Safeguarding Adult Review

Sheila

Note: Sheila is a pseudonym used for the purposes of this Report.

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Contents **Page**

1. Introduction

1.1 Rotherham Safeguarding Adults Board (RSAB) initiated this Safeguarding Adult Review (SAR) in 9 April 2018. It followed an incident when a 99 year old woman who lived alone and was supported by a care package was found dead at her home 13 days after discharge from hospital. There were no documented entries in her care records at home to indicate whether carers from the domiciliary care agency had attended since her hospital discharge on the 4th December 2017. It was not clear at that time if she had received adequate food and nutrition and suitable hydration.

1.2 The aim of a SAR is to promote learning and improvement action in order to prevent future incidents involving death or serious harm. The Care Act 2014[1] states the following:

(1) A SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—

(a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

(b) condition 1 or 2 is met.

(2) Condition 1 is met if—

(a) the adult has died, and

(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

(3) Condition 2 is met if—

(a) the adult is still alive, and

(b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

(4) A SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

1.3 In this case an adult with care and support needs died after discharge from hospital and there was concern that there may have been contributory neglect. This Overview Report provides an overview of the deliberations and recommendations of the Safeguarding Adult Review Panel and Independent Author, drawing overall conclusions and recommendations from the information and analysis contained in agency audits, chronologies and discussion at a Practitioner Learning and Reflection Day.

[1] See http://www.legislation.gov.uk/ukpga/2014/23/section/44

1.4 Contributors to the Report include the following:

- The Care Agency (CA)
- Rotherham Metropolitan Borough Council (RMBC) Adult Social Care (ASC), Housing and Public Health (Hospital Social Work Team)
- RMBC ASC, Housing and Public Health (Rothercare)
- Rotherham NHS Foundation Trust (TRFT)
- The Family
- South Yorkshire Police (SYP)

1.5 This Review seeks to capture as much learning as possible for the agencies involved.

1.6 The woman at the centre of this review is referred to in this report by the pseudonym Sheila by agreement with her family.

2. Circumstances that led to a concise Safeguarding Adult Review being undertaken

2.1 Sheila was a 99 year old lady who lived alone in an owner occupied bungalow. She had received support services since 30 March 2015 provided by RMBC. From 26 May 2015 she had received a domiciliary care support package consisting of four visits each day from a Care Agency to support her personal care and nutritional needs. She also received a pendant alarm from Rothercare.

2.2 Her last admission to hospital before her death was for a period of two weeks from 24 November 2017 with a discharge date of 4th December 2017.

2.3 On the 18 December 2017 South Yorkshire Police informed the Hospital Social Work Team at RMBC that Sheila had been found deceased by her daughter at her home on 17 December 2017. It was not clear at this stage how long Sheila had been deceased and the nature of her death. There were no documented entries in her care records at home to indicate whether Care Agency carers had attended since Sheila's hospital discharge on the 4 December 2017. It was not clear whether Sheila had received adequate food and nutrition and suitable hydration following her discharge.

2.4 The police advised there had been a standard post mortem which indicated death by 'natural cause'.

2.5 The following agencies were known to be involved in Sheila's care:

- Rotherham Metropolitan Borough Council (RMBC) Adult Social Care, Housing and Public Health (Hospital Social Work Team.)
- Rotherham Metropolitan Borough Council (RMBC) Adult Social Care, Housing and Public Health (Rothercare)
- Rotherham NHS Foundation Trust (TRFT)
- The Domiciliary Care Agency (Regional Director)

2.6 After correspondence with the Coroner, the Independent Chair of RSAB initiated a Safeguarding Adults Review on 9 April 2018. The main issue of focus was the hospital discharge procedure.

2.7 Expressions of Interest were sought for the role of Independent Author, and Older Mind Matters Ltd was commissioned on 8 June 2018.

2.8 The timescale to be covered by the review was agreed as March 2015 until the date of death.

2.9 The detailed process of the SAR is set out under heading 4, Process of the Safeguarding Adult Review.

2.10 Independent Chair/ Author

The Author of this report is by professional background a psychiatrist and family and systemic therapist specialising in work with older adults and with broad clinical and multi-agency experience in the North West and West Midlands. She has acted as Chair and/or Author, and expert medical adviser/ consultant to Domestic Homicide Reviews, Safeguarding Adults Reviews, Serious Case Reviews and Local Case Reviews in the past. She has no connections or ties of a personal or professional nature with the family, with Rotherham Safeguarding Adults Board or with any other agency participating in this review.

3. Terms of reference

3.1 Introduction

3.1.1 The request for a Safeguarding Adults Review was agreed by the Independent Chair of RSAB in April 2018.

3.1.2 A SAB must undertake reviews of serious cases in specified circumstances. Section 44 of the Care Act 2014 sets out the criteria for a Safeguarding Adults Review (SAR):

3.1.3 A SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if— (a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

(b) condition 1 or 2 is met.

3.1.4 Condition 1 is met if—

(a) the adult has died, and

(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

3.1.5 Condition 2 is met if—

(a) the adult is still alive, and

(b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

3.1.6 A SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

3.1.7 Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to—

(a) identifying the lessons to be learnt from the adult's case, and

(b) applying those lessons to future cases.

3.1.8 The Care Act Statutory Guidance 2014 states that in the context of SARs: "*something can be considered serious abuse or neglect where, for example the individual would have been likely to have died but for an intervention, or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect*".

