

Portsmouth Safeguarding Adults Board

Pamela Ratsey Safeguarding Adults Review: Overview Report

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1. INTRODUCTION

- 1.1. The Portsmouth Safeguarding Adults Board (PSAB) commissioned a Safeguarding Adults Review, starting in November 2020.
- 1.2. The Care Act 2014, Section 44, requires that Safeguarding Adults Boards arrange a Safeguarding Adults Review when certain criteria are met. These are:
 - When an adult has died and abuse or neglect has been a contributory factor, or has not died but has experienced serious abuse or neglect, whether known or suspected, and;
 - There is a concern that partner agencies could have worked more effectively to protect the adult.
- 1.3. Safeguarding Adults Reviews reflect the six Safeguarding Adults principles, as defined in the Care Act. These are empowerment, prevention, proportionality, protection, partnership and accountability.
- 1.4. The aims of the Safeguarding Adults Review are to contribute to the improved safety and wellbeing of adults at risk and to provide a legacy to Pamela Ratsey and a comfort to her family. It was the family's wish that Pamela's full name be used in this report, instead of a pseudonym.
- 1.5. There are clear review objectives which have been addressed to achieve these aims. Through a shared commitment to openness and reflective learning, involved agencies have sought to reach an understanding of the facts (what), an analysis of the facts with findings (so what), recommendations to improve services and to reduce the risk of repeat circumstances and a shared action plan to implement these recommendations (what now). It is important that the actions are monitored by the PSAB to ensure that the review makes a positive difference in the lives of adults at risk.
- 1.6. It is not the purpose of the review to re-investigate suspected abuse or neglect, or to apportion blame to any party.
- 1.7. The review process to meet these aims and objectives has followed a clear path. The Independent Reviewer has critically analysed merged chronologies and relevant agencies records and interviewed representatives; leading to a workshop and review outcome meeting; and culminating in a presentation of the overview report and action plan to the PSAB for endorsement. The key workshop analysis and findings are weaved into the report.

- 1.8. The review concentrates on the most relevant period, from 01/01/17 when concerns about Pamela’s welfare came to the notice of agencies, to 31/07/18 when Safeguarding Adults Enquiries were finalised.
- 1.9. A contribution by family to the review has been enabled through meetings by the Independent Reviewer with two nieces, both of whom were actively involved in consistently raising concerns about Pamela’s physical health and care for about 6 to 8 months leading up to her death.
- 1.10. Representatives of agencies contributing to the review, through online interviews (unless otherwise stated) with the Independent Reviewer, are listed below (the homes are anonymised and titles are those which applied during the reporting period):
- Safeguarding & Learning Disability Services - Portsmouth City Council, Adult Social Care
 - Portsmouth City Council, Adult MASH Team
 - Portsmouth City Council, Continuing Healthcare Section
 - Hampshire County Council, Governance & Assurance Team
 - Solent Community Nursing Team
 - Care Home Team – Solent NHS Trust
 - Pressure Relief and Tissue Viability Service – Solent NHS Trust
 - Blood and Bowel Service – Solent NHS Trust
 - Solent Older Persons Mental Health (OPMH) Team
 - Community Mental Health Nursing Team - Solent OPMH Team
 - Portsmouth Clinical Commissioning Group (via email)
 - General Practitioner (via email)
 - GP Partner (via email)
 - PHL Integrated Urgent Care Ltd.
 - Business Manager - The Residential Care Home (via email)
 - Registered Manager – The Nursing Home (via email)
 - Safeguarding Team - Portsmouth Hospitals NHS Trust (via email)
 - Serious Case Reviewer – Police Operational HQ (via email)
 - MED-PTS Ambulance South Services Ltd. (via email)
 - Care Quality Commission (CQC) (via email)

2. CIRCUMSTANCES LEADING TO THE REVIEW

- 2.1 Pamela was an older person, who had been living with acute mental illness and dementia, and developed pressure ulcers whilst resident at a Residential Care Home from May 2017 to January 2018.
- 2.2 She received support from a range of agencies, most notably Community Nursing in relation to the care of pressure ulcers.

- 2.3 Concerns about poor care and neglect of Pamela at the Residential Care Home were raised by family and other agencies from July 2017 to February 2018. She moved to a Nursing home at the end of January 2018, where she died on 04/03/18.
- 2.4 The PSAB was satisfied that the conditions for a Safeguarding Adults Review were met as Pamela was an adult with care and support needs who died in circumstances of abuse or neglect, and it is considered that services should have been more proactive in safeguarding her; thereby meeting the conditions outlined in the Care Act 2014, Section 44, on the commissioning of Safeguarding Adults Reviews.
- 2.5 The review has followed Safeguarding Adults Enquiries, initiated in November 2017 and February 2018, which feature within this report.
- 2.6 A Coroners' Inquest reported in October 2019 that Pamela "died of osteomyelitis (caused by a grade 4 sacral pressure sore) and pneumonia. The pressure sore had deteriorated to such a critical level due to a lack of regular repositioning at her previous care home". The Coroner concluded that Pamela died of "natural causes contributed to by neglect".
- 2.7 The Safeguarding Adults Review has been completed by an Independent Reviewer from November 2020 to June 2021, within the period of a global Covid-19 pandemic.
- 2.8 The analysis has focused on the key themes, which were agreed at an initial planning meeting and are outlined in the Terms of Reference:
- How effective was multi-agency needs and risk assessment and communication?
 - How effective were Safeguarding Adults Enquiries in addressing concerns about neglect?
 - How effectively was mental capacity, mental health and the user voice addressed?
 - What was the impact of resource and environmental issues on the decisions and actions of agencies?
 - Which procedures and guidance apply and were these followed?
 - What concerns were raised by the Coroner's Enquiry?

3. PEN PICTURE OF PAMELA

- 3.1 Safeguarding Adults Reviews (SARs) should provide a window into the lived experience of people affected by the examined circumstances.

3.2 Pamela is described by her family as vibrant, glamorous, funny, quick witted, loyal and caring.

3.3 She was one of five children, born and raised in Portsmouth. On leaving school, Pamela worked in a greengrocers shop and then as a telephonist. Later, she devoted her time to caring for her husband, who was unwell.

3.4 Pamela was very gifted in arts and crafts, including knitting and making jewellery.

3.5 Her family ask professionals to reflect on their concern that this was the same person who "was left sitting in urine and faeces for hours". They believe that "the moment she entered residential care she was completely disempowered and so were her family and friends".

4. FACTS

Prior to January 2017

4.1 Pamela was known to the Solent Older Persons Mental Health (OPMH) Team from 08/06/16, following a referral from her GP who was concerned about her mental health. A Consultant Psychiatrist who had seen Pamela at the time advises that she was experiencing paranoia within the context of underlying dementia. Anti-depressant and anti-psychotic medication was prescribed, with poor compliance. Pamela was deemed to be competent to make decisions for herself concerning mental health.

January to July 2017

4.2 On 01/01/17, Pamela contacted the Police to report a theft from her home and officers attended over subsequent days. With no grounds to suspect theft, they notified the assigned Community Mental Health Nurse and Hampshire Adult Social Care. Following attentive input from the Community Mental Health Nurse and GP, Pamela was admitted to an acute hospital on 20/01/17, as she was not taking medication and presented with paranoid ideas. She was detained under the Mental Health Act 1983, Section 2, on 22/01/17, following discussion with her sister who agreed that admission was necessary, and was transferred to an Older Person's Mental Health Unit. Pamela felt too unsafe to return home, was suspicious of staff intentions and was refusing medication. She became a voluntary patient on 15/02/17 and medication relating to Alzheimer's Disease commenced. Pamela remained independent in dressing and managing personal hygiene (with assistance at times provided or declined), a food and fluid chart was introduced with daily prompting from 29/04/17 and she was fully continent. Her skin was observed to be intact throughout her stay, although dry and fragile, and her mobility was 'slow but steady'.

