Warwickshire Safeguarding Adults Board

Safeguarding Adult Review

‘John’

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TABLE OF CONTENTS

		Page no.
1.	Introduction	3
2.	Circumstances leading to the review	5
3.	Key themes identified for this review	5
4.	Pen picture of John and perspective of his brother, Harry	6
5.	Summarised Chronology	7
6.	Analysis and findings	16
7.	Recommendations	22

1. Introduction

1.1. This Safeguarding Adults Review (SAR) is primarily concerned with promoting quality, integrated and personalised care systems and practice for people living in care homes, with a particular focus on people living with learning disabilities. Whilst direct omissions relating to John's learning disability have not been evidenced, it is possible that unconscious bias contributed to gaps in practice. In responding to the LeDeR Annual Report 2022, Mencap pointed out that the "risk of avoidable death for people with a learning disability is still twice that of the general population." [1]

1.2. The Care Act 2014, Section 44, requires that Safeguarding Adults Boards must arrange a Safeguarding Adults Review (SAR) when certain criteria are met. These are:

- When an adult has died because of abuse or neglect, or has not died but experienced serious abuse or neglect, whether known or suspected, and;
- There is a concern that partner agencies could have worked more effectively to protect the adult.

1.3. A SAR referral for John was received by Warwickshire Safeguarding on 29/03/23, on the basis that "there may have been opportunities to have identified issues related to the provision of care and have taken action to prevent (John's) death." A Board Rapid Review Meeting[2] was held on 17/07/23, which established that the threshold criteria for a SAR had been met, as there are questions about John's care and whether this could have been better coordinated between agencies to ensure that he received the right level of care and support required for his complex, changing needs. It was further noted that John was left on the floor overnight before medical assistance was requested and he was admitted to hospital on 26/11/22. On admission, he was found to have a fractured neck of femur, which is believed to have predated this fall. Whilst a formal Safeguarding Adults Enquiry has not been held, the decision to undertake a SAR is recognition that the neglect is not attributed to any one single agency rather it is systemic across the piece.

1.4. The review overlaps with, and is independent of, a range of other related enquiries, reviews and inspections. These comprise a Police investigation and Care Quality Commission inspections. A Coroner's enquiry and a LeDeR review are both pended, awaiting the outcome of the Police investigation and this review.

[1] Mencap website; 'Mencap responds to the 2023 LeDeR report', 30/11/23

[2] https://www.safeguardingwarwickshire.co.uk/safeguarding-adults/safeguarding-adults-partnership/safeguarding-adults-reviews

1.5. SARs are required to reflect the six safeguarding adults' principles, as defined in the Care Act. These are empowerment, prevention, proportionality, protection, partnership and accountability.

1.6. The aims of the review are to contribute to the improved safety and wellbeing of adults with care and support needs, to provide a legacy to John and reassurance to his brother, and to empower managers and practitioners within involved agencies.

1.7. There are clear review objectives which have been addressed to achieve these aims. Through a shared commitment to open and reflective learning, participating agencies have sought to reach an understanding of the facts (what happened), an analysis and findings (what went wrong and what went right), recommendations to improve systems and practice and to reduce the risk of repeat circumstances, and a shared action plan to implement these recommendations (now what).

1.8. The review process to meet these aims and objectives has followed a clear path. The Independent Reviewer has chaired an initial panel meeting to agree the review terms of reference; conducted research by critically analysing Individual Management Reports, chronologies and relevant records held by involved agencies and by interviewing representatives of agencies; culminating in a planned Safeguarding Adults Review panel meeting, a practitioner workshop, an action planning meeting, and presentation to the Safeguarding Reviews Subgroup and Warwickshire Safeguarding Adults Board.

1.9. The period covered by the review is from 21/12/21 to 02/12/22, which aligns with the duration of his residence at the Care Home referred to in this report and his hospital admissions. Contextual information prior to this period is also considered.

1.10. The reviewer has met with Harry, brother of John, who has supported and contributed very positively to the review learning, most importantly by providing a pen picture of John's life. His main expectation of the review is to find out what happened to his brother towards the end of his stay at the Care Home, and whether the quality of care deteriorated.