3.1.9 All SARs will reflect the 6 safeguarding principles as set out in the Care Act and RSAB multi-agency procedures. In addition, SARs will:

- Take place within a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice;
- Be proportionate according to the scale and level of complexity of the issues being examined;
- Be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed;
- Ensure professionals are involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;
- Ensure families are invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.
- Focus on learning and not blame, recognising the complexity of circumstances professionals were working within;
- Develop an understanding who did what and the underlying reasons that led individuals and organisations to act as they did;
- Seek to understand practice from the viewpoint of the individuals and organisations involved at the time and identify why things happened;
- Be inclusive of all organisations involved with the adult and their family and ensure information is gathered from frontline practitioners involved in the case;
- Include individual organisational information from Internal Management Reviews / Reports / Chronologies and contribution to panels;
- Make use of relevant research and case evidence to inform the findings of the review;
- Identify what actions are required to develop practice;
- Include the publication of a SAR Report (or executive summary);
- Lead to sustained improvements in practice and have a positive impact on the outcomes for adults.

3.2 Case Summary

3.2.1 Sheila was a 99 year old woman who lived alone in an owner occupied bungalow. She had received support services since 30 March 2015 provided by RMBC. From 26 May 2015 she had received a domiciliary care support package consisting of four visits each day from a Care Agency to support her personal care and nutritional needs. She also received a pendant alarm from Rothercare.

3.2.2 Her last admission to hospital before her death was for a period of two weeks from 24 November 2017 with a discharge date of 4th December 2017.

3.2.3 On the 18 December 2017 South Yorkshire Police informed the Hospital Social Work Team at RMBC that Sheila had been found deceased by her daughter at her home on 17 December 2017. It was not clear at this stage how long Sheila had been deceased and the nature of her death. There were no documented entries

in her care records at home to indicate whether Care Agency carers had attended since Sheila's hospital discharge on the 4 December 2017. It was not clear whether Sheila had received adequate food and nutrition and suitable hydration following her discharge.

3.2.4 The police advised there had been a standard post mortem which indicated death by 'natural cause'.

3.3 Questions to be answered by the Agency Reports and considered by the Overview Report

1. What was the role of your agency in Sheila's care?
2. What was the role of your agency in Sheila's care in the four weeks prior to her death?
3. What was the role of your agency around Sheila's discharge from hospital?
4. Outline what changes have taken place since this incident.
5. Did your agency comply with the policies and procedures that existed at that time.
6. Were there any gaps in processes, policies and procedures including record keeping at that time.
7. What learning may be drawn from this incident?
8. What good practice was identified in relation to Sheila's care?

3.4 Scope

The review should take into account agency involvement from March 2015 until the date of her death.

3.5 Method of Review

3.5.1 The Care Act 2014 Statutory Guidance states that the process for undertaking SARs should be determined locally according to the specific circumstances of individual cases. No one model will be applicable for all cases. The focus must be on what needs to happen to achieve understanding, remedial action and, very often, answers for families and friends of adults who have died or been seriously abused or neglected.

3.5.2 The SAR sub group agreed that the main issue leading to the review was the hospital discharge process and a learning review related to this issue would be undertaken.

3.5.3 A chronology will be used alongside a brief report from each agency on their own learning. A Practitioner Learning and Reflection Day will then be held to determine lessons identified for improvement.

3.6 Independent Reviewer and Chair

3.6.1 The named independent Lead Reviewer and Author is Dr Susan Mary Benbow.

3.7 Organisations to be involved with the review and agency reports required

- Rotherham Metropolitan Borough Council (RMBC) Adult Social Care, Housing and Public Health (Hospital Social Work Team.)
- Rotherham Metropolitan Borough Council (RMBC) Adult Social Care, Housing and Public Health (Rothercare)
- Rotherham NHS Foundation Trust (TRFT)
- The Domiciliary Care Agency (Regional Director)

3.8 Project Plan – timescales

3.8.1 The following timescales are critical in order that the final overview report can be presented to RSAB at their scheduled meeting on 21st January 2019

3.8.2 Timescales:

1. Terms of Reference agreed 28/06/2018
2. Request for Agency audits and chronologies 05/07/2018
3. Agency audits and chronologies due by latest 06/08/2018
4. Agency audits and chronologies circulated (following Quality Assurance Process by author) 28/09/2018
5. Practitioner Learning and Reflection Day 12/10/2018
6. 1st Draft of Overview Report Distributed 02/11/2018
7. Comments on version 1 by 16/11/2018
8. Circulate version 2 30/11/2018
9. Comments on version 2 by 07/12/2018
10. Version 3 circulated 21/12/2018
11. Overview report presented to RSAB 21/01/2019

3.7 Family engagement

3.7.1 Sheila's family will be invited to contribute to the review. Contact will be undertaken, preferably prior to the Learning Event, and again before the process is completed to share the learning.

4. Process of the Safeguarding Adult Review

4.1 Context

4.1.1 As part of the safeguarding investigation a decision making meeting was held on 12 February 2018.

4.1.2 Subsequently the request for a Safeguarding Adults Review was agreed by the Independent Chair of RSAB on 9 April 2018. The Chair concluded that the criteria for a SAR were met.

4.1.3 The following agencies were known to be involved in Sheila's care:

- Rotherham Metropolitan Borough Council (RMBC) Adult Social Care, Housing and Public Health (Hospital Social Work Team.)
- Rotherham Metropolitan Borough Council (RMBC) Adult Social Care, Housing and Public Health (Rothercare)
- Rotherham NHS Foundation Trust (TRFT)
- The Domiciliary Care Agency (Regional Director)

4.1.4 The timescale for the Review was set as March 2015 until the date of her death.

4.1.5 Case file audits and chronologies were requested and provided by:

Agency	**Abbreviated as**	**Author**
The Care Agency involved	CA	Regional Director
Rothercare	n/a	Rothercare Manager
Rotherham Metropolitan Borough Council	RMBC	Head of Service – Safeguarding and Professional Practice
Rotherham NHS Foundation Trust	TRFT	Named Nurse Adult Safeguarding

4.1.6 Additional information was sought from:

- South Yorkshire Police (SYP)
- The GP
- Yorkshire Ambulance Service

4.2 Family Involvement

4.2.1 Sheila's daughter spoke with the Independent Author over the telephone in October 2018 and kindly provided information about her mother and her own concerns.

