



# SAFEGUARDING ADULT REVIEW OVERVIEW REPORT

## Acknowledgements

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## Version control

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4	19 <sup>th</sup> May 2020	Amend post panel



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## 1. Introduction

- 1.1 This Safeguarding Adults Review (SAR) focuses on the case of Peter. In late June 2018, Peter was found dead in a hotel bedroom. Peter had been in hospital since April 2018 and was discharged to the hotel on his discharge at the beginning of June 2018.
- 1.2 The case was referred to the Safeguarding Board in July 2018, by the police. Initially a decision was made that the case did not meet the criteria for a SAR. This decision was subsequently reviewed, and a decision was made to undertake this review.
- 1.3 From April 2015, Section 44 of the Care Act 2014 places a statutory duty on local Safeguarding Adults Boards (SABs) to arrange SARs.
  - When an adult, with needs for care and support, (whether or not the local authority was meeting any of those needs) in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult; OR
  - If an adult in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect and there is concern that partner agencies could have worked more effectively to protect the adult.

## 2. About the Author

- 2.1 The author is Independent of this case and any of the agencies involved. He is the chair of the Cambridgeshire and Peterborough Safeguarding Adults Review sub-group.

Mr Chapman is a retired senior police officer and senior investigating officer. He has since been involved in working with local authorities, the health and third sector and the Church of England in a safeguarding capacity.

He has authored Serious Case Reviews, Safeguarding Adult Reviews and Domestic Homicide Reviews.



### 3. Methodology and terms of reference

3.1 The purposes of a SAR are: -

- Learn from cases where there are clear concerns that agencies have not worked as well together as they might; and which demonstrate areas of practice that could have been delivered more effectively and additionally
- Consider whether or not serious harm experienced by an adult, or group of adults at risk of abuse or neglect, could have been predicted or prevented, and use that consideration to develop learning that enables the safeguarding adults partnership in Warwickshire to improve its services and prevent abuse and neglect in the future.
- Agree how this learning will be acted on, and what is expected to change as a result.
- Identify any issues for multi or single agency policies and procedures.
- Publish a summary report, which is available to the public.<sup>1</sup>

3.2 The Warwickshire Adults Review sub-group decided that a proportionate review would be undertaken. Each agency identified as being involved with Peter was asked to prepare chronology and asked to attend two practitioner learning events. These events allowed the case to be discussed, and areas for development and areas of good practice to be identified.

3.3 The family were notified of the review and the author, with a police representative, had the opportunity to meet with Peter's former partner and two of his sons.

3.4 Terms of reference for the review were agreed and these are at appendix A. The terms of reference identified the focus of the review as between 1<sup>st</sup> June 2017 and the end of June 2018.

. The areas identified by the panel for consideration were:

- Effective use of assessments and using these to identify individual's care and support needs and providing appropriate timely support, proportionate to their care and support needs.
- Assessment of mental capacity in decision making.

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<sup>1</sup> Warwickshire Safeguarding Adults Board SAR Protocol and Guidance - [https://www.safeguardingwarwickshire.co.uk/images/downloads/WSAB\\_SARs\\_Protocol\\_and\\_Guidance\\_-\\_June\\_2019\\_-\\_v30\\_.pdf](https://www.safeguardingwarwickshire.co.uk/images/downloads/WSAB_SARs_Protocol_and_Guidance_-_June_2019_-_v30_.pdf)



- Effectiveness of discharge arrangements which recognise care and support needs of the individual and are based on assessment of need, and ensure appropriate arrangements are made to cater for these needs.
- Availability of suitable accommodation for persons with care and support needs.
- Maintaining oversight and management of patient's ongoing health needs following discharge from hospital.

3.5 The agencies identified as having relevant involvement in the case, who provided a chronology and took part in the discussion, were: -

- University Hospital Coventry and Warwickshire NHS Trust
- South Warwickshire Clinical Commissioning Group
- Rugby Borough Housing
- Warwickshire County Council Adult Social Care
- Warwickshire Police
- Together Housing Support
- South Warwickshire Foundation Trust
- Coventry and Warwickshire NHS Partnership Trust
- West Midlands Ambulance Service