1.11. The reviewer has met with the professional lead representatives of relevant agencies, either face to face or online, and acknowledges that all contributed positively to the conduct and outcome of the review:

2. Circumstances leading to the review

2.1. John was resident at the Care Home from December 2021. He experienced a range of mental and physical health concerns, comprising a learning disability, cognitive impairment after a brain aneurysm in 2005, autism, chronic kidney disease, and a history of chest infections and pneumonia. At some point around April or May 2022 it seems that his mobility and self-care further deteriorated and by late October 2022 he was experiencing multiple falls and hospital admissions, not all related to falls. John slid out of bed in the late evening of 25/11/22 and received minimal care whilst on the floor for 16 hours (including two hours awaiting an ambulance), until his admission to hospital the following afternoon. He died in hospital on 02/12/22, with a presenting fracture to his left hip (believed to be an older injury), early symptoms of sepsis and a chest infection. Following John's death, a series of parallel investigations were undertaken resulting in civil enforcement actions being taken. This was deemed to be a proportionate and sufficient regulatory response in this instance.

3. Key Themes identified for this review

3.1. The review has an overriding theme, to consider the challenges of multi-agency assessment and support when a service user is presenting complex and deteriorating mental and physical health needs within a care home setting.

3.2. John had a learning disability and he experienced traumatic events, and the review is also concerned with the extent to which agencies recognised and responded to these factors. Whilst direct omissions relating to these lived experiences have not been evidenced, the reviewer and some contributors acknowledge a potential link to his escalating needs not being recognised. The LeDeR Annual Report 2022 (not related to John) found that "appropriate care is associated with reductions in the risk of dying", and recognised the importance of care planning in meeting the needs of people with learning disabilities, as well as the appropriate use of Deprivation of Liberty Safeguards (DoLS) in assuring the delivery of care.

3.3. There is a specific focus on the following key themes.

3.4. How effective were multi-agency needs assessments and risk management; with consideration of the multi-agency response to John's deteriorating condition, hospital discharge, falls risk assessments and risk management meetings?

3.5. How effective was the care provided by the Care Home and other agencies?

3.6. How effective was consideration of mental capacity and personalisation; including Mental Capacity Assessments, DoLS, and active listening to John's voice?

3.7. How did resources and environmental factors impact on care; with consideration of the Covid pandemic and whether a care home setting was appropriate to meet John's needs in later months?

3.8. How compliant were agencies with key legislation, policies, procedures and practice guidance?

4. Pen picture of John & perspective of his brother, Harry

4.1. SARs should provide a window into the lived experience of adults at risk.

John was a White British man, born in the West Midlands in 1944. He was the youngest of four brothers. At the age of 7, he began attending a specialist school for people with learning disabilities. Harry recalls that he spent much of his childhood at home and walking in the surrounding area. He enjoyed his own company and the company of others. From his mid-teens, John worked in a local company on machines, whilst continuing to live with his mother. His brother recalls that he never said how he felt about his early life, but generally seemed contented. He attended college, always loved music (particularly Elvis), and enjoyed painting model cars.

John experienced severe headaches and had an operation for a brain aneurysm in 2005, which affected his cognition and speech and meant that he needed support with practical tasks and was no longer able to work. Early in the same year, his mother died and Harry remembers him standing silently at her graveside. He had a range of other medical conditions, comprising epilepsy and seizures since childhood, chronic kidney disease, a history of chest infections and pneumonia. The Coventry and Warwickshire Partnership Trust (CWPT) Learning Disability Team recognised the possible onset of dementia from 2007.

John moved to a care home and on to different supported housing addresses, and his brother feels that carers were generally inattentive, which meant that he became more dependent and would not speak. This was with the exception of one carer who supported him in developing independent living skills and he began to speak again. Harry describes him as strong-willed and that he needed encouragement to be independent and express himself. Also, he was very protective of other vulnerable people.

His brother remembers that John loved the Care Home on moving there with the support of Social Services; that he was liked and encouraged by carers, made friends, was

accompanied occasionally to Wolves football matches, played guitar and watched television. However, he is concerned that when John deteriorated physically, his personal hygiene deteriorated and he was left on the floor for many hours after falling. Harry does not feel that he would have been able to say if he was in pain. He considers the main learning for agencies should be to recognise the importance of communication and physical activity for people with learning disabilities to lead full and meaningful lives.