4.2.2 She was contacted again after the final report had been drafted to share with her the learning that had been derived during the SAR.

4.3 Process of the SAR

4.3.1 Terms of reference were developed and agreed following the appointment of Older Mind Matters Ltd to provide an Independent Author.

4.3.2 Agency audits and chronologies were requested for return by a date in August.

4.3.3 A Safeguarding outcomes meeting took place on 1 October 2018.

4.3.4 A Practitioner Learning and Reflection Day was held on 15 October 2018 and attended by the following agencies:

- The Care Agency
- RMBC
- Rothercare
- South Yorkshire Police
- TRFT

4.3.5 Subsequently a first draft of the SAR report was produced and circulated for comment/ additional information.

4.3.6 The report was revised and further developed following receipt of comments and a second version was then circulated for comment/ feedback.

4.3.7 The report was revised following receipt of comments and then a third draft was circulated for comment. Panel members were asked to confirm that they had read the recommendations.

4.3.8 A final version of the report was then presented to the RSAB on 21 January 2019.

5. Facts of the individual case

5.1 Summary

5.1.1 Sheila was a frail elderly woman aged 99 with memory problems and impaired mobility who lived alone in a bungalow supported by four calls daily from a home Care Agency for meal preparation and personal care. She had a keysafe fitted and a Rothercare alert system.

5.1.2 On 24 November 2017 a carer at Sheila's home contacted Rothercare to say that Sheila had fallen. The carer was advised to call an ambulance.

5.1.3 Paramedics attended the property and found Sheila in a state of 'undress' on the floor.

5.1.4 She had 'ECG stickers on her body' which were thought to be from her previous hospital admission. The paramedics highlighted concerns regarding standards of personal care. Concerns were raised regarding possible neglect and acts of omission on the part of the home Care Agency.

5.1.5 Sheila was admitted to hospital as an emergency that same day.

5.1.6 On the ward a Mental Capacity assessment and a community care assessment were carried out by a social worker on 28 November 2017. Sheila wanted to go home. The social worker concluded that "at the time of this assessment I have assessed (Sheila) as having capacity to make this decision at this time."

5.1.7 The assessing social worker spoke with Sheila's daughter by telephone on two occasions following this. Sheila's daughter felt that 24 hour care may be needed in the future but agreed to her mother's discharge home with a care package.

5.1.8 The social worker spoke with the home Care Agency on 1 December 2017 and, following this call, discharge home was organised for 4 December 2017.

5.1.9 Sheila was discharged home on 4 December 2017.

5.1.10 On 17th December Sheila was found deceased at home by her daughter, who had been unable to visit earlier because of adverse weather. It was not clear how long before that she had died.

5.1.11 There were no documented entries in her care records at home to indicate whether carers had attended since she was discharged from hospital on 4th December 2017.

5.1.12 It was reported that Sheila had soiled herself, and that the commode was overflowing. There was food in the kitchen, which raised questions about whether Sheila had eaten during this time. Due to the weather conditions and that her

daughter lives at a distance, Sheila's daughter had been unable to visit her mother earlier following her discharge from hospital. Her first visit or contact with her mother was on 17 December 2017.

5.1.13 On 18 December CID, SYP, informed Social Services that Sheila had died.

5.2 Outline Chronology of Key events

5.2.1 The edited chronology below highlights key events over the period March 2015 to December 2017.

Date	Source	Details
30/3/2015	RMBC & Care Agency	Sheila started to receive seven hours/ week home care.
19/10/2015	RMBC	Daughter requested reassessment as the Care Agency had not turned up on two occasions. Contracting concern completed.
1/2/2016	RMBC	Social worker visit following three missed calls in December 2015. Key from keysafe missing. No change in existing needs noted.
3/5/2016	RMBC	Fast response team making two calls daily following a fall with ensuing hip and back pain for support, support in mobilising, personal care, prompts for eating, check for pressure sores. Two calls daily home care. Meals on wheels. Memory problems noted.
3/5/2016		Admission to Rotherham District General Hospital.
10/5/2016	RMBC	Daughter advised that mother will require additional support on discharge. Advised to contact hospital Social Work (SW) team.
26/5/2016	RMBC	Personal budget awarded. Change to 14 hours/week home care.
27/5/2016	RMBC	CARATS (Fast response care and rehabilitation in the community) say Sheila "has not got rehab potential" – requesting "respite" for tonight.
30/5/2016	RMBC	Rothercare: Sheila found in bed with no evidence of food or drinks.

