



London Borough of Newham A Thematic Safeguarding Adults Review

June 2019

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Introduction

- 1.1 The Newham Safeguarding Adults Board (NSAB) identified 4 vulnerable men who died between 2017 and 2018. The men's cases highlighted similar themes which increased their vulnerability. These included their age, numerous hospital admissions, limited informal support in the community, concerns of self-neglect or neglect by another and limited engagement with statutory agencies.
- 1.2 The NSAB commissioned a Safeguarding Adults review to identify if there were lessons regarding how agencies worked together to safeguard individuals who are older males, with limited informal community support, hospital admissions and at risk of self-neglect or abuse by another.
- 1.3 The Safeguarding adults review looked into detail at the involvement and communication of the multi agencies in supporting the adults. A chronology of statutory agencies intervention for each individual is included in the main body of the report.
- 1.4 The review identified individual interventions with a lack of multi-agency information sharing and risk assessment.
- 1.5 The learning from this review will help the Newham Safeguarding Adults Partnership Board improve their efforts to safeguard people in similar circumstances in Newham.
- 1.6 Mr. B's family is engaged in participating in the SARs. Ongoing attempts are being made by the NSAB on contacting Mr. C's family to share the learning from the SAR.

Summary of Learning Points from Review

The following themes and learning were identified from the review

- 2.1 Professionals need to be competent in communicating with the adult and partner agencies to conduct a holistic risk assessment which should support professional decisions. All risk assessments should be recorded in a standardized format.
- 2.2 A hospital discharge planning policy and procedure should be embedded that clarifies communication pathways and accountability to support safe effective discharge for vulnerable adults in the London Borough of Newham.
- 2.3 Partners to understand the concept of 'safeguarding is everyone's business' and the need to share information and work together to achieve the best outcomes for vulnerable adults. Local Authority have the legal duty to conduct the safeguarding section 42 enquiry or make sure others do.
- 2.4 Professionals must demonstrate skill and competence in applying the Mental Capacity Act 2005 key principles and statutory duties throughout work with vulnerable adults. This

includes identifying when an individual makes an unwise decision versus the individual not having the ability to make a specific decision. Professionals should seek legal advice regarding High Court Inherent Jurisdiction applications in cases where the Adult at Risk has capacity, all options to mitigate the risks have been exhausted, and a risk considered in vital or public interest remain.

- 2.5 The Local Authority offer Carers a Carers Assessment to support them in their role. Care Act 2014.
- 2.6 Advocacy must be offered to an adult to support them in their assessment when they have substantial difficulty to engaged and there is no appropriate individual to support them through an assessment. Care Act 2014.

3. CONTEXT OF SAFEGUARDING ADULTS REVIEWS

3.1 Under Section 44 of the Care Act 2014, Safeguarding Adults Boards (SAB) must arrange a Safeguarding Adults Review (SAR) if:

- I. There is reasonable cause for concern about how the SAB, member of it or other persons with relevant functions worked together to safeguard the adult and the adult dies as a result of abuse or neglect, whether or not it was known or suspected before the adults dies (s44(2)) OR'
- II. If the adult is still alive and the SAB knows or suspects that the adults has experienced serious abuse or neglect (44(3)).

3.2 In addition, SAB's are free to commission a SAR in any other situations where it is thought there is valuable learning for the partnership (s44(4)). It is on this basis that the Newham SAB has commissioned this thematic SAR.

3.3 A key principle for completing a SAR is to ensure there is a culture of continuous learning and improvement across the organizations that work together and the approach taken to the reviews should be proportionate to the scale and the level of complexity of the issues examined. With this in mind the Newham SAB have commissioned a combined approach of using four case studies to provide a smarter and more effective review than completing four stand-alone reviews.

3.4 The SAB commissioned an independent author to provide the SAR report. The author is an experienced safeguarding practitioner, consultant and trainer. She holds a professional background as a social worker working across all service areas of safeguarding adults. The author is independent of the Newham SAB.

3.5 A SAR is not designed to hold individuals or organizations to account. Other processes exist for the purpose. The SAR enables all information from partner agencies to be reviewed in one place enabling the author to identify key areas for development to support SAB partners to improve ongoing safeguarding practice.

3.6 The Care Act 2014 (s44(5)) states each partner must co – operate and contribute to the review, identifying lessons to be learnt and apply the lessons to future practice.

3.7 The Department of Health's six principles for adults safeguarding should be applied across all safeguarding activity.¹ The principles will be considered throughout the SAR as follows:

Empowerment	Understanding how service users were involved in their care; involving service users or their representatives in the review
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¹ Department of Health (2016 Care and Support Statutory Guidance Issues under the Care Act 2014)

Prevention	The learning will be used to consider how practice can be developed to prevent future harm to others
Proportionality	The learning of four cases will be more effective in the learning
Protection	The learning will be used to protect others from harm
Partnership	Partners will co – operate with the review considering how partners are working together to safeguard adults in Newham
Accountability	Agencies will be transparent in the review with the SAB holding individual agencies to account for agreed recommendations.

4. BACKGROUND TO THE THEMATIC REVIEW

The Newham Safeguarding Adults Board commissioned a thematic safeguarding adults review (SAR) following concerns of how effectively agencies were responding to their duties under the Care Act 2014 implemented in 2015. The SAR was commissioned following the death of four males whose circumstances have similarities.

The key similarities included:

- Male aged between 75 and 97 years' old
- Died shortly after hospital admission or discharge from hospital admission
- Limited informal support in the community
- Acceptance of explanations from the adult on how they would manage when discussed with them but no evidence of professionals demonstrating professional curiosity when the comments and circumstances do not correlate.
- Limited engagement with statutory services
- Concern of self-neglect

5. TERMS OF REFERENCE AND METHODOLOGY

Terms of Reference

5.1 The SAR included responses from agencies working with the four individuals who are subject to this review.

5.2 The scope period for the review is as follows:

- a. Mr. A September 2016 – August 2017
- b. Mr. B May 2016 – June 2017
- c. Mr. C 2013 – 2018
- d. Mr. D March 2017 – March 2018

5.3 The specific themes considered:

a.	Frequent hospital admissions and effectiveness of discharge planning
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b.	Referral response to concerns of self-neglect
c.	Multi agency information sharing
d.	Risk management
e.	Application of the Mental Capacity Act 2005
f.	Knowledge and application of the Care Act 2014 section 68 advocacy
g.	Safeguarding adults policy and procedure – self-determination versus statutory duty to conduct enquiries
h.	Professional curiosity

5.4 The adults who are subject to this review are all deceased. 3 of the 4 gentleman did not have any family actively involved in their care.

