronology of such a conversation.

In **June 2010** significant concerns regarding pressure ulcers and weight loss (the latter in both MT and JT) were recorded on GP records and district nursing records and those concerns were recorded as known to the home care service.

The concerns regarding weight and diet had by this point existed for around three years (the GP first referred JT to the dietician in June 2007). The failure of professionals to get together to share information and assess the level of risk around those concerns persisted.

The SWAST IMR states as a general point that “Staff...need to consider challenging the status quo where someone’s condition appears to be unacceptable”. This challenge was absent across agencies.

On 7 **September 2010** The DCC home care record states that “JT reported to be asking for more food and Mr T saying [she]has had enough” Despite the considerable concerns recorded on this issue in June there is no record of multiagency conversations or proactive actions to change the situation. There is no safeguarding adults alert. An alert would be indicated in such circumstances. There needs to be an understanding that neglect would not need to be either proven or intentional for an alert to be necessary. A thorough assessment and action/protection plan was required.

A week later a district nurse visited who had not seen JT for three weeks and noticed how thin she had become.

The GP recorded on a home visit that there was “natural decline” and that: “Husband reports meals that sound proper: Weetabix, cottage pie, cheese, bread etc. Observations: not dehydrated.” This was passed on to the District Nurse. The observations of the district nurse and of the carers do not indicate a “natural decline”. Again the GP conveys a sense of resignation and acceptance where a sense of the degree of risk and a proactive response is required. MT when interviewed as part of this SCR said that this GP had been good to them and occasionally visited when he happened to be in the vicinity. MT conveyed a sense of respect for the GP and gratefulness for what he had done to support them. It may perhaps have been that MT did not perceive the level of risk to JT in part because he trusted the judgement of those such as the GP who had themselves failed to perceive that level of risk.

**On 22 September 2010** there was a review of housing related support and a risk assessment. Increased risk was recorded including potential safeguarding risks because MT was leaving the door open when he went out thus exposing JT to risk. He refused to have a key safe. The Provider might have alerted DCCACS here. It is recorded in the IMR that housing support staff “did not have occasion to raise a safeguarding alert”.

On the **24 September** a joint visit was carried out by a social worker and district nurse. The visit is recorded in DCC case recording: “Saw JT in bed. MT was present. Explained that home care was concerned that JT is losing weight. MT reported that [GP] had visited and advised that JT take Complian which MT stated he was putting in her food. MT said she was losing weight because of not getting out of bed. [Nurse] advised that she would fax the community dental team at DCH as JT has a tooth problem which may be interfering with her eating. Agreed with [nurse] to contact each other again in one month, to review”. There is no record of such a follow up contact between this social worker and nurse taking place.

In **October 2010** the support worker continued to record that there were no problems and all was fine. The District Nurse records refer on 22 October to the fact that JT’s tooth was still painful. She was taking pain killers and MT requested dentist. It is concerning that given the concerns about JT’s weight

loss this issue has not been afforded greater priority. There is nothing in records to suggest that this is followed up.

**November 2010** A GP home visit recorded acute bronchitis; JT hallucinating; urine symptoms. "Getting very frail, discussed hospital, agreed stay at home"

**December 2010** district nurse records "'very little flesh on bones now. Husband says she's eating. To discuss with GP" The GP refers again to the dietician for advice / guidance and on a home visit observes that JT is very thin but that MT reports that she is still eating.

#### **4.2.12 2011**

On **29 January 2011** a GP out of Hours home visit was made to JT. The GP diagnosed possible UTI and described JT in notes as "very cachetic" (extremely malnourished) There is no record to suggest that this rather extreme observation was discussed following the home visit. There was now significant concern regarding JT's weight but still no multiagency discussion. The SWAST IMR observes in relation to the five occasions when clinical care was delivered by the Trust in this case: "None of these contacts resulted in questioning of JT's condition. Even when the GP noted that JT was cachetic this did not apparently prompt further enquiries"

In **March and April** the dietician makes telephone calls to MT. This is three months after the GP referral at which time the concerns about weight loss were significant. Advice was given and a letter to the GP planned as well as a referral for swallowing assessment and a review in 2-3 months. This is inconsistent with the level of concern.

In **April 2011** care provision for JT was transferred from DCC to a new care provider. The new care provider recorded that the transfer had gone well and "MT was happy with the help he was getting" No changes were made to the care plan.

This did not reflect MT's feelings about the new care provider. In the conversation with MT (as part of this review) he was forceful in expressing criticism of the new provider. He described the carers from DCCACS who were initially involved with the care of Mrs JT as "brilliant" but said that the new care agency's carers were "not so good". An example was that Mrs JT's hair was never washed. He said that the DCCACS carers cajoled Mrs JT and sang songs with her so that she felt more able to accept care from them. The new carers, he said, were "a lot different" and JT did not want them there. He said that they were not experienced. He described how two "girls" would come in the morning with another shadowing them to gain experience and the next day the person shadowing would arrive to do the job. On occasions when JT said she didn't want them MT said they did just go away. Mr MT said that they had said to him that he had "just as well care for her himself as he had done it for so long"

In the same month a new social worker took over JT's case as her social worker was on long term sick leave

Such significant changes at a point when levels of concern and risk are high would indicate the need for robust exchange of information, review of needs and risk, robust recording, detailed discussion and clear plans to monitor

areas of concern. Since none of this was evidenced this would surely render the change in personnel risky.

The new care provider's IMR indicates that the information passed to them by DCCACS at the point of handover of care was inadequate.

**June 2011** the SLT visits and discharges JT from the service giving advice and recording that swallowing is most likely compromised due to poor positioning.

There are two episodes of bronchitis during this month and the GP records that JT is "very frail now"

**August 2011** the care agency record that there is "no need to update the care plan. They say in the records that JT has a lot of cradle cap, picking up a theme from June when the records note that JT's hair needs to be washed and they would buy some dry shampoo.

**5 October 2011** Dietician telephoned MT 6 months after the previous contact (when this review had been planned for 2-3 months). There is no response from MT and no record that the dietician tries again soon afterwards.

**October and November 2011** the care provider records indicate that the care package is "still meeting JT needs" In November the care agency records that JT is "increasingly thin but that a nutritionist is coming to see her". This belief that the very presence of an appropriate professional would address issues without the need for follow up or challenge was prevalent in this case. It is highlighted by the ambulance service in their IMR as cited above. The need for follow up and checking on the actions of others was, by this point, urgent.

**December 2011** the dietician again calls MT (almost 3 months after the call when MT was not at home in early October). A record of this call is evident in a letter to JT's GP in which the dietician states "Mr T feels that his wife hasn't lost further weight, although her body weight remains low, and would like to achieve some weight gain. We discussed some additional ways to fortify Mrs T's food and drinks which Mr T is keen to try" The dietician says she will review in 2 to 3 months time.

Is this timescale for review soon enough in view of the level of risk? What is the established risk assessment to support rationing of a service which has lack of resources? Given that MT has to date had little success with implementing advice to fortify foods what actions have been taken to support him in being more successful this time /what evidence is there to suggest this might be successful on this occasion? How far is MT aware of the consequences of further unsuccessful attempts to support JT in gaining weight?

#### **4.2.13 2012**

**5 January 2012** The podiatrist visited commenting in records that JT's "nails very long" The records show that despite records showing that the podiatrist should be calling every 12 weeks the last visit was on July 18 (almost 6 months previously). On the same day MT attended the GP surgery due to concerns about his own weight loss and appetite. Blood tests were taken by

the GP. The implications for MT's own health had been mostly ignored by professionals.

**8 January 2012** MT was taken to hospital by ambulance following a stroke. He called the ambulance himself. The care agency arrived to find JT left alone and referred the situation to the joint Dorset, Bournemouth and Poole Out of Hours Service for Social Care (OOHS). (The South West Ambulance Single Point of Access Service had already alerted the OOHS team around 40 minutes earlier). It is recorded that the SWAST left JT vulnerable and the property unsecured. The care agency are recorded to have visited throughout the morning so that JT was not alone for too long. An interview with MT as part of this review, when he had a neighbour and friend present, produced further information to that in the records. Speaking of the day he was admitted to hospital following a stroke, Mr MT's neighbour said that Mrs T was left on her own. They thought the door was locked and so her brother in law came and pulled the alarm cord in the neighbour's bungalow but was told there was no service on a Sunday.

The neighbour said that Mrs JT was left alone by the care agency carers that day and expressed the view that the care agency should have had a record of numbers of relatives/contacts who they could have called rather than leaving JT alone. Alternatively they could have knocked on the neighbour's door. The neighbour reported that they did not do so. The neighbour and friend said that they were shocked at the state JT was in that day.

The housing provider IMR states that the SWAST triggered the alarm at the home of MT and JT and that Tunstall UK responded. SWAST requested that the operator make a call into the property at hourly intervals to check on JT's welfare until her carer arrived at 7am. This Tunstall did (although it is not part of their role and therefore there are no procedures associated with such a role). The ambulance service left the front door open. The carer is then recorded to have been with JT until 9:06 when she contacted Tunstall to say that she was leaving JT but that JT was sleeping. It is not clear whether JT would have been able to summon assistance and whether she was still in possession of a pendant alarm. There is some uncertainty as to whether JT did respond to the hourly calls made by Tunstall. Checks on pull cords had been carried out regularly and these were in good working order. However on the last occasion when pendant tests were carried out JT was not listed as having an alarm and therefore no check was carried out.

The SWAST IMR states that one of the ambulance crew's first instincts was to take JT as well as MT to hospital but that "Mrs T was definite saying that 'I want to stay here and the carers come in'" It is reported: "The neighbours were all elderly. The availability of family was checked with Mrs T" There is a question as to whether JT understood the consequences of this decision.

It is noted that "The voice box for responding to the call line was outside the bedroom door, and it is unlikely that Mrs T could be heard from that distance" This raised the question of whether there had been an escalation plan in case JT did not respond. Such a plan is not recorded. The crew were unaware of the social services out of hours number and did not have this option stored on their mobile phone.

