Safeguarding Adult Review

Mr A

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Introduction to the Safeguarding Adults Review- by David Cooper Independent chair of Portsmouth Safeguarding Adults Board

While none of Mr A's relatives were known to be still alive at the point of publication of this report, his death no doubt touched a number of people, who were close to him over the years. As the report indicates he was known as an intelligent, polite and independent man. While his health was deteriorating, he had a right to expect a better quality of life during the last months of his life.

I want to take this opportunity to thank Jane Brentor for completing the review, and members of the Safeguarding Adults Review Sub-group, especially Tracey Keats and Lorraine Burton, for finalising the action plans to implement the recommendations from the Safeguarding Adult Review.

The review was commissioned by the Portsmouth Safeguarding Adults Board at a meeting, on the 19th March 2014, in line with the Boards Multi Agency Learning and Review Framework, and was managed through the convening of a SAR Board. At the outset the case was identified as a Serious Case Review, but with changes to safeguarding arrangements introduced by Care Act 2014, it has been completed as a Safeguarding Adults Review (SAR). Ms Brentor was appointed as an independent investigator, and commenced work in May 2014.

It is important to say that the purpose of a Safeguarding Adults Review is not to apportion blame to an individual or organisation, but to identify the lessons to be learned and apply these to future cases to prevent similar harm occuring in the future; however the report does highlight a number of failings by organisations

The Safeguarding Adults Review Board agreed the following terms of reference for the review;

- To establish the chronology of events in relation to Mr A as relevant up to and immediately following his death,
- To examine the adequacy of the interdisciplinary collaboration and communication between all agencies involved in the care of Mr A or in the provision of services to him, during the relevant period including delays in the processes,
- To establish whether local policies and relevant legislation have been adhered to,
- To prepare an independent report, based on the findings and make recommendations to the Safeguarding Adults Board, ensuring the report is without bias or favour.

Background

The events outlined in the report are very distressing. Mr A was a vulnerable man, who was well known to local services. The warden of the supported housing scheme in which he lived, reported in January 2013 that his health was deteriorating, and that he was losing weight and self-neglecting. Medical and social care support was sought, and provided.

The report states that from March 2013 onwards Mr A's condition continued to deteriorate, and in the following 3 months before his death he was visited by professionals from 10 agencies. Despite this, communication between the agencies was very poor e.g. his medication was removed and there is no record of this being shared with the Community Nurse. He was also referred for a brain scan but there was no record of this in the medical notes.

On the 1st May 2013 a multi-agency meeting took place, and attempts were made to provide alternative care for Mr A, but without success. This was over a Bank Holiday weekend. On the 5th May finding him on the floor, an ambulance was called, but he was not admitted to hospital. On the following day staff visited in the afternoon and found Mr A had not moved since their morning visit, an ambulance was called and he was admitted to hospital. Where his condition continued to deteriorate, and he died on the 13th May.

Conclusions and actions

The report draws a number of important conclusions. These are detailed in the report, so I will not go in to them in detail here, other than to draw your attention to the lack of a clear medical diagnosis, poor communication, and coordination amongst the various agencies and professional involved in Mr A's care, and the lack of a robust risk assessment, and the availability of commissioned care provision over a Bank Holiday period. It is also disappointing that there was a significant delay in commissioning a Safeguarding Adults Review.

Given the wide range of agencies, and professionals involved in Mr A's care at this time, the report concludes by making a number of recommendations of a multi-agency nature, and these have been coordinated into an action plan. However once again it is disappointing that some agencies have again lacked urgency in assisting with the completion of an action plan.

Local agencies in Portsmouth will now need to demonstrate sustained action and urgency, as the Portsmouth Safeguarding Adults Board takes forward the actions to implement the recommendations in this review.

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Executive Summary

Background

The circumstances of Mr A's death, the care during the months immediately prior to his death and the actions that followed his death fulfil the conditions to warrant a Safeguarding Adult Review (SAR).

The purpose of this case review was to:

- To establish the chronology of events in relation to Mr A as relevant up to and immediately following his death in May 2013.
- To examine the adequacy of the interdisciplinary collaboration and communication between all the agencies involved in the care of Mr A or in the provision of services to him during the relevant period including consideration of delays in the processes.
- To establish whether local policies and relevant legislation have been adhered to.
- To prepare an independent report based on the findings and make recommendations to the Safeguarding Adults' Board ensuring that the report is without bias or favour.

The review was based on Internal Management Review reports and chronologies and interviews with report authors and other relevant individuals. None of Mr A's known relatives are known to be still alive at the point of publication of this report.

Overview of chronology of events

Mr A was a man who was misdiagnosed with a learning disability in his very early years and had been supported throughout his life by his family or other services. He was, however, an intelligent man who was generally polite and independent although his appearance was usually quite dishevelled. He spent the last seven years of his life in a supported housing scheme managed by Portsmouth City Council (PCC) and, during the last four months of his life was visited by professionals from ten different disciplines. He had been mostly independent, only having 2 hours help per week from Age UK to help him shop until December 2012 when he started to exhibit behaviour that was unusual to those who knew him at the housing scheme.

On the 14th January 2013 the Housing Scheme Manager made a referral to Adult Social care (ASC), identifying poor fluid intake, loss of weight and self-neglect. ASC identified this referral as high priority. After a further period of strange behaviour Mr A was supported to visit his GP in February 2013.

The GP undertook blood tests and referred to physiotherapy and again to ASC for a package of care. The GP also planned to communicate with the pharmacy services for a Nomad tray and made a referral to the psychogeriatrician service. The physiotherapy service, following a request for information from the GP, identified Mr A's referral as 'routine'.

A visit to the GP on the 5th March resulted in an audiogram to investigate the 'buzzing sounds' that Mr A was experiencing. Six weeks after referral to ASC, an Independence Support Assistant (ISA) was allocated to assess Mr A and made an assessment that Mr A needed care to help him in the mornings and to prompt him to take his medication. This was commissioned and the independent care provider,

Care UK, started care provision on the 14th March. As a result of the GP referral to the psychogeriatrician, the Older Persons Mental Health (OPMH) service's support worker visited on the 13th March and agreed to visit weekly to help Mr A to develop a routine and keep his flat tidy. During that assessment visit it was established that Mr A showed no signs of paranoia and scored 30/30 on his mini mental test.

The OPMH worker also referred for a Nomad and requested an Occupational Therapy (OT) assessment. There was no plan to pursue a diagnosis. A visit from the ISA on the 19th March noted that Mr A's medication was strewn around his flat and followed this up the following day with a call to the GP. It was clear at this time that the initial referral for a Nomad had not been made and that the GP had only made such a referral on the 20th March. The ISA discussed Mr A with the OPMH support worker with both identifying that Mr A left a lot of money around his flat.

During the week of the 23rd March, Mr A was recorded by care workers as having frequently been sick but there was no follow up plan and medication checks were not recorded throughout that week. Housing staff noted that Mr A's bizarre behaviour was continuing and he was said to be cutting up his clothes.

At the beginning of April the OT visited but, due to Mr A's tiredness and ill health, needed to visit four times, completing the assessment on the 24th April when it was noted that Mr A's functioning was below that to be expected for his age and offered follow up OT support. Mr A continued to have episodes of sickness. On the 12th April, the physiotherapist visited at the same time as the district nurse, the Age UK shopping support worker and the OPMH support worker. The physiotherapist indicated that Mr A had sufficient help and did not need physiotherapy; the community nurse was present to dress a wound of unknown origin to Mr A's calf; the OPMH support worker was present as a routine visit but noted how difficult Mr A found multiple visitors and that he was not eating well.

The community nurse had clearly visited before but notes were missing. There was no recorded communication between these agency visitors despite their joint attendance at Mr A's home. Medication was still seen to be strewn around the flat and the OPMH support worker removed all medication, identifying that Mr A may be at risk of over medicating. It is said that this information was conveyed to the community nurse but the nursing service has no record of this. On the 19th April the housing service's notes show that the OPMH support worker visited with a psychogeriatrician from St James hospital and referred Mr A for a brain scan but there is no record of this in the health notes. A commode was ordered for Mr A by the housing service. Care UK visits continued but there were no records of medication checks or note that medication was unavailable for 24 consecutive visits.

On the 22nd April the ISA took Mr A to the bank to obtain documents to enable a financial assessment, where Mr A exhibited a high level of agitation. Regular community nursing visits continued until 24th April when they stopped with no forward plan and despite the need for continued wound dressing. The physiotherapist received a further referral and contacted the ISA for background information but did not visit. The GP received notification that Mr A had had hearing aids fitted. Following further episodes of bizarre behaviour and sickness, and in response to a call from the Housing service, the ISA visited on the 29th April and noted that Mr A was not eating. No plan was made to address this but, again in response to a call

from the housing service the following day, the OPMH support worker visited and witnessed a very messy and potentially dangerous state in Mr A's flat. The OPMH support worker was still present when a duty GP visited who was told that medication had been removed 12 days earlier. The only plan that was made by the covering GP was for a further blood test and urine test and to discuss the medication with Mr A's allocated GP. No record of such a discussion is recorded in the GP notes. The covering GP has since confirmed that this action did not happen.

A meeting between OPMH service, ASC and Housing took place on the 1st May. As a result a plan was recorded to increase care to twice daily and make referrals to other services. The results of the urine test ordered by the covering GP were returned to the surgery on the 2nd May but no plan was made to address the findings which were showing serious signs that should have had attention. Two calls were made by housing services to the OPMH support worker on consecutive days describing bizarre and risky behaviour by Mr A. ASC services attempted to find a provider to provide the increased care but were unable to and, eventually, OPMH intermediate care services agreed to undertake evening visits on the next two days. This was over a bank holiday weekend. Finding Mr A on the floor on the 5th May, housing services called 999 and ambulance staff called but, after discussion with the out of hours doctor, did not admit to hospital. On the 6th May, Care UK staff visited in the afternoon and found that Mr A had not moved since their morning visit and called 999. Mr A was admitted to hospital.

Portsmouth Hospitals (NHS) Trust (PHT) carried out treatment to resuscitate Mr A and address his low blood pressure and low body temperature. By the 9th May, Mr A's condition was deteriorating and on two occasions a brain scan was requested. A plan for end of life care was discussed with Mr A's sister who had only very limited contact with him by this time and Mr A died just after midnight on the 13th May.

Other information

- Although no specific mental capacity assessment took place, the majority of professionals involved considered that Mr A had the capacity to make informed decisions, particularly if he was given one to one time in which to consider actions.
- The information recorded in the primary care notes indicate that Mr A's blood pressure and kidney function were not showing significant impact from the lack of medication when blood and urine samples were analysed until the final few days before his hospital admission.
- I was told that, at the time, several agencies were suffering from staff shortages and a lack of consistent management.
- There appeared to be some lack of clarity on the part of the GP practice about the way to order a Nomad medication management box.

Analysis

It is important to stress that all the people who have been interviewed as part of this case review have been professional and caring. In no instance did I feel that anyone was deliberately negligent or purposefully superficial, in fact most people appeared to have a fondness for Mr A and a desire to support him. In the majority of people I

have also experienced a willingness to acknowledge areas where they may have failed and a keenness to learn from the outcome of the review.

Analysis of the events was undertaken in response to a series of questions:

- Were assessments sufficiently adequate to identify the reasons for Mr A's behaviour?

At the end of 2012 and the beginning of 2013 several incidents occurred that were out of character. However, during subsequent assessments, Mr A is recorded as scoring a full record on a mini mental test and, in interviews with staff during this review, he is consistently said to have had the capacity to make informed decisions. A plan was devised to support him but no investigations were set up to establish a diagnosis. Despite ten agencies (or disciplines within agencies) being eventually involved with Mr A and seven of these being health disciplines, there remains no diagnosis or explanation for the quite dramatic changes in Mr A's behaviour.

- Was there a sufficiently holistic approach to how care was provided?

The primary support and care for Mr A was provided by:

- Primary care providing routine response to surgery visits and a home visit when required;
- Housing services providing a supported housing function;
- Adult social care undertaking assessment and commissioning of a care package;
- Community nursing to dress a leg wound;
- A care agency providing half hour daily visits to maintain hygiene and prompt medication;
- Older people's mental health services visiting approximately weekly,
- Therapy assessment (OPMH);
- Physiotherapy;

Although the housing scheme manager undertook several calls to other agencies individually, with increasingly desperate pleas for support, agencies did not liaise in order to respond to these calls. Mr A's medication was removed from his flat by OPMH services on the 12th without a safe plan to reinstate it. The discussions that are said to have happened with community nursing and primary care did not result in the creation of a plan or any record of agencies working together to resolve the lack of medication or address the maintenance of Mr A's dignity and care in a rapidly deteriorating situation.

- Where necessary, were risk assessments undertaken appropriately?

There were three occasions when significant risks were identified that should have led to risk assessments by ASC but did not. No formal risk assessment informed the community nursing decision to skip a visit following the visit to dress Mr A's leg wound on the 24th April and the lack of such an assessment appears to have allowed subsequent visits to 'drop off' the nursing list. No record exists of the OPMH support worker making a formal assessment of risk in removing medication from the flat. It is unclear on what basis the risks of leaving Mr A in his home on the first visit by the ambulance service were assessed. None of the agencies who could have

undertaken a mental capacity assessment (as part of the assessment of risk) took this action. The duty GP recognised the risks of leaving Mr A without immediate action on the 30th April but did not undertake a risk assessment, making assumptions without considering what would happen if those assumptions failed to materialise.

- Were arrangements in place to escalate crises to sufficiently qualified or senior staff?

Although allocation to an unqualified ASC worker took place in early March, it was not until the 30th April that a qualified social worker was made aware of the risks. Again, an unqualified OPMH support worker had been involved since early March and it was not until the meeting on the 1st May that a professionally qualified staff member was formally involved. Housing service staff attempted to gain support from other agencies on repeated occasions but did not inform any of their senior managers of the considerable risks they were witnessing.

- Were there issues associated with standards of practice and, if so, how did these affect the outcome for Mr A?

Care UK was commissioned to check medication but repeatedly did not carry out this task and did not report this failure. The primary care practice were aware that Mr A had been referred for a Nomad system but firstly failed to make the referral and then took no action despite knowing that the Nomad system would not be available for some weeks. The process for managing a CPA was not managed as it is designed to be; the GP and several of the involved professionals were not invited. ADC staff provided quite a significant level of personal care to Mr A despite the service not being registered with CQC for the provision of personal care. The ambulance services left a patient who was known to be without medication for some weeks, with a low body temperature and who was unable to stand. When the results of a urine test showed significant proteinuria no action was taken to respond. The Community Nursing service leaving a wound without attention for 12 days was also poor practice.