5. Summarised Chronology

5.1. Prior to December 2021

5.1.1. In January 2019, whilst John resided in a supported living flat, a Safeguarding Adults concern was raised by a Practice Nurse about burn and blister marks on his back. The domiciliary care agency conducted an internal enquiry, with a clothes dryer believed to have been the cause.

5.1.2. At the start of 2021, he fractured his hip in a fall, leading to the provision of 2:1 support, 8 hours per day. He had a further fall and his brother voiced concerns about the quality of care he was receiving.

5.1.3. Between January and November 2021, John had four admissions to Hospital, for a range of medical conditions and on one occasion an unwitnessed fall.

5.2. December 2021

5.2.1. On 13/12/21, John was admitted to Hospital with a high temperature and was treated on the Sepsis pathway for a respiratory tract infection. During his stay, a mobility assessment was completed and he was managing transfers with one carer. His Hospital Passport was not received from the domiciliary care agency on admission, although his patient record contained assessment and care plan details on his learning disability and needs. A Discharge Summary on the same date listed John's medical conditions and medication, which did not include pain relief.

5.2.2. A Hospital Discharge meeting was held on 20/12/21, involving a CWPT Community Learning Disability Nurse (part of a multi-disciplinary team, including a small acute service that provides daily visits to hospital), the Care Home Provider, Social Services and a hospital representative. A decision was taken for John to be discharged to a Care Home, a small residential home for up to 8 people with learning disabilities, within his local area. The Speech and Language Therapy (SALT) Dysphagia Team completed a triage and arranged an assessment for January 2022. A hospital bed and pressure relieving mattress were ordered. Also, a Mental Capacity Assessment was completed by a Social Services

Learning Disability Social Worker (separate to the CWPT service) prior to discharge, and a Best Interest Decision was taken to support John's move to the Care Home. John moved to the Care Home on 21/12/21 and his mood and engagement improved. A standard Deprivation of Liberty Safeguards (DoLS) referral was submitted on 24/12/21 and he was placed on a waiting list. The reviewer understands that his bedroom was personalised with pictures, although this has not been verified.

5.2.3. On 28/12/21, the South Warwickshire NHS Foundation Trust (SWFT) District Nursing Team received a Care Home referral for wound care and pressure relieving equipment. John was known to the service and a Nurse visited the following day, providing wound care and ordering a profile bed and chair cushion.

5.3. January 2022

5.3.1. A further District Nursing visit was completed on 01/01/22 for wound care. Care Home staff were following advice on pressure relieving equipment and administering barrier cream, However, John was distressed when his skin was touched. A further visit was scheduled in 12 weeks to check John's skin and his equipment use, and the Care Home was asked to contact District Nursing before then if concerns arose.

5.3.2. On 04/01/22, the Care Home rang 111 to request a repeat prescription of anti-anxiety medication that John had run out of. There were regular GP appointments from January to late November 2022, with a continued service by his known GP on transferring to the Care Home.

5.3.3. An initial placement review was completed by a Warwickshire County Council (Social Care and Support) Learning Disability Social Worker on 15/01/22. John's quality of life had improved and he was more independent, smiling and talking much more.

5.3.4. On the following day, the Care Home cancelled a dysphagia assessment by the CWPT Speech and Language Team (SALT) due to the Covid pandemic.

5.4. February 2022

5.4.1. A further placement review was undertaken on 15/02/22. The placement was considered to be appropriate and John was eating well, baking with staff, showering daily and choosing his clothes. His brother and an advocate (contacted afterwards) were supportive of the placement.

5.4.2. The postponed SALT assessment was completed on 24/02/22, with advice given as Care Home staff were not following assessed needs regarding supervision of eating and drinking at all times, as well as the texture of food. The Home responded that minimal

hospital discharge information was received in December 2021 about the inpatient SALT assessment, with no documentation of recommendations.