On receiving the call that JT had been left alone the OOHS team arranged for a care home manager to meet care agency staff at JT's bungalow to assess for admission. Following this assessment it was agreed that JT be admitted to the care home. JT arrived at the care home at around 18:30.

The OOHS state "Care South have been extremely helpful throughout the day ensuring MRS T's needs are met whilst this was being arranged"

**9 January Following JT's admission** to the care home, the manager was concerned about the state that JT was in. He made a safeguarding referral to DCCACS. The care home manager's impressions are recorded on that day as follows: "State of personal hygiene is such that he would not have expected to find in a person with such a comprehensive care package" On the same day the GP visited and his observations of JT are recorded as: "asking for a drink and drank enthusiastically, then given soup by nurse that she gobbled down. Curled up in bed, flexion contractures of left arm and legs, and extension contracture right arm. Hair matted .... Nurses have already washed he once, thick skin and scale on hands, very thin. Said, "hello" when greeted – thought it was 1964 and did not know where she was ... I explained Husband in hospital."

**17 January** DCCACS allocated a social worker to investigate the safeguarding concerns referred by the care home.

**1 February** The dietician reported in an email to the social worker: "Mrs T is bed bound and she appears to be very malnourished and emaciated. I noticed that her hair is very thin and falling out (which could be secondary to her poor nutritional status), her hair also looked very unkempt. Due to her condition we were unable to get an accurate weight for her but I estimate her BMI to be about 15kg/m<sup>2</sup>. [healthy range for BMI is 18.5 to 25] Certainly her appearance raises concerns of neglect by whoever was caring for her (?)."

An email from the GP to the dietician states: "History is of major CVA with severe spasm. The patient has been bed bound for over a decade and for much of the time the husband was the sole carer and did not want support. However, in recent years with the decline in both of their health some external input had been accepted. Mrs T herself was very wary of external input as this aggravated spasm but in recent years we have had the district nurse, home care and more recently dietetic input. In purely medical terms she would be better in a long term nursing home. However with patient choice over the years she has strongly preferred to stay at home, despite her family"

**1 February** A Safeguarding strategy planning meeting took place

**7 February** JT's mental capacity was assessed for the first (and only) time and JT was assessed as "having capacity to express wish to return home"

**21 March 2012** JT was admitted to a nursing home nearer to MT's home. During the interview with MT as part of this review, his friend expressed serious concerns about the conditions they found at the nursing home on visiting JT. The friend said that the smell of urine in the nursing home was

terrible and that Mrs JT had a mattress on the floor when she visited. There was neither cover nor sheets on the mattress and it was dirty and very smelly. The friend asked the manager for a clean bed. This was done by the following day. There are no records to substantiate these concerns.

Mr MT and the friend also said that he felt he needed to go in to the nursing home to feed his wife or she would not eat.

There was however some evidence of improvement during the time JT was living at the nursing home.

**22 March** In a visit to JT in nursing home GP diagnoses “significant dementia” (Just one month after an assessment that JT had capacity)

**May 2012** records indicate that JT is happy in the nursing home

**16 May** Safeguarding case conference is convened. The referral from care home came to DCC on 9 January.

**24 May** DNAR form completed in respect of JT

**29 May 2012** JT died following a stroke. Mr MT said it was a shock to him when his wife died as there had been no conversation that JT had been nearing the end of her life. Neither had her end of life care or treatment been discussed with him.

## **5 Analysis and lessons learned**

**5.1** JT’s situation identifies a number of key areas of practice where lessons must be learned about the way in which local professionals and services work together. These will be evidenced from records and reports and discussed below with reference to relevant literature in order to support learning. There are a number of agency specific issues which are being dealt with by individual agencies. These are outside the scope of this report. They will however appear in action plans associated with IMRs and will be monitored by the Dorset Safeguarding Adults Board. Agencies have shown a high degree of commitment in addressing these concerns. Some of the actions have been completed in advance of this SCR report being published.

The themes outlined below were recurrent and significant *across agencies*. They were identified as follows by the SCR panel:

- Multiagency working
- Risk identification, assessment and management
- Person centred approaches to practice; empowering and including people who use services
- Challenge (within and across organisations and in response to JT and MT decision making)
- Safeguarding Adults practice and processes
- Mental Capacity Act practice
- Working with stroke patients: standards and practice
- Carers’ assessments/support

Within these themes the following issues are particularly pertinent to learning lessons from this review and are highlighted:

- Working with individuals who decline services/treatment/do not attend appointments
- Pressure ulcer care, quality of practice and links with safeguarding and risk assessment
- Commissioning: clarity of role and expectations of providers/monitoring of those expectations
- Recording
- Do not Attempt Resuscitation (DNAR) guidelines and practice

*Evidencing of points made in the text is not exhaustive. The number of entries of examples against a particular agency does not necessarily reflect that this is a greater concern in relation to that agency than to another. This also relates for example to the thoroughness with which IMRs were completed.*

## **5.2 Basic poor practice on the part of individual staff/professionals**

Before summarising key specific issues which contributed to failures in this situation, the SCR panel felt that it is important to acknowledge that some of the failings are attributable to individual basic poor practice. The extent of that poor practice is underlined by the evidence of the extent to which JT had deteriorated by the time she was admitted to a care home in January 2012. Such poor practice included: the recording of concerns with no evidence of active follow up of those concerns; general inadequacy of recording coupled with a failure at times to use appropriate recording tools; statements in records regarding intended actions and then a failure to take those actions; actions not taking place within stated timescales; losing sight of the person: a failure on numerous occasions even to see or speak to JT when she was the subject of care and support (and at times the subject of significant concern); normalising of JT's condition when it was clearly problematic; taking the observations of other professionals at face value without question or any attempt to explore those comments/observations; failure to see obvious signs of deterioration and concern; lack of basic communication across agencies (not speaking to other staff or professionals and not communicating effectively with JT and MT). Many examples of these practice issues are highlighted in section 4. Individual poor practice will be addressed outside of this serious case review process but the need for staff training and supervision to address such basic issues is underlined.

## **5.3 Multiagency working**

**5.3.1** Situations like that of JT where there are ongoing needs and issues over a long period and which require input from a range of agencies demand clarity around aims and responsibilities as well as a key professional coordinating. This was not apparent in this case. Neither practice nor recording afforded clarity across agencies about the nature and the range of concerns; the necessary actions to address these; or who was responsible for those actions. A holistic assessment of the need and risk was never achieved or recorded.

**5.3.2** There was a lack of ownership of the key issues that required action. Professionals repeatedly deferred actions and decision making to others. This included deferring to MT. The Care South IMR states for example: “subsequent interviews with the HCAs [Home Care Assistants] involved and with HCSs [home care supervisors] showed a general opinion that MT was JT’s main carer therefore reporting concerns to him alone was sufficient for he was responsible for ensuring that JT was being cared for adequately. They had also taken comfort from the ad hoc presence of Health professionals over this period in the belief that had there been anything more that could have been done to improve JT’s condition, the Health professionals would have mentioned it or taken action themselves.”

Minutes of the safeguarding case conference in 2012 state: “The community nurses were undertaking “check” visits and they felt that the carers would follow up any concerns. It is acknowledged that it was an assumption that Care South carers would raise the concerns..”

**5.3.3** The lack of a clearly defined “lead” or “coordinator”, responsible for ensuring a clear action plan was set out and followed through, was problematic. At times professionals did refer concerns to one another, for example in September 2010 the DCCACS home carer emailed the social worker to report concerns (from the district nursing team) about JT’s weight loss. The home carer also reported that JT was asking for food and gasping for a drink when they visited. On 5 November the home carer again emailed the social worker and reported to the social worker that “JT was hungry and Mr T had again said that she had had enough and to wait until teatime.” These concerns are not brought into a formal assessment and action plan. They do not provoke a multiagency review of the situation. When in April 2011 the provision of home care is transferred to Care South this communication between the social worker and home carers appears to stop. The social worker was not proactive in stating that he was coordinating a clear care/risk action plan surrounding the presenting needs and risks. There is no review at this point of handover and no clarity about areas of risk and triggers for contacting him. This would have supported safer practice.

**5.3.4** Despite the existence of specific guidelines for professionals on a number of relevant care issues (eg pressure ulcer care, care of stroke patients, safeguarding adults guidance and procedures) which all highlight why and how multiagency/interdisciplinary working should take place little heed was taken of that guidance.

**5.3.5** Some specific examples of the absence in general of a partnership approach are illustrated below. Further examples will be evident in relation to practice relating to working with risk in the life of JT and in relation to safeguarding practice (see 5.4 and 5.7). All of these practice issues are inextricably linked.

| <b>Source of observation</b> | <b>Observation/issue (<i>comments in italics</i>)</b> |
|------------------------------|---|
| Synergy housing IMR          | “Assessment and support plan documents held in        |

|  |  |
|--|--|
| page 22                                  | relation to Mrs T do not contain much detail concerning her specific health and care needs”  |
| Synergy housing IMR page 20              | “there is no evidence in the records that there was any communication between Synergy Housing and other agencies involved in the care of Mrs T”  |
| Synergy housing IMR Page 12              | Care agency starts in July 2007 but Synergy has no record of which agency was the care provider and no contact details on file. ( <i>links to the above question</i> )   |
| DUHFT IMR Pages 11 & 12                  | “The investigation highlighted the need for liaison between agencies. There had been no joint visits between care agency and health”<br>“there appears to be a lack of clarity from the district nurse as to what the visits were for or how often the team were visiting” |
| NHSBPDC IMR 6/3/07                       | GP refers issues to Adult Social Care but no follow up of this recorded. <i>Next contact not until 22/5/07</i>   |
| NHSBPDC IMR page 11                      | It is “unclear if there was any multiagency meeting or case conference to enable professional liaison, consideration of JT’s vulnerability and agree an overall care plan”   |
| NHSBPDC IMR P13                          | “JT discussed at weekly MDT meetings” <i>There was no evidence that this supported multi disciplinary working.</i>   |
| South West Ambulance Service IMR page 12 | <i>refers to level of challenge required</i> “staff need to consider challenging the status quo where someone ‘s condition appears to be unacceptable”   |

**5.3.6** The minutes of the safeguarding case conference, May 2012 state “MB pointed out that all services involved thought that someone else would deal with the concerns. DCC reviews are a snapshot in time and DCC rely heavily on all professionals visiting daily to flag up any concerns to Social Services and recognising safeguarding issues”. There were however no meetings or conversations evidenced in the records which might have served to underline the necessity for such communications with DCCACS or any guidance to those visiting JT regularly as to the issues that they should pay particular attention to. The same minutes identify the absence of reviews by DCCACS where they might have been active in seeking out information from those daily contacts. In summary those minutes state “It was noted that multiple agencies involved with the care of JT have not worked together”

**5.3.7** An SCR into the murder of Gemma Hayter by the Warwickshire Safeguarding Adults Partnership <sup>1</sup> underlines the importance of front line care staff within the multi disciplinary team: “some detailed information about Gemma’s day to day life was held by front line support staff, who rarely have the opportunity to share that information. Current systems are often targeted

<sup>1</sup> Serious case review; the murder of Gemma Hayter, Warwickshire Safeguarding Adults Partnership, 9th August 2010

at public sector procedures when in fact direct support staff from smaller voluntary organisations are often the ones who will pick up the low level triggers.” The case of JT serves to underline the importance of statutory agencies facilitating and seeking out information from front line carers to inform assessment, monitoring and review processes. It underlines in turn the responsibilities of front line carers in alerting concerns.