4.3 With the support of the assigned Hampshire Social Worker and family (with Power of Attorney status for finance and health and welfare), Pamela moved to a Residential Care Home (funded by Hampshire County Council) on 23/05/17. A discharge summary was sent to the GP and the diagnosis was listed as 'mixed dementia with psychotic symptoms'. It was further noted that Pamela lacked the mental capacity to understand the treatment and care received, but there is no record of a Mental Capacity Assessment at this time. The Consultant Psychiatrist recalls that there was a presumption of capacity as Pamela was not refusing treatment and 'knew what she wanted'. The Community Mental Health Service, in contributing to this review, considers that a Residential Care Home placement was appropriate at this stage.

4.4 Pamela received 4 GP contacts between May and July 2017, following admission to the home. These concerned neck pain following a fall, conjunctivitis and dry legs, a telephone review and possible confusion. There was evidence of contact with the home, but not with family. On 08/06/17, there is a Surgery record that Pamela's cognition was variable and that she currently had 'capacity to agree to the decisions made in her care plan'.

4.5 On 30/05/17, the Community Mental Health Service visited Pamela to review her progress. Carers were advised to monitor psychotic depression symptoms. Pamela's family add that they were not invited on the visit and were unaware of the involvement of the service at this point. They recall that the Residential Care Home notes referred at the time to weight loss due to stress and that the CMHS were not notified of this. The current Residential Care Home Manager confirms staff recollections that Pamela was refusing food and a dietary plan was in place, but that there was no record of this being related to stress. The CMHS representative recalls that Pamela had settled, her appetite was improving and her fluid intake was sufficient. There was no evidence of paranoid thoughts, negativity or hallucinations on a visit to Pamela on 21/06/17 and she was discharged from the service on 28/07/17. The Community Mental Health Service, in contributing to this review, feels that Pamela's dementia had progressed and she had settled. There is no evidence of any further presentation of paranoid thoughts and the home did not re-refer to the OPMH service.

4.6 A Hampshire Social Worker conducted a prompt initial placement review on 30/06/17, without informing or inviting family. Vascular dementia was recorded and her memory loss had accelerated in recent months. Pamela was able to relay her wishes on a day to day basis, was independently mobile, required daily creaming of her dry legs to avoid skin breakdown and needed encouragement with personal hygiene. Pamela's family recall that the need for daily creaming of Pamela's legs was not met at the Residential Care Home and that this was recorded by the reviewing social worker, although this record has not been located.

4.7 4.5 By July 2017, family members noticed a deterioration in Pamela's physical health, including her mobility, and she was continually asking them

for a move away from the home; to a familiar area, family and a close friend. They contacted Hampshire Adult Social Care on 27/07/17 about Pamela's deteriorating condition and to request consideration of a Nursing Home, to be advised of closure following the review and that a Social Worker would be allocated. This is not evidenced in Hampshire case records.

4.8 A Residential Care Home body map was initiated on admission and the first record of markings was on 17/07/17, with a lump and a sore to the left buttock.

August to November 2017

4.9 The Residential Care Home body map recorded a red sore to Pamela's buttock on 04/08/17, as well as a bruised left wrist, and she was referred to Community Nursing on the same day. An initial visit was completed by an Agency Nurse on 05/08/17 and redness to the sacrum was recorded, with no broken skin and not requiring dressing. There is no Community Nursing documentation of a risk assessment or advice to staff. Pamela was discharged on 06/08/17, without documenting the reason.

4.10 The Solent Continence Service delivered continence pads from 09/08/17 to 04/03/18, without a break in service and without a request for any other continence support. The order was changed to more absorbent pads in December 2017.

4.11 A Residential Care Home risk assessment on 11/08/17 recorded that the sacral pressure ulcer was worsening. It was noted that pressure relieving equipment was provided, Community Nursing was requested, staff monitoring was in place and staff were aware of the importance of pressure ulcer care and skin integrity.

4.12 A new referral was received by Community Nursing on 11/08/17 and Nurses attended that evening. The wound seen on 05/08/17 had developed into a grade 4 pressure ulcer. On 12/08/17, the frequency changed to daily visits and the Home Manager told Community Nursing that the home was able to meet Pamela's care needs. Family members recall viewing Community Nursing notes in which a Residential Care Home representative was recorded as stating in July 2017 that they could not meet Pamela's needs. This has not been located in Community Nursing notes, although it is acknowledged that documentation was not sufficiently thorough. They add that a carer at the Residential Care Home advised them on 15/08/17 that Pamela needed a Nursing Home as she was 'quickly slipping out of the remit of their care.' A Community Nursing incident report was completed on 13/08/17, due to unsafe manual handling and faulty equipment. On the same date, the pressure ulcer had improved to grade 3 and a decision was taken by Community Nursing Staff to reduce visits to twice weekly.

4.13 There were 5 further Community Nursing (Support Worker) visits to Pamela in August 2017. Initially the pressure ulcer was graded as 3 and on the

final of these visits was 100% sloughy. A pressure relieving mattress was in place. On one visit the dressing had come undone. The community nursing service considers that there would have been a deterioration in the wound condition and that it would not have been possible to have seen the wound underneath. Pamela's family recall that a pressure relieving mattress was not provided at the Residential Care Home. The Community Nursing service representative states that a pressure relieving overlay mattress was provided, but that there were later delays in January 2018 (on moving to the Nursing Home) in the provision of a profiling bed and alternating air mattress.

4.14 On 15/08/17, the family contacted Hampshire Adult Social Care Duty to relay concerns about physical health deterioration and to request transfer to a home closer to family and a friend. Hampshire Adult Social Care contacted the Home Manager on the same day and a difficulty in managing was not mentioned by the home. An assigned Hampshire Social Worker contacted family on 25/08/17.

4.15 A Residential Care Home monthly care plan review in September 2017 recorded that fluids were to be encouraged; continence pads were to be changed regularly; was on pressure relieving equipment; Community Nurses attended to a pressure area; had regular analgesia for general aches and pains; mobilised with staff support and encouragement, was often unsteady; required the assistance of 1 to 2 carers with dressing and undressing; could communicate her needs and a Mental Capacity Assessment was in place regarding care and treatment; and had medication for anxiety. Other care plan review records were completed in July and August 2017 and in January 2018.

4.16 A further 9 Community Nursing (Support Worker) visits were undertaken in September 2017. On 07/09/17, the pressure relieving cushion was behind Pamela's back and she was sitting on the hard chair surface, with advice given. On three visits, the dressing had come off and the wound was exposed. A referral was made for Physiotherapy to assess for positioning and devices for comfort, but Pamela was not seen at that time.

4.17 The Hampshire Social Worker visited Pamela, her family, close friend and a Residential Care Home representative on 19/09/17, recording communication issues between family and the home, with advice given. The care plan was checked and Community Nursing visits noted. Community Nursing information was requested and it is not recorded whether this was received. On 26/09/17, the Social Worker spoke with the Community Nursing Service, which confirmed that Pamela did not need to move for her needs to be met.

4.18 The Social Worker completed a Continuing Health Care (CHC) checklist on 27/09/17 or 03/10/17. This was initially a positive checklist and was returned to the Social Worker on 18/10/17 by a CHC Nurse Assessor for more evidence to support weighting. The checklist was updated to indicate low needs overall. The Social Worker had apparently assumed mental capacity.

The checklist was resubmitted on 31/10/17 as a negative checklist. On 13/11/17, a Community Nurse and the Social Worker jointly completed the CHC checklist, concluding that Pamela did not require a full CHC assessment. A negative checklist was submitted to the CCG on 21/11/17 and the case was closed to CHC on the same day. Family members were of the view that Pamela required Nursing Home care, due to the deterioration in her physical health and they state that the Social Worker did not include family comments.