31/5/2016	RMBC	Reassessment requested. Sheila discharged last week, refusing to have “any care”, just wants to stay in bed, not taking fluids, diarrhoea yesterday. Carer 1 found her “quite confused” this morning, hip and shoulder pain, offered to call GP but Sheila refused.
2/6/2016	RMBC	Carer 2 had spoken with GP: “gastro-enteritis” was due to prescribed laxative and had now cleared. Sheila eating and drinking more now. Asked Care Agency to continue with 4 calls/day and keep ASC informed.
16/6/2016	RMBC	Home Care Manager: Sheila home for two weeks – mobility reduced and memory deteriorated. Wandering outside. Fall yesterday – Rothercare assisted her up.
16/6/2016	RMBC	Social worker visit. Sheila had said that she would access short term placement. During visit Sheila was getting ready for bed: said that she didn't want to be disturbed and wanted to be in her own home. She knew how to use her pendant alarm. Home Care Agency made aware. Case note. Identified that Sheila has diagnosis of Alzheimer’s disease. Home Care Manager informed that since discharge Sheila has been more forgetful, confused and repetitive but that she “has insight into her own needs and insight into any and all risks”, and now needs more support. “Is able to make decisions that directly affect her and due to this has fluctuating capacity”.
22/6/2016	RMBC & Care Agency	Reassessment requested by Home Care Manager. “Same ongoing problems as reported last week”. “Found (Sheila) “covered in faeces” last night”. “Trying to wander”. “Deteriorating day to day”. “Has told carers she does not want to be here any more” … “doesn't want to be at home”.
24/6/2016	RMBC & Care Agency	Call to Home Care Manager: “situation appears to have “settled down”…”
14/9/2016	RMBC & Care Agency	Phone call from Home Care Agency: Sheila is “confused and very unsteady”. “Food stock getting low”. Requesting GP visit and calling daughter.
30/10/2016	RMBC	Fast response team placed Sheila in short term placement following a fall.
6/2/2017	RMBC	Emergency hospital admission following a fall.

22/3/2017	RMBC	Rothercare visit – mobility poor, very confused, trying to walk down the path saying she was taking a library book back. Assisted indoors but kept wanting to leave the house. Daughter informed that GP has prescribed antibiotics as Sheila has a urinary tract infection.
25/3/2017	RMBC	Found on the floor, ambulance called, no injury.
13/7/2017	RMBC	Fast response nurse called duty social worker. Social worker visit. Sheila fell last night. Mobility very poor. Confused with poor short term memory. Trying to get out of bed independently. Needs constant prompts with eating, drinking. Nurse worried to leave her alone. Mental capacity assessment – no capacity around decision for respite care. 2 week "respite placement" agreed with daughter and Home till 27/7. Self-funding. Requires reassessment to see whether current care package is sufficient and suitable.
4/8/2017	TRFT	Chest pain – day admission to hospital.
7/9/2017	TRFT	"Collapse" – day admission to hospital.
11/9/2017	RMBC	Age UK Advisor requested Assistive Technology (vibrating pillow smoke sensor and bed sensor).
13/9/2017	RMBC	Ambulance service called when third party called ambulance as Sheila was banging on the window beckoning for help, and was confused when she answered the door.
14/9/2017	RMBC	Independent Living Officer visited and suggested Environmental Package plus an orientation clock. Daughter suggested in telephone call that it may be time to consider long term care.
30/10/2017	TRFT	"Found on floor" – day admission to hospital.
24/11/2017	RMBC	Emergency hospital admission. Paramedics attended the property on the 24/11/17 and found Sheila in a state on 'undress' on the floor. She had 'hospital ECG stickers on her body' from her previous hospital admission. The paramedics also highlighted concerns regarding standards of personal care. Social Worker Safeguarding screens on duty and regarding neglect, acts of omission on the part of home Care Agency.

28/11/2017		Social Worker carried out Mental Capacity Assessment and Community Care Assessment on ward. Sheila "was able to identify her care needs and was able to identify some risks. (She) was very clear about support that she would need and that she would be happy to accept. She was able to give information regarding how she would get help in an emergency." Social worker noted "at the time of this assessment I have assessed (Sheila) as having capacity to make this decision at this time. I am aware that her memory and capacity can fluctuate and therefore mental capacity will need to be re looked at, at the review". Phoned daughter who "didn't feel that her mum was coping at home now."
30/11/2017	RMBC Social work notes	Daughter "expressed her concerns regarding her Mum and her safety at home." Daughter "explained that it may be that 24 hour care may need to be considered (in) the future, however due to her Mum's strong feelings she agreed to trying again at home with the care package".
1/12/2017	ASC	"Discussed plan for discharge. (Care Agency) are able to restart care package on Monday 4th December starting with the lunch call. (Telephone call) to ward … to advise that (Care Agency) can restart care on Monday… " "Discussion with Team Manager, informed that care can restart on Monday lunch call… The best plan would be for her to return home on Monday morning. This was agreed by (Team Manager)."
4/12/2017	ASC input on 6/12	Sheila discharged home. (She was collected from the ward at 10.36 and transported home by a YAS 1-man ambulance.)
4/12/2017	ASC	An email exchange took place between a Safeguarding Social Worker and the Care Agency in relation to the ongoing safeguarding concerns. The Care Agency email states that they cannot get access to records "as (Sheila) is still in hospital" and the SW responds that, in conversation with Sheila's daughter, "she didn't seem sure whether her mum would be discharged home to(sic) into residential care" and that he couldn't see on the system that assessment had taken place yet. This appears to have reinforced the Care Agency's belief that Sheila remained in hospital.

8/12/2017	additional information	At the Practitioner Learning and Reflection Day we were informed that someone called to drop off eye drops for Sheila on 8 December 2017 and used the keysafe to gain entry. This person had known Sheila for some years and it is reported that she saw Sheila asleep in bed at the time of the visit and assumed that all was well.
18/12/2017	ASC	Phone call “from CID, South Yorks Police to (Social Worker). He informed (her) that (Sheila) has passed away. She had been found deceased at home yesterday (17/12/17) by (daughter). It is not clear how long it is since she passed away. No documented entries in her care records found at home to indicate whether carers had attended since being discharged from hospital on 4/12/17. It was reported that Sheila had soiled herself, her commode was overflowing, there was food left in the kitchen which questions whether Sheila had eaten during this time. (CID Officer) explained that due to the weather conditions and that (daughter) lives (at a distance). Daughter had been unable to visit Sheila since her discharge from hospital, her first visit or contact to (her mother) was on the 17/12/17.”

5.3 Background

Note: The background described below was not known in detail to agencies prior to Sheila's death and is derived primarily from family.