## **5.4 Identification, assessment and management of risk**

**5.4.1** The NHSBPDC IMR records: “The GP records document a gradual deterioration in JT’s condition over a long period of time. There is no singular event that can be identified as a trigger which precipitated a decline in health. Instead there is a combination of physical and mental ill health episodes over a prolonged period”. In such circumstances identification of areas of risk and allocation of responsibility for monitoring and addressing these is crucial. This structured approach was absent throughout including within the safeguarding process, despite local safeguarding adults procedures making specific reference to practice in the context of risk.<sup>2</sup>

**5.4.2** Examples illustrating this issue include a Synergy Housing record on 22/9/11 that a risk assessment and support plan took place. There do not appear to be any suggested/intended actions arising from this or any liaison with other agencies.

DUHFT observes in its IMR that the frequency of visits by district nurses appears to bear no relation to the level of risk/concern.

In the Care South IMR (page 14) weight/general appearance/hygiene issues and concerns are noted but nothing happens as a result of those concerns. Concerns were not passed on within or outside the agency and reviews did not identify that needs were not being met.

The Dorset County Hospital IMR identifies that the dietician’s advice was given over the phone and not in a timely manner (2011). It appears that the concerns over nutrition were not brought into a broader holistic assessment. For example a Braden assessment<sup>3</sup>, would have set these issues in the context of pressure ulcer concerns.

**5.4.3** A number of assessment recording tools would have supported this aspect of practice but these were not used consistently or as part of a holistic assessment of risk. This is evidenced in the DUHFT IMR which refers to a range of tools and standard recording formats (including: Waterlow score; Braden assessment tool; wound treatment chart; body map; MUST (Malnutrition Universal Screening Tool) score) which are not utilised as set out in organisational guidance and procedures and which, when used are not reviewed. The poor quality of recording was in general an obstacle to effective risk work. Recording is integral to good practice and is particularly important in the context of risk management where records support:

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<sup>2</sup> Bournemouth, Dorset and Poole Multi-Agency Safeguarding Adults Policy and Procedures, July 2011

<sup>3</sup>

[http://www.healthcareimprovementscotland.org/programmes/patient\\_safety/tissue\\_viability\\_resources/braden\\_risk\\_assessment\\_tool.aspx](http://www.healthcareimprovementscotland.org/programmes/patient_safety/tissue_viability_resources/braden_risk_assessment_tool.aspx)

formulation of a logical and informed view of the potential impact of and likelihood of harms occurring; informed discussion with the adult, their carers, and staff / professionals involved; inclusion of the adult and their carers in plans to manage risks; identification of any conflicts of opinion; clarification of lines of accountability; supervision of staff involved in managing risk; effective review of actions (checking back on the effectiveness of decisions and plans to mitigate risks).

**5.4.4** Informal comments made by respected colleagues/professionals often carried weight in respect of the perceived level of risk. For example in September 2003 the GP in liaison with the hospital says that JT's situation is "unchanged for many years" (displaying a level of resignation) and refers to a "natural decline" in September 2010, the DCCACS carers advise Care South, on handover of JT's care to them not to be shocked 'as this was what she was like'. These comments are taken at face value even though training and experience would indicate that a proactive approach is necessary. The lack of multiagency discussion, case conference, and risk assessment reduced the opportunity for challenge or clarification of these observations which served to normalise JT's condition in the eyes of some of the key players. As the SWAST IMR observed "staff need to consider challenging the status quo where someone's condition appears to be unacceptable". This can be more difficult for front line carers when professionals from statutory agencies are making such statements. A clear risk framework can empower staff with the information on which to base those challenges.

**5.4.5** Perhaps the same issue played out with MT. His perception may well have been that with all the Health and Social Care staff going in to JT, surely they would have taken any necessary action.

**5.4.6** In the context of risk, reviews were a significant issue. Reviews often did not pick up on risks that had been identified within single agencies. DCC failed to coordinate any review across agencies so that single agency reviews did not feed into the pattern of risk that was emerging across agencies. There was often an absence of any review of decisions/actions. Where a review took place there was a lack of clarity as to what was being reviewed because of the poor quality of assessments. The DUHFT IMR (page 12) acknowledges for example that "there was a lack of clarity of purpose of district nurse visits" DUHFT also acknowledges the lack of active review and the "need for joint establishing of review dates between health and social care" This would need to be in the light of the level of risk.

**5.4.7** There are numerous examples of the inadequacy or absence of reviews. For example Synergy Housing IMR Page 12 records the review of care plan 14/5/08. This records JT as "quite content with her lifestyle" Was JT aware of the alternatives? Was Synergy Housing undertaking the review of its housing support in the context of the range of issues presented to a range of agencies by JT's situation? Was the review measuring against a clear initial assessment?

The DH guidance “Prioritising need in the context of *Putting People First: A whole system approach to eligibility for social care*”, Guidance on Eligibility Criteria for Adult Social Care, England, DH, 2010 offers valuable guidance on reviews which is relevant across agencies as follows:

- Establish the extent to which the risks identified in the risk assessment are being reduced via the arrangements set out in the action plan
- Consider whether the needs and circumstances of the person and/or their carer(s) have changed and how this impacts on the level of risk;
- Support people to themselves review the risk decisions and how arrangements to manage the risks might need to be amended over time;
- Demonstrate a partnership approach across agencies and with the service user as well as their family and friends if they choose;
- Ensure that the risk assessment recorded in the care plan is up to date and takes account of new information / developments and identify any further action that needs to be taken to address issues relating to the risk;
- Support people to strengthen their informal support networks;
- A written record of the results of these considerations should be kept and shared with the person.

This would have assisted considerably in the case of Mrs JT.

**5.4.8** There are a number of themes in relation to failings in respect of identification, assessment and management of risk:

- Lack of clarity in identification, assessment and management of risk.
- Tendency to react to crises/events rather than being proactive in managing and acting upon areas of risk
- Action plans/review dates not in evidence. Risks are at times randomly recorded with no associated recommendations for actions to address them
- Inadequacy of reviews/absence of reviews
- The rationale for decision making was not clear especially where JT or MT declined services or treatment. This failed to make reference to mental capacity issues
- A tendency for assessments and activity not to “connect” with the reality or the breadth of concerns within the situation
- Assessments of the situation at intervals do not seem to take on board and track the accumulating range of risks or even bring all of them together at any one time. Nowhere are all the risks systematically documented in one place and discussed
- The heightening of the risk across time is not recorded or appreciated. The weight of JT and her general condition on admission to Cheverells Care Home bear this out
- There was at times a complete lack of awareness on the part of individual agencies as to which other agencies were involved and why. Indeed some agencies seemed unclear as to their own role
- There was a tendency to record information in relation to risk issues and on occasions to advise other agencies of issues and required actions. However there was a need to follow through on these alerts and to challenge colleagues within and across agencies when anticipated or promised actions were not taken

- Whether or not situations fall within the remit of safeguarding procedures there needs to be clarity as to how risk is assessed and managed and a willingness and accepted practice which facilitates meeting across agencies to discuss this.
- Issues with the quality of recording which might have supported more effective working with risk

**5.4.9 Commissioning of services** has a crucial role in underlining the importance of robust multiagency working within situations of risk.

**5.4.9.1** Regulations; contracts; service specifications can and do underline these issues and must be robustly monitored. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 states that service provision in relation to multiagency work in situations involving risk:

“Will lead effectively to manage risk (outcome 6) so that people who use services can be confident that when more than one service, team, individual or agency is involved at the same time in their care, treatment and support, or are planned to be in the future, the services provided are organised so that:

- All those involved understand which service has the coordinating role and *who is responsible for each element of care, treatment and support* to be delivered.
- Each service, team, individual or agency is involved when the plan of care is reviewed or brought up to date.
- Where appropriate all those involved discuss together the plan of care for the person who uses services.”

**5.4.9.2** The standards in the Quality Assessment Framework for Housing providers also reflect the need for a multiagency perspective. Standards 1 and 2 refer to “needs and risk assessments take into account the views of other services as appropriate” and “the service is aware of and seeks to take into account other care and support service provided”<sup>4</sup>

**5.4.9.3** Providers of services and others involved in the care of JT would have done well to heed this advice. It is important that such aspects of regulatory requirements are monitored in respect of contracts. This begins with clarity as to roles and responsibilities and required actions (and what to do if this needs to change). Were agencies clear *who was responsible for each element of care, treatment and support*? For example what were the aims and expectations of the housing support? What is the role of routine visits and welfare checks? How clear are these? Should Synergy Housing have notified DCCACS that they were often not able to gain access (and at time perhaps not spending the allocated time with JT)? (referred to on page 10 of Synergy IMR). How far were Care South able to fulfil their role and spend the allocated time with JT? Agencies must be clear as to their own contribution in the assessment and addressing of needs and risks.