- Were arrangements appropriate to be able to meet any limitations of service capacity?

Allocation within ASC took six weeks and two days and then a further six days before the first assessment visit. Such a wait could have resulted either from lack of workers to whom allocation could be made or insufficient process management but this delay was inappropriate. Community nursing staff members told me that they were under-resourced, and this was confirmed in interview with a senior staff member. This led to the cessation of visits to dress Mr A's wounds from the 24th April when he should have been receiving three visits per week. The lack of availability of commissioned care over a bank holiday was inadequate.

Conclusions

I believe that the lack of a diagnosis or investigations into Mr A's physical and mental state was significant in failing to devise a suitable plan.

I also concluded that communication between professionals, and actions as a result of communication, was extremely limited in planning Mr A's care despite both the number of agencies involved and the acknowledged complexity of Mr A's situation.

I also concluded that planning was not based on clear, objective risk assessments and neither was each agency's initial plan updated according to each assessed new risk that was presented.

I further concluded that a lack of availability of commissioned care or alternatives led to inconsistent staff providing care when the decision had been made to increase the daily care provision.

In the course of considering the circumstance of this case I must make a view as to the quality of professional practice and concluded as follows:

1 Within ASC there was, I believe, some lack of clarity about to whom and when to escalate issues which was most likely caused by inexperience and a desire to perform well and was not due to professional neglect on the part of the agency.
2 In considering the removal of medication by OPMH services, I do not believe that this was poor professional practice in the context of what was acceptable to the organisation at the time. However, it will be my recommendation that this needs to change.
3 Although it was inappropriate for housing staff, as an unregistered provider, to provide personal care, in the context of an environment where senior members of the housing staff authorise the provision of personal care 'in an emergency' and because no policy exists to describe how often emergencies can be tolerated, I do not conclude that these actions constituted poor professional practice but will recommend that clarity of personal care provision is improved.
4 In the case of the care workers from the care agency, I consider that there was professional neglect in that, as a commissioned organisation, they failed completely to record the monitoring of medication for at least 24 consecutive days.
5 In the case of the ambulance service, I am hampered by the lack of provision of a detailed IMR but I have concerns about the state in which Mr A was left on their first visit and will recommend that a full investigation is undertaken.
6 In considering the lack of follow up for wound dressing after a visit by the community nursing services on the 24th April, I have noted that the system for following this up was not sufficiently robust and conclude that this was not, in itself, poor professional practice but rather a system failure.
7 Lastly in the case of the primary care practice, I have considered the lack of a recognised system for following up actions resulting from covering GPs visiting the patients of another GP. This, by omission, allowed the lack of medication to continue and the blood and urine test not being followed up. I believe this is poor professional practice about which I will make recommendation.

Recommendations

Because of the length of time that has passed since Mr A's death and the willingness of organisations to learn and change, I have been informed, and have been shown evidence in some cases, of a number of processes, structures and procedures that have changed in that time. However this report includes all recommendations resulting from my findings. The following inter- and multi-agency recommendations are significant:

1. The reasons for the delay in the commissioning the SAR in this case should be investigated and, if poor practice or areas of omission are found, actions put in place to reduce the likelihood of such delay occurring again.
2. There should be a key professional identified to take coordinating responsibility in complex cases in line with better care recommendations and fully integrated working practice. Appropriate terminology will be devised to ensure that the term does not become confused with similar terminology used by individual disciplines to indicate a role that covers their own agency only.
3. In order that an identified lead worker has sufficient trust, respect and authority to support their role, there should be a greater emphasis on cross discipline training and, where possible and safe, there should be rotation of roles and 'role swaps'.
4. The application of the virtual ward approach or a fully integrated health and social care service must be a priority and a process for assessing its efficacy in increasing risk sharing and subsequent improvements in care planning must be put in place.
5. All agencies should review their Bank holiday arrangements in order to ensure sufficient cover is available to meet generic needs including with the availability of purchased care.
6. When there are significant staffing vacancies, risk assessments should be mandatory in each organisation to consider the impact and actions to minimise these. Community staff levels must be maintained at a safe level to manage both routine and high risk situations.
7. The already existing law relating to Mental Capacity assessments should be fully enforced and understood.
8. All agencies should challenge whether their Supervision policies are practically reasonable; are being complied with and whether there is sufficient oversight of unqualified workers with encouragement at induction stage to ask for help and not to view requests for advice as 'wasting manager's time' or failure due to a lack of skills.
9. All agencies should ensure that their workers clearly identify their professional status to avoid misunderstanding about the level of experience or accountability that might otherwise be assumed by other disciplines
10. There should be a review of the use of risk assessments – especially where issues of self-neglect, lack of financial management, poor nutrition and hydration exist. Any change of practice or finding of the need for greater emphasis resulting from this review should be included in routine training.
11. The positive impact of the extensive learning sessions which have been carried out in some of the Solent disciplines using information from the

internal review of Mr A's situation and which demonstrate positive learning and responsibility to change practice should be reinforced in all agencies as a result of the learning from this SAR report.

12. The means of supporting shared access to records when several agencies are involved should be further investigated as part of long term planning.
13. A means of enabling all agencies to value the contextual information provided by Housing officers with a day to day knowledge of their service users should be found.
14. The Procedures and Guidance for Multi-agency Safeguarding Adults Policy which were updated jointly with Southampton, Hampshire and the Isle of Wight in July 2013 and includes a section on Managing Self Neglect, Mental Capacity and Best Interests must be fully implemented.

The Report

Section 1 - Background

Mr A died in early May 2013 and the circumstances of his death fulfilled the criteria for commissioning a Safeguarding adult review (SAR) in that:

- There is reasonable cause for concern about how the Adult Safeguarding Board's member agencies worked together to safeguard *and*
- There were safeguarding concerns expressed just prior to death
- An individual was receiving services from more than one statutory agency at the time of death
- It is suspected that there is multi-agency learning that can be achieved by this review
- It is believed that death arose during the delivery of care.

At the Portsmouth Safeguarding Adults board on the 19th March 2014 it was identified that a review should be commissioned. At that time this was identified as a Serious Case Review but the Care Act 2014 has since named this process as undertaking a Safeguarding Adult Review (SAR). I was approached on the 15th May 2014 and my role as independent investigator was confirmed on the 20th May 2014. This was just over a year after the death of Mr A. The SAR has the following Terms of Reference:

Terms of Reference for Safeguarding Adult Review for Mr A June 2014

The purpose of this case review is to:

To establish the chronology of events in relation to Mr A as relevant up to and immediately following his death in May 2013.

To examine the adequacy of the interdisciplinary collaboration and communication between all the agencies involved in the care of Mr A or in the provision of services to him during the relevant period including consideration of delays in the processes.

To establish whether local policies and relevant legislation have been adhered to.

To prepare an independent report based on the findings and make recommendations to the Safeguarding Adult Board ensuring that the report is without bias or favour.

Conditions of review

Although the report will be completed under contract with Portsmouth City Council, it is commissioned on behalf of the Safeguarding Adult Board to which the report will

be submitted.

The report process will take as long as is necessary to sufficiently establish the facts but is expected to be completed by the 3rd September. Should further time be necessary, this will be agreed with the Chair of the Safeguarding adult review Board on behalf of the Safeguarding Adult Board. Should he be unavailable the Independent Chair of the Safeguarding Adult Board will be consulted.

Content of review report

The report will cover the following areas:

- Background to the commissioning of the review
- Information about Mr A
- Chronology of key events
- Analysis and Conclusions
- Recommendations and actions – to include wider learning points.
- References

Whilst it wasn't part of the remit of this SAR there was a delay between Mr A's death and the commissioning of the SAR which is something that agencies should attend to and I have made recommendations to this effect.

The SAR process started in May 2013 when I was approached to undertake this work. The SAR Board is made up of the Head of Adult Services for Portsmouth City Council (chair), the Safeguarding lead for Solent Health Trust, the Designated Nurse for Safeguarding Adults, NHS Portsmouth and IOW CCG and the Assistant Head of Adult Social Care (Assessment, Care Management and Social Work, for Portsmouth City Council. An initial SAR board meeting took place at the end of May with a follow up meeting at the end of June 2014; IMRs were requested for completion by the 18th July 2014 with a further SAR panel meeting at the end of July 2014. The majority of interviews with relevant staff took place during the last week of July and the first week of August 2014 whilst an interview with the GP took place the third week of August. Remaining queries were undertaken by email correspondence with various professionals during that period. A list of interviewees can be seen in Appendix B.

Significant work had been undertaken by Solent NHS Trust which provided useful background. However, it is necessarily the case that staff members found the length of time that had elapsed since the event made it difficult for them to remember or access information to inform the SAR and staff interviewed placed significant reliance on records when their own memory made answers uncertain.

Section 1.1 - Methodology

The report is based on information obtained from within Independent Management Reviews from:

- Portsmouth Adult Social Care (ASC)
- Solent Health Trust
- Care UK – independent care provider
- Portsmouth Housing Services

Safeguarding Lead responsible for North Harbour General Practice - the individual's allocated primary care provider.

Portsmouth Hospitals NHS Trust – the hospital to which the individual was admitted just prior to his death

In each case the IMRs were completed by clinicians or officers who were uninvolved in the care of Mr A and each included a chronology of their agency's actions in relation to Mr A. In addition South Central Ambulance only submitted a chronology due to their limited involvement but did respond in writing to questions arising from the chronology. In the case of Solent Heath Trust, it was agreed by the SAR panel that their Serious Incident requiring investigation (SIRI) report would replace the requested format for the IMR.

I met or had telephone contact with each of the authors of the IMRs to ensure correct interpretation of the reports and to ask some additional points of clarity and detail. In the case of the Housing Services' report I met with the author accompanied by the housing scheme manager.

Additional information was provided from the Police by the Joint Commissioning Team which indicated very limited involvement of Mr A with the police during his lifetime and nothing of significance to the SAR process.

Two of the agencies had several staff members involved with Mr A; these being Portsmouth Adult Social Care and Solent Health Trust. I therefore interviewed key members of staff within these two agencies and also met with both the General Practitioners who worked with Mr A during the period relevant to the review.

Interviews followed a pre-set written format, resulting from my reading of background information, meetings with the Safeguarding lead for Solent and the independent review author in Portsmouth City Council (PCC) but were expanded on during the meetings depending on the information resulting from these pre-set questions. I made notes during the meetings and at the end of each meeting I confirmed key points with the interviewees. Because I had taken the step of having this confirmation at the end of each interview, and because I do not want to add to what could be a bureaucratic process, I did not type out all the interview notes and neither did I send notes for signature. I am confident that each interviewee answered freely and that my notes were representative of their answers.

From the information obtained in the IMRs, the chronologies provided by each agency and information from interviews I completed an amalgamated chronology

using a comments column to add my own comments where information appeared conflicting or indicated questionable practice. This was also a useful vehicle to include information that may not have been known at the time of the action referred to in the chronology but that is relevant to the event.

I undertook a detailed analysis of this chronology, notes of interviews and IMR reports to reach conclusions and recommendations.

During the process of the SAR, three SAR panels were held, at the third of which the authors of the IMRs were requested to attend to answer the panel's questions. Two of the IMR authors failed to attend, one because of the unfortunate death of the individual and the other due to other pressing events. I therefore took forward the panel's questions to a further interview with the remaining report author. It was agreed by the panel chair that the question outstanding for the author who had died was not of such significance to warrant further follow up. A summary of the questions and answers was completed and this further informed the SAR report content.

Mr A had two sisters but only one of his sisters was involved at the time of the SAR review period and she had declined to be more than superficially involved. For this reason and because of the time elapse that had occurred since Mr A's death without any contact from any of the agencies, I considered it insensitive to meet with his sister as part of the process of the SAR. Further investigation since that time has elicited that both Mr A's sisters have now died and he is not known to have any other relatives.

Section 2 - About Mr A

I want to start this report with information about Mr A because it is important to me that readers of the report see him as a person and not just the subject of a serious case review. Throughout my findings I have experienced examples of professionals looking from their own view point alone but this report aims to provide a holistic picture.

Mr A was born in December 1933 and died at the age of 79 years. He had two sisters but did not appear to be much in contact with either of them during the period of his life when he was living at his last place of residence. Mr A was 'diagnosed' as having a learning disability when he was approximately 3 years old and there is anecdotal views held that one or both of his sisters had some limited social functioning. In fact, Mr A had a severe stammer that became worse if he was frustrated but he did not have a learning disability and he is stated as having achieved an Open University degree. However, his early diagnosis led to him leading what appears to be a somewhat sheltered life and, again from anecdotal knowledge only, it was felt that he and his sisters would need additional support when his mother went into care in 1986. For similar reasons he was later supported in 1988 into an Adult Placement environment, living with a family who offered him some care and support. This was followed by two further Adult Placement family arrangements but came to an end when the latest family were unable to continue with the placement because of their own health conditions. All of these placements were in Portsmouth because Mr A wanted to be near one of his sisters, who was in residential care, and the other sister who lived in Southsea.

When the final placement came to an end in 2002, Mr A was supported to accept a residential care placement because there were no further Adult Placement opportunities. This placement must not be seen to suggest that Mr A actually required the support that residential care currently offers but it does suggest that he was used to being supported throughout his life and more independent alternatives did not seem to be available at the time. In 2006, after 4 years in residential care, Mr A went to the rehab flat at Arthur Dann Court (ADC) – part of Portsmouth City Council's housing provision – and was assessed as being suitable for a tenancy. He was able to look after himself and needed minimal, if any, support; managing his shopping, washing and self-care.

Mr A has been variously described as an intelligent man; a man who liked to read; someone with rather eccentric behaviour and 'appearing as a street homeless person by appearance'; polite and dignified and able to say what he thinks. His speech difficulties did cause him to become frustrated at himself, sometimes biting his arm with his frustration but always apologising if he shouted or became angry. Even during the very last few days when Mr A could barely walk and asked for help to access the toilet, he asked to be left alone to use the facility and thanked the person who had helped him. It is clear that he valued his own independence and understood local and national events but may have held some misinformed beliefs – for example that he had to collect his pension weekly or 'it would be stopped'. It is possible that this led him to be determined to carry out his weekly visit to the bank and to do his shopping even when he was very limited in his ability and had

shopping support provided. Of those I spoke to, the housing 'scheme manager of Arthur Dann Court probably knew Mr A best and described him as:

'He was polite and respectful, a great reader of non-fiction, had a daily paper, read Shakespeare, looked dishevelled and was considered 'a character' from his appearance. He was a loner but not abusive. He did get frustrated and shouted when he couldn't make himself understood but would apologise.'