4.19 Community Nursing completed 8 visits in October 2017. On the initial visit, the wound was smaller but very red. The dressing had come off on three of these visits and was soaked in urine on one visit. It was decided that the continence pad change should be increased to two hourly. On 30/10/17, the dressing could not be changed as Pamela had faeces on her back and legs, but the action taken was not documented.

4.20 GP contact in this period included treatment for constipation, admission to an acute hospital on 06/10/17 due to a suspected stroke (ruled out) and treatment for a swollen ankle. There is no documented communication with family. Pamela's family questioned whether a Nursing Home was required and she was discharged back to the home, which confirmed that they could meet her needs, on the same day. She required two staff for all transfers and had double incontinence.

4.21 The Community Nursing Service (Support Worker) visited 8 times in November 2017. On one occasion a carer had changed the dressing as it was 'mucky'. By the end of the month, the wound appeared to be healed.

4.22 A Safeguarding Adults Concern was raised by Community Nursing with Portsmouth Adult MASH on 01/11/17, as they regularly found Pamela soaked in urine and on one occasion was left sitting in faeces for up to 4 hours, preventing pressure ulcer healing; and was isolated in her room. A Safeguarding Adults Enquiry commenced on 06/11/17 and a MASH Social Worker visited on the following day; meeting with a home representative and a Community Nurse and examining charts. The Social Worker met with Pamela and it is understood that mental capacity in relation to care needs was assumed. A concern about staffing levels was not followed up by MASH on the basis that there is not a CQC ratio. It should be noted that it is not in CQC's remit or role to define staffing levels or ratios in regulated services. The enquiry was closed by Portsmouth on 21/11/17 with isolation not substantiated, her skin soaked in urine inconclusive and faeces on her back and legs not substantiated. There was no apparent evidential trail for these findings and Pamela's family, who had been raising concerns, were not notified of or involved in the enquiry. Recommendations were made to the home to 'ensure all care planning and risk assessment documentation is updated effectively to include an increase in continence checks'.

4.23 On 18/11/17, the Hampshire Social Worker visited Pamela and her family, agreeing a move to an alternative Residential Care Home as trust had

broken down between the family and the home. On 05/12/17, the Social Worker visited again to review Pamela's needs. Pressure relieving equipment was found to be in place and Community Nursing confirmed that the sacral pressure ulcer was healing.

4.24 Pamela's family complained in writing to the Residential Care Home on 30/11/17, regarding Community Nursing not starting until mid-August 2017. Other concerns included not following Community Nursing repositioning advice; the call alarm often out of reach; some staff considering Pamela to be deliberately 'difficult'; receiving insufficient fluids and not receiving assistance in holding cutlery; erratic standards in personal care (greasy hair, dirty hands and nails and a soiled continence pad next to her); and poor communication with family. They stated that; 'as her condition has deteriorated we feel that there has been a failure to meet her needs.'

December 2017 to March 2018

4.25 There were GP contacts during this period, including 18/12/17 to treat a chest infection, which was discussed with family. Her mobility had decreased and she was not eating well which, in the view of the Community Nursing Service within this review, may have worsened a healed or new wound. There was also a visit on 16/01/18, in response to family concerns about confusion, nutrition and fluids, in which she was found to be eating and drinking well and not overtly drowsy or confused. The GP later stated to Police that he was not made aware by staff at any time of a history of pressure ulcers and that, when he saw Pamela on this date, 'there were not any obvious signs of neglect'. On 26/01/18, there was GP phone contact with the home to prescribe analgesia for pressure ulcer pain. A GP spoke with family when visiting on 27/01/18 (detailed later). There were two visits to Pamela on moving; a new patient review on 01/02/18 and a change in analgesia for pressure ulcer pain on 09/02/18 (detailed later). The surgery state that neglect was not observed and that 'it is not clear what the period of significant decline into palliative care was and when this was recognised'.

4.26 A manual handling assessment was completed at the home on 02/12/17; referring to dementia, anxiety, a risk of falls, assistance required with mobility and transfers, and independent movement in bed.

4.27 Portsmouth Adult MASH contacting the home on 04/12/17 for information relating to the family complaint letter. The Hampshire Social Worker visited on 05/12/17 in response to family concerns. Pressure ulcer care and pressure relieving equipment were in place and Community Nursing advised that the pressure ulcer was healing. It was recorded that trust between the home and family had broken down and Pamela's friend was finding it difficult to make the journey. The Hampshire Social Worker visited a second time on 18/12/17, meeting with Pamela, family, the manager and carers, and viewing care plans and risk assessments. It was felt that there was an accurate daily/monthly record and pressure relieving equipment was in place. The Social Worker

considered that the placement did not present a risk and that the care plan required updating. Family members recall raising concerns about the care plan with the Social Worker.

4.28 Community Nursing visited on 13/12/17, when the grade 3 sacral pressure ulcer was considered to have healed, there was no need for dressings and advice was given. The service to Pamela was terminated and carers were advised to re-refer if there was a deterioration in her skin integrity.

4.29 On 18/12/17, the home responded in writing to the family complaint; that the pressure ulcer guidance was followed and the wound had almost healed; Community Nursing only attend when the skin breaks down, as occurred in August; care plans were maintained and open to family involvement; a staff member was spoken to about saying to family that Pamela could be difficult; Pamela was independent in eating and had put on weight; fluids were provided; a hairdresser visited Pamela weekly; her nails were attended to weekly; she had a full body wash twice daily and frequently refused bathing; she was 'freshened and repadded' every four hours; and there were two recorded falls on consecutive days in July 2017 when she had a UTI (and none since). It is not indicated whether there was a risk assessment for bathing.

4.30 The Residential Care Home daily recording from 30/12/17 to 08/01/18 was examined in the course of the review. This refers to regular support with meals and fluids, medication, using the commode, changing continence pads, washing, applying cream and dressing. On 31/12/17, there is a record that a carer 'put clean dressing on'. This seems to refer to dressing a wound, yet Community Nursing had discharged Pamela on 13/12/17, as the wound had apparently healed. The record on 08/01/18 states; 'contacted D/N as Pam has a pressure sore above sacrum'. With regard to dietary needs, Pamela's family recall that she was not supported with using cutlery.

4.31 Community Nursing received the new referral on 08/01/18, regarding a sacral pressure ulcer to the same skin area as before. A Bank Registered Nurse visited Pamela on 09/01/18, but the wound was not assessed to determine the cause and was dressed in accordance with the previous care plan. Family members and Hampshire Adult Social Care were not informed.

4.32 A further 13 Community Nursing visits were undertaken in January 2017, with visits set for every other day. Bed rest and repositioning were recommended. On 21/01/18 a Registered Nurse noted wound deterioration, possibly grade 4, and that a further area had developed and seemed to be due to moisture on the skin. She viewed the repositioning chart and Pamela had been most recently turned 4 hours before, so she reminded carers that this should be 2 hourly. On 26/01/18, the wound was necrotic, Pamela was lying in urine on arrival and staff said they had changed her pad less than an hour before. She was wearing 2 pads and staff were advised to use a single pad and an under pad, to reposition regularly and monitor. On 27/01/18, the

wound was necrotic, Pamela was not drinking much and was dehydrated. Pamela's family recall supporting her with hydration. A Registered Nurse visited as a second pair of eyes on 28/01/18 and the wound was documented as grade 4. On 29/01/18 the Registered Nurse visited again and documented a risk of sepsis. There was evidence on a chart of turning every 1-2 hours. A final visit was completed on 30/01/18 and Community Nursing noted on the following day that Pamela had been lying in wet pads at times when they visited. Hampshire Adult Social Care were not informed of the deterioration and possible neglect. The Registered Nurse later gave evidence at the Coroner's Enquiry that Pamela appeared to be well-kempt when observed during Community Nursing visits. Pamela's family believe that some Community Nursing records were not disclosed to the Police and the Coroner, although the Community Nursing representative states that all available notes were disclosed to the Coroner in July 2019.