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<sup>4</sup> “Using the quality assessment framework”, Communities and Local Government, February 2009

**5.4.9.4** The service specification for provision of sheltered housing services, DCCACS includes the following. This also needs to be monitored as compliance with it would have supported JT's situation:

*"The provider shall maintain an awareness of the services available to service users both for immediate referral and for long term stability and make appropriate referrals. Service users shall be signposted to services as appropriate..."*

*The Purchaser has an expectation that the Provider will develop positive working partnerships with a wide range of local support agencies...*

*Access to healthcare: The Provider will ensure that staff are inducted and trained to observe medical and health needs and act accordingly...*

*Medication: Where there is a concern that a service user requires medical advice or help; the service user shall be actively encouraged to seek it. In serious situations, the Provider may need to make the referral."*

**5.4.10 Pressure Ulcers** presented a specific aspect of the risk to JT.

**5.4.10.1** The first manifestation of this issue appears in the records in 2007.

The Care South IMR (Page 13) identifies that at the point of handover to them from DCC carers it was known that JT was at risk of pressure ulcers but there was no clear assessment or action plan given to Care South. There should have been a clear partnership arrangement to manage this issue between carers, district nurses and others, *including JT and MT*. The RCN guidelines, 2005,<sup>5</sup> advocate a collaborative multiagency approach to pressure ulcer care. They refer too to the need for person centred care to involve and include patients and carers in decision making and in management of pressure ulcers; carers and patients should be informed as to potential risks/complications and when and how to seek help. There is specific guidance available to give to carers and service users. There is no evidence of such support to JT and MT or of their informed active involvement in managing this aspect of the risk.

The DUHFT IMR draws attention to the fact that there were never joint visits arranged with carers. The Care South IMR identifies that assumptions were made that because Health were involved they would be taking necessary action. Because there was no formal plan these informal impressions were perpetuated.

**5.4.10.2** There is a lack of accurate and detailed recording in relation to pressure ulcers in the care records. There was only one formal Waterlow<sup>1</sup> assessment during the period under review.

**5.4.10.3** Links between pressure ulcers and the issue of neglect/safeguarding were not made. However local guidance has now been issued in Dorset to ensure that those links are made.

## **5.5 Person centred approaches to practice; empowering and including people who use services and their carers**

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<sup>5</sup> *The management of pressure ulcers in primary and secondary care A Clinical Practice Guideline, RCN, 2005*

**5.5.1** In the context of managing risk as well as more broadly the issue of the **level of involvement and participation of JT and MT** (or rather the lack of it), in terms of understanding of the issues, assessment of the risk and in decision making and taking action is significant. The importance of such involvement is underlined repeatedly in the available literature “A key part of risk assessment is establishing both the individual’s perception of and attitude towards specific risks” Scourfield, P, 2010<sup>6</sup>.

For example, it has already been highlighted above that national guidelines on pressure ulcer care advocate a person centred approach and the importance of informing and involving patients and carers in pressure ulcer care. This was not the case for JT and MT. Likewise national guidance on working with stroke patients underlines the importance of those who have had strokes and their carers being involved, informed and included (see section 5.9). Again there was an absence of such involvement.

**5.5.2** Fundamentally, there was no outline in the records of any single agency giving a full picture of the biography and family composition of JT and MT. The nearest to this was during the assessments made by DCCACS in July 1995. The “building blocks” were not being put in place to form a relationship with JT and MT which would engender a level of trust and cooperation. This review has pieced together information from across agencies to understand the family composition and the chronology of significant events in the family and for JT. There was for example little attempt to establish the impact of the deaths of JT’s sons on her and on MT. It is at these points that opportunities might have arisen to engage more closely with them.

**5.5.3** There are glimpses of good person centred practice, for example MT when interviewed as part of this review said that the DCCACS home carers did try to engage with JT and her interests, singing songs with her whilst they carried out care tasks which she found difficult.

Braye, Orr and Preston-Shoot, 2011<sup>7</sup> refer to “real social work” in their paper on self-neglect. They concluded that self-neglect cases “required interventions founded on basic social work skills. Complex case management, which these cases often required, has to be accompanied with skilled professional practice, including an emphasis on relationships over time, trust building and ongoing assessments. A comment from a member of one of the focus groups which informed this research said: “these cases...are classically the ones that should be actively case managed on an ongoing basis and shouldn’t be this ‘target- assess- review- close’ under the care management process.....It should be about monitoring these vulnerable people that perhaps are not keen on engaging with us and don’t really want any service provision from us...it’s about switching it round a bit and considering that old fashioned concept of social worker time being a service

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<sup>6</sup> Reflections on the SCR of a female adult (JK), Journal of Adult Protection vol.12 issue 4, Nov 2010 page 25

<sup>7</sup> Braye,S; Orr,D; Preston-Shoot,M; SCIE report 44, (2011), Self-neglect and adult safeguarding: findings from research;

and a resource as well that we could use.” These observations are pertinent to practice across agencies in the case of JT.

**5.5.4** This emphasis on relationship, building trust, assessing and re-assessing over time should have been at the heart of agencies’ working with JT and MT especially in view of the reluctance to accept support. Agencies appeared to feel more comfortable with an approach which focussed on “services”; “solutions”; specific “actions” of a more tangible nature (such as resolving housing issues; adaptations to the bathroom; benefits advice).

For example in April/May 2002 an assessment took place by a DCCACS community care officer. The letter to the GP following that assessment states: “Mrs JT declined suggestions of placement at ...Day centre and ....rehabilitation centre” This is indicative of that kind of approach which seeks “service solutions” rather than carrying out a person centred assessment to find out what the issues and needs are from the individual’s perspective and to support them in finding ways of addressing those needs and wishes in ways that suit them *and manage the risks*. The DH guidance on risk, 2007 contains a *supported decision tool* to guide staff/professionals in having such person centred dialogue with those who use services. Agencies involved in working with JT would do well to make this available to staff.<sup>8</sup>

**5.5.5** The records in relation to JT contain frequent references to occasions when assessments were carried out in relation to JT but via communication with MT and without any involvement of JT. For example, the housing support worker carries out some “visits” on the doorstep (referred to in IMR March to September 2010); professionals fail to see JT because she is in bed sleeping. The dietician for example on a visit on 14 July 2007 records: “I chatted to husband then met patient at end. She was lying in bed watching TV” Further dietician assessments took place on the telephone via MT. A joint visit by the district nurse and the social worker took place on 24 September 2010. The record states: “JT was seen in bed. Mr T was present” The conversation seems to be between the professionals and MT with little or no involvement with JT. Given that one of the key reasons for the visit is weight loss it is surprising that the district nurse (at least) does not see JT out of bed.

**5.5.6** Practice in relation to the issue of service user “choice” was problematic. The response to choices which render individuals vulnerable and at risk needs to engage with the reasons for that choice alongside the level of risk and the individual’s capacity to understand the consequences of the choice. In the case of JT such a robust and analytical approach was absent. There are numerous examples of professionals going along with choices: not to go into hospital; not to accept aspects of the care regime; not to accept care or treatment offered where those choices were clearly problematic and clearly compromised JT’s health and wellbeing. In those circumstances rather than

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<sup>8</sup> DH 2007 “Independence, choice and risk: a guide to best practice in supported decision making”

simply acceding to JT's choice those involved should have engaged in dialogue and assessment and possible actions.

**5.5.7** Practice in working with individuals who decline support and treatment cannot be based on generalised assumptions and must respond to personal circumstances, level of risk, and any issues in relation to mental capacity where there are indicators (as there were in this case) that these are a relevant and a necessary consideration. These issues in relation to Mental Capacity will be discussed in **5.8** below.

## **5.6 Challenge (within and across organisations and in response to JT and MT decision making)**

**5.6.1** Professionals and care workers repeatedly took at face value the opinions of others in respect of JT rather than relying on their own knowledge, expertise and assessment of the situation. The SWAST IMR comments: "staff need to consider challenging the status quo where someone's condition appears unacceptable". This was an observation which might have been made in any of the IMRs. It applied to all those involved. There was little if any challenge of a situation where there should have been considerable weight of concern about the extent of poor practice and the emerging outcomes. The condition of JT when she was admitted to the care home in January 2012 underlines the considerable extent of poor practice in this respect.

**5.6.2** The Care South IMR records that during the handover from DCCACS carers to Care South, Care South were "told by the DCC in house team, that they should not be shocked by the condition of JT 'as this was what she was like'. "She had very matted hair, was under weight and had poor skin condition." Likewise the GP made similar remarks which indicated a level of resignation to JT's condition (including in October 2002; September 2003 and September 2010). The lack of multiagency discussion, case conference, and risk assessment reduced the opportunity for challenge or clarification of these observations which served to normalise JT's condition in the eyes of some of the key players.

**5.6.3** The Care South IMR acknowledges that staff failed to take account of the training they had received in safeguarding adults which should have led them to raise challenges. They failed to raise alerts when this would have been appropriate. They record that DCC and Health professionals conveyed an acceptance of JT's condition and an impression that everything possible was being done for JT. They should have challenged these views and alerted DCCACS to issues that constituted safeguarding alerts.

**5.6.4** Had professionals involved and empowered MT to a much greater extent and given him information as to what he should expect of each of the services attending to JT's health and support needs this might have enabled him to challenge the status quo.

**5.6.5** The lack of actions as a result of communication of concerns in relation to JT was an issue. When staff refer individuals to professionals for services they must check back and challenge where nothing appears to change as a result. This did not happen in the case of JT. This same failing is expressed in the SCR in relation to the murder of Steven Hoskin in Cornwall in 2007: "Communication is an interactive process. Information senders need to know that their information has been received and should confirm to what use it has been put. It is not enough to send or 'leave' a message. This leads to the error of assuming that information that has been passed on or shared will be 'known' by recipients."<sup>9</sup>

**5.6.6** There were many occasions when professionals should have both informed and challenged decision making by JT and MT particularly when that decision making carried significant risk. For example in an email to a dietician, the GP observes of JT "In purely medical terms she would be better in a long term nursing home. However with patient choice over the years she has strongly preferred to stay at home" There is little evidence of professionals sitting down with MT and JT to discuss the alternatives and the potential consequences of those choices. There are recurrent examples of necessary care not being given because of reluctance on the part of JT. For example in section 4.2.8 (above) it is noted that in June 2007 a bed bath is given "as far as JT would tolerate". It is observed that JT was controlling the level of care and that it is unclear as to the extent to which this is challenged and whether the consequences of this are explained to or understood by her. There is no record of such challenge taking place.