Methodology

5.6 The methodology applied for this SAR combined the IMR's and other case documents from each agency to contribute to the report.

5.7 The Independent reviewer was tasked to develop key recommendations (which should number no more than 6 main issues)

5.8 The Independent reviewer developed action learning plan for each agency as applicable which the NSAB will have responsibility to monitor and evaluate the effectiveness.

5.9 Following the report, four multi agency workshops, focusing on each individual subject to this review, will be facilitated with a view to disseminate the learning to all professionals involved in the individual cases.

6. THE 4 ADULTS

This section provides a summary of the 4 adults who are the subject of this review. It includes the key events and highlights the similarities and differences in their circumstances. This comparative data allows the NSAB to understand more about the individuals' journey with statutory partner agencies.

6.1 **Mr. A** was a 92-year-old man who came to the UK in the 1950s from the Dominican Republic. He spent 19 years working for British Rail and was the owner occupier of a two story home in East Ham where he had lived for over 40 years. He was divorced and had no known contact with his ex-wife, son or daughter.

Mr. A died in Newham University Hospital (NUH) on 23rd August 2017. The cause of his death was recorded as old age, myocardial infarction and hypertension. He was conveyed to hospital by the London Ambulance Service on 14th August 2017, and was then admitted after falling from his bed at home. A Safeguarding Concern was raised on 17th August 2017 by the nursing staff at the hospital due to his very poor physical presentation; appearing as though his personal hygiene had not been attended to for a long period of time. Nursing staff also observed that he was covered with faecal matter and had a white substance on his legs and face. It was reported that it took the nurses more than 20 minutes to clean his eyes so that he could open them again. The London Ambulance Service also reported that MR A's home was found to be in very poor condition.

Mr. A had been known to Adult Social Care since February 2013, and had been receiving a commissioned domiciliary care package from *London Care* agency since August 2016 with daily visits. His past medical history included hypertension, glaucoma, left eye visual impairment, cataracts and osteoarthritis.

Mr. A was admitted to Newham University Hospital three times in the 6 months before his death, either due to falls or becoming physically unwell, and after each admission he was discharged home with the same support package, declining any increase.

Summary of Key Events and Agency Involvements

26.09.2016 **Re-assessment** undertaken ASC Social Worker (Hospital Team). The report notes that MR A was discharged back home a month earlier, on 24.08.2016 with a single handed holding care package of three visits a day provided by London Care as there was no capacity for support to be offered by LBN's Enablement Service. Mr. A was repatriated back to Newham University Hospital from Charing Cross and Northwick Park Hospitals on 09.08.2016 after falling in the street and hitting his head on the pavement causing a bleed on his brain. He underwent right sided subdural hematoma drainage whilst in hospital. The report noted concerns around Mr. A's cognitive functioning, scoring 6/10 in an ATML test and refers to him being referred to the Memory Clinic by his GP. The Social Worker also stated that Mr. A was unable to retain information long

enough to make a decision to dispose of old furniture in his property to enable his safe discharge.

- 02.10.2016** **Mr. A's care package is reduced** by ASC (Social Worker) from 3 visits a day to 2 visits following assessment dated 26.09.2016. This was because Mr. A stated that he had employed a private cleaner.
- 22.10.2016** LAS attended following a 999 call, Mr. A explained he accidentally pressed his alarm. No injuries. No safeguarding concerns
- 24.12.2016** LAS attended a 999 call. Mr. A activated his pendant alarm as he could not find his keys. The care alarm company contacted police and ambulance as they could not get hold of Mr. A on the phone. No injuries noted. No safeguarding concerns

Key Events from January 2017 to August 2017

- 11.01.2017** Mr. A was seen by health care assistant at Medical Centre for ECG This was the last face to face contact with Mr. A.
- 27.02.2017** London Care reports no response from Mr. A when they visit. The allocated worker is notified
- 8.03.2017** LAS attended a 999 call. Mr. A was admitted to hospital following a fall. He had a large lump on his left eyebrow and a cut. Mr. A was slurring but moving all his limbs. Ambulance crew recorded that Mr. A had been drinking and was known as a regular drinker of whiskey
- 10.03.2017** Mr. A attended A&E after a fall; his package was restarted without admission.
- 12.03.2017** **Review** undertaken by ASC, Social Care Officer, (Hospital Team), carried out at Newham University Hospital after a short admission after Mr. A fell at home and was found by his carers. The report mentions that Mr. A was seen at the Falls Clinic and that a hospital OT would refer him to Age UK for a domestic cleaning service. Mr. A also refused the offer of day support and returned home with his existing care package. The outcome was for Mr. A to be reviewed again by ASC in 12 months.
- 12.03.2017** **Support Plan** completed ASC, Social Care Officer (Hospital Team) and signed by Mr. A. This is the only Support Plan document on the case file. Mr. A's identified needs are for washing, dressing, cleaning and preparation of meals and drinks due to his visual impairment. The care services are provided by London Care. The plan sets out two visits a day, 45 minutes in the morning to assist Mr. A with washing, dressing and preparing a meal and a drink, and then 30 minutes in the evening to help him get ready for bed and prepare a meal and a drink.