On his personal details care form, Mr A describes what is important to him as:

'*Being honest is very important to me, treat others how you would like to be treated. My independence means a lot to me and I appreciate any support I am given'*

By the time that Mr A began to deteriorate in December of 2012, his behaviour was described by the Housing Scheme manager as 'bizarre' and out of character but it was at this point that other agencies became involved who did not have a background of knowing Mr A's usual behaviour. It is clear that Mr A was assessed according to behaviour demonstrated in early 2013 rather than in the context of the rest of his lifelong behaviour. What is now known is that, by March 2013, Mr A was losing weight, had a wound but did not encourage others to see it and his behaviour was not typical.

Section 3 - Chronology of key events

Mr A was a man who had been mostly independent, only having 2 hours help per week from Age UK to help him shop until December 2012 when he started to exhibit behaviour that was unusual to those who knew him at Arthur Dann House, the housing scheme where he lived. On the 14th January 2013 the Housing Scheme Manager made a referral to Adult Social care (ASC), identifying poor fluid intake, loss of weight and self-neglect. ASC identified this referral as high priority. After a further period of strange behaviour such as screaming and placing torn up paper in a bag given to staff as laundry, Mr A was supported to visit his GP in February 2013 when staff reported poor self-care, throwing things and other behaviour changes. The GP undertook blood tests and referred to physiotherapy and again to ASC for a package of care. The GP also planned to communicate with the pharmacy services for a Nomad tray and made a referral to the psychogeriatrician service. The physiotherapy service, following a request for information from the GP, identified Mr A's referral as 'routine'.

A visit to the GP on the 5th March resulted in an audiogram to investigate the 'buzzing sounds' that Mr A was experiencing. Six weeks after referral to ASC, an Independence Support Assistant (ISA) was allocated to assess Mr A and, on visiting on the 6th March 6 days after allocation, made an assessment that Mr A needed care to help him in the mornings and to prompt him to take his medication. This was commissioned and an initial care assessment visit by the independent care provider, Care UK, took place the following day and care started on the 14th March. As a result of the GP referral to the psychogeriatrician, the Older Persons Mental Health (OPMH) service's support worker visited on the 13th March and agreed to visit weekly to help Mr A to develop a routine and keep his flat tidy. During that assessment visit it was established that Mr A showed no signs of paranoia and scored 30/30 on his mini mental test. The OPMH worker also referred for a Nomad and requested an Occupational Therapy (OT) assessment. There was no plan to

pursue a diagnosis. A visit from the ISA on the 19th March to review the progress of the package noted that Mr A's medication was strewn around his flat and followed this up the following day with a call to the GP to request information about the Nomad. It was clear at this time that the initial referral for a Nomad had not been made and that the GP made such a referral on the 20th March. The ISA discussed Mr A with the OPMH support worker with both identifying that Mr A left a lot of money around his flat. During the week of the 23rd March, Mr A was recorded by care workers as having frequently been sick but there was no follow up plan and medication checks were not recorded throughout that week. Housing staff noted that Mr A's bizarre behaviour was continuing and he was said to be cutting up his clothes.

At the beginning of April the OT visited but, due to Mr A's tiredness and ill health, the OT needed to visit four times, completing his assessment on the 24th April when he noted that Mr A's functioning was below that to be expected for his age and offering follow up OT support. Mr A continued to have episodes of sickness. On the 12th April, the physiotherapist visited at the same time as the district nurse, the Age UK shopping support worker and the OPMH support worker. The physiotherapist indicated that Mr A had sufficient help and did not need physiotherapy; the community nurse was present to dress a wound of unknown origin to Mr A's calf; the OPMH support worker was present as a routine visit but she noted how difficult Mr A found multiple visitors and that he was not eating well. The community nurse had clearly visited before but notes were missing. Medication was still seen to be strewn around the flat and the OPMH support worker removed all medication, identifying that Mr A may be at risk of over medicating. She said that she conveyed this information to the community nurse but the nursing service has no record of this. On the 19th April the housing service's notes show that the OPMH support worker visited with a psychogeriatrician from St James hospital and referred Mr A for a brain scan but there is no record of this in the health notes. A commode was ordered for Mr A by the housing service. Care UK visits continued but there were no records of medication checks or note that medication was unavailable for 24 consecutive visits.

On the 22nd April the ISA took Mr A to the bank to obtain documents to enable a financial assessment, where Mr A exhibited a high level of agitation. Regular community nursing visits continued until 24th April when they stopped with no forward plan. The physiotherapist received a further referral and contacted the ISA for background information but did not visit. The GP received notification that Mr A had had hearing aids fitted. Following further episodes of bizarre behaviour and sickness, and in response to a call from the Housing service, the ISA visited on the 29th April and noted that Mr A was not eating. No plan was made to address this but, again in response to a call from the housing service the following day, the OPMH support worker visited and witnessed a very messy and potentially dangerous state in Mr A's flat. She was still present when a duty GP visited who was told that medication had been removed 12 days earlier. The only plan that was made by the covering GP was for a further blood test and urine test and to discuss the medication with Mr A's allocated GP. No record of such a discussion is recorded in the GP notes. The covering GP has since confirmed that this action did not happen.

A meeting between OPMH service, ASC and Housing took place on the 1st May. As a result a plan was recorded to increase care to twice daily and make referrals to other services. The results of the urine test ordered by the covering GP were

returned to the surgery on the 2nd May but no plan was made to address the findings which were showing serious signs that should have had attention. Two calls were made by housing services to the OPMH support worker on consecutive days describing bizarre and risky behaviour by Mr A. ASC services attempted to find a provider to provide the increased care but were unable to and, eventually, OPMH intermediate care services agreed to undertake evening visits on the next two days. This was over a bank holiday weekend. Finding Mr A on the floor on the 5th May, housing services called 999 and ambulance staff called but, after discussion with the out of hours doctor, did not admit to hospital. On the 6th May, Care UK staff visited in the afternoon and found that Mr A had not moved since their morning visit and called 999. Mr A was admitted to hospital.

Portsmouth Hospitals (NHS) Trust (PHT) carried out treatment to resuscitate Mr A and address his low blood pressure and low body temperature. By the 9th May, Mr A's condition was deteriorating and on two occasions a brain scan was requested. A plan for end of life care was discussed with Mr A's sister who had only very limited contact with him by this time and Mr A died just after midnight on the 13th May.

It is critical to the understanding of this report that the table of events presented as appendix A is taken into account. This table does not cover the detail of every single phone call or record (which is available in each of the IMR reports) but does include the vast majority of contacts and, I believe, the amalgamated information from all agencies about key events of the period specifically from the end of 2012 to Mr A's death in May 2013 and immediately following this. The table is supplemented by information gained during recent interviews in order to present a comprehensive review.

Section 4 - Other information obtained during SAR

This section includes information that was presented to me and differs from the following section in that it covers statements of the facts or views, as interpreted by those interviewed and does not represent my analysis of those statements.

During interviews with some key staff members further information was gained which has informed this review but which cannot be integrated into the chronology. Although the source of each of the following points is known to me, it is not generally included as I made it clear during interviews that the information gained would not be used to attribute blame or be directly ascribed to single individuals. However, in some cases, it is unavoidable if the point is to be made.

Section 4.1 - Points are specific to Mr A's health and health management:

The view in the community was that Mr A had not had a prescription for his medication issued since at least January 2013 whereas there is a record in the GP notes of prescriptions being issued bimonthly, as was the usual practice for Mr A, in January, March and May. The pharmacy has not been contacted to establish whether these scripts resulted in issue of medication.

Although no specific mental capacity assessment took place, the majority of professionals involved considered that Mr A had the capacity to make informed decisions, particularly if he was given one to one time in which to consider actions.

However, when asked what those interviewed felt was wrong with Mr A's health, a number of people considered that he had 'mental health problems'. One statement made indicated that the speaker felt that most people treated Mr A as if he had mental health issues and this was certainly backed up by my impressions from a number of others during interviews.

Although I have been told by two people that the older peoples' mental health team members do not have the skills to identify physical health problems and it is clear to me that team members do see themselves as specialists, I was told that signs of physical ill health are addressed by those attending from the OPMH team.

The information recorded in the primary care notes indicate that Mr A's blood pressure and kidney function were not showing significant impact from the lack of medication when blood and urine samples were analysed until the final few days before his hospital admission. In the opinion of the GP I was told that although some limited reduced functioning could have been the consequence of the lack of medication, this is likely to have increased the susceptibility to other problems such as sepsis, due to reduced immunity, rather than having been the key reason for Mr A's deterioration in itself.

Section 4.2 - Points are specific to staffing and other resource issues:

A number of interviewees expressed the view that the policy of keeping more people in the community and reducing community hospital provision has meant that more vulnerable people require community attention. Although I have been told that staffing in the community nursing team has now been increased and vacancies are mostly covered, it is clear that there were significant staff vacancies at the time covered by this report (for example the North team was 205 hours short of being fully staffed).

I was told that, at the time, several agencies were suffering from staff shortages and a lack of consistent management. Care UK were at the point of closing their Portsmouth branch due to long term sickness of the local manager and an inability to recruit staff, especially male staff which, I am told, is an issue nationally. They were said to be 'in chaos' and it was acknowledged that audits, supervision and practice checking were not happening at the time. ASC had temporary Safeguarding service management and, I was told, were too busy to follow up some of the actions recommended in safeguarding meetings following Mr A's death.

The safeguarding leads for Solent and ASC told me that, when they are away, the attention to detail cannot be covered to the same level.

The ISA is an unqualified worker who, at the time, had only two and a half days of her working week available to her to cover her case load due to undertaking duty and having meetings. A number of other professionals felt that they were not made aware that she was not a qualified social worker. She explained to me that she felt that Mr A had been independent for seven years in ADC and should be supported not to lose that independence.

It is the experience of at least two people that I spoke to, that the wait for care to be arranged 'takes days'. However, I understand that the 'care finding' team can

access care within 24 hours and that there is no delay if care needs are urgent. This was clearly not the case during the bank holiday period in May 2013.

Both GPs to whom I spoke in Mr A's practice stated that they recognised that they have the responsibility for the health of their patients but that they feel disempowered by some of the processes they are required to practice as a result of their contract.

Section 4.3 - points specific to the communication and relationships between agencies:

It is the view of a number of people considering Mr A's situation in retrospect, that no individual or agency took ownership of his health and care problems. I am told that a number of different professional teams are based in shared buildings but that, although there is opportunity, they did not then and often still do not undertake informal or regular discussions about shared work. Although this could have been managed by applying the CPA process, it was not in this case. There was no clear CPA plan at the beginning of Mr A's involvement with the OPMH services but I am told that this is usual if a diagnosis is not known.

A number of people interviewed felt that the application of the Virtual Ward approach will have the impact of resolving the lack of ownership and certainly there is some hope that the 'Better Care Fund' will improve this with its focus on greater integration. I understand that a geriatrician leads the Virtual ward and that all disciplines are represented. However, I also had it made clear to me that there is a view that OPMH cases are less frequently bought to the meetings. One suggestion made to me was that there should be a 'key worker' if more than 3 or 4 agencies are involved.

On questioning the potential efficacy of having a key worker role, I was informed by one interviewee that this approach had been tried in the past but that individuals were not given sufficient authority and lacked confidence and understanding of the role of other professionals involved. It was that person's view that the approach would fail again unless greater cross learning and respect was achieved by having shared training days.

There was a high level of emphasis from the two doctors that I interviewed in the primary care setting that caring for 1,800 patients in the community means that there must be a reliance on the other disciplines in the community teams reporting when problems arise. I was told that if a patient is engaging with care, comes regularly to appointments and few problems are recorded as was indicated in Mr A's primary care notes, then a GP cannot chase up each individual patient.

The duty GP described the communication between agencies as poor and the communication with ASC in particular as 'abysmal'. Although a monthly meeting is held with community health services, the GP does not believe this serves to provide routine communication. A view was also given by this surgery's GPs that it was not believed that the Virtual ward approach works for primary care, believing that the community matrons 'control' the process and do not respect primary care views.

Section 4.4 - points specific to practice issues:

I was informed of the good working relationship between PHT safeguarding lead and PCC ASC staff and there genuinely appeared to be a high level of mutual respect.

There appears to be some lack of clarity on the part of the GP practice about the way to order a Nomad medication management box. The GP believes that there is no choice but to order through the Single Point of Access who will request from the community pharmacist and that this may take several weeks because, it was stated, there are only 2 community pharmacists available to undertake the assessment for Nomads. The benefits of this approach were understood but it was felt that the surgery has no control and does not receive any feedback – 'once it's gone, it's gone'. The duty GP also informed me that there are problems both with ordering a Nomad and changing or stopping particular medication. However, I was told by all other clinical practitioners that I interviewed that primary care and others can order Nomads direct from the chemist and can indicate a level of urgency.

The duty GP informed me that the record of the surgery having a low hospital admission rate is held in high esteem by the senior partner of the practice but that this acts as a deterrent to admissions even when some of the practice staff consider that admission would be in the patient's best interests.

It was made clear to me during my investigation period in 2014 by several people that safeguarding approaches are seen as matters of priority and given a significant level of personal attention with real accountability. I understand that currently ASC staff personally screen all ambulance and police referrals to identify those which need urgent attention (about 5%) and that the PHT safeguarding lead personally rings or contacts PCC if she feels that a referral is high priority and that a referral made by secure email may be missed.

Knowledge of supervision policies and training regarding safeguarding, self-neglect and mental capacity seemed widely understood and available although the actual practice of supervision varied with some Solent staff feeling that they did not have sufficient supervision during the time that they were working with Mr A. In the ISA's case she felt that her supervisor did not then offer her supervision for both Occupational therapy activities and social care activities which she feels were both required in the role of an Independence Support Assistant. I have been told that this may have been a lack of understanding on her part as the role was set up to support links between social care and occupational therapy senior staff from the outset. I was told that there is still a lack of 'ring fenced' time for supervision in both Solent and ASC.