## **5.7 Safeguarding adults process and practice**

### **5.7.1 The Bournemouth, Dorset and Poole Multi-Agency Safeguarding Adults**

Policy and Procedures <sup>3</sup> **are clear about the responsibilities of all staff to raise alerts:**

"Raising an alert/ concern refers to the duty of all employees of any service involved with adults at risk immediately to inform the relevant manager and the Safeguarding Adult contact point of a concern that an adult at risk: has been harmed or neglected or is being harmed or neglected or is at risk of being harmed or neglected. Is suspected of being harmed or neglected."

**5.7.2** However this is not always reflected in practice as recorded in the case of JT. The following illustrate this point:

The DUHFT IMR states (page 11) "There is no evidence of any disclosure by JT within the nursing records". This implies that such a disclosure is necessary in order for an alert to be necessary.

The Care South IMR, as above in paragraph 5.6.3 acknowledges a failure to make appropriate alerts to Adult Social Care despite safeguarding training having taken place It states that the 'acceptance' of JT's condition by DCC and Health professionals "led staff to believe that all was being done for her

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<sup>9</sup> The murder of Steven Hoskin, a serious case review, Margaret Flynn, Cornwall 2007

that was possible and hence they ignored safeguarding training” Whether or not a member of staff understands that steps are being taken outside of the safeguarding process to address apparent safeguarding issues that situation must still be alerted to DCCACS so that all aspects can be addressed in a holistic way.

The dietician who had some involvement seems unaware of the safeguarding procedures.

The Housing support provider states that there is “No evidence/reports or information from other agencies involved in the care of [JT] that there were any safeguarding issues” (page 24 IMR). This raises the question of whether the housing provider is clear as to what constitutes an “alert” as outlined in the local safeguarding adults procedures. As above all agencies have a duty to report concerns where an adult “Has been harmed or neglected or is being harmed or neglected or is at risk of being harmed or neglected or is suspected of being harmed or neglected”. The incident regarding the door would leave JT “at risk of being harmed or neglected”. Some of the concerns the housing provider had about JT would have at least constituted a risk of neglect. It is a common misconception that the “alerter” needs to have evidence of abuse or neglect before referring. This is not the case. A concern of the possibility is sufficient.

**5.7.3** The NHSBPDC IMR states that it is “unclear whether abuse or neglect issues were considered” or “whether primary care staff were working to multiagency safeguarding adults policies from July 2011 until JT’s death.” This IMR acknowledges: “Training is required to ensure there is understanding when quality of care or sub-optimal care meets the threshold of adult safeguarding and primary care’s responsibilities to the processes and reporting appropriately” This echoes a finding in an SCR carried out by Warwickshire Safeguarding Adults Board into the murder of Gemma Hayter <sup>2</sup> : “The Adult Safeguarding process and the threshold of significant harm relies on the presence of a single large trigger and fails to identify people at risk ...where the evidence is through a larger number of low level triggers” This is particularly an issue when those “low level triggers” are distributed across a range of agencies so that no one agency has the full picture.

**5.7.4** The effect of the above practice is that repeatedly, issues which should have led to agencies raising safeguarding alerts with DCCACS, were not referred to them. Examples of this are:

**Throughout 2007:** references to issues such as very long finger nails; pressure ulcers developing (right hip, sacrum, right ear lobe, left toe); JT generally unwell and losing weight and yet in receipt of care

**In 2009 and 2010** these concerns escalated and included personal hygiene issues. For example on 17 July 2009 a support worker visited: “Gill not well, can hardly talk, not eating or drinking well” MT calls GP. Possible UTI and acute bronchitis are diagnosed. . “Keen not to go to hospital, husband wants her to stay at home”. JT stays at home.

**7 September 2010:** DCC home care case notes record: “JT reported to be asking for more food and Mr T saying has had enough”

**5 November 2010:** Home carer reported to social worker that “JT was hungry and Mr T had again said that she had had enough and to wait until teatime.”

**29 January 2011:** An out of hours GP visited and noted that JT was very cachetic. This is an observation of an extreme condition and one that might reasonably be expected to provoke multiagency discussion regarding the level of risk and potentially a safeguarding referral given the circumstances.

**22 September 2011:** The support worker identified safety issues in that MT was leaving the door open when he went shopping and refused to have a key safe fitted. The safeguarding risks inherent in this are noted in the Synergy Housing IMR (page 14) but not reported.

**9 January 2012:** When JT is admitted to a care home the manager makes a safeguarding referral because “State of personal hygiene is such that he would not have expected to find in a person with such a comprehensive care package” This is a response that might have been expected much earlier in the period reviewed.

**5.7.5** JT was under the care of a range of professionals and of her husband. It was surprising therefore that her condition deteriorated to such an extent. As the SWAST IMR states, professionals should have been willing to challenge the status quo. The safeguarding process would have been an appropriate route through which to raise that challenge.

**5.7.6** On 9 January 2012 DCCACS was alerted to safeguarding concerns in respect of JT by the care home manager. However the **practice which followed was not consistent with local policy and procedures.**

**5.7.6.1** A strategy planning meeting was convened on 1 February 2012 (outside of the timescale for convening a meeting). The purpose of a strategy planning meeting is given in local procedures as: “This is a professional planning meeting. Its purpose is to address immediate risks, evaluate the information received and decide if an investigation should be undertaken and the process to be followed. If so, it will agree the terms of reference for the investigation...It is convened by the Investigating Manager within maximum 7 calendar days of the alert. The timescale must be commensurate with the degree of risk.”

**5.7.6.2** The minutes of the meeting fail to reflect the guidance for conduct of such a meeting as set out in the procedures. These state (paragraph 3.5.1.1 of the procedures) that the meeting must include: gaining the consent of the adult at risk; ascertaining their wishes; ascertaining the mental capacity of the individual; considering how the individual’s family might be involved and informed; undertaking a risk assessment; agreeing timescales and details of investigation; clearly recording a decision as to whether the concerns are founded and whether to investigate. This requires that agencies and professionals carry out enquiries on some of these questions in order to bring sufficient information on pertinent issues to the meeting. At least some of those agencies were unprepared because they had received insufficient information prior to the meeting(for example the ambulance service). The meeting should include “the manager of a provider service unless they are

named in the allegation, in which case advice should be sought from the Compliance Inspector for that service regarding who should attend.” Care South were not invited to the meeting. This meant that significant information was unavailable. There is no indication that JT or MT knew of the meeting. The minutes consisted of ad hoc information sharing, which was not organised into a risk assessment. The action plan consisted of contacting a range of professionals who had not been represented at the meeting, a plan for DCCACS to visit Care South and a commitment from DUHFT to complete a report. This clearly does not fulfil the stated purpose and outline of such a meeting.

**5.7.6.3** There was a significant delay before the case conference took place on 16 May 2012. Its considerations should, according to the procedures (paragraph 3. ) have included: the details of the case and the information contained in the investigator’s report(s); the evidence and, if substantiated, a plan of what action is indicated (a safeguarding plan); the outcomes the adult at risk wishes to achieve; a decision about the levels of current risks and a judgement about any likely future risks; agreement of individual responsibilities for taking actions and timescales; agreement on how the safeguarding plan will be reviewed and monitored.

**5.7.6.4** In fact the Conference consisted of an outline of the allegations (which were of neglect in relation to: personal care provision, nutrition and hydration, hair/oral/foot care, skin wounds/skin condition, continence needs). The agencies present then shared information on the concerns in an ad hoc way. This was not organised into a risk assessment which would have considered all aspects of the case and where the responsibility for each concern lay. On the basis of information shared there was a decision that the “block” on Care South “would now be reduced to a caution dependent on the action plan” This decision is made it appears despite DCC not having received the entire action plan (one of the actions is for Care South to send the action plan to DCC) and on the basis of three specific actions (two in respect of training of staff). Whilst it was acknowledged that all agencies had failed to work together there was substantial focus on Care South in the meeting and few actions for other agencies except that the ambulance service and Health service were to provide reports and that Health staff would undertake safeguarding training. It is not made clear what is meant by “the Health Service”. There was an acknowledgment that DCC needs to undertake reviews. The date for the case conference review was to be confirmed. This appears never to have taken place. There can be no certainty that all of the issues have been addressed.

**5.7.6.5** In summary the meetings failed to deliver on expectations set out in the procedures. There was a lack of objective consideration of the facts within a clear risk assessment and risk management framework. This led to

- Lack of a focus on the range of concerns and bringing these together in an assessment and then a protection plan
- Lack of facilitation of discussion bringing together the knowledge and expertise of all agencies

- Lack of accountability for carrying through suggested actions

There needed to be greater focus on the failure across agencies to take ownership of the presenting needs and risks and to coordinate efforts.

**5.7.7** There are a number of specific issues in respect of safeguarding highlighted by this case which need to be addressed and or underlined:

- A need for greater emphasis on and understanding of neglect and its place in safeguarding procedures and practice and in particular, situations where there is a cumulative pattern of deterioration rather than tangible and significant incidents.
- Clarity across Agencies as to what constitutes an “alert”
- A focus on disseminating and integrating into practice recent local guidance on the connections between pressure ulcers and safeguarding and integrating this into local safeguarding adults procedures.
- Procedural issues around the taking of photographs in safeguarding investigations including the need to date those documents.
- The need for clarity and recording around mental capacity issues
- A focus on the extent to which safeguarding training is effective and makes a difference in practice
- Timescales for meetings
- A commitment to involving provider services in safeguarding meetings except in clearly stated exceptions
- Ensuring that case conference reviews take place and that safeguarding investigations are properly concluded with all actions completed.
- A need for a prescribed format for recording of risk assessments/protection plans within the safeguarding process.