- 15.3.2017 – 8.08.2017** 5 telephone conversations with Medical Centre and Mr. A and his carer. These conversations focused on medication for pain management and reassurance about Moorfields referral
- 04.04.2017** MR A refused a visit from the Financial Assessment Team. He said that he was going out and did not receive any correspondence about the appointment.
- 26.05.2017** Rapid Response Nurse carried out full assessment. Referred to social worker to increase package of care and OT to assess environment.
- 1.06.2017** OT Rapid Response carried out a full OT assessment. Equipment ordered.
- 02.06.2017** Welfare visit from ASC, Social Worker (Rapid Response Team) after a GP referral due to Mr. A's loss of appetite. An arrangement was made with the care provider to purchase additional food supplies, and Mr. A told the Social Worker that he was willing to pay privately for a cleaning service. No further action was taken.
- 12.06.2017** OT Rapid Response visited – bath equipment being used but pressure relieving equipment still in packaging. Mr. A declined to use it.
- 23.06.2017** LAS attended a 999 call to Mr. A. Mr. A was experiencing pain all over and was admitted to NUH. Neighbour was present.
- 23.06.2017 –17.7.2017** While in NUH Mr. A was assessed by the physiotherapist, OT and dietician prior to discharge. Notes state that Social Services confirmed capacity. Mr. A raised concern about walking up stairs but was assessed as being able to walk up stairs
- 15.07.2017** Failed discharge as Ambulance crew could not get Mr. A up the internal stairs to his property, and he was returned by the ambulance to NUH.
- 17.07.2017** Mr. A was discharged home again with clarification from physiotherapy about his ability to transfer and with the aid of a carry chair.
- 24.07.2017** LAS attended 999 call from member of public concerned about Mr. A. Mr. A looked frail but said he was fine, did not open the door for the LAS.
- 25.07.2017** London Care's Branch Manager reported that Mr. A was refusing entry to his tea-time and evening carers. Mr. A did not want to drop his front door key from his window for the carers to use because it meant he had to get up and walk across to the other side of his property, which presumably he was finding very difficult. London Care requested that a key safe is installed and that an urgent review of his package is arranged. The key safe was ordered on 26.07.2017 via the ELMS system to be delivered and fitted by the Enabled Living team.

- 28.07.2017** Carers were unable to access the property as Mr. A had lost his door keys, and they were reliant to gaining entry through his neighbours who held a spare set, however they were out. EDT were notified. Mr. A had been contacted by phone and it was agreed that he was safe and would be re-visited again in the morning.
- 11.08.2017** Contact from London Care's Branch Manager, stating that Mr. A had been visited by their Field Supervisor and she had reported that his neighbour who was previously doing his shopping had now stopped and his kitchen cupboards were empty. It was also reported that he had cockroaches in his bedroom. The Field Supervisor brought him some emergency food supplies. Again an urgent social care review is requested and London Care claim that they did not receive a response to their first request 17 days previously.
- 13.8.2017** LAS attended 999 call. Mr. A was admitted to Newham Hospital having been found on the floor.
- 13.08.2017** Mr. A was admitted to NUH after falling at home. He was found to be cold, with a number of bruises and abrasions on his body and had not washed for some time due to caked faeces on his body, blocked eyes and poor skin condition. A safeguarding adults concern is raised by the NUH on 17.08.2017 raising concerns about neglect by carers.
- 23.08.2017** Mr. A died in hospital. The cause of death recorded by his GP on GP records is old age, myocardial infarction and hypertension.

6.2 **Mr. B** was a 75-year-old gentleman who lived in London Borough of Newham in extra care sheltered accommodation. The records indicate Mr. B had one brother but there is no other recorded information about Mr. B to give the reader a better understanding of his life history other than his medical concerns. Mr. B's niece contributed to the review, providing more information about Mr. B family history. He had 5 brothers and 2 sisters but only one brother supported him. Mr. B had a medical history of chronic obstructive pulmonary disease (COPD), hypertension, hypercholesterolemia and previous squamous cell carcinoma of the penis. There was also a documented history of ischemic heart disease. Mr. B was a heavy smoker. When Mr. B was a young boy, he was very close to where a Doodle Bug Bomb landed. As a result of this Mr. B experienced anxiety and nervousness throughout his life. Mr. B was admitted to the emergency department of NUH on the 17.06.2017 following an unwitnessed fall. He had a history of falls in the preceding months which had not previously been explored. He was referred to the falls clinic in 2012 but declined to attend. Mr. B was discharged home the same day at 7pm on the 17.06.2017. He was found deceased the following morning in his flat.

Mr. B had refused all offers for care and support assessments, stating he was managing fine. There is nothing from the records to suggest Mr. B did not have capacity to decline to participate in an assessment.

Previous safeguarding concern raised in October 2015 was an allegation of financial abuse by another tenant. Mr. B declined to participate in the enquiry. Actions were taken by Mr. B and his brother to prevent future money being taken.

Summary of Key Events and Agency Involvements

17.06.2017 **Mr. B** sustained a fall at 06:30 when trying to get out of bed. Noted Mr. B was unable to recall how he had fallen but had stood up by himself. Superficial cuts on right eye, hand and nose noted.
Comment made that the Mr. B reported no nausea, no vomiting, no dizziness, no loss of consciousness. Noted to have no active bleeding at that time.
Note made that this was the fourth fall in last three months, however he had not been reviewed in either hospital or by his own GP. Numerous tests undertaken before discharge arranged.

In Consultant 1's statement she notes that the patient was in discussion regularly with the nurses regarding the arrangements regarding his transport home and that he had to be dissuaded from going home alone and to wait for the hospital arranged transport.

Mr. B returned home by ambulance. Mr. B called on intercom system by the Support staff and stated he was fine.

18.06.2017 Routine morning check by support staff at Lawrence Hall. Patient found on the floor with large volume of blood which appeared to be coming from his head. Ambulance called. Mr. B had died.

Post mortem performed. Cause of death confirmed as Degenerative & Ischemic Heart Disease and Chronic Obstructive Pulmonary Disease

6.3 **Mr. C** was an 86-year-old gentleman known to ASC since 2008. Mr. C had difficulties talking, transferring and was cared for in bed. He lived with his two adult sons, (one of whom died in 2017). Mr. C was admitted to NUH on the 4 February 2018 due to malnourishment, swallowing difficulties and severe pressure ulcer damage to his sacral area which lead to sepsis. Records state Mr. C had dementia but there is no evidence of when and if this was formally diagnosed. He did not receive support from external agencies. His son was his sole carer. Last health intervention was a district nurse visit in 2014 to support with advice and guidance to son to manage Mr. C's pressure areas.