I asked about who PHT wards notify in the event of a death on the ward and understand that only the next of kin and the GP is informed. Ward staff do not have knowledge of sheltered accommodation housing. I also understand that a risk assessment/threshold tool has been devised but that this has not yet been authorised. It has been made clear that the likelihood of this being available to ward

staff is very low because it would expect too high a level of expertise in staff members who are not qualified to make such judgements.

Both the primary care practice in this case and some Solent staff identified a view that they are required to undertake 'tick box' activities due to the nature of the contracts with commissioners and that this can mean that they become task orientated and that it is more difficult to see the holistic nature of the people with whom they are working. They made it clear that this relates to the fulfilment of standards and measureable outcomes interpreted as required under contracts.

Section 5 - Analysis

Firstly it is important to stress that all the people who have been interviewed as part of this case review have been professional and caring. My findings have reinforced my belief that health and social care professionals come to work each day to do a good job and that the people with whom they work are at the centre of their involvement. In no instance did I feel that anyone was deliberately negligent or purposefully superficial, in fact most people appeared to have a fondness for Mr A and a desire to support him. In the majority of people I have also experienced a willingness to acknowledge areas where they may have failed and a keenness to learn from the outcome of the review. However, the purpose of this review is to rigorously analyse the actions, judgements and omissions that influenced the care that Mr A received and to identify areas of learning.

My analysis will be undertaken under a series of questions from which I will draw my conclusions:

Were assessments sufficiently adequate to identify the reasons for Mr A's behaviour?

Was there a sufficiently holistic approach to how care was provided?

Where necessary were risk assessments undertaken appropriately?

Were arrangements in place to escalate crises to sufficiently qualified or senior staff?

Were there issues associated with standards of practice and, if so, how did these affect the outcome for Mr A?

Were arrangements appropriate to be able to meet any limitations of service capacity?

Section 5.1 - Were assessments sufficiently adequate to identify the reasons for Mr A's behaviour?

Mr A had been known to be a polite, quiet man who valued his independence and, despite dishevelled appearance, was intelligent and read a lot. At the end of 2012 and the beginning of 2013 several incidents occurred that were out of character. It is

quite possible that these behaviours may be symptoms of confusion and Mr A was of an age where dementia may well have been considered. However, during subsequent assessments, Mr A is recorded as scoring a full record on a mini mental test and, in interviews with staff during this review, he is consistently said to have had the capacity to make informed decisions (although no staff member undertook a mental capacity assessment). No mental health diagnosis was ever recorded and no reason for changed behaviour was identified. I accept that the diagnosis may take several weeks to make and involves a series of tests to eliminate causes. However, no plan existed to inform a diagnosis.

Staff at the housing scheme recorded and described the episodes of bizarre or unusual behaviour; the GP, who was told of the behaviour changes, did make a full plan which included reference to Mr A's physical needs and did refer to the psychogeriatric services which led to the involvement of the OPMH team. The first visit by this team on the 13th March 2013 identified that Mr A had insight into his needs and a plan was devised to support him but no investigations were set up to establish a diagnosis. There does not appear to be a full assessment recorded from the initial visit and, although Mr A was treated as being on a Care Programme Approach, he did not have a CPA plan. The OPMH services agreed to provide a senior support worker to visit weekly despite there not being a mental health diagnosis. The GP ordered a blood test to 'exclude physical causes' for the change of behaviour but, when this appeared to be within reasonable limits, it is not clear whether further tests were requested. It is not until the CPA meeting on the 1st May 2013 that there is a reference to 'chasing the brain scan' and it is only verbally that I have been told that the GP did not see the need to chase the CT scan as the community team were not raising this as an issue. I was not shown any record of a request for a CT scan and it is not identified in the primary care chronology. Housing records indicate that the visit by the psychogeriatrician may have initiated a referral for a brain scan. Medication was not changed apart from in response to a possible chest infection and some signs of anaemia – there was no treatment identified as a result of a diagnosis that would explain the changed behaviour. Mr A's behaviour became more and more extreme. None of these behavioural or physical symptoms led to investigations resulting in a diagnosis prior to hospital admission.

Despite ten agencies (or disciplines within agencies) being eventually involved with Mr A and seven of these being health disciplines, there remains no diagnosis or explanation for the quite dramatic changes in Mr A's behaviour. There was not, at any time during the period covered by the chronology above, a diagnosis of mental health problems. Two requests were made by PHT for 'urgent brain scans' which actually took place on the day that it became clear that treatment would not be different whatever the diagnosis. It is, however, fair to say that some of those agencies had not been made aware of the extent of the behaviour changes.

Section 5.2 - Was there a sufficiently holistic approach to how care was provided?

During the majority of the period under review Mr A had the support of eight professional disciplines: primary care; community nursing; older people's mental health services, therapy assessment (OPMH); physiotherapy; adult social care; housing services and a care agency. During the review period there are a number of incidents where communication between up to three of these agencies at a time did occur but none of them undertook to initiate comprehensive discussions about Mr A's needs either with or without him. The OPMH services identified that they were 'not allowed' to record in the care agency's notes so preventing another opportunity for liaison. On the 5th May the ambulance service found Mr A unable to stand and with very low body temperature and with the knowledge that he had been without medication for up to two and a half months. In response to further questions, the ambulance service has explained that a discussion with the out of hours GP service (the 5th May was a bank holiday weekend) took place from Mr A's flat without access to any other services.

Although the housing scheme manager undertook several calls to other agencies individually, with increasingly desperate pleas for support, agencies did not liaise in order to respond to these calls. On the 2nd May, the day before a bank holiday weekend, the scheme manager rang the GP who advised contact with OPMH services who then handed on to ASC who did not ring back until late in the day. ASC only liaised with OPMH on that day because they could not obtain care and needed the OPMH intermediate care team to provide extra visits.

The removal of medication on the 12th April from Mr A's flat due to his non-compliance and a fear that he might accidentally overdose was perhaps a reasonable action although there was no risk assessment undertaken to evidence this. However, a plan was needed to enable the medication to be available for Mr A to use. OPMH services insist that the community nursing services were made aware but the nursing services insist that they would not leave a patient without medication had they been made aware. On the 30th April a GP (not Mr A's usual GP) was made aware by OPMH services that he did not have access to his medication but there is no record of this conversation or any action in the primary care record to rectify this.

My interviews with professionals involved has given me an impression of caring individuals who each take responsibility to varying extents for the tasks allocated to their discipline but all of whom fail to see Mr A as a whole person. The most holistic description of Mr A is recorded by the OPMH support worker on the 12th April but there follows no action to address the issues; for example there is no SALT referral despite a record of Mr A having difficulty swallowing, no question of changing the shopping activity with Age UK or of letting other agencies know that Mr A was at continued financial risk because of the money left around. Most importantly she recorded that she removed all medication and there is a disputed and informal discussion with the district nurse as the only action to address the lack of medication.

Section 5.3 – Where necessary were risk assessments undertaken appropriately?

A key role for ASC is to undertake assessment of the risks to individuals and those around them. On three occasions, significant risks were identified that should have led to risk assessments and a record of actions offered to address those risks. These were 1) on the first visit from ASC when risks associated with nutrition and finance were noted, confirming those identified at referral five or six weeks earlier; 2) on the 29th April when a visit again indicated a lack of nutrition and no medication; 3) during a telephone discussion on the 30th April when housing staff conveyed their concerns about broken glass, knives and tripping hazards in Mr A's flat. Just one day later the 'CPA' meeting at which the ASC worker was present, does note some of the risks but there is no record of a risk assessment and still the issues of nutrition and hydration (basic life needs) are not addressed as risks. On the 3rd May the stated risks identified by housing staff of risks to Mr A and those around him still did not result in a risk assessment and, instead, the focus is around trying to create sufficient cover over the bank holiday.

However, it is not just the role of ASC staff to undertake risk assessments. It has been acknowledged that community nursing staff, when short staffed, made decisions about whether a visit could wait on the basis of risk. No formal risk assessment informed the decision to skip a visit following the visit to dress Mr A's leg wound on the 24th April and the lack of such an assessment appears to have allowed subsequent visits to 'drop off' the nursing list. This meant that Mr A was left with the same dressing on his leg between 24th April and the admission to hospital on the 6th May, by which time the wound was weeping and the leg wound had become a 'chronic necrotic ulcer with surrounding cellulitis up to his knee'.

Furthermore, no record exists of the OPMH support worker making a formal assessment of risk in removing medication from the flat. Informal discussions with a community nurse and even the discussion with the visiting GP three weeks later are insufficient to address what should have been identified as a major risk issue. Although the consequences of lack of medication do not appear to be demonstrated in blood and urine tests during those weeks, the OPMH support worker is not qualified to make a decision that medication is not needed.

The physiotherapy services did identify risks and there is a record of attention being paid to those risks but they relied on the services that they assume were being managed by other agencies. However, they did demonstrate professional good practice in feeding this back to referrers.

The visit by the ambulance services on the 5th May clearly identified low body temperature and an awareness of medication having been unavailable for several weeks. I have received only a brief chronology from the ambulance services and a note that 'From the notes taken from the call log we believe it would have been a clinical decision made by the ambulance crew and the doctor. The crew spoke to [another doctor] and the decision was made that ' it can wait until Tuesday to see the GP.'(as recorded in a response to questions I asked of the Safeguarding officer at SCAS). It is unclear on what basis the risks to Mr A were assessed other than that they were aware he had 'mental health issues' and a carer visiting later in the day.

They witnessed a man who could not stand, had low body temperature and no medication but left the care of this situation to a medically unqualified carer.

Housing staff records regularly show that they reported what they believed to have been risks to Mr A and those around him. When faced with a lack of action, there is no record of further risk assessments to minimise risks or to escalate and there appeared to be a willingness to understand the pressure on other agencies and consequently accept a lack of action.

None of the agencies who could have undertaken a mental capacity assessment (as part of the assessment of risk) took this action. The GP told me that he felt he was not qualified and did not ask for this information from any other agency after his referral to the psychogeriatrician; the ASC services should have considered mental capacity as part of assessing capacity to make informed decisions when OPMH services are known to be involved; OPMH services should routinely consider mental capacity in considering action plans. Although each of the workers from these agencies told me that they considered Mr A had mental capacity, they each witnessed behaviour that made this questionable at least some of the time. The oft repeated plan to manage medication by means of a Nomad would rely on Mr A's capacity to understand the process and consequences, as he did not have medications support throughout the day, but no assessment was made to verify this. The decision to manage his finances by means of 'piggy banks' assumed that Mr A had the capacity to do this despite his very obvious behaviour demonstrating that he did not take into account the risks of leaving money around when so many people were visiting.

The duty GP recognised the risks of leaving Mr A without immediate action on the 30th April but did not undertake a risk assessment, making assumptions without considering what would happen if those assumptions failed to materialise. It has since been acknowledged by the duty GP that Mr A should have been admitted to hospital.

Section 5.4 – Were arrangements in place to escalate crises to sufficiently qualified or senior staff?

Daily visits were taking place by Care UK staff who witnessed deteriorating behaviour in Mr A - days of sickness and vomiting effects and a risky environment in the flat - but did not report these findings to other agencies and only escalated to senior staff in their own agency five days prior to admission to hospital. The author of the Care UK IMR has acknowledged that this was inadequate and not the practice expected of visiting care staff.

The unqualified Independence Support Assistant in ASC noted a number of risks and it is clear from information above that she did not formally undertake risk assessments and she has since reported that she was 'too overwhelmed by the messy flat' to consider the remaining risks. She did, however, describe Mr A's care needs as 'complex'. She has accepted that her commitment to her role made her feel less willing to seek help for fear of having 'failed'. Eventually, on the 30th April, she made a qualified social worker aware of the risks.

The unqualified senior OPMH support worker had significant experience in the field and was used to making practical decisions. It is, however, very questionable as to whether it was her role to remove medication completely. She described a process whereby all the recording by staff in her role was 'verified' by a senior and relied on this to ensure that her actions were understood by senior staff. It was again not until the meeting on the 1st May that a professionally qualified staff member was formally involved.

The intermediate Care Team (OPMH) noted quite extreme risks on the 4th May and had the benefit of objectivity having not been previously involved but, again, relied on the regular team to pick up the issues after the bank holiday without escalation to senior staff.

The staff members at ADC were increasingly concerned and sought help from a number of sources, which was entirely appropriate, and were clearly frustrated by the lack of support for the activities that they had to undertake on a day to day basis. Housing Scheme managers do not have regular supervision beyond an annual personal development meeting and no guidance about escalation of risk situations has been provided. This was confirmed by the Housing Scheme Manager of ADC; she is managed by a Sheltered Housing Manager who in turn is managed by an assistant manager who, in turn, is managed by the overall Housing Manager who completed the IMR. The Housing Scheme Manager is supported by six support assistants in ADC.

Section 5.5 - Were there issues associated with standards of practice and, if so, how did these affect the outcome for Mr A?

Although some of the points made in this section have also been included elsewhere, I have chosen to highlight them separately because they may demonstrate poor or inadequate practice specifically.

Care UK were commissioned to check medication but, not only failed to record that they were doing this, but actually must have failed to undertake this task at all during the period that Mr A was without any medication. They did not carry out a task for which they were commissioned and did not report this failure which maintained the lack of attention to Mr A continuing to have no medication.

The process for managing a CPA was not managed as it is designed to be. The GP and several of the involved professionals were not invited.

ADC staff provided quite a significant level of personal care to Mr A. However, the service is not registered with CQC for the provision of personal care. The service sanctions the provision of personal care 'in an emergency' and this is evidenced by a basket of cleaning and personal care equipment being provided to the staff for this purpose. However, if care is not available then the likelihood of repeated 'emergencies' will be high with housing staff routinely providing personal care several times as was the case with Mr A.

The method of ordering a Nomad system has involved a certain amount of confusion with the primary care team, in this case, believing that they can only order through the community pharmacist despite being aware that this can take weeks or even

months. They appear to have accepted this belief without taking responsibility for the consequences.

Mr A was losing weight and those who knew him well were describing very changed behaviour. Each of those primarily involved in the care from ASC and OPMH dealt only with the more obvious circumstances experienced during each visit.