**5.7.8** Regulatory requirements on safeguarding adults are clear (for example the Supporting People Quality Assurance Framework and outcomes 4 and 7 in the Health and Social Care Act regulations) and form a significant part of contract requirements. The local safeguarding procedures (sections 4.6 and 4.7.1) in Dorset also refer to requirements of providers and commissioners in respect of safeguarding. Contract monitoring must be robust on these fundamental issues against which contracts will be monitored.

## **5.8 Mental Capacity Act: issues and practice**

**5.8.1** The failure to assess JT’s capacity and the failure to work consistently within the principles of the MCA were issues for all agencies involved. Those principles and consideration of assessment of capacity were central in the case of JT in a number of contexts: refusal of care; refusal of medical examination; refusal of admission to hospital.

**5.8.2** Often opinions were expressed about JT’s mental capacity but were not followed up with formal MCA compliant assessment. Action (or inaction) was

then based upon those uninformed judgements. A clear example of this is recorded on the DNAR (Do not attempt resuscitation) form completed by the GP on 24 May 2012 (see 5.8.9 ).

**5.8.3** The principle of presumption of capacity seemed to be followed without question. JT's decision making was clearly problematic and she made a number of decisions which left her vulnerable. This should have led to questions about JT's mental capacity rather than those refusals being constantly taken on face value. Keywood, K, 2010 underlines the following in this respect: "Professionals can and should consider the reasoning abilities of those who benefit from the statutory presumption of capacity. Partly because it does not necessarily respect autonomy to make no inquiry of a person's decision-making abilities but equally significantly, an approach which does not ask questions of a person's presumed competent wishes can result in profound self-neglect"<sup>10</sup> There were occasions where these principles should have come into play. On 17 July 2009 when the support worker visited: "Gill not well, can hardly talk, not eating or drinking well" MT calls GP. Possible UTI and acute bronchitis is diagnosed. "Keen not to go to hospital, husband wants her to stay at home". JT stays at home.

**5.8.4** The **IMRs of agencies involved with JT reflect a lack of engagement with the principles and practice guidance set out in the Mental Capacity Act and in the Code of Practice.** For example: the NHSBPDC IMR (Page 12) states that it was "unclear at what point JT's mental condition deteriorated. This deterioration was recorded as JT having dementia on admission to both residential homes" and "Latterly it is not clear when JT has significant cognitive impairment that there were documented capacity assessments or "Best Interests" decisions made in line with the MCA 2005, by GPs or the Primary Care Teams". This lack of documented assessment, it acknowledged, "raised questions about the appropriateness of some decisions made by MT on her behalf regarding care". In fact it also raised questions about the decisions of professionals regarding care or the lack of it in some instances. For example, lack of examination in hospital (12/9/03) because JT was concerned this might bring on spasms; lack of consent to have care/respite care in the face of significant stress in the caring role for MT; agreement on more than one occasion by professionals (including the GP and ambulance crew) that JT would not be conveyed to hospital. The Out of hours service for Social Care (OOHS) also refer to the lack of MCA compliant verification of JT's capacity: "It was identified at the point of referral that [JT] was not able to communicate but was able to understand. This appears to have been taken by the Out of Hours Officer as fact without any further determination of her ability to communicate or her mental capacity" The Synergy Housing IMR (Page 20) acknowledges that there was no formal assessment of capacity but expresses an opinion about lack of capacity in JT's last year of life. The Care South IMR refers indirectly to this issue stating that JT "also made it clear that she did not like being touched or moved-adherence to these wishes

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<sup>10</sup> Keywood, K, 2010, Medical Law Review Case Comment: Vulnerable adults, mental capacity and social care refusal

may have inadvertently contributed to her condition.” There is no linking of this statement with the issue of JT’s mental capacity to make an informed decision on acceptance of care. There should have been.

Similarly the SWAST acknowledge their shortcomings on this issue in relation to refusal of examination by JT (page 6, IMR), as does the NHSFTIMR and the DUHFT IMR.

DCCACS recorded one mental capacity assessment in February 2012 but they too acknowledge the need for the following: “Greater consideration in capacity assessments of not only whether someone is able to make a decision but whether they are able to understand the implication of the decision. Where capacity issues need to be assessed this should be recorded on appropriate mental capacity act form with clarity about what decision the capacity is being assessed against” In fact, although recorded on such a form the February 2012 assessment lacked such clarity. It simply records the decision as “care needs.” This is a broad area rather than a specific decision. The conclusion is also muddled: “I have assessed [JT] as having capacity however, I do not feel she has insight into the evident lack of personal hygiene, poor nutrition/dehydration or the pressure sores she was suffering with on admission to the ...care home” This said the assessment records that “yes” JT can use or weigh the information to make a decision (based on degree of awareness and insight, evidence of reasoning processes).. Failure on this point should lead to a conclusion that JT lacked capacity on the specific issue.

**5.8.5** This issue relates back to an earlier issue; that of the lack of cognitive/psychological assessment for JT on suffering the two strokes. Whilst it has been reported by health professionals involved in this SCR, that psychological testing may not have been prominent in the treatment of stroke patients in the 1990s it was certainly not unheard of and, in someone of JT’s age, might helpfully have been considered. As a result of this omission there was a lack of awareness throughout of the specific impairments caused by the damage to her brain. A presentation at Birmingham University concerned with the Mental Capacity Act and stroke patients in the context of research consent suggests that when judging capacity in stroke patients a “careful, integrative assessment of cognition must be done, looking at the spectrum of impairment present, and the potential impact of this on specific decision-making”<sup>11</sup>

**5.8.6** The question of whether an individual lacks understanding of the potential consequences of decisions is complex. It requires that professionals practice within the five core principles of the Mental Capacity Act. Clearly JT at least needed under principle 2 of The Act to be given sufficient support and information to assist her insight and understanding of all the relevant issues. Dorset’s safeguarding procedures are clear on this point stating that: *“Professionals may need to support people in understanding that decisions need to be made and why, what the effects may be and check whether there are any alternatives.”*

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<sup>11</sup> “Consent and Mantal Capacity”, Kathryn Law Stroke Research Facilitator, May 2009

*“Those involved in assessing capacity need to be satisfied that everything practicable has been done to help and support the person to participate to the fullest extent in the process involved in making this particular decision.”*

There are numerous examples where JT needed to be appraised of the possible consequences of the decisions she was making, particularly in the context of refusal of services/treatment as her condition deteriorated.

**5.8.7** On the subject of making best interests decisions the local safeguarding procedures state: “Any decision made on behalf of a person who lacks the capacity to make their own decision must be made in the „best interests” of that person. This means trying to find out what is most important to the person concerned and what they would have wanted, not what would make life easier for the people involved in their care. Consultation of all relevant persons is required.” This was an issue, for example in the decision as to whether a DNAR decision should be made on behalf of JT in May 2012 (see below 5.6.9).

**5.8.8** Had JT been assessed at any point as lacking capacity an IMCA may have been introduced to her. The Dorset procedures state: “**Independent Mental Capacity Advocate (IMCA)** – An IMCA is someone appointed to support a person who lacks capacity but has no one to speak for them, such as family or friends. They are only involved where decisions are being made about serious medical treatment or a change in the person’s accommodation where it is provided by the National Health Service or a local authority. The IMCA makes representations about the person’s wishes, feelings, beliefs and values, at the same time as bringing to the attention of the decision-maker all factors that are relevant to the decision. The IMCA can challenge the decision-maker on behalf of the person lacking capacity if necessary.” An IMCA may have been a positive resource in this case but the lack of a mental capacity assessment made consideration of this impossible. The local safeguarding procedures might helpfully draw to the attention of staff that the Local Authority can appoint an IMCA in safeguarding cases where the individual is not “unbefriended”. In other circumstances they would need to be “unbefriended”.

### **5.8.9 Practice in relation to the DNAR decision in May 2012**

**5.8.9.1** Right at the end of JT’s life there was a decision made to apply a DNAR decision to JT. There are real questions about this in relating to JT’s own capacity and the level to which MT was informed and involved about the decision making process. There are inadequacies in recording in the day to day records and on the DNAR form. These issues need to be addressed. The care home and the NHSBPDC need to ensure that protocols are in line with national guidance and are followed.

**5.8.9.2** When MT was interviewed as part of this review he was asked whether he was aware that JT was nearing the end of her life. MT said it was a shock to him when his wife died as there had been no conversation that JT had been nearing the end of her life. The NHSBPDC IMR however states: “On 22/3/12 GP recorded that nurses have discussed resuscitation status with

MT who indicated that he would like her to be resuscitated” Then the IMR states that on a visit by the district nurse on 23/5/12 the staff again queried resuscitation status as it was not recorded and “the GP made contact on 24/5/12 and recorded that MT was now in agreement with a Do Not Resuscitate order” It appears that the GP was responsible for this discussion with MT but it is not recorded in the chronology nor is any discussion with MT by any professional after 22/3/12 when MT said that he would like JT to be resuscitated.

**5.8.9.3** It is important that local guidance is consistent with national guidelines on this issue. National guidelines include the following <sup>12</sup>:

“It is not necessary to initiate discussion about CPR with a patient if there is no reason to believe that the patient is likely to suffer a cardio respiratory arrest.”

“DNAR decisions apply only to CPR and not to any other aspects of treatment”

“All establishments that face decisions about attempting cardiopulmonary resuscitation (CPR) including hospitals, general practices, care homes and ambulance services, should have a policy about CPR attempts. These policies must be readily available to and understood by all relevant staff. “

“The views of those close to the patient should be sought, unless this is impossible, to determine any previously expressed wishes and what level or chance of recovery the patient would be likely to consider of benefit, given the inherent risks and adverse effects of CPR.”

DNAR guidance provided for IMCAs by Action for Advocacy states: “When a DNAR decision is made it should be recorded clearly, together with the reasons for it and the names and designation of those involved in the discussion and decision. If no discussion takes place either with the patient or with those close to them, the reasons for this should be recorded.”