From 2013 to 2018 there were three additional concerns raised regarding potential neglect. They were all found as unsubstantiated.

Summary of Key Events and Agency Involvements

- 13.02.2018 Safeguarding concern raised by Hospital and LAS alleging the son neglected to care for Mr. C.
- Mr. C was referred to Tissue Viability Nurse for advice regarding dressing.
- Social worker contacted ward requesting Mr. C not be discharged until the safeguarding enquiry was concluded.
- 23.02.2018 Mr. C was fast tracked to palliative care. The fast track palliative care referral was sent to Newham CCG service. Although a Newham resident Mr. C was registered with a Waltham Forest GP.
- 26.02.2018 Mr. C discharged. No MDT discharge meeting. Failed discharge as access to the home could not be gained.
- 27.02.2018 Mr. C was discharged home with no equipment, no planned district nurse visit nor commissioned care package
- 28.02.2018 ASC Enquiry Officer raised concern with the GP regarding the failures following phone call with Mr. C's son. Enquiry Officer contacted GP, District Nurses and Waltham Forest Brokerage to chase up support and care package.
- 28.02.2018 Care Package started
- 01.03.2018 Mr. C readmitted to NUH due to breathing difficulties. His son called the ambulance.
- 15.03.2018 Safeguarding concern raised against Bart's Health Trust regarding neglect of Mr. C by failing to provide the appropriate palliative care on discharge.
- 18.03.2018 Mr. C died in hospital.
- 27.03.2018 Enquiry Officer recommends safeguarding concern raised against son closed as the abuse was unintentional and the son is willing to work with agencies to support Mr. C

- 6.4 **Mr. D** was an older 96-year-old gentleman who lived alone in his own home. There are regular referrals to ASC across a number of years from professionals identifying concerns regarding Mr. D self-neglecting and living in poor housing environment. None of the referrals resulted in assessments.

London Ambulance Service (LAS) raised a concern in 6 February 2018. Mr. D was refusing to travel to hospital. The Fast Response Unit were called to encourage Mr. D to go to hospital.

The Fast Response Unit found the home and the patient was very unkempt. The electricity has been condemned in the kitchen. Running a small hob in the kitchen, the cooker is being run from an extension lead, from another part of the property. Mr. D had very poor personal hygiene, very smelly and dirty. Mr. D was wearing a rubber nappy under his trousers, they were frayed and ripped. The sheets on his bed were filthy. The accommodation was freezing cold. The house was falling apart, wallpaper hanging off the wall with massive areas of mould. Curtains and clothes were moth eaten. Very unkempt everywhere. Mr. D stated he did not want any help but the Fast Response Unit assessed him as not having capacity

According to the concern raised Mr. D's accommodation was presenting with a fire risk, electrical cables running everywhere. (for fire and cooker two ring hob). Kitchen door was wedged up with the kitchen table. The Fast Response Unit found a letter from electric company condemning the kitchen.

Mr. D was supported to hospital and was admitted. He was discharged home after refusing support or services. He continued to have visits from the Community Nurses to dress a complex venous wound until his last admission to NUH where he died in March 2018.

Summary of Key Events and Agency Involvements

Mr. D regularly attended his medical Centre for health checks and medication reviews between 2012 and 2017. This included regularly attending outpatient appointments. His last appointment was 20.12.2017 for medication review. It was noted in 2016 he started to miss his ophthalmology clinic appointments and in 2017 he declined his seasonal influenza vaccination for the first time.

06.02.2018 Community Nurse from ELFT visited and found Mr. D with blood on his face. He stated he had had a fall. Initially he was reluctant for examination but then finally agreed and a non-urgent ambulance was called to transport him to hospital. He was reluctant to attend and so the Fast Response Unit were called to encourage him to attend. He eventually agreed to go and was admitted to NUH for observation overnight.

07.02.2018 Hospital social worker met Mr. D and offered an assessment. Mr. D declined and social worker felt he had capacity to decline. He agreed for social worker to contact the council and London Fire Brigade regarding kitchen safety. He declined a physiotherapist functional assessment. No evidence of a referral to District nurses to reinstate visits for wound care. No evidence of agreed actions progressed.

12.02.2018 – 27.02.2018 Mr. D was visited by the community nurse weekly. Dressings removed and new dressings applied.

- 14.02.2018 Safeguarding concern logged by ASC. Decision for No section 42 enquiry, reason recorded; insufficient grounds for concern.
- 06.03.2018 – 7.03.2018 Healthcare assessment visited Mr. D no response. Community Nurse contacted A&E (records do not state which hospital) and was informed Mr. D had been in hospital but was due for discharge 6.03.2018. Community Nurse informed Mr. D was to be discharged today. There are no hospital records of Mr. D being admitted during this period.
- 08.03.2018 Community Nurse visited. No response initially. Police were called, Mr. D opened the door. Community Nurse assessed Mr. D and called an ambulance, Mr. D admitted to NUH.
- 11.03.2018 Mr. D died in hospital with sepsis after admission for pneumonia.
- 18.04.2018 Safeguarding Manager gathered facts prior to arranging home visit to address safeguarding concerns raised on 14.03.2018 but discovered Mr. D had died on 11.03.2018. The document recording is contradictory as it states that on the 14.02.2018 the decision was not to proceed to section 42 enquiry. The reason recorded insufficient grounds for concern. It is noteworthy that the recording is not clear on the presented documentation as to the sequence of events. Records are ambiguous as to whether the decision not to be conduct a Care Act 2014 section 42 enquiry was made before or after M D's death.

7. THEMATIC REVIEW AND ANALYSIS

The themes that emerged from the review are considered under five key areas of practice.

- a. Risk Assessment
- b. Hospital admissions and effectiveness of discharge planning
- c. Multi-agency information sharing
- d. Application of the Mental Capacity Act 2005
- e. Care Act 2014 Carers and Advocacy

7.1 Risk Assessment

7.1.1 It is well established that the factors that increase an adults' vulnerability to abuse and neglect need to be taken into account when assessing any risk to an adult.² The individuals vulnerability needs to be considered in conjunction with the individuals views and with consideration to their capacity to make a decision regarding their safety.