5.3.1 Sheila was 99 when she died and had been a teacher all her life. She is described as fiercely independent and, though frail and prone to falls towards the end of her life, was a strong resilient woman who wanted things her way and had the ability to bounce back after setbacks.

5.3.2 She trained as a teacher, married and had her only daughter in the 1940's. She went back to teaching when her daughter was 3 years old, married women had not been allowed to continue teaching, but there was a shortage of teachers after the War so they were able to continue.

5.3.3 Sheila and her husband enjoyed touring in their caravan and she was an active member of a local church. She played the organ, supported Christian Aid, and did knitting and crochet. She also loved reading. Her family was spread out over the country, apart from a sister, herself elderly, in Barnsley. Later in life church members used to visit and keep in touch with her.

5.3.4 Sheila engaged an architect to design her bungalow which was built in the mid 1960s and where she lived until her death. She had a routine there and could get through on "automatic pilot". She told her daughter that she would be there until "they take me out in a box".

5.3.5 Her husband died of cancer in 2003 and Sheila helped to care for him at home until the end. After that she lived on her own.

5.3.6 As she grew older she had several falls and strokes. She became very deaf (which she blamed on noisy children at school) and communication was best in writing. Her daughter noticed later that her mother's short term memory was poor but questions whether she had Alzheimer's disease, as her long term memory remained good and her deafness isolated her.

5.3.7 On her 90th birthday, despite having had a fall recently, Sheila went to Scotland on a tour. She started to have home care after falling and fracturing her shoulder and the care and support she needed gradually increased after that, although she did not really like having to have support. She could not hear the telephone so her daughter was unable to call her and relied on the carers to do their job. She knew that if there was a problem they would contact her. One time Sheila went into a Care Home for respite after a fall, but she told her daughter it was like prison and thought the other residents were "dead". Her daughter found out that her mother was on a dementia unit and she clearly disliked it.

5.3.8 Her deafness and frailty meant that Sheila became increasingly isolated, vulnerable and reliant on the carers who were eventually going in to care for her four

times daily. Her friends had mostly died. An elderly neighbour used to go in to see Sheila and take her a paper, but died a few months before the events leading to Sheila's death. At one time the milkman used to take milk in to her, but with the introduction of a keysafe and carers, this was no longer possible and she started to use long life milk. Her daughter lived at a distance but continued to visit regularly. Plans were already underway for Sheila's 100th birthday.

5.3.9 During her last admission Sheila's daughter had some reservations about her returning home but knew that she wanted to be in her home and that she had disliked the respite home. She stocked up the bungalow with food for her mother's discharge and planned to visit on the first weekend after discharge but unfortunately it snowed and her daughter was snowed in at home some considerable distance away. As a result she couldn't visit her mother until December 17th by which time she had died.

5.3.10 Afterwards everyone was very good to Sheila's daughter, particularly the Police. Her daughter rang the Care Agency to tell them about her mother's death, and the person who took the call was really nice and said someone would call back, but they failed to do so and have not contacted her since.

6. Analysis of individual case

6.1 Introduction

6.1.1 We know now that Sheila died of natural causes approximately 24-36 hours before her daughter's visit and the immediate cause of death was given as hypertensive heart disease, although the pathologist could not rule out the possibility that a lack of care and support following Sheila's discharge played a role in her death. We know too that there was evidence that she had eaten and taken fluids and that she was not on any medication. Nevertheless her death and the discharge that preceded it (when care did not restart as expected) flag up a need to review events and in particular discharge processes to avoid similar occurrences in future.

6.1.2 The SAR has also flagged up broader issues in relation to Sheila's care and studying the chronology it appears that Sheila was having increasing contact with services towards the time of her final hospital admission, suggesting that she was coping less well at home. However no one person had an overview of her increasing difficulty in coping.

6.2 Areas of interest

Agency audits were asked to consider eight questions.

6.3 Questions 1 and 2: Agency roles in Sheila's care, in particular in the four weeks prior to her death

The Agency audits set out their respective roles in Sheila's care. The Practitioner Learning and Reflection Day brought together information from the agencies involved and highlighted the following issues:

6.3.1 ***The pendant alarm***

6.3.1.1 Sheila was not wearing her pendant alarm after discharge from hospital. Whilst she was at home it would not uncommonly be activated unintentionally and initiate a response, since she was unable to hear and communicate over the intercom. Sheila was transported home by transported home by a YAS 1-man ambulance. The ambulance service is clear that they do not take responsibility for getting people that they have transported home to wear their pendant alarm. There was no relative to encourage her to wear it since Sheila lived alone with her closest relative at a distance and normally visiting weekly. When a high risk person returns home it would be helpful to be clear who takes responsibility for making sure they wear their alarm and to have this as part of standard practice. Alternatively it was suggested that the Integrated discharge team could add a question about whether someone has their pendant in place to their checklist.

6.3.1.2 A simplified pathway between Rothercare and assistive technology was highlighted in the Practitioner Learning and Reflection Day as

an area for possible improvement. Sheila had a falls pendant and an environmental package. A bed sensor had also been requested.

6.3.2 Open safeguarding investigation

6.3.2.1 At the time of Sheila's final admission a safeguarding concern was raised in relation to possible neglect/ acts of omission on the part of the home Care Agency. Sheila was noted to have 'hospital ECG stickers on her body' which were thought to be from a previous hospital admission and there were concerns expressed regarding standards of personal care. At the time of the Practitioner Learning and Reflection Day it was still not clear how long the ECG stickers had been in place and further questions were raised. The valid point was made that Sheila was an independent and strong-minded woman who was able to decide how far carers should assist with her personal care and that her choice needed to be respected. Care Agency staff told us that Sheila undertook her own personal care as far as possible and was supported by carers in relation to parts of her person that she couldn't reach. This highlights a difficult area: how far are care staff members responsible for standards of personal care and how do they reconcile any responsibility with the wishes of individuals to do things for themselves. In practice this has to be a negotiation taking a person's mental capacity and physical abilities into account.