**5.8.9.4** In this context the DNAR form which was completed in respect of JT is problematic in a number of respects:

- It records JT as lacking capacity with no evidence in the records of any assessment to show that this is the case. The diagnosis of end stage dementia on the form is surprising as, until admission to the care home, no mention is made of dementia in the records.
- There is no clear evidence in records of a conversation with MT except on 22/3/12 (with the nurses) when he is said to have expressed a preference for JT to be resuscitated. MT himself does not recall such a conversation. The DNAR form records that the nursing team “have discussed with husband who is happy with DNAR” Even if the

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<sup>12</sup> “decisions relating to cardiopulmonary resuscitation A joint statement from the British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing October 2007’

conversation did take place the lack of recording of it is a serious oversight.

## **5.9 Working with stroke patients: standards and issues**

**5.9.1** The national stroke strategy (DH, 2007) indicates a number of key issues for effective care of stroke patients. This review should provoke consideration of the adequacy of local practice in this context.

How would the standards support better practice in the case of JT?

How can this support best practice in the future?

How do we/should we ensure the standards apply to those whose stroke was pre 2007?

Should there have been annual checks/reviews as set out in the national strategy? These are not evident in the chronology.

**5.9.2** Aspects of the strategy/national guidelines which, if put into practice, would have supported JT's situation considerably are set out below:

### **5.9.2.1 *Well coordinated partnership working***

"People who have had a stroke and their carers value continuity, being kept informed, being included and having a clear, consistent point of contact with services. Well-co-ordinated, partnership working between health and social care services is of central importance" (National stroke strategy)

### **5.9.2.2 *Facilitating long term improvement in the patient***

"Recovery can continue for many years after an individual has had a stroke, so it is important that commissioners consider how to provide access to services over the long-term." (National Stroke Strategy). Instead in the case of JT there was evidence of a simple resignation to and acceptance of her condition with no indication that the situation was capable of change for the better and therefore no thought of providing input to facilitate such improvement.

### **5.9.2.3 *Access to emotional/psychological support***

"People who struggle to adjust to the longer-term effects (both those who have had a stroke and their carers) need access to emotional support services. In the first instance, all staff working with stroke can, and often do, provide emotional and psychological support. These can range from access to good peer support or local counseling services through to referral for psychiatric and psychological services." (NSS)

There is no evidence of any input from psychological services for JT or MT. Whilst information has been contributed to the review indicating that psychological aspects were not routinely addressed in the 1990s this is not universally true and for someone as young as Mrs JT when she suffered her first stroke the psychological implications would have been significant.

### **5.9.2.4 *Reassessment when the situation changes***

The National clinical guideline for stroke Third edition Royal College of Physicians 2008 (incorporating NICE guidelines) also identifies good practice which would have supported Mr and Mrs T and would support similar

situations in the future. It further underlines the need for further assessment when a situation of a patient changes. In the case of JT there was no recorded reassessment even when she suffered a second stroke in 1998.

#### **5.9.2.5 Carers assessment**

The above underlines too the need for carers assessment and appropriate support when a patient is transferred home following a stroke. The carer should have clear guidance on how to seek help/support as necessary and to be reminded of this at regular intervals. The carers assessment should be revisited when significant change in the situation occurs.

### **5.10 Carers assessment/support**

The above underlines the need for carers' assessments. There was an absence of such assessments in respect of MT except for one in 1995.

**5.10.1** The relevant legislation is the Carers (Recognition and Services) Act 1995 and the Carers (Equal Opportunities) Act 2004. The purpose of a carer's assessment is to assess the ability of the carer to provide and to sustain the provision of care. Local authorities have a duty to inform carers about their right to request an assessment even where a service user refuses an assessment. If a carer does not request an assessment the local authority in any case has a responsibility to take account of the carer's ability to undertake caring activities.

**5.10.2** The National Stroke Strategy underlines this issue: "Carers are vital in providing support for people who have had a stroke and medical professionals and providers must acknowledge this when looking at the long-term support for people who have had a stroke. Carers are entitled to an assessment in their own right for support, and access to ongoing, long-term support services"

**5.10.3** This was clearly a pertinent issue in the case of Mr and Mrs T. MT gave the clear impression when visited as part of this SCR process that he had wanted to do what his wife asked in any case even though at times he admitted this was too much for him. It seemed that in some ways staff / professionals colluded with this by suggesting that JT did not go into hospital/by saying he could care for her himself. On more than one occasion MT became overwhelmed by the role of caring for his wife before asking for help. It was at one such point that DCC carers became involved.

### **5.11 Specific issues inherent in the circumstances surrounding JT's admission to hospital and her subsequent care**

There are a number of situation specific issues in relation to this period which must also be underlined by this serious case review. They will not form the basis of detailed analysis or multiagency recommendations in this report. However the Dorset Safeguarding Adults Board will want to be particularly vigilant in ensuring that these aspects are included in individual agency action plans and that the implementation of those actions is monitored and signed off

by the Board. It is important that these issues do not detract from the cumulative issues which ran throughout the 22 years which have been the focus of this review and which are of primary importance in ensuring that lessons are learned for the future.

*The SWAST practice in relation to provision for a dependant when the primary carer is conveyed to hospital.* SWAST has already revised its standard operating procedure in May 2012: "Provision for dependants when the primary carer is conveyed to hospital-advice for crews.." This includes reference to the need to consider mental capacity issues. It includes looking at options of family, friends or neighbours who might attend.

*Issues relating to the availability of a system to call for assistance in an emergency at JT/MT's bungalow.* Synergy Housing have already investigated the administrative issues associated with this and have put in place some improvements.

*The practice of the care agency in respect of ensuring JT's safety.* JT was left alone for some periods during the day on which MT was admitted to hospital. Care South and other care providers must ensure robust procedures for such a situation.

*The practice of the joint Dorset, Bournemouth and Poole Out of Hours Service for Social Care (Children and Adults) and in particular their ability and the practice around cross referencing to the main records system for DCCACS so that they are able to undertake a risk assessment based on all of the available information.*

*The concerns expressed by MT's neighbour and friend about the initial conditions in the nursing home to which JT was transferred in March 2012.* The Chair of this review has raised these concerns with DCCACS.

## **6 Conclusions**

**6.1** JT was an adult at risk known to a range of health and social care agencies. She had a range of health related conditions which rendered her increasingly dependent and isolated. JT was, for her own reasons, at times reluctant to accept care and treatment offered by professionals. This should have been explored with her by staff and professionals. This reluctance, combined with the increase in health and care needs was challenging to the effective management of risk. The situation demanded basic good practice, a high level of continuity and communication across agencies as well as an ability to keep track of a situation, which continued over two decades, in order to ensure that needs and risks were adequately addressed. A number of failings combined in this situation leading to agencies and professionals failing to recognise, acknowledge and address the serious level of deterioration in JT's condition.

**6.2** There were a number of identifiable and specific issues which must form the basis of learning from the case of JT. However this report has underlined too the extent of individual poor basic practice evidenced by the poor condition that JT was in when admitted to a care home in January 2012 despite the involvement of a wide range on professionals. This individual practice is being addressed outside of this serious case review (which is itself a learning process) but it highlights the essential need for robust supervision of staff and the need for training on basic as well as specialist areas of practice in some cases.

**6.3** In the **1990's** when JT suffered a first stroke (**and ongoing**), issues associated with working with **stroke patients** emerged. The *range* of necessary assessments was not considered. In particular psychological assessments were never carried out. These might have been helpful in respect of capacity issues at a number of points. They might have been helpful to guide carers, including MT. Indeed following JT's second stroke in 1998 there is no evidence of any assessments or reviews taking place in relation to the implications and effects of the stroke. There was clear evidence that national guidelines for working with stroke illness did not apply in JT's case. The National Stroke Strategy was not published until December 2007 but the core principles would have been known.

**6.4 Carer assessment:** The significant difficulties which MT experienced in caring for JT were first recorded in **1995** and then again in 2002 following which this issue arose repeatedly. There is only one formal carer assessment recorded in July 1995. This was never formally reviewed.

**6.5** A theme relating to the **reluctance to accept / refusal of care, respite, treatment by JT ran throughout the chronology. This decision making should have been informed by and explored by professionals alongside JT.** JT had reasons for her reluctance and she should have been supported to understand the alternatives and the potential outcomes of her decision making. MT also refused offers of care and treatment on behalf of JT. He too required that professionals be more proactive in these situations. Right at the beginning in **1990** when JT suffered the first stroke records make us aware that there was an issue with JT failing to attend appointments and concerns about the extent to which she would comply with therapy appointments. This theme continued. In 2003 for example JT was discharged from hospital without having had an examination because she said this would set off spasms. Professionals were complicit with her wishes despite the presence of significant risk and the distinct possibility that neither JT nor MT had any real insight into the possible consequences of such decisions. There is no indication of any questioning of JT's capacity in this respect. There were no recorded attempts to support JT's or MT's understanding of the consequences of these "refusals".

**6.6** There was little attempt to establish a relationship of trust and cooperation with JT and MT which might have supported staff and professionals in gaining greater acceptance of care and support by JT and MT. There is little insight in

the chronology into their family and background or their motivation in decision making.

**6.7** Associated with this, **practice lacked a person centred focus**; an approach which sought to both understand and inform the perspective and the decision making of JT and of her husband.

**6.8** In **2007** concerns began to accumulate so that a **holistic assessment of need and risk** was very clearly indicated. This assessment would have informed judgements as to how to respond to those instances when care, respite, treatment was refused/declined by JT. It would have formed the basis of an action plan for managing and addressing the risks across agencies with clarity around who was coordinating the action plan, who was responsible for specific actions and how and when this would be monitored and reviewed. This was never achieved.

**6.9** One of the evident flaws was that a lack of clarity existed even within individual agencies about role and responsibility. This clarity of role as well as clarity around mutual expectations across agencies was required. This issue is relevant to commissioners as well as to providers (as they set out expectations of providers in contracts and monitoring of those expectations).

**6.10** One of the key features of the risk assessment and a plan to manage those risks should have been in relation to **pressure ulcers**. These were **first recoded in May 2007**. The assessment of pressure ulcer risk needed to draw on related issues such as nutrition/weight (which again began to emerge as a clear issue in 2007). This was not evident in records. One formal "Waterlow"<sup>13</sup> assessment of the risk in respect of pressure ulcers was undertaken in June 2007. A Braden pressure ulcer risk assessment would have given an accurate focus on nutrition. There was no evidence that such an assessment ever occurred. Inadequacies in recording contributed to the inability to recognise the escalating risks.