7.1.2 In all four cases, there was a record of some or all of the following factors that can increase an adults' vulnerability to abuse or neglect.

	Mr. A	Mr. B	Mr. C	Mr. D
Limited informal community support network	✓	✓	✓	✓
Known to misuse alcohol	Unclear from records	X	X	Unclear from records although one record alludes to the fact Mr. D drank whiskey regularly
Frequent hospital admissions	✓	✓	X	✓
Refusal to accept services or refuse to engage	✓	✓	✓ Families refusal	✓
Concerns about neglecting	✓	✓	✓	✓

² London Multi – Agency Adult safeguarding policy and procedures April 2019

oneself or their environment				
Impaired or fluctuating capacity	✓	X	✓	✓

7.1.3 Through the collation of chronologies, there is evidence that some of the factors that increase the adults' vulnerability were recorded in the individuals' written records. There is no evidence that the individual factors that increased vulnerability were considered when making a decision on how to progress with the support to the adult. Each incident such as the hospital admission, refusal to allow carers in, declining medical appointments was viewed as an isolated incident.

7.1.4 Mr. A frequently did not allow the care provider access and when he did, he threw the keys from the top floor window. When Mr. A was discharged, the initial discharge was delayed as Mr. A was concerned about his ability to mobilize up the stairs. If a thorough holistic multi-agency risk assessment had been completed, the issue of access for the care provider and Mr. A's ability to mobilize may have been considered in the context of risk. This may have resulted in a key safe and other equipment to support a safe discharge being fast tracked.

7.1.5 Mr. A was admitted to hospital at least 4 times between June 2017 and August 2017. The admissions were in relation to falls and feeling unwell. 4 admissions, in a 3-month period, for a vulnerable person in receipt of care and support should be a flag for a multi-agency assessment. The admissions were from the community, this and in conjunction with the concerns from the Care Agency should have triggered an assessment with Mr. A in his own home to enable professionals to assess how he was coping in his environment at that point in time. In Mr. A's case the reassessments were offered and declined in the hospital.

7.1.6 Despite Mr. C being registered with a GP, with knowledge of his poor health and no contact for 5 years, there was no obvious mechanism to flag Mr. C as someone who is vulnerable, to trigger Health Services making contact.

7.1.7 ASC had received two safeguarding concerns about the care that Mr. C was receiving from his sons. Both safeguarding enquiries were concluded as not substantiated. At this point in time Mr. C's health was deteriorating and the factors that increased his vulnerability were evident but the professionals did not flag the need for a multi-agency risk assessment.

7.1.6 Learning from published Safeguarding Adults Reviews and serious case reviews, often highlights that the risks were hidden from view or that the adult does not recognize the risk themselves. The findings urge front line practitioners to exercise greater professional curiosity to identify the abuse and address the risks.

- 7.1.7 This review identified some missed opportunities to explore the individuals' presentation and circumstances in more depth. Such as through the multi-agency hospital discharge planning, reassessment or through the multi-agency safeguarding pathway.
- 7.1.8 Promoting wellbeing, Care Act 2014 section 1 does not mean simply looking at a need that corresponds to a particular service. Robust risk assessment and recognition of what an adult is capable of achieving as well as who they are willing to accept support from is key in supporting an adult to mitigate risks.

Risk Assessment Analysis Conclusion

Risk assessments involve collecting and sharing information through observation, communication and investigation. It is an ongoing process that involves persistence and skill to assemble and manage relevant information in ways that is meaningful to all concerned.³. A risk assessment is a dynamic process that requires a flexible approach to an individual's change in circumstances. Risk assessment is about working with the adult to identify ways they can be supported and empowered to mitigate the risks posed to them to ensure a quality of life that is acceptable to the adult themselves. Risk assessments must not simply be a description of the risks but include how the identified risks are to be managed. Risk assessments should focus on both the positive and negative consequences of the risky action.

The review has highlighted an absence of competent risk assessments. The quality of the risk assessment is hampered by professionals only considering a single event, such as hospital discharge, rather than the risk assessment being done holistically with information shared across agencies. A key factor is poor communication between agencies for example in Mr. D's case the community nurses not being kept informed of hospital admission or discharge. On occasion, such as with Mr. A and Mr. D safeguarding concerns were raised to ASC but ASC did not address the concerns or respond to the referrer.

Adults declining or not engaging with services, safeguarding concerns raised by individual agencies and more than one hospital admission should all have individually and collectively been a prompt for a further risk assessment leading to proactive actions such as follow up of equipment, assessments, home visits.

Learning Point: Professionals need to be competent in communicating with the adult and partner agencies to conduct a holistic risk assessment which should support professional decisions. All risk assessments should be recorded in a standardized format.