Specific policies already existed for 'the Assessment, Prevention and Management of Leg ulcers'; 'Tissue Viability – The Prevention and Management of Wounds'; Self Neglect and Adult Safeguarding Guidelines' and I am told that there has been increased training to specific teams regarding these policies. However, on questioning the three community team members that I spoke to, they did not appear to have a real awareness of the policies but did say they would know where to look for them.

The ambulance services left a patient who was known to be without medication for some weeks, with a low body temperature and who was unable to stand. This was together with reported concerns from the Housing staff.

The on duty primary care doctor visited on the 30th April and was told that medication had been removed; noted oedema of both hands and feet, a low body temperature and low saturations; was made aware of housing and mental health staff concerns; noted the dressing but made no examination and took no action apart from ordering a blood and urine test. When this test showed significant proteinuria still no action was taken the following day and, again a day later, another GP referred the concerned housing services to the OPMH services despite a record existing in the notes of these findings. Anecdotally I have also been told that Mr A's experience of primary care may have been affected by the belief that Mr A's appearance and difficulty in communicating made him less likely to receive full investigations – this was based on antibiotics being prescribed for a chest infection without a chest examination.

Leaving a wound without attention was clearly poor practice although the cause of the oversight has been acknowledged.

None of the services paid attention to the offer of Therapy support to prevent decline or assist Mr A to improve his functioning.

Section 5.6 – Were arrangements appropriate to be able to meet any limitations of service capacity?

The referral made by staff at ADC to ASC was allocated code 1 priority. This was the highest level of assessed priority in response to the information that Mr A was neglecting his personal care and mismanaging his medication and food intake. Allocation took six weeks and two days and then a further six days before the first assessment visit. No interim follow up was offered apart from in response to a call from the housing scheme manager. The potential impact of poor nutrition could have been significantly exacerbated within that time, seriously worsening the risk. Such a wait could have resulted either from lack of workers to whom allocation could be made or insufficient process management. This is evidenced by the information from the ASC mental health worker who told the scheme manager that 'Mr A was on the highest of priority list but there are also others on the list.' It has also been

confirmed by a senior ASC staff member that there were some process management issues in the team at the time.

Community nursing staff members told me that they were under-resourced, and this was confirmed in interview with a senior staff member. They believe that this led to decisions having to be made routinely to miss some planned visits on the basis of information handed over from the previous day's visits. This led to the cessation of visits to dress Mr A's wounds from the 24th April when he should have been receiving three visits per week.

Already described is the passing from agency to agency experienced by ADC staff on the day before a bank holiday weekend. Care UK and, it is assumed, no other agency commissioned or provided by ASC, could provide an increase in care to meet Mr A's needs described as desperate by the housing staff. The Intermediate Care Team stepped in to provide evening check visits. However even they were unable to confirm that they could take on this task until the end of the day before the weekend as they feared they too would be short of resources.

Anecdotally there was a view from the OPMH services that additional social care 'always took days to set up'. This has been partially confirmed by the ASC worker who recognised that getting authority for additional care and then getting a start date was not always timely at the time. However, she felt that usually care can be accessed urgently if necessary. It is unclear whether resources or processes were the cause of delays.

Initially I had some concern that the approach of having limited numbers of safeguarding leads in the key agencies relies significantly on individual commitment and availability. On discussion however, I accept that safeguarding should not be seen to be the responsibility of single professionals and that all others involved should take their own responsibility whether or not the named 'safeguarding leads' are involved.

As a point of clarity the lack of a coroner's report has been the subject of some uncertainty during this review. The usual reasons to request a coroner's report are that a death is unexpected and/or that an individual was considered to be under safeguarding investigation. Because the details of the community provision and the fact that safeguarding referrals were not known about at the time of his death, no action in this respect was taken. However, in view of the findings in this report, the coroner will be approached for a view.

Section 6 - Conclusions

Section 6.1 lack of diagnosis

I believe that the lack of a diagnosis or investigations into Mr A's physical and mental state was significant in failing to devise a suitable plan. At this stage it is not possible to know what it was that caused Mr A's confusion and behavioural changes. However, it is clear that he experienced rapid behaviour change, bizarre behaviour, did not have short term memory loss and experienced buzzing in his head. Tests demonstrate that the effects of lack of medication were not the whole, or possibly even the main, cause of his health changes but no one put his numerous symptoms together to inform a diagnosis. He was hampered by his pre-existing communication and sight limitations but a normally polite, intelligent man became someone who lacked dignity and self-control at the end of his life. It is perfectly likely that whatever care package or support Mr A could have had would not have prevented that sad end but it is also possible that others could have been helped to understand and support him in a different way if attention had been paid to his diagnosis. It is also possible that he appreciated being able to stay in the environment he knew and retain some independence which may have been taken from him 'for his own good' if his behaviour had been found to be caused by a medical cause. However just before his admission to hospital his statement that 'he felt like hell and wished he were there' clearly indicates that he needed a different type of support in his final days at home.

Section 6.2 communication

I also conclude that communication between professionals, and actions as a result of communication, was extremely limited in planning Mr A's care despite both the number of agencies involved and the acknowledged complexity of Mr A's situation. There was knowledge by each that other agencies were involved but there were frequently noted references that another agency would take responsibility for an action without confirmation or liaison and, when actions did not take place such as the continued lack of a Nomad, no worker took key responsibility.

Despite caring and well intentioned staff being involved there was a lack of coordination and communication which meant that a thorough plan of support was not available and agencies became reactive rather than proactive. Information existed to lead the various agencies to more thoroughly investigate but various individuals attempted to perform their own remit without taking account of the information known to the Housing services and joining this up to form a context of Mr A's own life.

The meeting on the 30th April, described as a CPA, was an opportunity missed to coordinate the care and care failings in relation to Mr A and take actions to rectify these.

It is likely that poor practice and willingness, or other reason, not to take ownership of Mr A's whole care needs was significant. Each agency seems to have worked almost in isolation or at least quite independently. As an independent reviewer, I have the benefit of retrospective and comprehensive knowledge which has given me

the advantage of seeing the deterioration in Mr A's behaviour, his continued weight loss, the lack of a diagnosis and the absence of detailed holistic action plans. However, it would have been possible for much of what I have found to have been shared at the time had one agency taken ownership or had one or more case conference meetings taken place.

Section 6.3 Lack of risk assessments and the impact of service capacity

I also conclude that planning was not based on clear, objective risk assessments and neither was each agency's initial plan updated according to each assessed new risk that was presented. Housing staff made strong efforts to inform other agencies of risks regarding Mr A's health and the potential risks to other residents at ADC. They were right, in my view, to identify these risks but their willingness to tolerate lack of support appears to have preventing them being much more assertive about ASC allocation and they failed to report the quite severe risks they were witnessing to more senior housing staff.

I also consider that there was a lack of assessment of Mr A's mental capacity. I accept that there is an assumption of mental capacity unless there is reason to investigate otherwise but, in Mr A's case I believe that his behaviour gave sufficient reason for mental capacity assessment on numerous occasions which should have informed practice; for example on considering financial protection, medicine management and his ability to decide his own future.

In my view a wait of over six weeks between referral to ASC and the first visit to assess by an allocated worker is an insufficiently timely response to a potentially high risk situation, described as poor nutrition and hydration that could have been life threatening and did not sufficiently take into account the outline risk assessment that had taken place when identifying the referral as 'code 1' or high risk. I further conclude that limitations on service capacity played a part in the level and timing of support provided to Mr A. This failure, whether it was due to reduced or inadequate team capacity or a failure to adequately manage process through a lack of service management, signifies failure due to service capacity limitations.

In addition, the described need to 'drop' some daily visits due to lack of sufficient community nursing staff and the fact that there were significant vacancies in the team is, without doubt, a factor in the failure to adequately manage Mr A's nursing needs that resulted from service capacity issues. It is likely that the lack of fresh dressing or swabbing of Mr A's calf wound led to the necrotising ulcer and the spread of cellulitis to his knee that was present when he was admitted to hospital.

I further conclude that a lack of availability of commissioned care or alternatives led to inconsistent staff providing care when the decision had been made to increase the daily care provision. I believe that this meant that, not only did Mr A receive intimate personal care from yet more people who he did not know but also they were unable to understand the context of his needs. There was wholly insufficient planning and resources available to cover a crisis situation during a period when professionals would be unavailable over the May bank holiday. The lack of care availability; the lack of ownership for the risks and the inadequacy of the eventual response which

left the housing staff to manage a deteriorating situation with only an emergency out of hours number to contact was inadequate.

Section 6.4 Failure of escalation

It is my opinion that there were a number of failures to escalate issues to the right level of authority or experience and I have addressed these in section 6.5 below.

Section 6.5 – Consideration of professional practice

In the course of considering the circumstance of this case I must make a view as to the quality of professional practice. I have specifically looked at the responsibilities of Adult Social Care, the OPMH support services, the housing services, Care UK, the ambulance service, the community nursing service and the primary care provision to Mr A.

In the case of ASC, an unqualified worker was allocated to work with Mr A. I have no reason to believe that was inappropriate at the start of the period of assessment. The role of ISA carries with it some professional responsibility but is also subject to management by a qualified worker. Individual supervision can only lead to managing actions if information is escalated and it has already been established that the complexity of Mr A's situation was not escalated in a timely way. It is possible that the determination to maintain Mr A's independence could lead to a disinclination to seek alternatives and I believe that this played a part in the lack of more comprehensive plans with Mr A. Clarity of supervision arrangements appeared to be in some doubt to the worker themselves with uncertainty about access to both Occupational Therapy and Social Work expertise and I have since been told that both disciplines could have managed the complexity of Mr A's circumstances. There was therefore, I believe, some lack of clarity about to whom and when to escalate issues which was most likely caused by inexperience and a desire to perform well and was not due to professional neglect on the part of the agency.

In the case of the OPMH services, again an unqualified worker was allocated and was, in my view, appropriate to undertake the function of helping Mr A to develop a routine and keep his flat clean. Whether the mental health services should have remained involved without a mental health diagnosis being ascertained is questionable but OPMH services do not appear to think this unusual from my discussions. Removal of medication when a situation is described (although without a risk assessment) as being high risk is understandable and the process of relying on qualified workers undertaking peer review of recording was considered sufficient to monitor the actions of unqualified staff. The removal of medication without a secure plan to follow this up should not, in my view, have happened but the service appears to accept that appropriate action was taken to manage this by passing on the information to community nursing services and, later, verbally to the covering GP. This situation was not poor professional practice in the context of what was acceptable to the organisation at the time. However, it will be my recommendation that this needs to change.

Housing staff provided a high level of personal care for Mr A. Although the staff cannot be blamed for acting in a supportive way when Mr A was clearly in danger or distressed and individual staff members acted humanely, sadly, by supporting Mr A in this way, it is likely that this was the means by which a number of housing staff became infected with diarrhoea and vomiting. Although I do not have specific evidence of this, it was the view expressed by the Scheme manager. The agency was acting without the registration of CQC for the provision of personal care. I believe that it is also likely that, by tolerating the provision of care by ADC staff, other care provision was seen as less urgent. However, in the context of an environment where senior members of the housing staff authorise the provision of personal care 'in an emergency' and because no policy exists to describe how often emergencies can be tolerated, I do not conclude that these actions constituted poor professional practice but will recommend that clarity of personal care provision is improved.

In the case of the care workers from the care agency, I consider that there was professional neglect in that, as a commissioned organisation, they failed completely to record the monitoring of medication for at least 24 consecutive days and this was a task for which they were specifically commissioned. It appears that the agency was about to close their local branch and so were in a state of disarray with limited management or audit available.

In the case of the ambulance service, I am hampered by the lack of provision of a detailed IMR and have only the interview with the Safeguarding Lead for SCAS who spoke to me without notes. It was his view that the decision to leave Mr A without admitting him on the 5th May and after what he assumes (because it is general practice) that a full examination took place was 'an unusual' decision. He stated that, had the level of leakage and swelling around the leg wound dressing that was present the following day on admission to hospital, been witnessed by the ambulance staff on the 5th May, it should have received attention within four hours. Leaving the primary care practice to follow up on the 7th would therefore seem negligent. However, I do not have sufficient evidence to conclude that this was the case and will recommend that a full investigation is undertaken.

In consideration of whether there was poor professional practice in the community nursing team, I have reviewed the decision to 'drop' a visit to dress Mr A's wound on the days following the 24th April. On its own this would not have been negligent as it appears that the decision was based on information from the nurse who undertook the previous visit (a student nurse) and the intention was to replace the visit on a following day. The fact that the system for following this up was not sufficiently robust and further visits were not highlighted on the visit rota was not, in itself, poor professional practice but rather a system failure.

Lastly in the case of the primary care practice, I have considered the actions of those who were primarily involved in the days towards the end of Mr A's life. I accept that, in general, GPs rely on the community team and would not have reason to question the health or be aware of deterioration of individuals. The surgery does not have a recognised system for following up actions resulting from covering GPs visiting the patients of another GP. This, by omission, allows situations to develop whereby planned actions, such as happened with Mr A's care not being discussed and the blood and urine test not being followed up, to happen and this is poor professional practice about which I will make recommendation. I remain concerned about the

practice, as represented by my interviews with two of the partners, being unwilling to take responsibility for the impact of their understanding of the Nomad ordering system.

Section 6.6 – Final comments in relation to the Terms of Reference

This report has established the chronology of events in relation to Mr A as relevant up to and immediately following his death in May 2013.

In examining the adequacy of the interdisciplinary collaboration and communication between all the agencies involved in the care of Mr A, I have concluded that there were failures of communication and holistic working and, in examining the provision of services to him during the relevant period, I have concluded that there were failures to undertake adequate risk assessments, escalate risks to sufficiently experienced or responsible staff, some limitations of service capacity which caused delays and, in some instances, failure to provide care and, lastly, some lack of adherence to service standards and good practice.

I am unable to make a conclusion about the adherence to agency polices. I met many staff who could not quote their agency's policies relating to management of self-neglect, supervision, safeguarding and others but accept that practical, professional and emotional commitment to the principles of the policies is more important than specific awareness of the policies themselves and I believe that this was present in the staff I interviewed. However, there are some instances of a failure to fully comply with relevant legislation by omission rather than commission. Specifically this relates to the lack of application of the Mental Capacity Act as described above.

I have therefore produced an independent report based on the findings and make the following recommendations to the Portsmouth Safeguarding Adults' Board with the expectation that these will be fully considered and an action plan devised to address them within three months of the final presentation of this report, the implementation of which will be overseen by the relevant board as agreed by the Portsmouth Safeguarding Adult Board.