5.5. March 2022

5.5.1. A District Nurse visited John on 16/03/22 to provide wound care, noting that carers were applying barrier cream and monitoring his skin condition. Care Home staff advised that John was not using pressure relieving equipment. A District Nursing *Decision Against Advice* form was completed to document that John was choosing to decline this support, without the completion of a risk assessment or consideration of a Mental Capacity Assessment.

5.5.2. John fell in the lounge on 16/03/22, having missed the edge of the sofa when sitting, with no injury noted.

5.6. April 2022

5.6.1. A bruise was noted by Care Home staff and a recording made of a suspected fall on 09/04/22.

5.6.2. In a GP telephone consultation on 12/04/22, there was discussion on falls, anaemia, care decisions and the possibility of a Mental Capacity Assessment. This led to Occupational Therapy (OT) and Physiotherapy input regarding a walking aid. A dementia code was added to the primary care records, corresponding with the Care Home record. This was followed by a GP visit on the following day. John presented as quiet, not eating since the day before, resistant to examination, and he had an old bruise to his abdomen. Staff advised that John had slipped from his bed a few days before. Antibiotics were prescribed due to a possible infection.

5.6.3. Care Home staff rang 111 on 14/04/22 at 06.21, as John had fallen in the lounge prior to 6 am and had a lump on his forehead. A telephone assessment was completed, resulting in advice and pain relief (although the Home record does not clarify if administered), as well as a referral to the GP at 07.01 for further management and to social care and support. District Nurses referred to Community Physiotherapy and OT for a walking aid and were advised to ask the Home to refer direct to the Learning Disability Team. Paracetamol was administered for pain relief on the evening of 16/04/22.

5.6.4. An NHS Continuing Health Care (CHC) Review was completed on 19/04/22, with a decision taken to continue with joint funding, acknowledging that John had complex health needs. On the following day, District Nursing responded to a Care Home referral for support with improving mobility by advising to refer instead to the Learning Disability Team. A bruise to John's knee was noticed on 22/04/22, and a possible fall recorded.

5.7. May 2022

5.7.1. During May 2022, the Care Home recognised that John was declining in his physical health, mobility, transfers and self-care. An urgent referral was made on 01/05/22 to Occupational Therapy, although it has not been clarified if this was to Social Care and Support or CWPT. Social Care and Support do not have a record of a referral in May or of a concern being raised. However, a Social Care and Support OT assessment was completed a month later.

5.7.2. On 07/05/22, Care Home staff rang 999 at 00.30, as John had experienced a witnessed epileptic seizure. This was the first ambulance visit within the review period and was regarded as a category 1 (highest) call urgency. A telephone assessment was completed and admission was not considered to be necessary. The seizure was fleeting and the only recent episode witnessed by staff. There was no indication of a medication error and, after completing tests, John was "left in good care of staff."

5.7.3. The Care Home contacted CWPT on 09/05/22 to request a Physiotherapy assessment, as John was unsteady on his feet and prone to falls. An initial CWPT Community Learning Disability Team (CLDT) assessment, including a Psychiatrist, was completed on 12/05/22 and John attended, without actively contributing. Diagnoses were documented as comprising a learning disability, autistic spectrum disorder, dementia, chronic kidney disease, epilepsy, and hypertension and dysphagia. John could walk unaided for short distances, but was unsteady and prone to falls, most recently two weeks previously. He would sometimes slip off the couch where he slept (had a pressure mattress on bed, but was not sleeping there), or miss the arm of a chair. Care Home staff repeated that minimal information on assessed needs was provided on hospital discharge in December 2021. A GP referral was made on 23/05/22 for the support of a Nephrologist regarding kidney function, following a letter received from the CWPT Learning Disability Service. A CWPT Physiotherapy telephone triage was completed on 27/05/22, with falls noted and a referral on for Physiotherapy support. On the same day, John's CWPT Learning Disability Consultant requested information from his GP on his epilepsy diagnosis and seizure history, and it is unclear if this was received. In the letter, John was described as being able to initiate interactions and to respond, communicating his needs in short sentences; was independent in personal care with encouragement; could walk unsupported for short distances, but was unsteady and prone to falls, and needed a wheelchair outdoors; and that staff reported his mood as "up and down." The Care Home documented a risk assessment on John's mobility, unsteadiness and falls.