**6.11 Mental Capacity** should have been a key consideration **throughout the chronology**. The presence of a disorder of the brain (following two strokes) along with regular refusal of services/treatment resulting in significant risk might have indicated a need for such an assessment. JT's refusal of the offer of admission to hospital (by the ambulance crew) in January 2012 might for example have been questioned. The core principles of the Act were not evident in practice. Of particular importance was principle 2 relating to supporting decision making. Practice around the DNAR decision at the end of JT's life was not in line with national guidelines (however, this would not have affected the outcome).

**6.12 Failures in effective multiagency working** became most apparent from **2007 onwards** although this issue was prominent throughout. During 2007 the number of agencies represented in providing care and treatment

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<sup>13</sup> <http://www.judy-waterlow.co.uk/downloads/Waterlow%20Score%20Card-front.pdf>  
<http://www.judy-waterlow.co.uk/downloads/Waterlow%20Score%20Card-back.pdf>

accumulated. By the end of that year the following were involved with JT: nurses; GP; Housing Support Officers; Community rehabilitation team (CRT) OT and physio; DCC Community Care Officer; Social Worker; Dietician; Chiropodist. The failure of any effective joining up of professional input and assessment was marked from this point and became even more marked in 2010. There were clear issues about ownership of decisions and a need for challenge across agencies and disciplines.

**6.13** In the context of multiagency working and of identification and management of risk the **absence of challenge across disciplines and agencies** as well as a lack of challenge to the decision making of JT (and of MT) was significant.

**6.14 Practice in the context of the Bournemouth, Dorset and Poole safeguarding adults procedures** was found wanting. There should have been a number of alerts raised notably in the period from **2007 to 2012** by a range of professionals. This did not happen until **January 2012** when JT was admitted to a care home on MT's admission to hospital. When the situation was referred into the safeguarding process in January 2012 the practice in carrying out that process was not consistent with guidance in the local policy and procedures nor was it robust.

**6.15** The agencies involved in this Serious Case Review are committed to ensuring that the issues represented here are addressed. Examples of that commitment have already been demonstrated in section 5.11. They have identified actions within their own agency which will help to ensure that single agency shortcomings are addressed. The recommendations in section 7 below will form the basis of a Dorset Safeguarding Adults Board action plan designed to address multiagency failings.

## **7 Recommendations**

### **7.1 Fulfilling commissioning responsibilities by ensuring that contracts and the monitoring of contracts ensures that the practice of provider services addresses the learning from this review**

That commissioners fulfill their statutory role in ensuring, through robust monitoring of contracts, that the care arrangements they have a responsibility to fulfill are provided by organisations and staff whose practice demonstrates: sound assessment of need and risk; involvement and empowerment of service users; effective partnership working; good practice in respect of safeguarding adults. This requires that contract monitoring officers are trained to monitor performance against these issues.

### **7.2 Establishing a clear framework and principles for the identification, assessment and management of risk across agencies including a focus on working with those who are reluctant to engage with services and treatment.**

**7.2 a)** That Dorset Safeguarding Adults Board agrees a framework and principles in line with underpinning legislation for the effective identification, assessment and management of risk, including a commitment to multiagency

meetings where the need for this is indicated. This is especially important in the context of cases falling outside the safeguarding adults' framework or which are perceived to fall outside it. However the principles will apply in all cases involving risk.

Training will embed this guidance in practice.

The Board will monitor the impact of this new guidance on practice.

**7.2 b)** That there is a review across agencies of existing procedures and advice addressing issues presented by those who are reluctant to engage with services and treatment. That this includes revising the current Dorset Safeguarding Adults Board Interagency Community Risk Management Protocol, July 2012 and incorporating this into the above risk framework so that practice with those who are reluctant to engage with services is grounded in robust approaches to risk as well as an awareness of mental capacity principles and practice. That there is training and multi disciplinary discussion about approaches to working with vulnerable people who refuse services

**7.2 c)** That Dorset safeguarding adults board adopt a structure/template for recording risk assessments and decisions at safeguarding meetings

### **7.3 Improving and monitoring practice in relation to the Mental Capacity Act**

That the effectiveness of MCA training is monitored in respect of a) assessments of capacity and b) evidencing in practice of the 5 core principles of the Act. That this SCR is used as a case study (alongside others) to inform learning and development in a variety of forums. The Board will undertake to monitor the effectiveness of MCA training, looking for evidence in practice and leading change in respect of training and practice accordingly.

### **7.4 Implementing best practice in working with stroke illness**

That relevant agencies ensure that local guidelines for working with stroke illness are in line with national guidelines and that these are implemented

### **7.5 Improving practice in working alongside carers and in carrying out carers' assessments**

That DCCACS carry out an audit to ascertain practice in relation to carer assessments and that appropriate action is taken according to the findings. That the Board adopt a Carers Charter (such as that in use in Worcestershire-see link) requiring that all agencies take account of this in their practice with carers. This charter should take account of the ADASS guidance on carers and safeguarding adults and the seven key messages set out within this.

<http://www.adass.org.uk/images/stories/Policy%20Networks/Carers/Carers%20and%20safeguarding%20document%20June%202011.pdf><sup>14</sup>

<http://www.worcestershire.gov.uk/cms/carers-unit/carers-charter.aspx><sup>15</sup>

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<sup>14</sup> carers and safeguarding adults – working together to improve outcomes

<sup>15</sup> The Worcestershire Carers Charter

## **7.6 Strengthening understanding of the relationship between pressure ulcer care and Safeguarding Adults**

That there are clear expectations on making the links between pressure ulcer care and safeguarding adults for all staff across agencies. That these links are made clear in the local safeguarding adults policy and procedures and that this is integrated into practice through training and supervision. This area of practice will be monitored by the Safeguarding Adults Board.

## **7.7 Learning and Development: Safeguarding Adults. Evidencing of effective training and supervision particularly in respect of: issues of neglect and reluctance to accept services; clarity in understanding of what constitutes a safeguarding adults “alert”**

That Dorset Safeguarding Adults Board audits the evidence of safeguarding training having taken place across agencies; that the training includes a clear focus on strategies for dealing with issues of neglect and reluctance to engage with services; that it enables a clear understanding of the issue of what constitutes an alert; that supervision policies across agencies include mandatory reference in supervision sessions to safeguarding adults

## **7.8 Ensuring that all identified risks associated with the case of JT have been addressed via the Safeguarding Adults process**

That the Board satisfies itself that the safeguarding process has adequately addressed all of the risks and issues presented by the case of JT via the safeguarding process through a final case conference review to follow up any outstanding issues from the review of 23 August 2012

## **7.9 Challenge across agencies /individual professional accountability**

Organisations must nurture a culture which encourages and values constructive challenge and debate. Managers and staff at all levels must be encouraged to seek clarity, to challenge decisions and to escalate issues and concerns within a well defined process. There were examples where agencies passed on concerns which they were aware were not subsequently acted upon. It is not sufficient for professionals/staff simply to pass on those concerns. Each has a responsibility and accountability to ensure that issues concerning the safety and wellbeing of individuals with whom they are working are addressed. This includes active follow up of referrals, contacts, concerns to ensure that actions are taken to reduce perceived risk/concern. No Secrets, 2000, (quoting from the Independent Longcare Inquiry 1998) states *“no individual agency’s statutory responsibility can be delegated to another. Each agency must act in accordance with its duty when it is satisfied that the action is appropriate. Joint investigation there may be but the shared information flowing from that must be constantly evaluated and reviewed by each agency”*. The development of a culture where mutual challenge at practice level (as well as at a strategic level) is embraced as positive is important learning in the context of this SCR.

## **7.10 Ensuring robust practice in relation to Do Not Attempt Cardio Pulmonary Resuscitation (DNAR)**

That the Board assures itself that providers of Health and Social Care are following national guidelines on DNAR.

### **7.11 Embedding person centred principles in practice and guidance**

That member agencies to the safeguarding adults board ensure that person centred principles are embedded in practice and guidance and that this is underpinned by training and supervision.

In particular practice must engage with the individual and be built on a service user led perspective rather than on the available services and interventions.

Service users and their carers must be empowered with information so that they know what to expect of services, can be actively involved and are supported by that information.

## 8 References

ADASS, July 2011, Carers and Safeguarding Adults – working together to improve outcomes

BMA, the Resuscitation Council (UK) and the Royal College of Nursing, October 2007, “decisions relating to cardiopulmonary resuscitation”; a joint statement

Bournemouth, Dorset and Poole Multi-Agency Safeguarding Adults Policy and Procedures, July 2011

Braye, S; Orr, D; Preston-Shoot, M; SCIE report 44, (2011), Self-neglect and adult safeguarding: findings from research;

British Medical Association, the Resuscitation Council (UK) and the Royal College of Nursing, A joint statement, October 2007 *Decisions relating to cardiopulmonary resuscitation*

Communities and Local Government, February 2009, “Using the quality assessment framework”

DH, 2007 “Independence, choice and risk: a guide to best practice in supported decision making”

DH, 2007, National Stroke Strategy

DH, 2010, “Prioritising need in the context of *Putting People First: A whole system approach to eligibility for social care*”, Guidance on Eligibility Criteria for Adult Social Care, England,

Keywood, K, 2010, Medical Law Review Case Comment: Vulnerable adults, mental capacity and social care refusal

Law, K, Stroke Research Facilitator, May 2009, “Consent and Mental Capacity”,

NHS Quality Improvement Scotland, Braden Risk Assessment

RCN, 2005, The management of pressure ulcers in primary and secondary care, A Clinical Practice Guideline,

Scourfield, P, Journal of Adult Protection vol.12 issue 4, Nov 2010 page 25  
Reflections on the SCR of a female adult (JK),

Royal College of Physicians 2008 (incorporating NICE guidelines), National clinical guideline for stroke Third edition

Warwickshire Safeguarding Adults Partnership, 9th August 2010, Serious Case Review; the murder of Gemma Hayter