³ London Multi – Agency Adult safeguarding policy and procedures April 2019

7.2 Hospital admissions and effectiveness of discharge planning

- 7.2.1 It is not the remit of this review to consider whether the adults were medically fit for discharge. The focus of the review is that once the decision was made to discharge the four adults who are subject to the review, that the correct procedure was followed with a focus on a safe discharge. Three of the adults were affected by the lack of effective discharge planning.
- 7.2.2 Learnings from published safeguarding adults' reviews reveal a continuous theme regarding the quality of hospital discharges from acute hospitals. A discharge plan from a multi-agency perspective that is understood and communicated to all professionals with the adult at the center of the plan is considered the best way to achieve positive outcomes.
- 7.2.3 Both Mr. A and Mr. C initially had a failed discharge, which resulted in them returning to NUH and being discharged the following day.
- 7.2.4 In Mr. A's case this was caused by his reluctance to mobilize up the stairs. Although the records indicate the OT had completed an assessment at the hospital and assessed Mr. A as being able to mobilize. It is not clear whether, he voiced his concerns or if this was ever explored with him prior to discharge.
- 7.2.5 In Mr. C's case the ambulance crew could not gain access to Mr. C's property. This highlights immediate concerns regarding the planning in Mr. C's case, as Mr. C lived with his son. It is not clear what conversations were had with Mr. C son to arrange the discharge.
- 7.2.6 In Mr. C's case the care package and equipment that was agreed as part of the discharge plan was delayed. The care package was only started 2 days after Mr. C had been discharged. This poor planning increased the risk to Mr. C as he was already considered vulnerable and at risk of neglect by his son, who provided his care. Mr. C's son had also clearly stated in the assessment that he wished to have more support to care for Mr. C, due to the high level of care that he needed.
- 7.2.7 In Mr. A's case there was a delay in providing the equipment and when the equipment arrived there was no named responsible individual to support Mr. A as to how to use the equipment. It was found still in the packaging. The discharge planning should have considered a multi-agency approach with consideration to the concerns the staff at NUH had raised about the lack of care that Mr. A was receiving from the Care Agency. There was no planned approach to address the concerns but Mr. A was discharged with the same care package provided by the same care agency.
- 7.2.8 The safeguarding concern that was raised by the London Ambulance Service was not taken into account when the social worker offered Mr. D an assessment. There is a lack of understanding of the risks that were reported in his living environment. The hospital discharge should have triggered a follow up visit by the social worker and community nurse. This would have been an opportunity to complete a thorough assessment. There

is no evidence that the hospital discharge team linked into the community nurses on discharge. As the community discharge records indicate they were visiting Mr. D and getting no replies which lead to them contacting the hospital and being given three different dates of discharge for Mr. D.

Hospital Admissions and effective discharge planning analysis and conclusion

Hospital discharges from acute hospitals in the London Borough of Newham require clearer multi agency protocols. Three out of the four cases reviewed identify the hospital discharge being poorly managed due to a lack of multi-agency planning. Use of safeguarding processes where there are concerns for an individual or others, require agencies to consider risks before discharging. This includes risk to the individual or to others.

A safe discharge would include a contingency plan to follow up any actions from the discharge, ensuring that the adult has a single point of contact to address any concerns. This was not evident in the cases reviewed.

The 'wellbeing principle' and the core duty of 'promoting individual wellbeing' placed on local authorities exercising any care and support functions, emphasizes the importance of working in a holistic way with the individual. Hence the description of 'wellbeing' detailing the nine areas that must be taken into account to consider individual wellbeing.⁴ In this review the interaction with the individuals was service lead and when an adults declined a care and support assessment, there was no consideration of how to work with the adult through other agencies that the adult would accept support from for example the community health, equipment provision or care agency. This links to the following point in 7.3 multi-agency partnership working.

Learning Point: A hospital discharge planning policy and procedure should be embedded that clarifies communication pathways and accountability to support safe effective discharged for vulnerable adults in the London Borough of Newham

7.3 Multi- agency information sharing

7.3.1 Mr. A was frequently referred to ASC by the care agency for a reassessment, due to an increase in his care needs, when his health and welfare was declining. The care provider regularly could not gain access. The requests were not responded to other than a key safe being ordered, but not given priority. Input from community health services highlight need for medication management and for equipment (including toilet aids and a pressure

⁴ Department of Health & Social Care; Strengths-based approach: Practice Framework and Practice Handbook February 2019

relieving mattress which was not unpacked). A referral to memory clinic failed as Mr. A did not attend. A urinary sheath was fitted to manage Mr. A's incontinence however the prescription was either not raised by ELFT CHC or not received/ actioned by GP surgery and there is no further mention of this or support for his incontinence.

- 7.3.2 There is no evidence in records reflecting practitioners understood the risks posed to Mr. A nor that information was shared between agencies to highlight the concerns. There were two missed opportunities to share information; through a reassessment of need that was requested but not actioned and through the hospital discharge planning.
- 7.3.3 Mr. C was known to ASC and was initially assessed in 2013 when a care package was commissioned but soon after cancelled by Mr. C's sons. Mr. C's needs had not changed but it was felt that his sons could manage to care for him. It is not clear from the records what Mr. C's view was at this time. The cancellation of a care package and the sons taking on the caring role, should have triggered a dialogue and agreement with Mr. C's GP as to who was to monitor and support both Mr. C and his sons in their caring role. Mr. C was registered with the GP but although vulnerable, had no contact with the GP for 5 years prior to his hospital admission.
- 7.3.4 Mr. C was admitted to hospital in February 2018 and despite two concerns being raised about the care he received from his sons (One son died in 2017), and a request by the social worker to have a multi-agency discharge meeting to plan the discharge, this did not happen. Mr. C was discharged back to the care of his son.
- 7.3.5 The delay in Mr. C's care package which has been discussed in point 7.2.7 may also be attributed to poor multi-agency communication and information sharing regarding the risks posed to Mr. C due to the circumstances of his health deterioration.
- 7.3.6 Mr. D was in receipt of services from Community Nursing for a year prior to his death. The nurses called the ambulance on two occasions. On a third occasion March 2018 the nurses were unable to gain access for 3 days and called, the hospital (not named in records) each day and were informed that Mr. D would be discharged that day. On the third day the nurse gained access and Mr. D was admitted to hospital. The review has highlighted that over the three days that nurses had no access (6 – 8 March 2018) Mr. D was not admitted to hospital, which leads to the assumption he was in his home but not opening the door.
- 7.3.7 On the 6 February 2018 the Fast Response Unit raised a concern about Mr. D neglecting himself and his environment. The community nursing had been visiting for 12 months prior to this incident but there are not recorded referrals to ASC raising concern about Mr. D.
- 7.3.8 The safeguarding concern did not trigger a multi-agency discussion prior to Mr. D's discharge back to the community. The social worker offered an assessment and this was

declined but there is no evidence of the social worker exploring if other agencies are involved in Mr. D's life. The hospital did not refer back to community nurses once Mr. D was discharged. The hospital discharge planning including the consideration of the safeguarding concern was a missed opportunity to share information and agree who best and how to support Mr. D. He allowed the community nurses in to his home so was not disengaged with health, this may have been an avenue of support for Mr. D.