#### **4. Family details and background**

- 4.1 Peter was the father to six children. He was previously married and had one child from this marriage and he then had a long-term relationship with his then partner, with whom he had another five children. Although he had been estranged from his partner for around 10 years, he had been living in her house with one of his sons for the last 5 years.
- 4.2 Peter had been employed by the council most of his working life and the family believed that he received some form of pension from this. Peter was diagnosed with diabetes around 5 years ago and his mobility had become more difficult. Prior to going into hospital Peter had been able to walk to the local shop (about third of a mile away) but would have to take breaks on the route.
- 4.3 The family described Peter as a very stubborn man, he would not do things unless he wanted to. The family believed that he was taking his medication for his diabetes but after he was taken to hospital, they found he had not been. They had found insulin hidden in places such as his shoes.
- 4.4 One of Peter's sons and his partner had visited Peter on a daily basis when he was in hospital. The son was working long hours and then cycling to the



hospital to visit his father. He continued to visit daily when Peter was discharged. As there was no fridge in the hotel the son would keep Peter's insulin at home and cycle each day to the hotel to administer the insulin. The son would also take meals to his father when he could.

- 4.5 The family would describe Peter as an alcoholic and he had been like this for as long as they could remember. Before going into hospital Peter would drink 12-15 cans of strong beer every day. In hospital he had been without alcohol and the family believed they were told that if Peter had another drink he would die.
- 4.6 The former partner was not able to have Peter back to her house and therefore he was homeless, and this was apparent from the time that Peter was admitted into hospital. It was the son's intention to privately rent a house in which he, his partner and his father could live but he had been unable to find a suitable house.
- 4.7 As far as the family were concerned there had been no plan for Peter on discharge. They were aware that the council were involved to source accommodation and that a support worker would be in contact. They could not recall being given any advice or support on medication or diet. They had not been told that there would be any support from district nursing to administer his medication.
- 4.8 The family state that they were not consulted or asked for any views on Peter's care and they were not aware of any assessment of Peter's needs taking place. Although there are hospital records which indicate that there were ongoing conversations with Peter regarding his discharge, and his family, while he was a patient.
- 4.9 The family felt that Peter was definitely able to make his own decisions and had a good ability to recall events, they did not doubt his mental capability. This is substantiated by the various agencies involved with Peter.
- 4.10 The family stated that Peter did not want to be in a hotel but accepted it. He was moved twice whilst in the hotels with the last hotel being in the City centre, which was not an ideal location for him. His family said Peter preferred the previous hotel.
- 4.11 Peter's son in particular felt that Peter was 'dumped' when he was discharged from hospital and they were left to support him with no help.



## 5. Summary of Facts

- 5.1 Peter was diagnosed with diabetes in August 2014. The GP had been seeing Peter on a regular monthly basis regarding his diabetes reviews, from when he was first diagnosed up until his last visit on the 4<sup>th</sup> November 2016. Unfortunately, Peter did not attend his follow up diabetic appointment on the 5<sup>th</sup> December 2016. He also failed to attend Diabetic Retinal Screening appointments during 2017.
- 5.2 In June and July 2016, during GP consultations the GP noted that Peter smelt of alcohol. In the first Peter stated that he was drinking 35 units per week<sup>2</sup>. On the second visit Peter stated he was drinking excessively and losing weight. There was no recorded advice or support given or signposted for alcohol abuse.
- 5.3 The GP records show that in November 2017, two letters were sent to Peter for diabetic retinal screening appointments. Peter did not respond or attend the appointments. Peter was being prescribed insulin, and this was on a repeat prescription. Peter had not collected, or had collected on his behalf, these prescriptions since 2016. Peter's non-attendance was followed up by the GP by letter but is now apparent that Peter had moved addresses and the likelihood is the letters were not received.
- 5.4 The GP visited Peter at home on 19<sup>th</sup> April 2018 following a phone call to the surgery requesting a home visit. The surgery was told that Peter was suffering from severe leg pain, trouble going to the toilet. The GP found that Peter was very unkempt and sitting in a chair. Peter had been soiling himself and could barely stand. The GP noted that he looked cachectic<sup>3</sup>. The GP recorded that Peter had not showered since December 2017.
- 5.5 On examining Peter's records the GP noted that he had suffered abnormal weight loss in 2016 and was diabetic. Peter disclosed drinking 6 or more cans of beer per day. Patient transport was arranged to take Peter to hospital, which it did that day. The GP recorded that the ex-partner stated that she was no longer able to cope with caring for Peter.
- 5.6 The GP wrote a letter to the hospital to accompany Peter detailing a history of weight loss and incontinence of faeces for a few months. It stated he had an alcohol intake of 6 cans of beer per day and was very unkempt. The GP also included Peter's history. The GP also contacted GP Liaison at the UHCW

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<sup>2</sup> NHS advice is **men** and **women** are advised not to drink more than 14 **units** a **week** on a regular basis. <https://www.nhs.uk/live-well/alcohol-support/calculating-alcohol-units/>

<sup>3</sup> Cachectic - physical wasting with loss of weight and muscle mass due to disease.



and informed them of Peter's home condition. The GP was informed that Age UK would be informed, and they would see what transpired during Peter's assessment in hospital. Although the admission letter implied that there was self-neglect, there was no referral for self-neglect made at this time.