4.33 CQC contacted Portsmouth on 10/01/18 regarding their concern about the standard of care and leadership at the home and a safeguarding concern they had raised on 04/08/17. The local authority Safeguarding Adults Team recorded that they had found no concerns.

4.34 Residential Care Home records for 23/01/18 to 25/01/18 were examined as part of this review. These refer to Community Nurses redressing a sore and support with meals and fluids, using the commode and hourly changing of pads as required, personal care, managing transfers and a reference to turning on the third day only.

4.35 The Independent Reviewer has examined the turning chart for Pamela from 22/01/18 to 30/01/18, against a plan of 2 hourly repositioning (changed to 1 hourly from 25/01/18) and there are gaps. There was minimal turning of every 3 to 7 hours in the first 3 days. There were also gaps in 4 of the other 6 days (1 gap of 4 hours, 2 gaps of up to 7 hours, 1 gap of 2 hours, and 2 gaps of up to 3 hours).

4.36 An out of hours GP visited Pamela on 27/01/18. Care staff reported that Pamela was eating and drinking well and they were repositioning and changing her pad hourly. The GP informed Pamela's family that Pamela was well hydrated and he had no concerns.

4.37 Pamela was transferred to a Nursing Home by family on 30/01/18. On arrival, the Home Manager observed that she was dehydrated, mouth dry and sore, ears 'revolting', dry matted skin in her hair, eyes gunky and crusted over, a grade 4 sacral pressure ulcer in very poor condition, grade 3 pressure ulcers to both heels and her left foot that were not relayed, requiring full assistance with meals and had a good appetite, and tolerated fluids little and often. Contributing to the review, the Home Manager recalls that Pamela was in the final stages of life. She raised a Safeguarding Adults concern with Portsmouth and reported her concern to CQC. She is not in a position to comment on the period of decline prior to admission. On a pre-assessment

visit to the Residential Care Home, she could see no evidence of a position change chart in her room, no care staff entered to change her position and her sister said that she was always lying on her back. A MED-PTS Ambulance Crew member, involved in transporting Pamela to the Nursing Home, later stated in a witness statement for the Coroner that they could not recall having any concerns about the patient during transfer.

4.38 GP visits to Pamela were completed on 01/02/18 and 09/02/18, recording and informing CQC about the Nursing Home concerns. She was treated as a palliative care patient, but was not considered to be end of life, and the plan was for additional pain relief.

4.39 Contributing to the review, five Residential Care Home staff who cared for Pamela state that they provided the best care they could and followed instructions in regard to turning and changing continence pads; that Community Nurses were contacted and visited when dressings came undone. However, it has been established in this review that there was evidence of soaked pads and of dressings undone.

4.40 On 30/01/18 and 01/02/18, a Safeguarding Adults Concern was raised by family and the Nursing Home Manager with Portsmouth Adults MASH regarding the standard of care provided by the Residential Care Home. A Safeguarding Adults Meeting was held at the Nursing Home on 30/01/18; attended by a MASH Social Worker, family members and the Home Manager. A MASH triage decision was taken on 01/02/18 to commence a Safeguarding Adults Enquiry, then closed on the same day as an enquiry was already open and this would be incorporated. On 02/02/18, the MASH Social Worker completed an unannounced visit to the home; finding gaps in the turning charts, redness on heels not body mapped or photographed, and inadequate food and fluid provision in charts. The MASH Team noted on 08/02/18 the absence of a multi-agency approach. On 09/02/18, the Solent Care Home Team (CHT) advised that Pamela had two pressure sores, both grade 4, to her sacrum and heel. The Safeguarding Adults Enquiry was signed off again on 12/02/18, with findings of unsubstantiated and inconclusive, and the home was asked to ensure that care plans and risk assessments were updated. Hampshire records indicate that the safeguarding concern was not relayed to them at this point.

4.41 A new referral was submitted by the Nursing Home to the Continuing Healthcare Team for Funded Nursing Care on 31/01/18. An assessment visit was completed on 07/02/18 by a CHC Nurse Assessor and fast-track CHC eligibility was agreed by the CCG, as Pamela was possibly entering a terminal phase.

4.42 The MASH Social Worker visited the Nursing Home on 06/02/18 to discuss the concerns. The Home Manager reported that, on her visit to Pamela at the Residential Care Home, her 'mouth was so dry it looked sore where no mouth care was being given.' She did not see a pressure relieving mattress.

4.43 The Solent Care Home Team provided advice to the Nursing Home on Pamela's pressure ulcer and general care from 09/02/18 onwards. A CHT general TVN Link Nurse visited on 09/02/18 to assess and offer advice. There was no referral for this support whilst Pamela was in the Residential Care Home.

4.44 Pamela was seen at the Nursing Home on 09/02/18 by a Dietician. A nutritional assessment was completed and nursing staff at the home reported that she was eating well and supported with high protein drinks. Pamela had gained weight since admission. A Diet Plan & Review was completed and carers advised to continue encouragement to eat little and often.

4.45 On 15/02/18, the MASH Social Worker visited the Nursing Home to meet with family and the Home Manager. The Hampshire Social Worker contacted Portsmouth MASH on 22/02/18. This was followed by a MASH Social Worker visit to the Residential Care Home on 23/02/18; then contacting Portsmouth CCG to discuss weight loss, falls and a lack of risk assessments. On 27/02/18, there was a further visit by the MASH Social Worker to the Nursing Home to discuss concerns with family and 4 months Community Nursing notes were requested from the PCCG (with a note of one week viewed). On 26/03/18, MASH contacted the GP Surgery and were advised that there were no concerns about neglect whilst they were visiting Pamela at the Residential Care Home.

4.46 On 23/02/18, a Hampshire Adult Social Care Duty Social Worker contacted family for updated information and a Social Worker was assigned on 26/02/18 to review family concerns. There was contact between Portsmouth Adult MASH and the Hampshire Social Worker on 09/04/18 and 05/06/18 to update on the enquiry. The only reference in Hampshire records of the Portsmouth-led enquiry in February 2018 was that of family advising on 05/02/18 that Pamela had moved home as a safeguarding emergency. Pamela's family recall that they had been unaware that the assigned Social Worker was planning a review in response to their concerns.

4.47 An Out of Hours GP visited the Nursing Home on 04/03/18 and verified Pamela's death.

4.48 On receiving notification of Pamela's death on 04/03/18, Hampshire Police commenced an investigation into the standard of care provided by the Residential Care Home.

4.49 A Multi-Agency Safeguarding Adults Planning Meeting was held on 20/03/18, chaired by Adults MASH and involving Community Nursing and the Police (minutes signed off on 13/06/18), with family not invited. Community Nursing advised that Pamela's heels were red but intact when observed on the day of transfer to the Nursing Home, but two grade 3 pressure ulcers to her heels were identified on transfer. Concerns regarding repositioning, continence care, nutritional care and possible dehydration were discussed. It was agreed

that, alongside other enquiry actions, the Police would decide whether there were grounds to consider criminal neglect.

4.50 On 26/03/18, the Police advised that the threshold for a criminal enquiry was not met. Advice had been sought from the Crown Prosecution Service (CPS) and medical experts and the decision was reached that no potential criminal offences were identified. The Serious Crime Review Team reviewed and confirmed the decision in April 2018 and again in November 2019.

4.51 On 26/03/18, the Police emailed Portsmouth to advise that the GP who had visited Pamela at the Residential Care Home had no concerns about neglect.

April to July 2018

4.52 A Portsmouth Adults MASH, 'Safeguarding Enquiry – Outcomes and Closure Summary' was signed off on 20/07/18; relating to the concern received on 01/02/18. This stated that intentional neglect was not substantiated and that risk had been reduced. The report stated that a Mental Capacity Assessment was completed and that Pamela lacked mental capacity.