Section 7 - Recommendations

MULTI AND INTER AGENCY

The reasons for the delay in the commissioning the SAR in this case should be investigated and, if poor practice or areas of omission are found, actions put in place to reduce the likelihood of such delay occurring again.

There should be a key professional identified to take coordinating responsibility in complex cases in line with better care recommendations and fully integrated working practice. Appropriate terminology will be devised to ensure that the term does not become confused with similar terminology used by individual disciplines to indicate a role that covers their own agency only.

In order that an identified lead worker has sufficient trust, respect and authority to support their role, there should be a greater emphasis on cross discipline training and, where possible and safe, there should be rotation of roles and 'role swaps'.

The application of the virtual ward approach or a fully integrated health and social care service must be a priority and a process for assessing its efficacy in increasing risk sharing and subsequent improvements in care planning must be put in place.

All agencies should review their Bank holiday arrangements in order to ensure sufficient cover is available to meet generic needs including with the availability of purchased care.

When there are significant staffing vacancies, risk assessments should be mandatory in each organisation to consider the impact and actions to minimise these. Community staff levels must be maintained at a safe level to manage both routine and high risk situations.

The already existing law relating to Mental Capacity assessments should be fully enforced and understood.

All agencies should challenge whether their Supervision policies are practically reasonable; are being complied with and whether there is sufficient oversight of unqualified workers with encouragement at induction stage to ask for help and not to view requests for advice as 'wasting manager's time' or failure due to a lack of skills.

All agencies should ensure that their workers clearly identify their professional status to avoid misunderstanding about the level of experience or accountability that might otherwise be assumed by other disciplines

There should be a review of the use of risk assessments – especially where issues of self-neglect, lack of financial management, poor nutrition and hydration exist. Any change of practice or finding of the need for greater emphasis resulting from this review should be included in routine training.

The positive impact of the extensive learning sessions which have been carried out in some of the Solent disciplines using information from the internal review of Mr A's situation and which demonstrate positive learning and responsibility to change practice should be reinforced in all agencies as a result of the learning from this SAR report.

The means of supporting shared access to records when several agencies are involved should be further investigated as part of long term planning.

A means of enabling all agencies to value the contextual information provided by Housing officers with a day to day knowledge of their service users should be found.

The Procedures and Guidance for Multi-agency Safeguarding Adults Policy which were updated jointly with Southampton, Hampshire and the Isle of Wight in July 2013 and includes a section on Managing Self Neglect, Mental Capacity and Best Interests must be fully implemented.

ADULT SOCIAL CARE

1. The new approach to safeguarding training which was launched in august 2013 with six day training sessions must be provided as mandatory to all social workers in order that all social workers (not just those identified as safeguarding team investigators) will take responsibility for lower level investigations so making safeguarding 'everybody's business' and the holistic nature of the new approach must be emphasised in order that it is fully appreciated.

1.1 All safeguarding follow up meetings must happen within 21 days or, if cancelled, another date must be made at the point of cancellation to prevent 'drift' and responsibility must be allocated for checking caseloads of any individuals who are off sick.

1.2 Management oversight of the role of Independence Support Assistant must be formally provided by both Occupational Therapists and Social workers.

1.3 Information sharing by accessing RiO through specific workers and admin staff must be maintained.

1.4 If not already the case, training should be considered on the impact of multiple disabilities on person centred planning.

2. SOLENT NHS TRUST

OPMH

2.1 Clarity of diagnosis or investigations leading to diagnosis should be a priority in OPMH cases as part of the initial plan.

2.2 Decisions about removal of medication should be approved by a qualified clinician unless in an emergency in which case a qualified worker should be involved within 4 hours and alternative arrangements should be put in place within 24 hours

2.3 CPA meetings should include all involved agencies. If the multi-disciplinary case sharing, decision making and planning is managed via the Virtual Ward then this

should not be given the status of a CPA or that approach should be recorded as the means of managing the CPA

2.4 Record must be made of all visits or interactions even when the visit is only to accompany another agency or clinician.

2.5 The Strategic Operating Procedure to manage the use of the RIO electronic recording system to reduce the gaps in the primary care record should be fully operational by the end of 2014.

2.6 All existing OPMH staff should receive training on the 'identification and response to the deteriorating patient' and this should routinely be included in training plans for new personnel with the referral to Speech and Language Therapy (SALT) included as a consideration in this.

3. COMMUNITY NURSING

3.1 Community Nursing visits must be subject to daily recording with missed visits highlighted and bought forward to the following day to prevent them 'dropping off' the list.

3.2 A process for identifying the reason for loss of patient held notes and any risks associated with the loss of such notes should be developed. If patient held notes are critical to the ongoing care, sufficient information to allow good management must be kept in agency held systems.

3.3 A duty system with community nursing staff specifically identified to carry out unplanned visits to reduce the pressure on the planned visit rota should be implemented.

3.4 Student nurses should not attend patients identified as complex except with a qualified professional.

4. PHYSIOTHERAPY

4.1 Triage should not be based on prior knowledge or experience of falls if a new referral is received – a visit should be advised.

5. SALT

5.1 The response to poor nutrition and loss of weight needs clarity of risk assessment in order to triage.

6. CARE AGENCY

6.1 It should go without saying that care agencies should undertake the tasks identified on the care plan.

6.2 There should be sufficient staffing to provide continuity of carers.

6.3 The Personalisation team created in mid-2013 (or other appropriate resource) must have the remit of making care provision more meaningful, implementing person centred recording and ensuring appropriate personalisation training to staff. This will

include spot checking care plans and ensuring that the escalation process is working in practice.

7. JOINT COMMISSIONERS

7.1 Commissioners must have in place a means of accessing information from providers (including micro commissioners such as care management staff) to identify occasions when task based care is inadequately provided, if this does not already exist as part of contract monitoring.

7.2 Continuity of carer should be a stipulation of personal care contracts if it is not already.

7.3 Recognition of greater impact on primary care of keeping people in community settings rather than hospitalisation must continue to play a part in the use of the Better Care Fund.

8. SCAS

8.1 A detailed investigation, similar in style to an internal management review, should be undertaken of the actions of visiting SCAS staff attending Mr A on the 5th May 2013 and any information about any consequent actions should be provided to the Safeguarding Adults Board by an agreed date.

8.2 The process for authorisation of non-admission, where there is an alternative view expressed by the visiting ambulance staff, should be reviewed and clarified to commissioners

8.3 Where risk is identified, there should be a record of the information that informs the actions that are taken to minimise that risk by the use of a recognised risk assessment process.

9. PHT

9.1 As part of safeguarding training, all staff should be encouraged to understand that a safeguarding issue may apply to others beyond the specific patient in question.

9.2 Ward staff should be encouraged to take details of other agencies involved in addition to the next of kin to enable appropriate actions to inform in the event of death

9.3 The use of the risk assessment /threshold management tool should be clarified

9.4 The process for safeguarding referrals should be unified so that the same approach is used across the Trust including the ED team with a question to be added to the incident report form – ‘is this a safeguarding issue?’.

10. NHS ENGLAND LOCAL AREA TEAM

10.1 The method of ordering Nomad must be clarified to primary care so that there is consistent knowledge and understanding within all GP practices that there are two processes for ordering Nomads and that these are within the control of the referrer depending on level of urgency.

10.2 Shared responsibility must be taken by GPs covering patients who are not 'their' patients during the absence of the allocated GP. A means of follow up on subsequent days or handover must be in place to ensure continuity of care and reduce the impact of missed information failing to inform the whole picture, including a risk assessment of leaving actions until the allocated GP is available.

10.3 GPs must be supported to take ownership of resource limitations recognising the impact this may have on their relationship with patients.

10.4 In managing the National Contract, there should be consideration of the administrative burdens placed upon contracted health services where practitioners are emphasising quantitative performance indicators over qualitative indicators, to support and encourage them to reduce the unintended consequence of limiting holistic approaches in providing services.

10.5 NHS England should be made aware of the possible influence that the maintenance of reputational high performance may be having on the practice of hospital admission decisions in the surgery involved in this case.

11. HOUSING SERVICES

11.1 Housing Scheme managers need to be encouraged to understand the key role that they hold in maintaining the day to day knowledge of individuals and be encouraged to actively inform assessments of need. They should be encouraged to be assertive in referring changes to behaviour in the context of having known an individual.

11.2 Housing managers need to emphasise to housing scheme managers that an understanding of limited resources in other agencies should not allow them to tolerate unacceptable risk and be supported to escalate concerns appropriately.

11.3 If the practice of not providing supervision is continued, then guidance must be created to inform and support scheme managers to escalate risk situations appropriately.

11.4 There should be a clarification of the limits of what tasks can be undertaken regarding the provision of personal care and how often repeated 'emergencies' should be tolerated.

11.5 There needs to be clarity about flat clearance in the absence of a willing next of kin and the timescales around this.

Acknowledgements

I have been extensively helped by the Safeguarding lead in Solent and members of the administrative team in PCC in setting up and arranging venues for interviews during this SAR.

Each of the authors of the IMRs and all interviewees have been willing to answer questions and offered me open access to the information I have needed.

References

The Mental Capacity Act 2005

The Care Act 2014

The Better Care Fund allocations guidance

The BMA's description of primary care contracting

Qualifications of report author:

A qualified social worker, with twenty six years practice experience, twelve years of which were at senior management level in Adult Social Care with a Diploma in Social Administration, an Open University qualification in Senior Management . A Post Graduate Certificate in Strategic Management and having chaired a Local Authority Adult Safeguarding Board for four years.

Appendix A

Chronology of Events regarding Mr A – combined actions of all agencies.

Mr A was born in December 1933 and died on 12th May 2013.

Date	Agency	Action
Approx. 1936	n/k	Thought to have been diagnosed with a learning disability. NB Mr A was said to have an Open University degree at the time of his death.
1988 – 2003	PCC - SS	3 different Adult Placements
2003 – 2006	PCC - SS	Residential care
2006	PCC – H	Became resident in Arthur Dann Court, initially as a rehab placement and then as a permanent resident. After initial support for shopping and orientation Mr A was independent.
December 2012 – end January 2013		
End of 2012	PCC – H	Reports that Age UK were finding it difficult to keep Mr A's flat clean and did not want to continue to visit because of 'his strange behaviour'. By this time Mr A had twice weekly cleaner from Age UK (not arranged by Social Services)
7.12.12	PCC – H	Record of swearing by Mr A
10.1.13	PCC – H	Incident of diarrhoea and vomiting. Very, very agitated and shouting
14.1.13	PCC - ASC	Referral to Social Services from Housing manager. Duty response the next day and placed on waiting list with allocation code 1 (high)
In December 2012, staff at ADC, where Mr A was resident, reported that Mr A had been rude and swearing which was recognised as very unusual. The Housing Scheme Manager saw Mr A most days and felt that she knew him well. He had been independent needing very little support from the staff at ADC but further unusual behaviour was noted by ADC staff during January and February 2013. During this period, on 14th January, the Housing Scheme Manager made a referral to Adult Social Care (ASC) in Portsmouth City Council (PCC) identifying poor fluid intake, loss of weight and self-neglect, issues that should have been considered as high risk.		
28.1.13	PCC – H	ADC staff spoke to Mr A asking him not to take his teeth out in the lounge, not to throw cutlery and tea towels outside his door. Also had a call from Age UK cleaner who said she would not go into flat as Mr A acting strangely
30.1.13	PCC – H and ASC	Housing manager chased referral, told not yet allocated. Housing manager said Mr A is neglecting himself and poor intake of food and fluids and appears to have lost weight. Housing Manager said to be happy to await allocation, monitor and feedback if situation changed
31.1.13	PCC – H	Mr A had put his dirty washing on the road outside and was lying on the floor outside his flat.
February 2013		
3.2.13	PCC – H	Almost midnight – pulled cord for urgent help saying he needed some food. Appeared unaware of time

17.2.13	PCC – H	Mr A gave staff a bag apparently of laundry but it was full of ripped up newspaper
19.2.13	PCC – H	Incident of screaming and 'making funny noises' in lift
20.2.13	GP	GP took bloods and referred to physiotherapy and to SS for package of care. Also planned to communicate with pharmacy for Nomad tray and referral to psychogeriatrician
Mr A was supported to visit his GP, in February 2013 to whom the Housing Scheme Manager identified behavioural changes, throwing things and poor self-care. Unfortunately it appears that the referral to the community pharmacy for the Nomad did not take place. No consideration here appears to have been undertaken as to whether Mr A had the mental capacity to manage the Nomad. It was considered that the blood test would 'exclude physical causes for the changed behaviour'. This is the initial stage of excluding some diagnoses which could be followed up with further testing if inconclusive.		
21.2.13	Solent	Physiotherapy asking GP for medical summary and identified no reported falls so triaged as routine
22.2.13	GP	Referral to psychogeriatrician
25.2.13	GP	Practice nurse took blood to exclude physical causes of behaviour changes and poor mobility
27.2.13	PCC – ASC	Allocation ISA with case weighting code 2 (highest unless safeguarding)
Allocation to a social care worker did not take place until some six weeks after referral. Although the Housing Scheme Manager had told ASC that she was willing to wait and would report back any further changes, she did say in interview that she felt unsupported. An Independence Support Assistant (ISA) was allocated. This is an unqualified role and the individual undertook ASC 'duty' work two days a week and was only able to spend two and a half days a week on her considerable case load. In February 2013, the ISA had been working in this role for eighteen months. At this time social care professionals did not routinely have access to the computer recording systems of Solent professionals.		
28.2.13	PCC – ASC	Assessment contact made and visit arranged for 6.3.13
March 2013		
3.3.13	PCC – H	Carer told ADC staff that Mr A was lying on the floor surrounded by his shopping
5.3.13	GP	Practice nurse undertook audiogram to investigate difficulty hearing and buzzing sounds
6.3.13	PCC – ASC	Assessment visit by ISA – agreed to seek half hour visit by carers for personal care and medication checks 7 days per week
7.3.13	Care UK	Care assessment visit
This care was provided by Care UK who started the package on the 14th March, following the assessment visit on the 6th. Care UK records show that that they were commissioned to undertake personal care and medication prompting. Care UK undertook an initial assessment on the 7th March. This includes a reasonably completed 'personal details' form, although several elements of the form are not completed, but a very poorly completed 'emergency transfer form' which should have included - but does not - assessed needs, medication and preferences and identifies another GP in the practice rather than Mr A's GP . It is now apparent that the author of the IMR for Care UK did not have the paperwork that was later made available to the report author and so did not comment on this but did confirm that carers working for Care UK routinely prompt people to take medication and that the sort of package provided to Mr A was fairly standard for the tasks identified.		