6.3.2.2 There was difficulty in progressing the safeguarding investigation because the Care Agency records were locked in Sheila's property after her admission to hospital and then after her death records were removed by the Police. Safeguarding contacted Sheila's daughter on 1 June 2018 , 21 August 2018 and in early September. She declined attendance at the Safeguarding outcomes meeting on 1 October 2018 requesting feedback, which was provided on the 3 October 2018.

6.4 Question 3: Discharge from hospital and "miscommunication"

6.4.1 As identified by the SAR sub group the hospital discharge was a major area of focus. Agencies were asked in their audits to address the following question: what was the role of your agency around Sheila's discharge from hospital?

6.4.2 Originally Sheila's discharge from hospital was planned for 1 December 2017 but it was held back for care to be restarted on the following Monday. It appears that, if she had been discharged on 1 December 2017, she would have received support over the weekend from a Fast Response Team. The Social Worker involved was not comfortable with bringing in a care provider new to Sheila and opted to delay discharge until her usual Care Agency could restart care. However, at the Practitioner Learning and Reflection Day the Care Agency informed us that the Care Agency has a policy of restarting care within 24 hours irrespective of the day of the week.

6.4.3 A telephone conversation between a social worker and the Care Agency on 1 December 2017 concluded with the two people involved taking away different understandings on what had been agreed.

6.4.4 The social worker believed that care would restart on 4 December 2017 and that Sheila should be booked on early transport in order to be home in time for a lunchtime call by the Agency. This is what the ward arranged and what went ahead.

6.4.5 The Care Agency believed that discharge was not definitely going ahead and that a further call from the social worker would confirm whether or not discharge would take place the following Monday. When they received no further call, they concluded that Sheila was not being discharged home on 4 December 2017.

6.4.6 What might have contributed to this "miscommunication"? The discussion took place over the telephone so there is no record of exactly what was said. There was no subsequent written confirmation by either party to the call regarding what had been agreed. The Social Worker believed that she had made a direct and unambiguous request for the Care Agency to restart Sheila's care package. The Care Agency believed that the Social Worker was going to get back to the Agency to confirm whether the care restart was required, and when she did not, they assumed that no care was required, therefore none was arranged. Avoiding miscommunications involves the use of clear precise language.

6.4.7 Issues relating to communication are commonly identified in a range of investigations into serious Incidents. The Patient Safety Initiative Group NHS Improvement uses the term "safety-critical communication failure", and that term might be applied to what happened in this case. On page ii of their Report[2] they state that they:

"… found many examples of the kind of communication failure that could happen to almost anyone where the circumstances are challenging, the communication setting is less than ideal or the person doing the communicating is having a bad day."

6.4.8 The same Report identifies six key challenges that affect everyday spoken communication. These are listed below – the points are taken from page 22 of the Report and presented in a bulleted list for clarity:

- "the communication environment (which should ideally provide adequate time, privacy and comfort for spoken communication),

[2] From Report of the Patient Safety Initiative Group NHS Improvement July 2018. See https://improvement.nhs.uk/documents/3346/MUCH_MORE_THAN_WORDS_FINAL_8.pdf

- information exchange (relying on adequate and appropriate information to be passed between the right people at the right time),
- attitude and listening (respect and attentiveness have proven safety-critical benefits),
- aligning and responding (good conversations benefit from a parallel channel via which speakers continually check understanding and orient to how the other is reacting),
- creating the preconditions for effective team communication (everyone must feel confident to speak up about lapses or threats to coordination and continuity), and
- communicating with specific groups (additional care and communication are needed, for example, for children and those with limited English, impaired hearing, limited capacity to understand or a mental health condition)".

6.4.9 The two areas that may be most likely to have influenced the miscommunication in this case are probably the communication environment and aligning and responding, which may be influenced by underlying assumptions.

6.4.10 The Report concludes that there are no easy answers to "safety-critical communication failures", and is itself a prelude to further work, but it raises questions about how environmental issues might contribute to communication failures (eg privacy, lack of noise and interruptions during spoken communications), how pressure of work might influence communications, and whether there is a role for training and for reflective practice focusing on spoken communications.

6.4.11 Thus a "miscommunication" in a telephone conversation resulted in Sheila being discharged home and care not being restarted. There was no requirement for written confirmation of discharge date. There was no arrangement to follow up discharge and ensure that care had been restarted. Sheila was particularly vulnerable because of her deafness, which meant that she was unable to use the telephone, and because of her isolation (contributed to in part by her deafness) (see para 6.8.1 below concerning vulnerable individuals and complex discharges). The Police concluded that a breakdown in communication had occurred.

6.4.12 In addition, it appears that the Local Authority's computer system was not updated with details of Sheila's assessment and discharge which resulted in the Care Agency's understanding that Sheila had not been discharged being reinforced by an e-mail exchange between a Safeguarding Social Worker and the Care Agency on 4 December 2017 in relation to the ongoing safeguarding concern. The Care Agency email states that they cannot get access to records "*as (Sheila) is still in hospital*" and the SW responds that, in conversation with Sheila's daughter, "*she didn't seem sure whether her mum would be discharged home to(sic) into residential care*" and that he couldn't see on the system that assessment had taken place yet. This appears to have reinforced the Care Agency's belief that Sheila remained in hospital.