5. CRITICAL ANALYSIS

5.1 General overview

There is evidence of agencies endeavouring to address Pamela's needs and risks, alongside some positive communication. The deficits in individual and collective responses should be viewed in this context. This section incorporates service improvements since the period covered by the review.

5.2 Family overview

Pamela's family acknowledge some positive contributions by professionals but feel that agencies lost sight of Pamela and did not listen to her voice or the voice of her family, too readily accepting the Residential Care Home perspective. They raised concerns from July 2017 that the home was not meeting Pamela's needs, following deterioration in her physical health. Their concerns escalated in the following months, based on visiting Pamela every day, and they feel that she required Nursing Home care from September 2017 or before. They add that communication by the home with family was poor.

The family are concerned that Hampshire Social Work allocation ended following a review that was undertaken without family awareness or involvement in June 2017, that contact with Community Nursing was limited to a folder in her bedroom and that contact with the GP was limited to an occasion when they requested a visit. They feel that the CHC checklist was

completed without family information and a comprehensive assessment of Pamela's nursing needs.

Family members complained to Portsmouth in November 2019 that Adult Social Care had failed to safeguard Pamela, despite two Safeguarding Adults Enquiries. The response in January 2020, following an investigation, acknowledged that the enquiry was poor, some procedures were not followed and family were not properly consulted. Improved systems and practice were outlined and an apology issued for the distress caused.

5.3 How effective was needs and risk assessment and communication?

Overview: It is clear from the Coroner's Enquiry outcome that Pamela's pressure ulcer and general care was neglected. Involved agencies acknowledge that a coordinated response to Pamela's increasing needs and risks was not provided.

PSAB and Hampshire SAB: Prior to awareness of safeguarding concerns in November 2017, there was a general lack of professional curiosity in recognising and addressing poor care standards through available routes; intervention by visiting agencies, care management review and contract monitoring.

Portsmouth and Hampshire SABs joined in 2016 with two other SABs in introducing a 'Multi-Agency Risk Management Framework' (MARM), which was revised in June 2020. The framework includes guidance on self-neglect, domestic abuse and non-safeguarding concerns, but does not cover residential settings.

A Quality Improvement Team has since been developed, working alongside the Contract Review Team to implement an improved quality improvement framework; incorporating a planned provider concerns dashboard.

The Residential Care Home: A sore to Pamela's sacral area was observed in mid-July 2017 and Community Nursing support began a month later, when the home states that her skin broke down. It is unclear whether Pamela required specialist nursing care for a developing pressure ulcer. There were concerns about pressure ulcer and related care and staff at the Care Home were acknowledging difficulty in meeting Pamela's needs from August 2017. However, this was not conveyed to Hampshire, to trigger an informed review, and relatives recall that the residential care home maintained in September 2017 that they were able to meet Pamela's needs. Carers may have caused tissue damage in August 2017, due to unsafe manual handling and faulty hoists. Pamela was left on a hard chair in September 2017, with the cushion placed behind her back. She was left with faeces on her back and legs for up

to 4 hours, whilst soaked in urine, in October 2017. Community Nursing was not contacted when dressings came off on 7 occasions from August to October 2017. The Community Nursing Service states that the wound may not have healed underneath in December 2017 and poor care may have contributed to further skin damage. There is a Residential Care Home record of staff applying a dressing at the end of December 2017, with the implication that there may have been a wound at this time. Also, Pamela was unwell, had poor nutrition and was more immobile, which may have contributed to skin damage; without notifying Community Nursing of this development. The home re-referred to Community Nursing in January 2018, due to a wound in the same position, caused by moisture on Pamela's skin. Community Nurses found Pamela lying in wet pads in late January 2018 and on other occasions. There were gaps of up to 7 hours in repositioning around this time and it is unclear whether she was nursed continuously on a pressure relieving mattress. By the end of January 2018, when Pamela's health had rapidly deteriorated, she had been seriously neglected by the home.

The home has provided assurance to the Quality Improvement Team of improvements in leadership, care standards and safety. This is monitored and the CQC rating has raised from inadequate to requires improvement.

OPMH: The OPMH Team were responsive to Pamela's needs and risks in January 2017, initiating hospital admission and maintaining close monitoring until she was settled at the Residential Care Home and her acute mental health needs were managed. There is evidence of ward staff creaming and monitoring Pamela's dry skin, which was intact on discharge. The Community Mental Health Service recalls that the team had not observed poor practice at the home.

Solent Community Nursing Team: On visiting in August 2017 to assess redness to the sacrum, it was decided that Community Nursing was not required. The assessment visit was undertaken by an Agency Nurse rather than a substantive member of staff, a risk assessment was not completed and advice to carers was not documented. The service recommenced a week later, when the area of redness had deteriorated to a grade 4 pressure ulcer.

The sacral pressure ulcer appeared to have healed by mid-December 2017; with a further presentation by mid-January 2018 and deteriorating to grade 4 (also grade 3 to heels) by the end of January 2017. The Solent CHC Service comments that this appears to represent improvement until mid-January, followed by a deterioration. She adds that the presentation of Pamela on transfer to the Nursing Home is unlikely to be explained by deterioration on that day, yet Community Nursing had visited immediately prior to transfer. The pressure ulcers to the heels 'seemed to have developed incredibly quickly from a red presentation'; that the nature of how she was transported and whether she had a habit of rubbing her feet together could be possible

explanations. The CNC Service considers that, with poor care, it is unlikely that the sacral wound had fully healed in December 2017.

They believe that the frequency of visits in September 2019 was appropriate. However, poor repositioning, poor nutrition and poor continence care may have contributed to skin breakdown. They would have expected Community Nurses to have raised concerns with Hampshire to trigger a review, yet a later safeguarding concern to Portsmouth was the only escalation. Also, advice to carers is generally not documented.

The CNC Service comments that Community Nursing Support Workers were attending to Pamela, rather than Registered Nurses, aside from a joint visit with a Registered Nurse on 02/11/17 to assess the sacral pressure ulcer and care received. Support Workers are described as proficient in pressure ulcer care, but that further Registered Nurse visits would have been good practice.

They further comment that the Registered Nurse who visited Pamela in mid-January 2018 should have assessed the wound to establish the cause of the skin breakdown and developed a new Community Nursing care plan, rather than continue with the previous plan. These were completed later in the month. They believe that there should have been a CNT Case Manager involved in Pamela's care, who could have reassessed and determined whether a Nursing Home was necessary, and that a change in the care plan or Nursing Home care may have been necessary earlier in January 2018.

The CNC Service confirms subsequent improvements; a reorganisation of locality teams, key workers, improved electronic recording system (with care plans and body maps), alignment with an expanded Care Home Team, a TVN in each team, weekly Registered Nurse visits to patients with similar conditions to Pamela, reviews by an experienced nursing Case Manager, and a Pressure Ulcer Panel that regularly reviews all known pressure ulcers.

The Solent Quality and Safety Team completed 3 incident reports relating to Pamela; in August 2017 regarding unsafe manual handling due to faulty equipment, October 2017 regarding safeguarding, and January 2018 regarding a category 3 pressure ulcer. The TVN specialist in the review confirms that the latter concern should have been investigated by a designated Pressure Ulcer Panel.

Solent NHS Tissue Viability, Continence and Care Home Services: The Community Nursing Team and Residential Care Home did not request TVN support at any time, despite concerns about the management of pressure ulcers and related care. The TVN representative in the review states that Community Nursing should have requested TVN input and that all Community Nurses receive training on tissue viability to flag concerns. She adds that,

since the incident, there is now increased coordination between the two areas of service; including TVN Specialist Nurses in the Community Nursing Team.

Aside from the delivery of continence pads, the home and Community Nursing did not request support from the Continence Service, despite concerns about double incontinence and the potential impact on pressure ulcer care. The Continence Service provides related services, including training for carers and advice on wider continence management; which homes are made aware of. She adds that carers should check if the absorbency of pads has been exceeded, as urine becomes granulated and the skin should remain dry. The home did order more absorbent pads in December 2017. She comments that the use of two pads at the same time was not good practice, as this causes increased friction to the skin.