- 5.7 Peter was admitted to hospital and diagnosed with Chronic Pancreatitis, diarrhoea secondary to pancreatic insufficiency, vitamin D deficiency and hypothyroidism. He had co-morbidities of type 2 diabetes mellitus, hypertension and alcohol excess with liver disease. Peter remained in Coventry hospital but did move on to Rugby Hospital on 25<sup>th</sup> May 2018.
- 5.8 In the early part of his admission Peter was given support for an alcohol detox therapy and he continued appropriate supportive drugs, through his admission and on discharge. Medical staff discussed his alcohol use with him and the health benefits of not abusing alcohol.
- 5.9 Peter's discharge planning was started on 20<sup>th</sup> April 2018, when he was seen by an occupational therapist from the Integrated Discharge Team. Peter gave his consent for his son to be spoken to and on 24<sup>th</sup> April 2018, the son confirmed that Peter could not return to the previous partners address as he was not coping there.
- 5.10 On 25<sup>th</sup> April 2018, Peter was seen and agreed that he could not return to the partner's address and he would consider residential care until private rental was available, which the family were seeking to source.
- 5.11 On 24<sup>th</sup> May 2018, the hospital recorded that Peter was homeless and a referral was sent to Adult Social Care (ASC). The ASC records show that the referral was received by the Hospital Social Care Team (HSCT). ASC were also sent a copy of the Continuing Health Care checklist. The referral stated that the family had requested a social care assessment. The hospital records show that Peter was admitted with self-neglect, but this was not communicated in the referral to ASC. No referral was sent to ASC on the basis of self-neglect.
- 5.12 The hospital records show that they were informed by ASC that Peter had been offered a residential moving on bed but had declined this offer.
- 5.13 On 24<sup>th</sup> May 2018, Rugby Borough Council (RBC) received a discharge letter from the hospital and on 30<sup>th</sup> May 2018, the hospital formally referred Peter to RBC for emergency housing.



- 5.14 On 25<sup>th</sup> May 2018, ASC received a discharge notice from the hospital which stated that Peter was fit for discharge, again the notice states that the family have requested a social care assessment. The HSCT worker identified that Peter had housing needs.
- 5.15 On 29<sup>th</sup> May 2018, Together housing support received a referral from ASC at the hospital. The referral identified that Peter was an inpatient at the hospital and was fit for discharge. It stated that Peter was homeless, and this had been confirmed by RBC. He wanted to remain in Rugby to be near to his son. It stated that Peter was insulin dependent and required district nursing support twice daily. Peter also had reduced sensation (Neuropathy) and required a zimmer frame to mobilise. The referral stated that prior to admission Peter had been alcohol dependent, ASC had no further information on this. Peter also suffered from anxiety. The referral was due to Peter requiring support with housing.
- 5.16 On 30<sup>th</sup> May 2018, ASC HSCT were informed by Together that they would support Peter on discharge, but the allocation of a worker would take 2-3 weeks.
- 5.17 In early June 2018, the housing team at RBC contacted the hospital to establish what Peter's needs were regarding accommodation, in terms of accessibility. It was established that Peter would be able to climb up to two flights of stairs, this followed a hospital assessment on mobility.
- 5.18 During his stay in hospital Peter was investigated and treated for a number of conditions. He is described as arriving in hospital as quite unwell but medically made good progress and after treatment and interventions, was moved to the Rugby Hospital to facilitate discharge. It was diagnosed that he had chronic pancreatitis and colitis. He had an investigation for bowel cancer and colitis<sup>4</sup> was discounted. He was found to have pancreatic insufficiency secondary to chronic pancreatitis and commenced on Creon<sup>5</sup> tablets.
- 5.19 Acute alcohol withdrawal was managed with medication and intravenous infusion. He remained on Vitamin B strong and thiamine. A CT head scan was performed with no abnormal findings. He was found to have monoclonal

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<sup>4</sup> Colitis - Colitis refers to inflammation of the inner lining of the colon.