6.4.13 Another factor identified in the Practitioner Learning and Reflection Day is the distinction between setting up new packages of care and restarting existing packages. The latter had been regarded historically as more straight forward but some people being discharged from hospital may be particularly vulnerable and dependent on their care package so that restarting a care package may need particular care. (see para 6.8.1 below regarding vulnerabilities)

6.4.14 The discharge process has been reviewed by the Integrated Discharge team, a collaboration between TRFT and RMBC. It is agreed that any assessment of care needs following discharge is the responsibility of the SW team. I am informed as follows:

In the line with the NHS 'Home First' policy and to provide continuity of assessment we plan to implement a new approach to our discharges. The plan is to implement a briefer proportionate assessment while the person is in hospital and then complete a more holistic assessment in the persons' own home. Our view is that completing a full assessment a person in hospital while they are ill does not provide an accurate picture of their potential. The approach to give the person time to optimise with the aid of enhanced care support (including intermediate care / Reablement) and speak to them in their own environment. The workers will be involved with the person for up to 2-weeks post discharge.

6.4.15 I support the principle of this plan, which fits with the discharge to assess model[3]. Assessment whilst people are in hospital and assessment whilst they are in their own home may be very different. Involving staff for up to 2 weeks post discharge should also offer a safety net and may prevent early breakdown in home placement. It fits with one of NICE's key principles in relation to discharge planning[4], namely:

Ensure continuity of care for people being transferred from hospital, particularly older people who may be confused or who have dementia.

It might also allow earlier discharge from hospital where appropriate. These potential changes could be audited by the Trust.

[3] See NHS England's Quick Guide: Discharge to Assess available at https://www.nhs.uk/NHSEngland/keogh-review/Documents/quick-guides/Quick-Guide-discharge-to-access.pdf

[4] See NICE Guideline NG27 available at: https://www.nice.org.uk/guidance/ng27/chapter/recommendations#discharge-from-hospital

6.5 Question 4: Changes that have taken place since the incident

6.5.1 *Integrated discharge team*

The Integrated discharge team is responsible for two weeks after discharge and carry out a check call within 24-48 hours of discharge. This is a change in practice introduced after Sheila's death.

A flow chart has also been developed and implemented to guide ward teams and ensure that care providers are contacted and that information is documented. It aims to minimise the risks associated with discharges.

6.5.2 *Rothercare*

Rothercare is now notified when a client is discharged from hospital.

6.6 Question 5: Policies and procedures that existed at that time

6.6.1 *Care Agency Hospital Admissions Checklist*

The Care Agency involved in this SAR had a policy involving the use of a hospital admission checklist designed for sharing information with the hospital and the checklist had been in place for some time. The Agency policy also required hospitals to be contacted daily to check on the status of clients who had been admitted and this involved a great deal of work. The Care Agency policy was not followed in respect of Sheila's discharge and the question was raised as to whether the policy was proportionate and appropriate. If discharge plans are clearly understood by all involved than this level of intensive follow up should not be necessary. The Agency involved suggested reviewing the policy but ceased trading during the course of the SAR.

6.7 Question 6: Gaps in processes, policies and procedures including record keeping at that time

6.7.1 *Distinction between new care packages and restarts*

At the Practitioner Learning and Reflection Day it was suggested that it might be good practice to require restarts of care to be put in writing to Care Agencies.

6.7.2 *Delay in uploading assessments*

Sheila was reassessed by a social worker to assess whether long term care or respite care was appropriate and necessary. There was a delay in the reassessment being uploaded to the system so that when the Care Agency exchanged emails with a safeguarding social worker on the date of her

discharge home all concerned assumed that Sheila remained in hospital and the system had not been updated with the assessment. (See para 6.4.7 above for more details of this exchange.)

6.7.3 Use of the Hazards tool

This tool looks at vulnerabilities but is not used routinely. The Practitioner Learning and Reflection Day raised the issue of what triggers the use of the Hazards tool and whether it could have a useful role in identifying high risk individuals.

6.8 Question 7: Learning from this incident

6.8.1 *Identifying highly vulnerable individuals/ complex discharges*

Sheila was particularly vulnerable in terms of her discharge home for a number of reasons:

- Advanced age (99)
- Living alone
- Forgetfulness/ diagnosed dementia condition
- Her physical health – she was frail and prone to falls because of impaired mobility
- Impaired communication due to deafness which meant that she was unable to communicate using the telephone and verbal communication was difficult at times
- Social isolation – close friends had died and her physical health meant that she was prone to falls and effectively confined to her bungalow
- No family living nearby – her daughter lived a distance away and was unable to visit because of adverse weather until some time after her mother's discharge from hospital
- In addition there was an open safeguarding investigation at the time of her discharge
- Fluctuating mental capacity noted in relation to major decisions
- An additional factor was the time of year/ weather

These factors contributed to her high level of dependence on the care package provided by the Care Agency. There was one visitor to her bungalow after discharge when someone called to drop off eye drops on 8 December 2017 and used the keysafe to gain entry. This person had known Sheila for some years and it is reported that she saw Sheila asleep in bed at the time of the visit and assumed that all was well.

6.8.2 *Lack of information sharing*

The IT systems of agencies involved in the SAR do not link so it is not possible to see how often someone is being seen by different agencies. An accessible system linking health and social care would facilitate information sharing. Some IT systems allow for alerts to flag up vulnerabilities. Would an accessible system have flagged up Sheila's increasing difficulty in coping at home and her frequent contacts with services?

6.9 Question 8: Good practice

6.9.1 Respecting Sheila's wishes to return home

Sheila was a strong-minded woman who had expressed the wish to remain in her own home and her wishes were respected, whilst at the same time efforts were made to support her.

6.9.2 A system of following up on discharges

This was not in place at the time of Sheila's discharge but the Integrated discharge team early follow up is an example of newly introduced good practice.