The Solent Care Home Team received no request for involvement with Pamela until after she moved to the Nursing Home, when a TVN link nurse attended and provided advice. As a change, every residential care home now has an assigned nurse and a multi-disciplinary meeting is held at each home every 5 weeks.

CCG and Portsmouth Continuing Healthcare Service: The Continuing Care Team is an integrated service, with the Local Authority as the lead agency. The team case manages Nursing Home residents, whilst Residential Care Homes are covered by Community Nursing.

The initial positive CHC checklist was returned on quality checking and resulted in a negative outcome. The Continuing Care Team Service considers that the checklist seems to have been accurate, in that it did not trigger a full CHC assessment and was aligned to national guidelines as evidence-based. It is intended as a screening tool and is subject to quality checks, as occurred. A list of NHS England and Portsmouth CHC Team training compliance is held for Portsmouth CCG and Council staff. Pamela's family recall being advised that a Social Worker was required to complete the checklist.

The CHC service states that the fast track route on transfer to the Nursing Home is a standard process when a patient is rapidly deteriorating in health. They consider that it is difficult to gauge when it was an appropriate time to consider a Nursing Home placement for Pamela; whether Community Nurses had concerns about deteriorating health earlier in January and could have relayed this to Hampshire Adult Social Care? Their view is that a residential care home was appropriate until January 2018, notwithstanding whether the particular home was adequate; that the fast tracked CHC assessment may have been appropriate some days before it was completed, dependent on when Community Nurses observed a rapid deterioration in Pamela's physical health.

The CHC service considers that there were deficits in the care provided by the home and in the scrutiny provided by partner agencies, including whether care plans were rigorously checked.

The point at which Pamela's complex needs required Nursing Home care is unclear, but there seem to have been grounds for reconsideration at an earlier point, possibly by mid-December 2017 or earlier in January 2018.

Hampshire County Council: The Hampshire assigned Social Worker was attentive to Pamela's needs in securing a residential care home in May 2017, with Pamela viewing potential placements.

The initial CHC checklist was revised with Community Nursing support and the outcome seems to have been appropriate at the time.

The Social Worker conducted a prompt initial placement review in June 2017, but without family contact or involvement, which was a missed opportunity to embed engagement. Closure and transfer to an unallocated review system of placements considered to be stable, pending annual review or contact, is practiced in many local authorities. Some allocate inactive review cases for a consistent contact point. The Hampshire representative in the review considers that this would not be logistically feasible; that the call centre, coupled with local team duty systems, provide a response to concerns raised on unallocated cases.

The family contacted Hampshire Adult Social Care in late July 2017 to request a transfer due to distance and that the home was not meeting Pamela's needs. The Social Worker was assigned following further family contact in August 2017 and made contact in the same month, leading to a review visit in mid-September 2017. The Independent Reviewer considers that a period of almost two months to review concerns raised by family was not a sufficiently responsive timeframe, whilst understanding that local teams were under significant workload pressure. This constituted part of a delay in arranging a move to an alternative home (ultimately arranged by family), whilst also awaiting an Occupational Therapy assessment.

Pamela had been upset in October 2017, on hospital discharge, and told family that she did not wish to return to the Care Home. This anxiety was not picked up by agencies and her wish to move close to her friend and family was not addressed with urgency. Whilst acknowledging that the Social Worker did consult with appropriate parties and reviewed records, the Independent Reviewer considers that communication and trust between the family and the home appeared to be the pressing narrative. The family concerns warranted a deeper probing of practice at the home by all agencies, as occurred to some degree at a later stage.

General Practitioners: The GPs did not record any concerns relating to Pamela's care at the Residential Care Home. Given the concerns raised by family, there was an apparent lack of professional curiosity and communication by visiting agencies, including GPs. An Out of Hours GP visited a few days before Pamela's transfer to the Nursing Home with a poor presentation, without raising concerns. Pamela's family believe that GP contact was mainly by phone and recall that they requested an unannounced visit by the Out of Hours GP in January 2018, but that this was announced. There is no record of this consideration in the service notes.

Hampshire Police: The intervention by Hampshire Police in January 2017 was thorough and personalised, with effective communication contributing to Pamela receiving hospital inpatient support.

Ambulance Service: There is no evidence that the care provided to Pamela on transportation to the nursing home was a concern or led to deterioration of the pressure ulcers. The attendant Ambulance crew would not have been familiar with Pamela and did not report any unusual circumstances.

5.4 How effective were Safeguarding Adults Enquiries in addressing concerns about neglect?

PSAB: Whilst family, Community Nursing and the Nursing Home raised Safeguarding Adults concerns; agencies did not work proactively, individually or collectively, to safeguard Pamela from neglect. Safeguarding Adults Enquiries lacked clarity and depth, falling short of reasonable expectations in addressing neglect.

Portsmouth City Council: The level of communication between Portsmouth Adults MASH and Continuing Health Care with Hampshire Adult Social Care about Safeguarding Adults and Provider Concerns Enquiries was not robust. This was a two-way responsibility, as MASH was accountable for the Safeguarding Adults response and had a responsibility to communicate concerns and actions, whilst Hampshire held case accountability and had a responsibility to actively engage. There was an over-reliance on communication by email. The Hampshire Social Worker was asked by Portsmouth MASH in November 2017 to undertake a review and did so, but there is no record of any request for other placing authorities to conduct reviews as part of a wider organisational enquiry, which may have highlighted a pattern of concerns. A larger scale Organisational Abuse Enquiry relating to the Residential Care Home was not opened by Portsmouth until March 2018, which the Adult Social Care and MASH representatives have indicated should have been earlier. They add that there would be merit in improving collaboration with the Contracts and Quality Improvement Teams on sharing

quality and safeguarding patterns of concern, replacing informal weekly meetings with a formal process.

Safeguarding Adults Concerns in Portsmouth are triaged by Adults MASH, holding the case if a new referral or transferring to the appropriate team if allocated. This aligns with the Pan-Hampshire Safeguarding Adults Policy and Procedure. There is a 28 day timescale to complete enquiries, with an escalation process if exceeded, which was not followed. As a newer development, the 'Multi-Agency Framework to Support Decision-Making in Relation to Safeguarding Adults Concerns' is an updated procedure in 2020; linked to the London Safeguarding Adults Board (LSAB), 'Safeguarding Adults Multi-Agency Policy, Process and Guidance' (June 2020).

The Portsmouth Adult Social Care and Adults MASH representatives in the review have acknowledged that the two Safeguarding Adults Enquiries were not completed to a satisfactory standard. They point to deficits in the engagement with Pamela and her family, insufficient management oversight and the involvement of a newly qualified Social Worker, insufficient professional curiosity, a lack of joined up working with Hampshire Adult Social Care, inadequate record keeping and documentation, a disproportionate emphasis on findings rather than on risk reduction and learning outcomes, and an unclear and inconsistent triage and Safeguarding Adults Manager decision-making process.

An initial Safeguarding Adults Concern was received at the start of November 2017, leading to a decision 5 days later to commence a Safeguarding Adults Enquiry, with a Social Work visit undertaken the following day. This process constituted a slight delay in the SAM decision and initial visit, as there were sufficient grounds to suspect neglect on the referral date. A MASH response that the service had no control over staffing levels, in view of CQC not having a regulated ratio for staff to residents, was unhelpful as it could consider whether staffing was adequate to meet dependency levels. It should be noted that it is not in CQC's remit or role to define staffing levels or ratios in regulated services. A Planning Meeting was not held. There were positive elements in the initial Social Work response, with a scrutiny of some records, but there was a lack of professional curiosity, management oversight and comprehensive liaison with Community Nurses. Closure of this enquiry in late November 2017, with not substantiated and inconclusive findings, did not involve a thorough consideration of the referral information, a multi-agency approach, a robust evidential trail (including no evidence of a deep dive scrutiny of all relevant Care Home records), and a Safeguarding Plan. Pamela's family, who had been raising concerns since July 2017 about the level of care falling short of meeting Pamela's increasing needs, were not notified of or involved in the enquiry, only receiving information in January 2018. This was a missed opportunity to have promptly addressed quality concerns and neglect.