<sup>5</sup> Creon medication - CREON is a prescription medicine used to treat people who cannot digest food normally because their pancreas does not make enough enzymes due to a variety of conditions.



gammopathy of undetermined significance (MGUS)<sup>6</sup> which was low risk and the GP was asked to monitor.

- 5.20 He was also seen regularly by the diabetic team and he was offered advice and support for his unstable blood sugars and changes were made to his insulin regime. He was also reviewed by the dietetic team and advice on diet and supplements was given. He was found to have an abnormal thyroid level and advice was sought from the Endocrine team and he was commenced on low dose levothyroxine<sup>7</sup> with a request for the GP to monitor. He was also started on iron supplements because of low blood iron levels.
- 5.21 On 6<sup>th</sup> June 2018, Peter was discharged to the first hotel. Together were informed and on the basis that Peter was receiving twice daily carer support and had a family network he was not considered high priority for the allocation of a support worker.
- 5.22 On discharge ASC closed Peter's case on the basis that he had no care and support needs, that referrals had been made to Together to support Peter and to RBC to provide housing. Also, that Peter had been placed in temporary accommodation at the hotel.
- 5.23 On 7<sup>th</sup> June 2018, housing staff at RBC spoke to Peter's son and discussed housing options. The son informed them that it was his intention to rent privately in a house that could accommodate Peter. RBC had considered general housing but there was no suitable accommodation available to meet Peter's needs, the hotel was allocated as a temporary measure pending a full assessment. A full housing assessment was to be undertaken in mid July 2018.
- 5.24 On 12<sup>th</sup> June 2018, a dietician from the hospital contacted ASC with concerns regarding Peter's ability to prepare meals at the hotel as he only had access to a kettle and was therefore only able to eat instant dried noodle type food. The dietician stated that when admitted to hospital Peter was highly malnourished. The dietician was given the details of RBC and food providers to call. The same day the dietician contacted Peter by phone, the dietician planned to offer an appointment at the dietetic outpatient's clinic.

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<sup>6</sup> Monoclonal gammopathy of undetermined significance (MGUS)<sup>6</sup> - MGUS is a blood condition that happens when plasma cells (a type of white blood cell) develop unusually in the bone marrow.

<sup>7</sup> Levothyroxine - Levothyroxine is a medicine used to treat an underactive thyroid gland (hypothyroidism). The thyroid gland makes thyroid hormone which helps to control energy levels and growth. Levothyroxine is taken to replace the missing thyroid hormone.



- 5.25 On 13<sup>th</sup> June 2018, Peter attended his GP with his son. He was given more medication.
- 5.26 On 21<sup>st</sup> June 2018, the hotel contacted RBC to notify the housing department that Peter had soiled his bed and there would be an additional cost for a new mattress.
- 5.27 On 23<sup>rd</sup> June 2018, Peter's son went to the hotel as he could not contact him, he had seen him the previous evening. The son could not gain access to the room so got assistance from hotel staff. On entering the room, they found Peter deceased.
- 5.28 Police attended the death, which was deemed non-suspicious, the police were concerned regarding the facilities that Peter had access to. There was no fridge and therefore no method of storing Peter's insulin or food. Peter also only had access to a kettle and no other cooking facilities.
- 5.29 On discharge from hospital Peter was in hotel accommodation from 6<sup>th</sup> to 23<sup>rd</sup> June 2018. During this stay he moved to two other hotels as there were capacity issues in the hotels.

## 6. Analysis of involvement

### 6.1 **Effective use of assessments and using these to identify individual's care and support needs and providing appropriate timely support, proportionate to their care and support needs.**

6.1.1 ASC records show that a care assessment was requested in a referral forwarded from the hospital, this had been requested by Peter's family. There is no record that this took place. The duty social worker recalls at least two conversations with Peter, one where his son was present. The social worker recalls agreeing to get Together to support Peter with housing. These discussions were not recorded, and this is recognised as a learning point. The reasons for the lack of records was probed and there were no systems or capacity issues identified rather than it being an oversight.

6.1.2 It does not appear that Peter's history, finances or other needs were discussed. There is no record of this, and the conversations as described would not constitute an effective assessment of need.

6.1.3 Although there was evidence the hospital had received concerns from the GP regarding the home conditions there was no reference of self-neglect made by the GP, although this was implied. The hospital did refer in records that Peter had self-neglected but when the request for ASC to undertake an



assessment was made, the referral did not articulate this and was made purely on the basis that the family had requested an assessment.