11.3.13	GP	Surgery visit by Mr A for review of audiogram
13.3.13	Solent – OPMH	Core Assessment noted MMSE 30/30 with insight into self-neglect and no delusion or paranoia. Agreed to visit weekly to support keeping flat clean and develop a routine. Referred for NOMAD and to OT
14.3.13	GP	Referral sent to audiology dept
The audiology review resulted in a letter being sent to the audiology department for an appointment. It must be remembered that Mr A already suffering from speech limitations and had a squint and had what was recorded as 'poor eyesight'. The buzzing sound meant that he could not hear clearly, speak clearly or see clearly by this time.		
16.3.13	GP	Letter received from OPMH with plan: Senior support worker to assess mental health needs Care package once daily Senior support worker to visit and work on routine and flat tidiness OT assessment for functional abilities GP to set up Nomad
Weekly visits were provided by a senior support worker. This plan was communicated to the GP. No working diagnosis was made and there was no plan to pursue a diagnosis recorded. It remains unclear why the mental health service developed a care plan that covered such basic tasks without a mental health diagnosis and no plan to establish such a diagnosis.		
14.3.13 – 18.3.13	Care UK	Carer visits record frustration in MrA, medication spread throughout flat, flat messy, money and clothes on floor, smell of vomit, being unable to help with meds
On no occasion did any of the Care UK carers record during this period that they had checked medications despite this being an allocated task.		
19.3.13	PCC – ASC	Visit to Mr A– saw medication scattered across floor
19.3.13	Solent – OPMH	Visit – Mr A about to go out to Tesco's. Noted a lot of money around flat.
19 - 22.3.13	Care UK	Recorded some agitation but becoming settled. No medication documented
20.3.13	PCC – ASC	Telephone call to GP who was acknowledging that there is no evidence of an earlier referral States 'symptoms interfere severely with patients routine' Obvious confusion – no action taken
It was also clear, during this time, that the apparent referral for a Nomad was identified as the means of managing the medication that was found scattered in Mr A's flat, again without any consideration of whether Mr A had the mental capacity to manage a Nomad. This was chased up by the ISA resulting in what looks to be the first referral from the surgery to the community pharmacists.		
20.3.13	GP	Nomad referral to community pharmacist
21.3.13	GP	Referral faxed to physiotherapy
21.3.13	PCC – ASC and	ISA contacted senior support worker to establish reason for involvement and was told that there is a lot of money scattered over the flat. They agree that ISA is to discuss this with Mr A

	Solent OPMH	
During this period there were two instances of communication between the senior support worker and the ISA to identify roles and to make a plan to support Mr A's money management by buying 'piggy banks'. No arrangements suggested re external support with finances such as appointeeship There was no communication from Care UK carers with any other professionals. Overbuying but clearly capable of shopping despite agency also doing this.		
21.3.13	PCC – ASC	Visit – Mr A on floor with trousers down and coat and blazer buttoned up over his lower body – communication difficulties prevented establishing why but ISA helped Mr A to rectify himself. £165 found in notes on bed and £5 in lounge and advice given to make money less visible. Mr A agreed to two 'piggy banks' to be purchased by senior Support worker. Some practical support in clearing up and putting shopping away – several duplicated items all in date. Mr A given option of increase of cleaning care to 2 hours or a deep clean – he chose the first and was aware he would have to pay. ISA agreed to arrange increase with Age UK
23.3.13 – 29.3.13	Care UK	Noted that Mr A on floor on 23.3.13, appeared to have been sick on 25.3.13, was feeling sick on 26.3.13, had stomach trouble and a blocked toilet on 27.3.13, had puffy eyes on 28.3.13 and was cutting up his clothes on 29.3.13. On none of these days were medications documented
27.3.13	GP	Noted that Mr A had painful hands yesterday but better today. Carer at ADC, advised to monitor.
29.3.13	PCC – H	Mr A said to be cutting up his clothes
April 2014		
30.3 to 5.4.13	Care UK	Some agitation noted but more settled
2.4.13	Solent – OT	Visit to assess but Mr A too tired
The assessment for motor and processing skills was carried out by the therapy team. In this case it was to be completed by the OPMH Occupational Therapist and was finally completed on the 25th April. Further input to prevent decline and enhance capabilities was identified as an option but does not seem to have been taken up.		
6-12.4.13	Care UK	Recorded episodes of sickness and frequently in bed during day but settled. No record of medication checks.
6.4.13	PCC – H	Mr A 'half naked and retching'. Record that he 'desperately needs more care' NB There is no record, on this occasion, of this being identified to ASC.
10.4.13	Solent – OT	Assessment visit with further visit arranged for 17.4.
11.4.13	Solent – OPMH	Visit but Mr A was asleep
12.4.13	Solent – OPMH, District Nurse and Physio	DN present to dress wound – indication that previous visits have taken place but notes missing. Physio left after saying that mobilisation around flat is satisfactory and No further Action following referral from GP; noted medication around flat and flat messy but recorded involvement of other agencies to manage these issues DN concerned about medication around flat

		OPMH noted MrA's frustration and being overwhelmed with so many visitors – he was trying to eat a meal but was noted to cough on eating. She considered poorly fitting dentures or a swallowing problem and expressed her lack of certainty about whether the cough mixture bought by Mr A would help in view of this. OPMH noted that Age UK do shopping which was repeated by Mr A– stating that Mr A need not go shopping therefore and is wasting money. OPMH spoke to Housing scheme manager and noted that Mr A takes money from the bank weekly. Also that he has an appointment for a hearing aid. Also that Mr A has asked for contact with his sister. DN identified 3 x weekly visits to dress wound. OPMH appears to state that all medication will be removed from flat and there is mention of discussing this with GP although unclear who will do this. OPMH notes also record that two previous calls have been made to the surgery re the availability of a Nomad. A record made in OPMH files that there was a discussion with the DN who was also present.

This is the first recorded visit from the community nursing services to dress a wound on Mr A's leg, about which there is no record of how this occurred but there is reference to notes being missing and, on questioning, it is clear that these cannot be traced. The loss of notes is recorded but there is no record of any further plan to investigate how this occurred and neither is there any apparent concern about what could have happened to the notes. However, it is apparent that the notes that were missing were the patient held notes so the responsibility for their loss does not necessarily lie with the nursing staff. There is reference to a care plan that was clearly available to the nursing staff from previous visits and it is apparent that previous visits to undertake wound dressing had taken place.

The senior support worker stated that she would remove all medication and, later, told the report author that she was concerned that Mr A may accidently overdose. She was clear, and her records show, that she told the District Nurse who was present that she intended to do this and that a discussion should be held with the GP although it is not clear who would undertake this discussion. The report author was also told by one of the community nurses that they were unaware of the medication having been removed and that they would, had they known, have taken steps to set up alternative plans for medication. It is important to note here that, during interview with one of the community nursing staff, the report author learnt that she considered that the nursing team were very busy and were experiencing staff shortages. She described that the team had 'four or five sheets' of closely written names of patients to be seen by between five and eight staff at any one time. She explained that, if the team could not undertake all the visits, they would decide who could be missed each day but did not have a continuity method for making sure that missed visits did not occur on consecutive days and therefore that patients could 'drop off this list'.

12.4.13	Age UK	Visit to do cleaning
12 - 17.4.13	Care UK	Record only that Mr A was settled but no record of medication
17.4.13	Solent OT	Visit unsuccessful because no purchases to test sandwich making etc. Noted that there was no food in cupboard
17.4.13	PCC – ASC	Visit – some clearing of papers but unable to find bank statement for financial assessment.
17.4.13	Solent – DN	Dressed wound
19.4.13	Solent – DN	Dressed wound

19.4.13	PCC-Housing	Record of a visit by the OPMH support worker and a consultant from St James and a note that 'Mr A is to have a brain scan'
On the 19th April the senior support worker visited with a consultant from St James hospital who, according to the record made in ADC, identified that Mr A needed a brain scan. There is no record of this in the Solent chronology. This visit may be quite critical in that it could represent the only apparent action to identify a mental health diagnosis but no details are available.		
22.4.13	Solent - OT	Telephone call from ADC saying that a doctor had visited and Mr A would benefit from a commode. OT agreed to order
On the 22nd April a commode was ordered which appears to have been delivered within the usual five working days. This was requested by Housing services following a discussion with Mr A who told the Housing support worker that the doctor had said he must use the toilet rather than use pads but that he felt it was too far for him to walk. It is not possible to establish whether this was Mr A's GP (there is no record in the GP notes) or the consultant who visited from St James. However, it does seem reasonable that a clinician would be likely to tell Mr A not to use pads when there was no physical incontinence in order to maintain his normal functions and, again, reasonable that a request for a commode to reduce the distance to the toilet would be an appropriate action for the Housing services officer to take.		
22.4.13	Solent – DN	Dressed wound
22.4.13	PCC - ASC	ISA took Mr A to the bank where he was quite agitated and his behaviour was said to be unusual by the bank staff
During the visit to the bank, Mr A became very agitated and staff at the bank, who clearly knew Mr A well, tried to help him and described his behaviour as unusual and out of character.		
23 – 28.4.13	Care UK	Recorded as being settled, despite being on floor for two of the days and no record of visit on last day. No medication checks recorded.
During the latter half of April, visits by Care UK staff are recorded regularly but, for 24 consecutive days, no medication checks were recorded and Mr A was said to be 'settled' on each occasion when the carer left despite the descriptions by other agencies of levels of disruption and distress.		
24.4.13	Solent – DN	Student nurse. Dressed wound
Regular community nursing visits took place to dress the wound until the 24th April when they stopped with no forward plan.		
25.4.13	Solent – OPMH	Generally tidied and cleared up money into cash box. Noted no Nomad and record of intention to follow up.
25.4.13	Solent – OT	Undertook assessment of motor and process skills. OT notes that Mr A was significantly below the expected capabilities of a person his age and stated that 'occupational therapy services may be indicated to enhance and/or prevent further decline'
25.4.13	Solent – physio	Referral received, poor outdoor mobility, difficulty rising from sitting. Plan to liaise with other health care professionals
It does not appear that such a visit took place prior to Mr A's admission to hospital and, following a further referral, it is noted by the physiotherapy triage, that Mr A had been admitted and therefore the case was closed to the physiotherapy services.		

25.4.13	Solent-physio	Call to ASC who offered to support if communication difficulties. Plan for physio to visit.
26.4.13	GP	Letter received to say that bilateral hearing aids fitted
27.4.13	PCC – H	Mr A lying on the floor having been sick all over his clothes. When support offered he shouted at the ADC staff member to get out
29.4.13	PCC - ASC	Visit in response to call from Housing manager – same day response. Lots of torn up paper and smell of urine. Noted not eating, advised to have the support from ADC but Mr A felt they were too busy. Noted he needed help with microwave and that he said he did not eat because he always felt sick. Recorded that more support is needed
The ISA visited and noted that Mr A was not eating. There does not appear to have been any immediate plan for additional care at this point despite the poor nutrition and unwillingness to eat.		
29.4.13	Solent – OPMH	Call to surgery to enquire after Nomad. Told that a referral had been made on 20/3/13 but may take some time longer and that they 'should just wait'.
This confirms that the first referral did not take place in February. In the view of the Community Mental Health Nurse 'when a nomad is required and if there is no-body monitoring medication we contact the surgery by phone to request a nomad & this is set up straight away by liaising with chemist and GP'. She stated that 'no other surgery in the area will refer to community pharmacist if a nomad has been requested and the chemist is willing to supply'.		
30.4.13	Solent – OPMH	Same day response to a call from Housing Manager. Flat in severely messy state – paper, broken crockery and glass, knives, hot chocolate on walls. Spoke to carer who said that there is often faeces spread around bathroom with John unable to clean himself and returning to bed soiled. Noted that Mr A had lost weight, showing signs of fluid retention under eyes, difficulty passing urine and puffy hands. Told Dr who visited at the same time that no medication available to Mr A as they had been removed due to non-compliance.
30.4.13	GP	Covering GP visited – mental health nurse and community matron present. Identified that he was throwing his medication out, very unsteady on feet, noted dressing on leg (but no evidence of examining this), oedema on both hands and feet, low blood temperature and low saturations – good BP and 'well perfused'
The covering GP noted the dressing on Mr A's leg but did not record any examination of the dressing. The GP remembers that it was not leaking through and there was no red or swollen area around the dressing. The only plan that was made by the covering GP was for a further blood test and urine test and to discuss the medication with Mr A's allocated GP. No record of such a discussion is recorded in the GP notes. The covering GP has since confirmed that this action did not happen with the allocated GP, assuming that the practice nurses would fulfil this task or that the feedback from the planned CPA meeting would inform the action plan that would be made by the allocated GP. The covering GP recognises that there is no formal process of handover when duty visits are made. No plan, other than chasing the Nomad, was made to ensure medications would be taken. By this time Mr A had been without medication for at least two weeks and, more likely, had not been taking his medication regularly for between six weeks and two months. The primary care IMR author states that 'one could argue' that other options could have been considered; these being hospital admission and urgent medication supervision and clarified that these were not discussed with Mr A and no follow up was arranged. During an interview with the covering GP, who is a partner in the practice, the report author was told that it was recognised that the low blood pressure and low saturations as well as the oedema were		