Multi-agency information sharing analysis and conclusion

There is a need to strengthen multi – agency working and responses across the London Borough of Newham partnership. Learning from recommendations of national SARS, the importance of effective multi- agency working is a common theme. In this review the lack of sharing information has been highlighted in three of the cases. The impact on the adult was either a delay in an appropriate response to their assessed care and support needs or a total lack of response which increased the vulnerability of the adult at that point in time.

The provider agency supporting Mr. A and the Fast Response Unit for Mr. D raised concerns for the individuals' safety. They should have a mechanism to escalate their concerns if an appropriate response is lacking from a partner agency, in this case ASC. The key phrase 'Safeguarding is everyone's business' should be reflected in practice with a clear escalation protocol to overcome obstacles that hinder an appropriate multi agency response. The protocol should be embedded throughout the safeguarding partnership.

Learning Point: Partners to understand the concept of 'safeguarding is everyone's business' and the need to share information and work together to achieve the best outcomes for vulnerable adults. Local Authority have the legal duty to conduct the safeguarding section 42 enquiry or make sure others do.

7.4 Application of the Mental Capacity Act 2005

- 7.4.1 Mr. A was admitted to hospital three times in a 6-month period due to falls and feeling unwell. His home care agency raised numerous concerns about his deteriorating health and wellbeing. Mr. A refused an increase in his care at hospital but there is no record of the professionals considering Mr. A's ability to understand the risks of returning home with a small care package. His capacity has not been considered in any of the contact with him. The records fail to record a concern about capacity nor a record that there was no concern that he had capacity and was in that case making an unwise decision regarding the care and support he accepted.
- 7.4.2 Mr. C's records state he was unable to communicate and he had a diagnosis of dementia. There is a distinct lack of consideration or assessment of Mr. C's capacity throughout professional's interaction with him.

7.4.3 ASC records indicate that professionals have concerns about Mr. D capacity and that an assessment of capacity in relation to his ability to make decisions of his living environment was needed. This assessment was not completed.

Application of the Mental Capacity Act 2005 analysis and conclusion.

The review highlights a lack of application of the Mental Capacity Act 2005 in all four cases. There is a distinct lack of recording of consideration or assessments under the Mental Capacity Act 2005.

The five principles which underpin the Mental Capacity Act 2005 are not considered when working with the four adults.⁵

In three of the four cases there is a record of questioning the adult's capacity to make an unwise decision but there is no evidence of a mental capacity assessment. The best interest decision in the event, the adult lacked capacity to decide about care and support needs, could have potentially resulted in a different outcome for the adult due to the presenting risks.

Learning Point: Professionals must demonstrate skill and competence in applying the Mental Capacity Act 2005 key principles and statutory duties throughout work with vulnerable adults. This includes identifying when an individual makes an unwise decision versus the individual not having the ability to make a specific decision.

Professionals should seek legal advice regarding High Court Inherent Jurisdiction applications in cases where the Adult at Risk has capacity, all options to mitigate the risks have been exhausted, and a risk considered in vital or public interest remains.

7.5 Care Act 2014 Advocacy and Informal Carers

7.5.1 All the individuals reviewed had an individual in the community supporting them to various degrees. There is no evidence in the records of any of them being offered a carers assessment to support them in their role as a carer. There is no recognition that in Mr. D's case, his friend had moved across London and was no longer able to provide the same level of support to Mr. D.

7.5.2 No consideration has been given as to whether the named carers are able to support the adults in the assessment process. It would have been appropriate to explore with Mr. A and Mr. D in more detail the reason for the declining of an assessment. From the information recorded it can be assumed that they both had substantial difficulty engaging in an assessment and care and support planning. Offering the support of an independent advocate could have potentially resulted in a different outcome for the adults.

⁵ Mental Capacity Act Statutory Guidance 2005

- 7.5.3 Mr. C was being cared for by his son and the records highlighted concerns for how his son is providing the care. Mr. C should have been offered an advocate to support the assessment process. The type of advocate would depend on the outcome of the capacity assessment in the event it had taken place.

Care Act 2014 Advocacy and Carers

This review highlighted the failure of professionals using their statutory duties to support informal carers. The records lack detail, in recognizing the role the carer has in supporting the individuals' nor the ability of the carer to continue to offer ongoing support when either their or the individuals' circumstances change.

Although records indicate that three of the four adults may have been considered to have substantial difficulty engaging in the assessment and care and support planning, there is no consideration of who would be the appropriate individual to support them. Nor in the absence of an appropriate individual, a referral for an independent advocate or in Mr. C's case potentially an Independent Mental Capacity Advocate.

Key Learning: The Local Authority must offer Carers a Carers Assessment to support them in their role. Care Act 2014

Key Learning: Advocacy must be offered to an adult to support them in an assessment when they have substantial difficulty to engaged and there is no appropriate individual to support them through an assessment. Care Act 2014

8. RECOMMENDATIONS

Recommendations made by this thematic review for the NSAB are listed first and then followed by those arising from the SARS for individual agencies.

8.1.1 The SARS strongly identified that there is a need to strengthen front line practice in conducting holistic **risk assessments**.

- NSAB has an existing risk assessment tool which is linked to cases of self-neglect. This tool is not routinely used. It is recommended that this is adopted as a generic safeguarding risk assessment tool. The tool needs to be embedded in practice across all partner agencies in Newham.
- Professionals' use of risk assessment tools can be inconsistent, with this in mind all professionals should be trained specifically on identifying risk and conducting a risk assessment and specifically how this should impact on decision making.
- Just as with assessments including mental capacity assessments, the importance of regularly assessing risk at critical points should be considered best practice.
- The supporting guidance must be developed to include how to conduct a risk assessment when the adult declines engagement and include the importance of communication and information sharing between agencies.

8.1.2 ASC have implemented a '3C flag' system for customers that present with three new contacts over a 6-month period. This should flag the need for a more urgent response from ASC, as it is an indicator that the individual may be deteriorating or their circumstances have changed. It is recommended that the same '3C flag' system is embedded across partner agencies including Health.

8.2 Review **Multi-Agency Hospital Discharge Policy**. The policy should stipulate best practice in making safe and effective arrangements for safe discharges based on a multi-agency risk assessment.