A second Safeguarding Adults Concern was received at the end of January and start of February 2018. The Enquiry involved a more robust evidence trail, with the MASH Social Worker consulting with family and the two homes and examining records to find gaps in recorded care. However, a request for Community Nursing notes was not issued until almost a month later and was incorrectly directed to Portsmouth CCG. There is a note of the Social Worker reading nursing notes on 01/03/18, but it is not clear whether all notes were received and read, whether there was consultation, and what these contributed to the enquiry. The Solent NHS Safeguarding Team was not consulted. There was no discussion by Adults MASH with the GP until after Pamela's death and no professional curiosity when advised that the GP had not identified concerns; for example, asking for a professional opinion on Pamela's presentation when she arrived at the Nursing Home. The unsubstantiated and inconclusive findings did not appear to follow the evidential trail and were based on an inappropriate threshold of intentional neglect; as neglect can be unintentional. The enquiry was not closed until late July 2018 and the Adult Social Care and Adults MASH representatives acknowledge this constituted drift. An Organisational Abuse Enquiry was not instigated until March 2018, without clear evidence of links to the Safeguarding Adults Enquiry or cross-border communication.

The representatives point to subsequent improvements within Adults MASH in regard to staffing, personnel, procedures and practice. There is an increased emphasis on personalisation, family involvement and outcomes. They feel that the approach would now be to support the home and family to address the relationship rift, alongside professional curiosity in exploring the areas of concern raised by family. A new recording system, SystemOne, enables MASH Social Workers to access relevant primary health information on adults at risk. Triage decisions follow a set format, with a daily triage 'huddle' to ensure management oversight. All concerns are tracked and themes identified. There is improved integration with other health and social care partners, including the Contracts and Quality Improvement Teams.

They state that it would be difficult to evidence if all Health and Social Care staff, including Social Workers, have received up to date Safeguarding Adults training; and would therefore support a recommendation for checks on training compliance. Multi-agency risk management training is provided within Adult Social Care and to partner agencies, as is managing concerns and making referrals training. There are fortnightly two-hour Safeguarding Adults Clinics, providing 20 to 30 minute case consultation slots.

Hampshire County Council, Adult Social Care: The Independent Reviewer considers that Hampshire, having received family concerns from July 2017, should have more fully probed how the home and supporting agencies were meeting Pamela's needs and more actively engaged in safeguarding, whilst recognising that information was not relayed about the second enquiry.

Hampshire Police: The decision to close the formal investigation into Pamela's death seems consistent with the threshold for criminal investigation; as decision-specific mental incapacity and wilful or deliberate intent were not evident. Pamela's family have questioned this decision and a Police representative is in contact with them, separate to this review.

An advisor provided expert evidence to the Police, concluding that Pamela's care was 'poorly managed' and in the last six months 'did not meet her needs'.

5.5 How effectively was mental capacity, mental health and the user voice addressed?

Overview: Whilst mental capacity was referred to at various points by involved agencies, there appears to have been a lack of clarity and consistency about Pamela's fluctuating mental capacity and, when incapacity was indicated, no evidence of Mental Capacity Assessments.

An organisational 'self-audit' of Mental Capacity Assessment practice and training compliance was completed in 2019; leading to the issue of further guidance, materials and recommendations to partner agencies.

Agencies did not appear to give weight to the voice and concerns of Pamela, who was experiencing complex mental health concerns and wished to move; and her family who visited on a daily basis, held Power of Attorney status for finance and health and welfare decisions and had consistently raised concerns.

The Residential Care Home: There is no evidence of carers engaging with Pamela about her lived experience at the home. Family concerns were considered defensively, rather than actively listening to and addressing these, and they feel that they were not updated on changes in Pamela's presentation.

OPMH: There is no evidence of Pamela's paranoid ideas resurfacing after she had settled at the home, or of her dementia presenting concerns regarding care. However, it may have been helpful in understanding Pamela's complex needs and her voice, if further involvement had been initiated.

On hospital discharge to the home, it was noted that Pamela lacked mental capacity to understand the treatment and care she was receiving, yet there is no record of a Mental Capacity Assessment by any agency at this or any other time. The Consultant Psychiatrist at the time of discharge recalls an appropriate presumption of capacity.

Portsmouth City Council MASH: The Adult Social Care and Adults MASH leads have questioned whether Pamela may have had fluctuating mental capacity in the latter stages of her life and that this was not sufficiently

considered. They point to minimal evidence of engagement with Pamela in the first enquiry and no evidence in the second.

Hampshire County Council: In completing the CHC checklist over late September and early October 2017, it is understood that the Social Worker assumed mental capacity.

In the review in June 2017, family members were not invited or informed. This was inappropriate, given the need to actively involve family, particularly those with Power of Attorney status.

General Practitioners: There is a GP record in June 2017 of Pamela having the mental capacity to make decisions about her care plan. On the Out of Hours visit in late January 2018, it was noted that her confusion fluctuates. There was very limited contact by the GPs with family.

5.6 What was the impact of resource and environmental issues on the decisions and actions of agencies?

The Residential Care Home: It has not been suggested that resources were a contributory factor in the provision of equipment at the home. It is the view of family that staffing concerns contributed to gaps in care.

Solent Continuing Care Team: The CHC Service comments that decisions about CHC funding are not based on financial considerations, in line with the national framework.

Portsmouth City Council Adult MASH: It is acknowledged by the Adult Social Care and Adult MASH representatives that the Adult MASH Team was inexperienced and short of staff, which they state has since been addressed. It is unclear whether the drift in the second enquiry was due to workload pressure and the timescales are now monitored.

Hampshire County Council: Review completion in response to family concerns was delayed, but it is not suggested that this was resource-based. It is recognised that there were particular workload pressures at the time.

5.7 Which procedures and guidance apply and were these followed?

Solent: The *Standard Operating Procedure for the Prevention, Assessment and Management of Pressure Ulcers in Adults'* is available on Solent. The TVN specialist in the review is unable to say if this procedure was followed by nursing staff.

The Department of Health and Social Care, *Safeguarding Adults Protocol – Pressure Ulcers and the interface with a Safeguarding Enquiry* was not produced as national guidance until November 2018.

Portsmouth City Council: It is identified that Safeguarding Adults Policy and Procedures were not followed by Portsmouth Adults MASH in undertaking enquiries.

Portsmouth City Council and CCG Continuing Health Care: The *National Framework for NHS Continuing Health Care & NHS Funded Care 2018* provides guidance on the conduct of CHC assessments. This stipulates that a checklist is only intended to identify whether a CHC assessment should be considered and the threshold, as clarified by the CHC lead in this review, is intentionally low in order to screen patients in rather than out.

6. FINDINGS

Overview: The Coroner found that neglect had contributed to Pamela's death and did not issue instructions on the prevention of future deaths. It is not within the remit of this review to find whether Pamela's death could, on the balance of probability, have been prevented by good quality care. However, it is clear that the risk could have been reduced and she could have lived the final months of her life in greater comfort and dignity.

The following findings relate to analysis provided in the previous section.