5.8. June 2022

5.8.1. A Social Care and Support Occupational Therapy video assessment was completed in early June, with the outcome that John had independent mobility and a poor gait. He was sleeping on a sofa by choice, in a foetal position. A profiling bed was subsequently

ordered and used by John, as well as bathroom adaptations and personal care support with showering. CWPT also made a referral to the Warwickshire Wheelchair Service.

5.8.2. A Continuing Health Care (CHC) Nurse completed the Decision Support Tool on 08/06/22 and noted that, whilst the Home Manager identified increased needs including mobility concerns, she also confirmed that the Home was able to meet these needs.

5.8.3. On 09/06/22, John tripped and hurt his side and back on a radiator. Care Home staff rang 111 at 00.03. A clinician rang back at 04.55 (after a previous failed call) and advice was given, as well as discussion around Social Care and Support involvement and mental capacity. Pain relief was advised and it is not clear whether this was administered. A referral was made to the GP for further management, who completed a video call and, on 15/06/22, referred to the dementia service. On the same day, a Social Care and Support Learning Disability Social Worker rang the Home to discuss John's health. A CWPT CLDN Nurse visited on the following day and completed a dementia questionnaire for people with learning disabilities. John declined to answer questions and it was advised that this would need to be repeated, due to a lack of historical information held by the Home.

5.9. July 2022

5.9.1. The Care Home contacted SWFT on 03/07/22 to raise a concern that John was presenting as lethargic and sleeping much of the time, but said that they would raise this during a GP annual health check that was due in the same week. It is not clear whether this health check was completed and Care Home staff further stated that the concerns were not accurate.

5.9.2. On the same day, the Care Home rang 999 at 23.02 as John had experienced a further seizure, bringing his knees to his chest and shaking for a few seconds (the first witnessed seizure since the May call-out). An ambulance arrived within 9 minutes and he was transported to George Eliot Hospital Emergency Department, arriving at 00.13 on the morning of 04/07/22. This was his first hospital admission since arriving at the Care Home and he was discharged back to the Home on 25/07/22. John was treated for drug-induced neutropenic sepsis (relating to low levels of a type of white blood cell in the bloodstream), aspiration pneumonia and acute kidney injury, and he acquired Covid during his stay. On 11/07/22, a referral was made to SWFT SALT and a telephone consultation was undertaken with staff on the ward. A standard Deprivation of Liberty Safeguards (DoLS) referral was made by the Hospital on 22/07/22. An OT and Physiotherapy mobility assessment was completed and he continued to need the support of one person.

5.10. August 2022

5.10.1. On 08/08/22, the Care Home referred to District Nursing due to two pressure ulcers, and a visit was undertaken on the same day. Staff had been applying barrier cream, but John

was often declining pressure relieving equipment. A further 4 visits were completed between 11/08/22 and 01/09/22. John was distressed and screamed when asked to stand for dressings to be applied, so a joint plan of applying cream, repositioning and observing was agreed. As John's skin was intact by late August, it was decided to pend District Nursing involvement until March 2023, with advice provided on regular checks and to contact the service if issues arose before then.

5.10.2. John fell from his wheelchair on 23/08/22 and he slipped in his room on 30/08/22.

5.11. September 2022

5.11.1. The CWPT CLDN rang the Care Home on 02/09/22 for a general update on John. The Home Manager said that he was presenting 'odd behaviours', which she believed were due to his dementia. He was awaiting a Psychiatry review.

5.11.2. On 14/09/22, the Care Home contacted SWFT with a concern about John's bowel functioning over the past 6 days. A Nurse visited, with no concerns raised, and carers were advised to monitor and contact the GP if necessary. The Home rang the GP on 21/09/22, to raise a concern that John had been experiencing diarrhoea for two weeks and C-difficile had been diagnosed. The GP advised admission and the Home rang 999. John was transported by ambulance crew (who considered that John did not have capacity to make a decision about admission) to George Eliot Hospital Emergency Department, arriving at 09.57 on 21/09/22. He remained in hospital until 27/09/22. During this stay, he presented as agitated and 'wandered'. A CT scan of his pelvis indicated no acute findings and he was discharged with antibiotics. There is no record of a mobility or falls assessment being completed during this admission.