Make a single health or social care practitioner responsible for coordinating the person's discharge from hospital. Create either designated discharge coordinator posts or make members of the hospital or community-based multidisciplinary team responsible. Select them according to the person's care and support needs. A named replacement should always cover their absence⁶

⁶ Transition between inpatient hospital settings and community or care home settings for adults with social care needs NICE guideline Published: 1 December 2015

The discharge policy should in addition include:

- The requirement to contact and invite community services to be part of the discharge planning.
- The role of the social worker
- Guidance on essential information sharing to ensure continuity of care and treatment including to mitigate risk.
- Agreed arrangements for who and how the actions agreed as part of the discharge plan will be monitored specifically in cases of high risk which may include an adult who does not engage with services.
- Clear expectations on who the adult can contact about their care and support plan.

Once the policy is updated and embedded the NSAB must seek evidence of its effectiveness in improving safe discharges.

8.3 Review **Multi Agency Information sharing** protocols across the partnership.

The information sharing guidance should include:

- A process of escalation and challenge where partners experience obstacles to information sharing.
- Reference to statutory requirement when to share information under Data Protection Act 2018.
- Good practice guidelines of recording information shared between partner agencies.
- Good practice guidance of seeking and recording the adults wishes of information shared including rationale when the information is shared without consent.

8.4.1 A Review of and compliance with the **Mental Capacity Act 2005** training program across Partner Agencies.

8.4.2 Introduction of Mental Capacity Act champions in agencies to support front line practitioners in developing their competence in applying the Mental Capacity Act 2005. Champions should be invited to attend the existing MCA forums facilitated by ASC to offer peer support and expert advice.

8.4.3 A multi-agency audit framework to support and assess staff competency in the application of the Mental Capacity Act 2005.

9. INDIVIDUAL AGENCY RECOMMENDATIONS.

The above recommendations refer to all partner agencies. The ones below are additional ones specific for the named partner agency.

9.1 Adult Social Care

It is recognized that some of the recommendations for Adult Social Care have already been initiated as a result of the independent management reviews submitted as part of this SARS.

- 9.1.1 The review has highlighted a number of staff competency areas that require attention. Specifically, in how practitioners respond to safeguarding concerns of adults in the community and in hospital. In order to be reassured that staff are skilled and competent in fulfilling their statutory duties ASC must consider a quality assurance framework. Research has proven that practitioners respond to a 'beyond auditing' approach which invites individuals to participate in live audits of their case work. It offers them an opportunity to 'learn on the job' supported by an internal or external expert supporting best practice.
- 9.1.2 The Service Redesign around the front door teams was initiated in August 2018. The effectiveness of the redesign must be evaluated to ensure that the delays in responding to referrals has been addressed. It is recommended that the impact on the redesign is reviewed as a recommendation from the SARS. The sample of cases that are audited should be large enough to reflect the culture change and not just reflect the change of individual practitioners.
- 9.1.3 Adult Social Care to review mandatory training matrix for all front line staff to include not exclusively but as part of the mandatory training:
- Duties to offer and assess Carers under the Care Act 2014
 - Duties of instructing independent advocates including IMCA's
- The effectiveness of the training and competence of staff to be evaluated through an audit framework as discussed in point 9.1.1
- 9.1.4 ASC to review decision making guidance as to when a safeguarding concern is progressed to a Care Act 2014 section 42 enquiry. Keeping in mind the ability for Local Authorities to conduct a non-statutory enquiry when the adult would benefit from early intervention, referral pathways should be established and embedded. The pathway should focus on a timely multi agency approach.
- 9.2 **Barts Health NHS Trust**
- 9.2.1 Review front line staff practice knowledge of safeguarding adults' policy and procedure with a specific focus on the identifying of the risk of abuse or neglect and the reporting pathway to Newham Adult Social Care.
- 9.3 **East London Foundation Trust**
- 9.3.1 Review front line staff practice knowledge of safeguarding adults' policy and procedure with a specific focus on the identifying of the risk of abuse and neglect and the reporting pathway to Newham Adult Social Care.

10. GLOSSARY

ASC – Adult Social Care

ELFT CHC – East London Foundation Trust Continuing Health Care

FRU – Fast Response Unit

IMCA – Independent Mental Capacity Advocate

IMR – Independent Management Review

LAS – London Ambulance Service

MCA – Mental Capacity Act 2005

NSAB – Newham Safeguarding Adults Board

NUH – Newham University Hospital

OT – Occupational Therapist

Safeguarding Adults Section 42 Enquiry – The Local Authority legal duty to conduct or ensure others conduct an enquiry when an adult who has care and support needs and is experiencing or at risk of abuse or neglect and as a result of those care and support needs is unable to protect themselves from with risk of, or experience the abuse or neglect

SARS – Safeguarding Adults Review

Vital Interest – a term used in the Data Protection Act 2018 to permit sharing of information where it is critical to prevent serious harm or distress, or in life threatening situations

11. REFERENCES

1. Department of Health (2016 Care and Support Statutory Guidance Issues under the Care Act 2014)
2. Department of Health & Social Care; Strengths-based approach: Practice Framework and Practice Handbook February 2019
3. London Multi – Agency Adult safeguarding policy and procedures April 2019
4. Transition between inpatient hospital settings and community or care home settings for adults with social care needs NICE guideline Published: 1 December 2015
5. SCIE: (2015) Adult Safeguarding Sharing Information
6. London Borough of Newham Self Neglect and Hoarding Protocol
7. London Borough of Newham Self Neglect Risk Assessment and risk levels matrix

12. THE REVIEWER

Belinda Oates is a qualified social worker registered with the Health and Care Professions Council. She has over 23 years' experience of working in the field of social care. Belinda gained practice experience initially as a front line social worker before progressing to management roles which included; multi-agency team manager and safeguarding adults operational and strategic manager.

Belinda has been working independently for the last 13 years. Her work as a consultant and trainer has focused primarily on safeguarding adults as legislated by the Care Act 2014 and Mental Capacity in line with Mental Capacity Act 2005.