6.1.4 When further explored at the review learning event it was accepted that the HSCT social care worker would have had access to the hospital records and it would have been usual practice for them to review the records when undertaking an assessment but due to the lack of ASC recording it cannot be established whether this occurred. Due to the lack of assessment of self-neglect it is assumed that this did not occur.

6.1.5 The concerns regarding the self-neglect in personal care, medication administration and alcohol abuse, which were recognised by both the GP and the hospital on admission, were not explicitly referred to ASC for assessment. It was considered that there were potentially three opportunities for a referral to be made highlighting self-neglect. The first by the GP at the time of admission, the second by the hospital when referring the case to ASC and the third when the CHC checklist was completed.

6.1.6 The Care Act 2014 (Statutory Guidance updated March 2016) included self-neglect as a category of harm and made it a responsibility of Safeguarding Adult Boards to ensure they co-operate with all agencies in establishing systems and processes to work with people who self-neglect and to minimise risk and harm. The Care Act placed a duty of co-operation on the local authority, police and health services and raised expectations about the cooperation of other agencies.

The Care Act places specific duties on local authorities in relation to self-neglect. (Care Act Section 9 and Section 11)

The Local Authority must undertake a needs assessment, *even when the adult refuses*, where-

- It appears that the adult may have needs for care and support,
- And is experiencing, or is at risk of, self-neglect.

This duty applies whether the adult is making a capacitated or incapacitated refusal of assessment.<sup>8</sup>

6.1.7 It was unlikely that Peter's case would have met the criteria of as section 42 enquiry under the Care Act, but a good assessment would provide a clear picture of need and lead to a good support plan. The West Midlands Multi Agency Policy and Procedures state: -

*Even when the criteria for statutory Adult Safeguarding Enquiry*

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<sup>8</sup> West Midland Guidance, Responding to self-neglect concerns and enquiries for adults with care and support needs in the West Midlands -

<https://www.safeguardingwarwickshire.co.uk/images/downloads/WM-Self-neglect-guidance-v2.0.pdf>



*under section 42 of the Care Act is not met, effective "safeguarding" can happen within other different processes and services, for example:*  
*- people can be supported to live safely through good quality assessment and support planning.<sup>9</sup>*

6.1.8 The referral that was sent to Together by ASC is an indication that there had not been an effective assessment as it referred to Peter being alcohol dependent but having no further details of this. Had there been an effective assessment of need this aspect would have been explored.

6.1.9 As there was no focus on the self-neglect and alcohol abuse in the referrals, there was not an effective assessment in these areas and Peter was deemed to have no care and support needs. The social care workers discussions with Peter were not appropriately recorded and therefore do not allow a view to be taken on Peter's care and support needs at the time of his discharge.

6.1.10 On 24<sup>th</sup> May 2018, ASC received a referral from the hospital together with a Continuing Health Care (CHC) checklist. The Checklist is a screening tool which can be used in a variety of settings to help practitioners identify individuals who may need a referral for a full assessment of eligibility for NHS Continuing Healthcare.<sup>10</sup>The checklist has 11 domains which are graded A,B or C. A 'C' grading is the lowest level of need, with an 'A' grading being the highest. Best practice is that the checklist is undertaken with the patient present.

6.1.11 The checklist for Peter indicated that it was completed with him present and that he was not supported, having been asked if he wanted someone present. In all 11 domains Peter was graded as C. Whilst these gradings may be correct as far as Continuing Healthcare is concerned the checklist did highlight that Peter required prompting with some daily functions.

6.1.12 It was deemed that Peter did not have care and support needs and whilst this may have been a fair assessment of Peter, at the time, the lack of recording of the discussions between the social worker and Peter does not allow the rationale to be understood. It would appear that Peter's history and previous poor self-care was not considered in the discussions and therefore did not form part of the rationale for reaching the conclusion that there were no care and support needs.

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<sup>9</sup> Multi-agency policy & procedures for the protection of adults with care & support needs in the West Midlands - <https://www.safeguardingwarwickshire.co.uk/images/downloads/WM-Adult-Safeguarding-PP-v1.pdf>

<sup>10</sup> Continuing Health Care check list - <https://www.gov.uk/government/publications/nhs-continuing-healthcare-checklist>



6.1.13 The district nurse support was not put in place and the medication was left for the family to manage. The information that there was to be district nursing support was then used by other agencies such as Together, when they prioritised the support that they would be able to afford to Peter. Together assessed that Peter had twice daily nursing support and his family and was not therefore a priority for a support worker.