5.12. October 2022

5.12.1. The Care Home rang 111 on 02/10/22 to report an accidental overdose of anti-psychotic medication, due to an error between the Home and Pharmacy over three days, which did not cause harm to John. The Home described John as 'lacking capacity'. A Safeguarding Adults concern was raised on the same day by the 111 service. The Home made three further 111 calls between 10/10/22 and 15/10/22 to request repeat prescriptions, with his epilepsy prescription named in at least one of these calls. A GP annual learning disability health check was attempted with the Care Home by telephone on 06/10/22, but there was no answer to the call.

5.12.2. On 17/10/22, the Care Home rang 111 regarding John's swollen legs and feet, leading to a GP follow-up video assessment and a referral to District Nursing, due to the swelling and Urinary Tract Infection (UTI) symptoms. The Nurse found no sign of infection on visiting.

5.12.3. The Care Home states that a referral was made to Occupational Therapy regarding mobility concerns on 19/10/22, and possibly again on 26 October. There is no record of this contact held by Social Services. By this stage, it seems that John was not able to stand independently.

5.12.4. John was admitted to George Eliot Hospital on three occasions in October 2022. The first was from 21/10/22 to 22/10/22, due to swollen feet and low HB levels, with a review planned at the Ambulatory Anaemia clinic on the day of discharge, and an associated outpatient appointment completed on 03/11/22 to remove this as a potential cause. The second was on 27/10/22 (the ambulance arrived 23 minutes after the call). Ambulance Service records provide details that John was feeling poorly, presenting 'unusual' behaviour, was intolerant of intrusions into his personal space, staff were 'force feeding" him and food was dropping from his mouth, there was no clear plan to address diet within the Care Home, he was dehydrated, and he had a UTI. He was discharged to the Home with antibiotics and was admitted again on 29/10/22, due to an unwitnessed fall from his bed and a soft tissue injury to his head. An x-ray was not completed.

5.12.5. The GP referred to Social Care and Support on 24/10/22 and visited on the following day, and it is unclear whether a detailed and urgent request for reassessment was made. Also, the Home referred to Social Care and Support, as John was struggling to stand.

5.13. November 2022

5.13.1. The Care Home referred to District Nursing on 02/11/22, as John was presenting with a raised temperature, was in pain as identified by clenching his fists, holding his stomach and drawing his knees up (but without being able to identify the location of the pain), was unable to mobilise, had swollen hands and feet, and was 'confused and disorientated.' There is no indication of pain relief being administered. A Nurse visited on the same day and agreed a monitoring plan, as well as following up a urine sample, without escalating the concern.

5.13.2. A Social Care and Support call was made to the Care Home on 03/11/22 to discuss OT needs (after an attempted call on 26/10/22). It was noted that there was a recent dementia diagnosis. His mobility was declining and he was unsteady, but he was independently mobile and there were no known health reasons, except possibly dementia or a UTI. On some days he had a stiff knee and he generally needed 2:1 support with transfers. John was placed on a waiting list for a Social Care and Support OT assessment.

5.13.3. On 07/11/22, the Care Home rang 999 at 21.06, due to an unwitnessed fall and cut to his head, as well as a graze above his left eye. He was unable to get up. Pending the arrival of an ambulance, staff were advised to keep John comfortable. An ambulance was dispatched at 04.30 on 08/11/22 (category 3, lower priority), arriving eight minutes later, and the crew felt that he did not have capacity to consent to admission or treatment. He

was unable to rise from the floor and had remained there for at least 7 and a half hours, waiting on an ambulance. John had said that he did not want to get up and it is understood that he generally responded to questions at the Home with 'no.' In hospital, he received an x-ray, blood tests and a mobility assessment, with an urgent referral made to the Community OT to assess mobility, due to multiple falls and hospital admissions. John had fallen 3 times in the 7 days prior to admission. The referrer was advised to contact the Learning Disability Team and John was discharged on 09/11/22.