6.9.3 Improved communication

Since Sheila's death staff in the Integrated discharge team are co-located and a safety check is carried out 24-48 hours after discharge. The Trust's rapid action to improved discharge systems is a positive change.

6.9.4 *Introducing changes to discharge practice in advance of this Report*

It is good practice that changes to the hospital discharge process have already been introduced in advance of completion of the SAR process with the aim of improving the discharge process and minimising associated risks.

7. Conclusions & recommendations

7.1 Lessons learned

7.1.1. The need to identify highly vulnerable individuals prior to proposed discharge

Sheila's discharge could be regarded as high risk for a number of reasons:

- A pattern of increasing difficulty in coping at home
- Advanced age
- Living alone
- Forgetfulness/ diagnosed dementia
- Frailty - prone to falls
- Impaired communication
- Social isolation
- No family living nearby
- Ongoing safeguarding investigation
- Fluctuating mental capacity
- The time of year when it took place

If high risk individuals are identified then options can be considered and closer follow up arranged following discharge.

Care agencies might consider identifying and flagging up high risk people receiving their support and considering whether extra checks are needed in some cases.

7.1.2. Improved discharge procedures

This review flags up how easily miscommunication can occur and the need to have in place a procedure that minimises this risk. The Integrated discharge team has introduced co-location of team members and a safety check call 24-48 hours after discharge. Both of these changes are to be welcomed.

7.1.3. Apology to Sheila's daughter

Sheila's daughter rang the Care Agency to tell them about her mother's death, and the person who took the call said someone would call back, but they failed to do so and have not contacted her since. She received no apology in relation to failure to restart care after her mother's discharge home and, although her mother died of natural causes, it cannot be ruled out that the lack of care played some role and may have influenced the quality of her final days of life. We were informed by the Police that the pathologist could not rule out the possibility that a lack of care and support following Sheila's discharge played a role in her death. I concur with this: after she left hospital no-one was in a position to observe whether there was a change in Sheila's health following her discharge home, and no-one was available to Sheila should she have wished to tell them about a change in her health.

The Care Agency told us that it considered that, in light of the criminal investigation, it would have been inappropriate to contact Sheila's family to discuss the incident. However, the duty of candour[5] is about being open and honest when things go wrong in health and social care and it would have been appropriate for the organisations involved in the discharge process to apologise that Sheila's discharge did not go to plan. NHS Resolution's 2018 leaflet Saying Sorry[6] expresses this well in saying:

Saying sorry is:
always the right thing to do
not an admission of liability
acknowledges that something could have gone better
the first step to learning from what happened and preventing it recurring.

7.1.4. The need to ensure that pendant alarms are used

When a high risk person returns home it is necessary to be clear who takes responsibility for making sure they wear their alarm and to have this as part of standard practice. Alternatively it was suggested that the Integrated discharge team could add a question about whether someone has their pendant in place to their checklist.

7.1.5. Restarting care packages

For high risk discharges from hospital, increased care needs to be exercised in all aspects. Written follow up to verbal requests for restart of care packages should be considered.

7.1.6 *Communication between professionals and information sharing*

At the core of this SAR lies a miscommunication between two people. It demonstrates how easily miscommunications can occur and how their consequences can be far-reaching and unexpected. It also demonstrates the high level of vulnerability of some people being supported by services. There is no way to completely prevent misunderstandings/ miscommunications between professionals, but checks and balances in the system can aim to identify problems at an early stage and prevent incidents like this. The use of the Hazards tool is suggested to identify high risk discharges and to trigger closer follow up after discharge. The checks now carried out by the Integrated hospital discharge team also offer a safety net for vulnerable people after discharge. It is also helpful if computer systems are kept as up to date as possible.

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[5] See the Care Quality Commission's 2015 document Regulation 20: Duty of Candour available at: https://www.cqc.org.uk/sites/default/files/20150327_duty_of_candour_guidance_final.pdf

[6] See the leaflet at https://resolution.nhs.uk/resources/saying-sorry/

7.2 Recommendations

7.2.1 RMBC/TRFT will provide agencies with whom they contract with the hospital discharge pathway to ensure that processes within the respective agencies comply with discharge pathway requirements and expectations.

7.2.2 Review the Hazards tool, which is used to identify high risk discharges, to consider whether this could be used or adapted to assist the discharge pathway. (TRFT, RMBC)

7.2.3 The Integrated hospital discharge team continues to carry out check calls to individuals at high risk following their discharge from hospital whether they are received new care packages or restarts of existing packages. (TRFT, RMBC)

7.2.4 The agencies[7] involved in the discharge process should apologise to Sheila's daughter for the misunderstanding which led to the failure to set up her mother's services after discharge. (TRFT, RMBC)

7.2.5 RMBC review and determine how to ensure that at risk individuals are provided with their pendant alarm on discharge from hospital and who takes responsibility for this. (RMBC)

7.2.6 Restart of care packages to be put in writing for high risk discharges. (RMBC)

7.2.7 TRFT and RMBC to explore whether this case can be used in training across health and social care in order to alert staff to the potential consequences of failures in communication. (TRFT, RMBC)

[7] The Care Agency involved in this SAR has ceased trading.

Glossary of abbreviations

ASC	Adult Social Care
CA	The Care Agency
CARATS	Fast response care and rehabilitation in the community
CID	Criminal Investigation Department
ECG	Electrocardiogram
GP	General Practitioner
IT	Information Technology
NICE	National Institute for Health and Care Excellence
NHS	National Health Service
RMBC	Rotherham Metropolitan Borough Council
RSAB	Rotherham Safeguarding Adults Board
SAB	Safeguarding Adults Board
SAR	Safeguarding Adult Review
SW	Social Work/ Social Worker
SYP	South Yorkshire Police
TRFT	Rotherham NHS Foundation Trust