6.1.14 Overall the assessments that took place were not effective in identifying if Peter had any care and support needs. More focus on Peter's history and lived experience prior to his admission could have given a picture of how Peter would be able to sustain more independent living.

6.1.15 Peter's alcohol abuse was a major factor for him and his family, whilst there was considerable treatment for this whilst in hospital no support seems to have been considered on his discharge from hospital. The hospital records show that there was not liaison with the Alcohol Liaison Team who would have provided the ongoing support and signposting to support organisations to build on the detox work undertaken in hospital. This is recognised as a learning opportunity.

6.1.16 There were two occasions, prior to Peter's admission to hospital, where the GP recorded that Peter was consuming alcohol in excess of recommended amounts or attending an appointment having consumed alcohol. Whilst this was recorded, there is no record of any advice or signposting to other support. This is likewise recognised as a learning opportunity.

## **6.2 Effectiveness of discharge arrangements which recognise care and support needs of the individual, are based on assessment of need and ensure appropriate arrangements are made to cater for these needs.**

### **AND**

### **Maintaining oversight and management of patient's ongoing health needs following discharge from hospital.**

6.2.1 The NICE Guidelines - The Discharge from hospital to a community or care home setting for adults with identified social care needs<sup>11</sup> states that the discharge coordinator should ensure that the discharge plan takes account of the person's social and emotional wellbeing, as well as the practicalities of daily living. Include:

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<sup>11</sup> NICE Guidance (Pathways) November 2017 - <http://pathways.nice.org.uk/pathways/transition-between-inpatient-hospital-settings-and-community-or-care-home-settings-for-adults-with-social-care-needs>



- details about the person's condition
- information about the person's medicines
- contact information after discharge
- arrangements for continuing social care support
- arrangements for continuing health support
- details of other useful community and voluntary services.

6.2.2 Both the NICE guidelines and the UHCW Discharge Policy<sup>12</sup> states that the family or carers, where there is consent, should be included in the discharge plan and receive a copy of it or in the case of the UHCW Discharge Policy a copy of the discharge checklist. This is to provide clarity to the patient and the carers/family on what support can be expected and is available on discharge. This does not appear to have happened as the family state that they were not aware of any plan or intended support apart from housing.

6.2.3 During Peter's admission in hospital the dietician had been involved in treating his pancreatic insufficiency<sup>13</sup> and on his discharge Peter was prescribed a supplement to aid his weight gain.

6.2.4 Post Peter's discharge the dietician made contact with the GP and Rugby Borough Council to express a concern that Peter had been discharged to the hotel where he only had access to a kettle and therefore dried instant noodle meals, which were not ideal for his nutrition. The dietician was to arrange follow up appointments in the community for Peter.

6.2.5 The discharge planning is described by UHCW as thorough. The patient and family were spoken to very frequently and all available options were discussed with Peter and his family and he was given choices. It appears that the intended district nursing did not transpire. The process to achieve this was for the discharge team to direct the ward staff to arrange this by phone. There is no record of this taking place. The UHCW discharge policy states that where district nursing is to be arranged the following should occur.

*If the patient requires the service of a district nurse following discharge, the referral must be completed and telephoned through to the single point of access (number available in Ward Discharge Resource Pack) The paper referral must accompany the patient on discharge and a copy retained in the healthcare records.*

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<sup>12</sup> UHCW Discharge policy -

<https://www.whatdotheyknow.com/request/250465/response/619395/attach/6/Discharge%20policy%20V3.0%201.pdf>

<sup>13</sup> Pancreatic Insufficiency - Pancreatic Insufficiency (EPI) is a condition which occurs when the pancreas does not make enough of a specific enzyme the body uses to digest food in the small intestine.



6.2.6 There is no record of the district nurse visits being arranged at the time of Peter's discharge. The discharge paperwork likewise did not make any reference to district nurse visits and it would appear that this was overlooked but then relied on by other services involved such as Housing and Together.

6.2.7 It is not clear that relevant health professionals such as the dietician were involved in the discharge plan, and had they been they would have been concerned regarding the facilities that hotel accommodation were able to offer Peter.

6.2.8 Peter's health requirements regarding his insulin medication storage and the need for a good diet were not communicated to Rugby Council and therefore were not factored into considerations when considering accommodation.