- 6.1 Finding 1: PSAB -** There was a lack of professional curiosity and risk management by professionals and agencies with responsibility to support Pamela. Increasing concern that her complex care needs were not adequately met by the Residential Care Home with support did not trigger robust escalation, individually or collectively, through care management reviews or contract monitoring. The Multi-Agency Risk Management (MARM) framework is not applied in residential settings, and contract monitoring and quality improvement frameworks required further development.
- 6.2 Finding 2: PSAB and Portsmouth Adults MASH –** The Adults MASH did not fulfil its statutory obligation to undertake proportionate, personalised and outcome-focused Safeguarding Adults Enquiries in response to concerns raised about suspected neglect in November 2017 and January/February 2018. In the initial enquiry, family members were not informed or involved and there was insufficient scrutiny of records to establish an evidence base. The findings in both enquiries did not match the evidential trail and the second was not aligned to a correct threshold. Outcomes were not focused on reducing the risk of further

neglect. In a wider sense, there was limited evidence of agencies proactively engaging in reducing the risk of neglect.

6.3 Finding 3: PSAB - There was minimal engagement with Pamela and her family in actively seeking and listening to their concerns, with a tendency to concentrate on a negative perception of family communication.

6.4 Finding 4: PSAB - There was a lack of clarity and consistency in the underpinning consideration of mental capacity and whether a Mental Capacity Assessment was required at times.

6.5 Finding 5: The Residential Care Home - Pamela's complex care needs were neglected at the home and internal concerns about managing needs were not shared with the placing authority or on hospital discharge.

In the view of the Coroner (refer to 6.6), it is likely that pressure sores to Pamela's feet/heels were missed by Residential Care Home staff in late January 2018.

Despite holding Power of Attorney status and visiting daily, concerns expressed by family were not taken seriously and they felt that they were not kept up to date on Pamela's changing needs.

The Coroner found that the current management of the Residential Care Home had 'revolutionised the way this home is run' and that the improvements in place meant that further assurances were not required.

6.6 Finding 6: Solent NHS – Community Nurses visited Pamela regularly; monitoring, providing advice and escalating a safeguarding concern. However, there was insufficient clarity about the advice offered and insufficient accountability in proactively following up concerns about pressure ulcer and wider care to reduce the risk of neglect. The Coroner found that the pressure sores to Pamela's feet/heels were unaffected by the transfer process to the Nursing Home in late January 2018, had 'happened some time before the move', and it is likely that they were missed by Residential Care Home and Community Nursing staff. Holistic support in meeting Pamela's complex needs was available through the Tissue Viability Nurse, Care Home Team and Continence Service, and none of these services were accessed. A re-referral for Older Persons Mental Health (OPMH) involvement may have contributed to a holistic review of her care needs and an emphasis on her voice.

- 6.7 Finding 7: Portsmouth City Council and CCG Continuing Healthcare Service** – The Independent Reviewer accepts the clear view of nursing representatives that the Continuing Health Care (CHC) checklist in October/November 2017 seems accurate in demonstrating that Pamela did not require a full CHC assessment. However, family members express that their views were not taken into account and that a robust assessment was not undertaken. CHC funding was fast-tracked in early February 2018 and there may have been grounds to have considered an earlier assessment from mid-December or early January, when Pamela’s physical health more rapidly deteriorated.
- 6.8 Finding 8: Hampshire County Council** – The Social Worker completed a prompt initial review when Pamela moved to the Residential Care Home, but this was undertaken and closed without informing or involving the family. There was a delay of almost two months in completing a review in response to family concerns and Pamela’s wish to move, followed by a further delay (including an OT assessment) in arranging a move. A review in December 2018 involved family and a scrutiny of records, but was not sufficiently probing and continued to prioritise communication issues. Whilst Safeguarding Adults Enquiries were the primary responsibility of Portsmouth Adults MASH, there should have been more active engagement in risk reduction as part of the initial enquiry.

7. RECOMMENDATIONS

Improvements already introduced in the aftermath of Pamela’s death are outlined in the analysis section; covering the quality improvement framework, safeguarding arrangements, mental capacity, residential care home and Solent NHS improvements. These are not replicated here, except the latter in terms of assurance. However, it is recommended that Portsmouth SAB continues to monitor the development and effectiveness of these initiatives.

The following recommendations are intended to build on recognised improvements.

- 7.1 Recommendation 1: PSAB and Hampshire SAB – To agree and embed across agencies an enhanced risk management framework for high risk cases involving pressure ulcer care, when the safeguarding threshold is not met.**

Specific recommended actions:

- 7.1.1 To review the pathway of care management reviews, leading to a consideration of MARM Meetings, when there are high risk concerns

(including pressure ulcer care) in residential and community settings. To incorporate a risk assessment threshold and/or matrix to support decision-making, coordination by an agreed agency/professional in each high risk case, and senior management oversight. To represent the pathway on a procedural flowchart.

- 7.1.2 To incorporate the Contract Review and Quality Improvement Frameworks in the pathway to address organisational concerns; including liaison with care managers on pre-placement checks.
- 7.1.3 To link the risk management pathway to safeguarding adults thresholds, clarifying when escalation to this level is required.
- 7.1.4 To review risk assessment training, with specific regard to the pathway, pressure ulcer care, developing a culture of professional curiosity and a strengths approach.
- 7.1.5 To check understanding of CHC checklists through a care manager staff survey following training, across 4 boroughs.
- 7.1.6 To consider a shared multi-agency care record in residents rooms, to enhance communication.
- 7.1.7 To review and audit cross-border communication on high risk and safeguarding cases; with consideration of a memorandum of understanding, key contacts list, direct contact expectation and information sharing on out of area placements.
- 7.1.8 To review safe hospital discharge arrangements, with a flag for high risk pressure ulcer circumstances; involving a checklist of key contacts and assurance that the discharge placement is viable.

7.2 Recommendation 2: PSAB and Portsmouth Adults MASH – To further enhance and provide assurance of proportionate, personalised and outcome-focused Safeguarding Adults Enquiries.

- 7.2.1 To audit Safeguarding Adults awareness and enquiries training compliance across agencies; ensuring that pressure ulcers, escalation and whistleblowing are incorporated.
- 7.2.2 To develop a scheme of safeguarding champions across health and social care teams, aligned to raising awareness in staff meetings.
- 7.2.3 To review the MASH establishment and access arrangements, with specific attention to specialist health advice.

7.2.4 To consider cross-borough peer review of some planning and enquiry outcome meetings, with specific attention to safeguarding principles of proportionality and personalisation; also contributing to consistency and communication.

7.2.5 To consider line manager sign-off in all complex safeguarding cases and senior manager oversight of overlapping provider concerns enquiries.

7.3 Recommendation 3: PSAB – To enhance and provide assurance of personalised support to service users and families.

7.3.1 To audit whether assessment and review documentation and practice is personalised; with specific attention to prompt contact, actively seeking and listening to the voice of service users and families in an agreed way, support and advocacy, and consistency of worker or of an informed contact point.

7.3.2 To provide clear and accessible posters and leaflets in residential care and nursing home reception areas on contact points when concerned about quality standards or abuse and neglect.

7.3.3 To consider creative ways of strengthening wider service user engagement and personalisation through service user scrutiny of new procedures, the use of pen pictures in some reports, and the provision of dementia life story training across residential care and nursing homes.

7.4 Recommendation 4: PSAB – To provide assurance that Mental Capacity Assessments and principles underpin professional practice across agencies.

7.4.1 To seek assurance across agencies of accessible forms and guidance on mental capacity assessments and best interest decisions; including provider responsibility, recording requirements and management oversight.

7.4.2 To audit compliance with single or multi-agency MCA training attendance; with staff surveys on embedded legal literacy.

7.4.3 To audit clear recording of mental capacity assessments and, in circumstances of presumed capacity and high risk, identification in a risk assessment of how the adult understands risk and what risk management measures are in place.

- 7.5 Recommendation 5: Solent NHS** – To further audit the effectiveness of Community Nursing improvements; with specific attention to assessment and monitoring by appropriately qualified staff, clear documentation of advice, communication with related services and partner agencies, escalation of concerns and clinical oversight.
- 7.6 Recommendation 6: Hampshire County Council** – To audit the provision of timely, robust and personalised care management reviews in residential care home settings.