not good signs and did indicate that Mr A potentially had a 'fluid overload' which was probably due to his lack of diuretic medication but that the physical examination showed that he looked well. The report author was told that it was felt that one should make a decision based on observations in preference to clinical readings. The report author understands that the covering GP was aware of the medication that Mr A should have been taking as a printed short history is provided prior to a home visit and that it was also known that the Nomad would be likely to be further delayed. The covering GP was aware of the planned meeting the following day and an assumption was therefore made that Mr A would be admitted to some residential or nursing care environment. For this reason it was felt that it would be inappropriate to change plans which the covering GP was reasonably confident would be changed again the following day. The covering GP now realises that this assumption did not lead to the making of a safe plan. The symptoms being experienced by Mr A were all indications of the diagnoses for which he should have been receiving medication. However, results of blood tests in the surgery from blood taken at this time, showed no change in levels from those taken in February 2013 which were considered normal for a person of Mr A's age. It should be noted that the report author was told by the GP that third stage kidney disease is also quite normal for a person of Mr A's age and that he is not recorded as having diabetes, although it appears that the SCAS staff member commented that there was no diabetes medication found during the visit on the 5th May which leads one to assume that diabetes could have been thought to be present.		
30.4.13	PCC - ASC	Received call from Housing manager re above situation and her concern about the dangers to Mr A. ISA escalated to qualified social worker and assistant team manager. ISA and qualified social worker to attend planning meeting on 1.5.13
30.4.13	Care UK	Noted patient distressed and settled by staff
This also appears to be the only occasion when the Care UK worker reported their concerns to more senior management within their own organisation. The report author was told that Care UK expect staff to report any concerns back on the same day and the incidents described prior to this date would normally have been expected to elicit escalation to senior staff. However, senior staff were mostly absent in the local office of Care UK at the time.		
May 2013		
1.5.13	Solent – OPMH	Meeting called as a 'CPA' (Care Programme Approach) but with only ASC, OPMH, Housing Manager. Noted that Mr A does not like a lot of people visiting but that, despite acceptance of OPMH and additional cleaning, Mr As behaviour and tidiness has not improved. Noted that Mr A is still awaiting a brain scan. Plan recorded as increase care to 45 mins am, 15 mins lunchtime and pm, although ASC record shows increase to two visits per day. To consider flooring as carpet is a trip hazard; request further physio, refer to SALT and to appointee service
The report author has been told that normally 'the nominated CPA coordinator fully assesses the person's needs with other people in their care and includes mental health needs, medication and side effects, employment, training or education, personal circumstances including family and carers, social needs, physical health, etc'. The meeting did not include anyone from community nursing, the occupational therapy services, physiotherapy services or an invitation to the GP. The meeting attendees noted that Mr A had worsened. The ISA described Mr A as not meeting the level of need that would justify residential care. This does not appear to have been fully accepted by other agencies although it is usual, although not always the case, that most ASC services provide additional community alternatives before moving from a care plan of only one visit per day to a plan for		

residential care. There is a single line reference to 'still awaiting a brain scan'. This is the first reference in the chronology from the health agencies, including the GP, of a referral for a brain scan but the Housing chronology records that Mr A 'is to have a brain scan' following the visit by the consultant from St James on the 22nd April and there appears to be no plan made to follow this up. There was still no working diagnosis of the reasons for Mr A's behaviour, despite all present believing (from interviews since) that Mr A did not have dementia and had mental capacity to make informed decisions. The meeting attendees concentrated on the physical environment and practical impact of Mr A's behaviour and failed to fully consider the reasons. In recent interview with the ISA she noted that she was overwhelmed with the practicalities and did not feel she had time to stop to consider other issues.		
1.5.13	Solent – DN	Visit to take bloods
2.5.13	GP	Blood and urine results show significant proteinuria
No action is recorded to address this. Proteinuria is the presence of protein in the urine and the most common causes are said to be diabetes or high blood pressure or an underlying kidney disease. Although in mild or temporary proteinuria, no treatment may be necessary, the surgery was aware of Mr A's condition and that he had been without medication. On questioning, the doctor who had undertaken the visit on the 30th April confirmed that 'significant proteinuria' would indicate a 'leaky kidney' which would probably need treatment within 24 hours. No action was initiated in response to the urine test result.		
2.5.13	Care UK	All well.
2.5.13	Solent – OPMH	Call from Housing scheme manager – Mr A lying outside another resident's door 'babbling incoherently' and unable to stand but crawled back to his bed. Also said that there was concern that he would interfere with other residents. The Housing scheme manager had contacted GP (this may be the blank entry referred to below) who said to contact OPMH but during this call she was advised to contact ASC. Later call back by OPMH to check outcome but still no contact and advised to contact senior support worker if concerned. Still later various phone calls but apparently no visit – eventually informed that duty ASC said a review would be made the next day. NB reference to senior support worker having visited in morning and not experiencing any problems but no actual record
The following day, in response to a call from ADC, another covering GP wrote very brief notes describing Mr A's behaviour as 'acting out' and giving advice for ADC to contact OPMH services. Mr A was assisted back to his flat (conflicting records state that he 'crawled' or was helped in a wheelchair) and back to bed.		
2.5.13	GP	Telephone consultation – advised call mental health team
2.5.13	GP	Empty entry
3.5.13	Solent - OPMH	Call to ADC – advised of Mr A having wandered naked and covered in faeces. Scheme Manager considers an increase in care will be insufficient.
3.5.13	PCC – ASC	Record of email from ASC finance team that they will be unable to take on the appointeeship with any degree of urgency. Record that SALT will visit in the community but on waiting list.

		In response to call from Scheme manager describing high risk situation, ISA spoke to senior SW who advised to ask OPMH ICT to help as care package unable to start. Call to OPMH ICT to request help over bank holiday as care package increase cannot start until after weekend – ICT could not confirm that they will definitely be able to visit. Plan for care package increase to start 6.5.13 and review visit 7.5.13 NB The 3rd May was the Friday before a bank holiday weekend.
3.5.13	Solent – OPMH	Call to 'Warden' to inform that the Intermediate Care Team would provide an evening visit to Mr A over the bank holiday in addition to the usual carer in the morning. Housing manager stated that Mr A was wondering naked and covered in faeces. Contact number given 'if she was concerned'
3.5.13	Solent – OPMH	Not clear who but OPMH took call and then rang ADC to tell them that the team leader for ICT confirmed that a visit at approx. 5 – 6 pm would happen over the weekend. Scheme manager very concerned, saying ADC cannot cope anymore and that Mr A should move
3 – 4.5.13	Care UK	No record of problems.
4.5.13	Solent – OPMH ICT	Home visit – noted Mr A thin and in oversized clothes; scaly lower legs; poor standing; unaware of how his flat came to be in a mess. (There does not seem to have been any plan to manage any of these issues on that day.) However, ICT worker chatted and Mr A said he felt happy not sad and liked his neighbours and the ADC staff. Food reheated and a drink made. Mr A happy to have further visits. Attempted to refer state of legs to DNs via SPA but closed as after 8pm.
OPMH ICT worker had the advantage of being new to the situation and could have been more objective about his findings. No plan was made to address the obvious confusion and weight loss – however, the attempted referral to the DN service was appropriate albeit not actually taking place due to the service being unavailable.		
5.5.13	PCC - H	ADC staff took Mr A his lunch and found him on the floor and unable to get up. Called 999. Mr A had yellow skin and red and swollen right eye. ADC record of ambulance visit notes that they wanted to take him to hospital but were advised to leave him at home for GP to be contacted to call the next day. There is also a note that the ambulance staff were concerned about the lack of medication and said this was the cause of the yellow skin.
5.5.13	SCAS	Housing called 999, ambulance staff report shows that Mr A had fallen and could not get up. They did not admit but are said to have wanted to admit. Noted that he had not had medication for 2.5 months. Referred to duty GP to discuss with own GP Safeguarding referral completed
The crew members noted that Mr A's hands were swollen and that this was backing up to his arms. There is limited record in the chronology of the ambulance staff decision making at the time but an email accompanying the chronology states that SCAS wanted to admit Mr A and so contacted the out of hours duty GP. A response from the ambulance service has confirmed that the duty GP in conjunction with the ambulance crew made a decision that 'it can wait until Tuesday' (i.e. after the bank holiday). The report author understands that it is routine to contact the GP in all cases where ambulance staff consider that they may be unable to treat safely at home. The decision is recorded as being based on Mr A having carers once a day and that he had mental health issues being		

currently under review. Other agencies were not involved in this decision. Information from the safeguarding lead role in SCAS confirmed that Mr A would have had what he described as a 'top to toe' examination where the presence of an old dressing and the possibility of a septic wound should have been considered. The examining ambulance practitioner would have had para medic qualifications and will have received level 2 safeguarding training. SCAS would have expected that they will have based the decision not to admit on clinical risk and would have considered medical condition, social elements and whether safe to leave at home. All SCAS staff will have assessment training and qualification and will all have completed level 2 safeguarding training. To put this in context, ambulance staff saw a person who, they were told, had seen his GP the previous week, had been without medication for several weeks, had fallen but was recorded as not dizzy on standing. It is conceivable that this played a part in the decision that two further days would make little difference. However, it was acknowledged by the SCAS safeguarding officer that this does appear an unusual decision in this case.

SCAS submitted a safeguarding referral because of their concerns about the nursing care Mr A was receiving in the community and lack of medication. This would indicate that they had noted the lack of clean dressing and considered that the lack of medication was a safeguarding risk. However, there appears to be no recognition of the fact that the referral was made on a bank holiday and may not receive attention immediately. No interim safeguarding measures were taken. However, contact with the GP surgery has established that the ambulance triage nurse requested a GP review visit on the 7th May (2 days later). The ambulance crew also made a referral to the Falls Service and gave ADC staff advice about ringing 999 if Mr A worsened.

5.5.13	PRRT	Receipt of SCAS referral – call to Scheme manager and checked RIO – noted that already known to OPMH and ICT with a referral already made to physio so felt that no further action from PRRT would be appropriate or of benefit to Mr Howard. Also noted that 'it appeared from records that Nomad only discussed on 12th April and therefore had not been without meds for long. NB There are 23 days between the 12th April and the 5th May.
5.5.13	Solent – OPMH ICT	Mr A dressed and eating a piece of cake. Requested help to urinate and thanked worker for bringing commode though asked to be left alone to urinate. ICT worker noted that they were told Mr A had very low BP; 3rd stage kidney failure; and had not been receiving medication with staff being very (++) concerned. Told by ADC staff that SCAS had raised a vulnerable person alert
5.5.13	GP	Letter from physio saying needs better met by community
5.5.13	Care UK	Washed but Mr A did not want food
6.5.13	Care UK	Morning – Mr A on sofa with trousers down and saying he 'felt like hell'. Unable to stand Afternoon – Mr A in same position and unable to stand or eat. Ambulance called. NB This is the beginning of the 2x per day visits by Care UK.
6.5.13	SCAS	Called again to Mr A. Noted low body temperature and inability to stand. Admitted. Appears that another Safeguarding referral completed.
6.5.13	PHT	Admitted – low BP, Low temperature, calf wound leaking, (see detailed chronology)

The ambulance staff found Mr A to have low blood pressure, low body temperature and expressed to ADC staff that, if he had been left, Mr A would be in a coma. Mr A was admitted to Queen Alexandra Hospital (PHT).

6.5.13	PHT	Incident form completed (but not safeguarding)
7.5.13	GP	Ambulance control triage nurse requested GP review on the 7th NB By the time this was planned, contact had been received that Mr A had been admitted.
7.5.13	GP	Informed by Ambulance that Mr A admitted with hypothermia and poor perfusion
7.5.13	PCC – ASC	ASC advised that Mr A admitted to hospital and that SCAS had been concerned that he would have been in a coma if left longer. Requested a 'section 2' due to need for Nomad NB 'Section 2' is a referral for social care assessment
7.5.13	GP, Solent OPMH	Telephone discussion between covering GP and Senior Support worker
7.5.13	GP	Received notification from A and E re admission with pneumonia – treatment of resuscitation, intravenous fluids, antibiotics, and a referral to admissions unit
8.5.13	LD liaison nurse QAH	Informed Community Mental Health nurse that Mr A in hospital and also that an incident form had been made due to leg ulcer and level of care in community.
9.5.13	PHT	Worsening condition. Space occupying lesion queried and urgent brain scan requested
10.5.13	PHT	Worsening. Safeguarding alert submitted
11.5.13	PHT	Urgent brain scan again requested. Decision made not to resuscitate
The second of these requests resulted in the brain scan taking place with results being difficult to interpret but not identifying more than minor abnormalities. The plan not to resuscitate was discussed with Mr A's sister who agreed to the plan. There is no record of the decision being discussed with Mr A himself and ward notes indicate that Mr A may have been unable to communicate by this stage. No reference was made in the PHT notes of a mental capacity assessment to assess Mr A's ability to participate in this decision.		
11.5.13	PHT	Discussion with NoK, (sister, who agreed with palliative plan.
12.5.13	PHT	Deteriorating, comfortable, said not to be distressed, palliative care only
12.5.13	PHT	Mr A died (approx. midnight)
Mr A died of multi organ failure just before midnight on the 12th May. Mr A's sister was informed of his death and ADC staff were informed some days later by OPMH services.		
13.5.13	GP	Letter from hospital received saying Mr A has severe Sepsis and having end of life care
July 2013		
16.7.13	PCC – ASC	ISA entered flat with another person to clear any money or important documents and to clear fridge. NB Two months after Mr A death with flat vacant and unused in this time.

Appendix B

Interviews carried out as part of Safeguarding Adult Review – Mr A.

11th July 2014

- PCC/ASC IMR author
- Solent Safeguarding officer

29th July 2014

- PCC/ASC Safeguarding Team Manager
- PCC/ASC Independence Support Assistant allocated to Mr A
- PCC/Housing ADC Scheme Manager (accompanied by Housing Manager – IMR author
- PHT, Quality Officer

5th August 2014

- Solent - Senior Support Worker OPMH and allocated to Mr A
- Solent (SALT) undertook initial document review for Solent
- Solent - Nurse who undertook SIRI
- Solent – Senior Staff Nurse in the team working with Mr A
- Solent - Senior Manager who commissioned the SIRI and is responsible for the PRRT, the community localities and has the lead for the Solent action plan resulting from the SIRI

14th August 2014

- Care UK Quality Manager (by phone)

20th August 2014

- GP allocated to Mr A

3rd October 2014

- South Central Ambulance Safeguarding officer (by phone)

9th October 2014

- GP at North Harbour surgery – saw Mr A as duty covering GP

Appendix C

Glossary of abbreviations

SAR	Safeguarding adult review
ASC	Adult Social Care
ADC	Arthur Dann Court
PCC	Portsmouth City Council
OPMH	Older People's Mental Health
ICT	Intermediate Care Team
ISA	Independence Support Assistant
IMR	Independent Management Report
SIRI	Serious Incident Investigation
NHS	National Health Service
GP	General Practitioner
CPA	Care Programme Approach (mental health)
PHT	Portsmouth Hospitals (NHS) Trust
PRRT	Portsmouth Rehabilitation and Reablement Team
CQC	Care Quality Commission