6.2.9 When Peter was admitted to hospital he had been living with family and even in those conditions he had neglected himself. It was said that he had not showered for some 5 months and he had not collected his insulin since 2016. The family would say that he was particularly bad at adhering to a medicine regime and had in fact hidden his insulin to avoid taking it. Peter had been treated for a complex variety of conditions and his wellbeing would very much depend on his ability to care for himself and take the required medication. It is not surprising that despite the best efforts of the family that Peter would find this difficult when living alone in unsupported accommodation.

6.2.10 When Peter was discharged from hospital Together made it clear that they would not be able to offer support for a least two weeks. This does not appear to have been recognised as a gap in support for Peter.

### **6.3 Availability of suitable accommodation for persons with care and support needs.**

6.3.1 Peter declined a move on bed in a residential setting but in the discussion event it was thought that this was unlikely to have been an option in his case because he did not meet that level of support. The family conceded that they were trying to source private rented accommodation but were unable to find anywhere suitable. They do not recall any other accommodation being offered other than the hotel.

6.3.2 General housing was considered by housing, but this was discounted due to the unavailability of anywhere suitable.

6.3.3 The fact that the family communicated their and Peter's wish to source private rented accommodation reasonably led the housing providers to plan for a temporary provision. This was to be the subject of full assessment but not for five weeks after Peter's discharge. The reason for this long delay was



due to new processes and Legislation being embedded and staff leave. The review is assured that a case such as Peter's would not under usual circumstances be the subject of such a delay.

6.3.4 Peter's impending homeless situation was known by professionals from a very early stage, yet a referral was not made to RBC until late May. This was probably due to the uncertainty of the housing situation and the ability of the family to secure private rented accommodation. It was agreed by all agencies at the discussion event that the earlier a referral could be made, the better chance of securing suitable accommodation. This has been further developed in other areas with a housing officer linked directly to the hospital ward. This initiative is believed to be developed in the UHCW, and this should be supported and encouraged.

6.3.5 It may be that the hotel accommodation was appropriate as a temporary measure, but it should have been accompanied by support, based on a clear assessment and this was not the case.

6.3.6 Since undertaking this review Rugby District Council has been awarded funding awarded funding for a housing liaison officer to work our if St Cross Hospital to support patients who may have housing need

#### **6.4 Assessment of mental capacity in decision making.**

6.4.1 From discussion with the family and from all the agency records there was no indication that Peter lacked mental capacity in any area. There is some evidence of self-neglect by Peter, prior to his hospital admission.

6.4.2 The discussion event highlighted that this propensity to self-neglect could have been highlighted by way of a referral to ASC at the time of Peter's admission and this should have led to a more investigative approach to his assessment. This said there was evidence that the hospital was aware of Peter's inability to care for himself as this was stated by the family on his admission. The ex-partner had said that he was not eating and drinking sufficiently, and the son had said that he was drinking excessively and had fallen on at least 15 occasions in the past 3 months, on occasions down the stairs. Regardless of whether or not self-neglect had been highlighted, the Care Act assessment by ASC should have identified any areas which he could not manage for himself.

### **7. What are the learning points from this case?**

- 7.1 The concerns and information that were first raised by the GP, of a person who was failing to care for himself and alcohol dependent, did not flow



through the system and therefore were not used at various points of decision making and assessment.

- 7.2 It was recognised that Peter was likely to be made homeless at a very early stage of his admission, but this was not effectively considered or addressed by referral until 1 month into Peter's admission. Earlier recognition may have allowed for consideration and placement into more supportive accommodation. The initiative to locate a housing officer within the hospital should be encouraged.
- 7.3 Effective assessments into all aspects of a persons need and care requirements are key to ensuring that the right level of support is available. It is important that the assessment is properly recorded.
- 7.4 Where a person is treated for alcohol misuse in hospital it is important to recognise that support could be required on discharge and support should be identified and offered, and that there is effective liaison with the alcohol liaison team.
- 7.5 The Integrated Discharge Team should ensure that all areas of health disciplines and other interested parties are aware of the discharge and what support is or is not in place.
- 7.6 It is important that where referrals are sent to other agencies that all relevant information is included, and they are of a quality to allow a full assessment.
- 7.7 There needs to be greater recognition and awareness of self-neglect and the West Midlands best practice guidance applied.
- 7.8 On any hospital discharge it is important that the patient is aware of what support is available and where appropriate the family/carers are also aware.
- 7.9 Where a person is being discharged and is homeless it is important that the housing provider is supplied with all the relevant information regarding the medical and welfare needs of the patient to allow for consideration of the best housing and accommodation options.
- 7.10 The process of allocating district nursing support on discharge should be reviewed to ensure that expected support is achieved.
- 7.11 Where a support agency is allocated it should be recognised if that support will not commence immediately and consideration given to whether this presents any risk.
- 7.12 Where there are signs or indications of alcohol dependency or abuse the person should be offered or directed towards appropriate support.



## **8. Recommendations**

- 1. University Hospital Coventry and Warwickshire NHS Trust should review their discharge procedure to ensure that all relevant health professionals are involved in the discharge plan and that the patient, and if relevant families and carers, are aware of the plan and support to be provided or available.**
- 2. University Hospital Coventry and Warwickshire NHS Trust should review the process for allocation of district nursing support to ensure that where this is required it is delivered and the request is appropriately recorded.**
- 3. University Hospital Coventry and Warwickshire NHS Trust should ensure that where intervention is given for alcohol misuse, that on discharge support services are identified in the community.**
- 4. Warwickshire Adult Care Services should ensure that where they are requested to undertake care needs assessments in hospital that the notes are reviewed, and the assessment is appropriately recorded.**
- 5. Warwickshire Safeguarding should consider whether the guidance on self-neglect is effectively embedded and whether any further agency awareness is required.**
- 6. Warwickshire Safeguarding should seek reassurance as to whether agencies are able to effectively identify and refer instances of self-neglect and where there are indications of alcohol abuse that a person is given suitable advice and signposted to support services.**



## Appendix A – Terms of Reference

### SAR – Warwickshire Safeguarding–

#### **BACKGROUND**

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—

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  
the adult has died, and

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).

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).

#### **CIRCUMSTANCES**

The subject of this review, Peter had a history of medical conditions including, chronic pancreatitis, vitamin D deficiency, hypothyroidism, type 2 diabetes, hypertension, alcohol liver disease, cataract, peripheral neuropathy and anxiety. Peter was admitted to hospital in April 2018 with reduced mobility. He was discharged in early June 2016 with medication. He was made homeless whilst in hospital and was provided temporary accommodation, on discharge, in a hotel. At the end of June 2018 Peter was found deceased in his hotel room by family members. He was seen by police and ambulance staff and described as very thin, virtually emaciated.

#### **SUBJECT**

Name	Date of birth	Date of death
Peter	March 1956	June 2018

#### **SCOPE**

##### **Time period:**

From 1<sup>st</sup> June 2017 to the end of June 2018.

Agencies are asked to consider and include any information which falls outside of these parameters which is or could potentially be relevant to this safeguarding review.

#### **METHODOLOGY**



This review will be conducted by using an appreciative inquiry methodology assisted by chronologies provided by agencies involved. This approach will be enhanced by a facilitated practitioner event.

### **CHRONOLOGIES TO BE REQUESTED FROM:**

- 1. University Hospital Coventry and Warwickshire**
- 2. South Warwickshire CCG**
- 3. Rugby Borough Housing**
- 4. Warwickshire Adult Social Care**
- 5. Warwickshire Police**
- 6. Together Housing Support**
- 7. South Warwickshire Foundation Trust**
- 8. Coventry and Warwickshire Partnership Trust**
- 9. West Midlands Ambulance Service**

### **TERMS OF REFERENCE**

#### Areas of consideration

1. Effective use of assessments and using these to identify individual's care and support needs and providing appropriate timely support, proportionate to their care and support needs.
2. Assessment of mental capacity in decision making.
3. Effectiveness of discharge arrangements which recognise care and support needs of the individual, are based on assessment of need and ensure appropriate arrangements are made to cater for these needs.
4. Availability of suitable accommodation for persons with care and support needs.
5. Maintaining oversight and management of patient's ongoing health needs following discharge from hospital.

If an issue is identified authors are asked to comment whether there has already been organisational remedial action or whether the issue still exists.

### **CHRONOLOGY**

A key incident chronology is requested from each organisation and a template will be sent for completion.

### **SIGNIFICANT PERSONS**

Relevant family members, and any other important personal network will be informed what the Safeguarding Adult Review is for, how it will work, what the parameters are and how they can engage in the review.

### **PRACTITIONER EVENT**



To be facilitated by Report Author. To generate learning arising from the themes present in the Chronology.