5.13.4. On the same day, the Care Home rang 999 at 03.04 am, due to a witnessed epileptic seizure that lasted for nine minutes. A category 1 call was assigned and a nearby ambulance arrived within two minutes. A red flag early warning of potential sepsis was noted. John was admitted to George Eliot Hospital again at 04.07 on 09/11/22 and was discharged on the same day, after a review.

5.13.5. The Care Home rang 999 at 19.53 on 12/11/22, following a fall and small cut to John's arm. A telephone assessment was conducted via a clinician call-back and a referral made to the GP for further management.

5.13.6. On 19/11/22, John was admitted to George Eliot Hospital, following a further unwitnessed fall out of bed at around 20.30 pm on 18/11/22 onto a slim crash mat, without sensors. The Care Home rang 111 at 21.17, then rang 999 as John could not get up, and a category 3 ambulance call-out was assigned. This arrived at 05.27 (over 8 hours after the call) and Paramedics considered that John was communicative and had capacity to make decisions. John arrived at hospital at 06.07. The Ambulance Service made a Safeguarding Adults referral due to concern about personal care, as John's top was wet with urine and his pad was soiled, with dry faeces on his skin that appeared to have been there for a considerable period. It was also noted that there were two carers covering two floors. This was received by Social Care and Support on 22/11/22. John was discharged back to the Care Home on the same day as admission, with a referral for a District Nursing review, due to multiple falls and hospital admissions. Also on the same day, District Nursing and/or George Eliot Hospital referred to Occupational Therapy for equipment to support manual handling, but were advised that the Care Home should contact Social Services Occupational Therapy instead. This further referral was not accepted on the basis that Occupational Therapy assessments are not carried out in care homes, which have a responsibility to undertake moving and handling assessments. A Physiotherapy referral was also rejected on the basis that Learning Disability patients are not within their remit. The Home advised a Social Worker on 23/11/22 that carers did not move John to administer personal care when he was on the floor, in case he was injured. The Safeguarding Adults referral was closed as it was considered that he was not experiencing abuse or neglect.

5.13.7. A visit was completed by Learning Disability Service on 23/11/22 and the dementia questionnaire was repeated, but not reviewed by a consultant before John died. It was recorded that John was discharged from hospital several weeks earlier with C-Difficile, had to self-isolate (affecting his mobility), he was prone to falls, would sleep sideways and push himself onto the floor at night (without apparent communication with John about why he did this), his bed was on the lowest setting with a slim crash mat alongside, carers were unable to lift him and on one occasion an ambulance was called (arriving 9 hours later). The Home Manager explained that they had asked Social Care and Support for a review and equipment to lift John from the floor, but that a Social Worker had not been assigned and an Occupational Therapy reassessment was awaited.

5.13.8. On 25/11/22, John was witnessed by carers sliding from his bed onto the crash mat at 23.00. He was left on the floor with minimal care provided and medical attention was not sought, as carers did not believe that he was injured. The Care Home rang 999 at 13.11 on 26/11/22, after 14 hours on the floor, with an ambulance arriving at 14.56 (category 2, arrived within 2 hours). On examination, Paramedics observed respiratory distress, a chest infection and sepsis. They made a further Safeguarding Adults referral on 26/11/22, due to the delay in escalation to emergency services, limited carer information, and faeces and urine on John's skin. He had not received fluids or painkillers whilst on the floor. The carers said that they could not lift John and that they checked him regularly.

5.13.9. John arrived at George Eliot Hospital at 16.01 on 26/11/22. On examination, he was found to have a fractured neck of femur, which on further examination was believed to predate this fall. He also had an earlier healed injury to three right ribs. A Mental Capacity Assessment was completed and a DoLs referral submitted. John was placed on the sepsis pathway. On 30/11/22 he had multiple organ failure and was placed on the end of life pathway.

5.14. A referral was made to Social Services on 26/11/22, which was a Saturday. On 29/11/22, the Hospital Social Care Team made contact with the ward and confirmed that John would be staying in hospital. Having contacted with the Care Home, the decision was made on 30/11/22 to open a safeguarding enquiry. The Learning Disability Team were made aware of John's admission and Hospital Discharge planning was considered; to include the Hospital Discharge Team, SALT, and transfer equipment including a hoist. On 28/11/22, the Hospital Elderly Trauma Orthopaedic Nurse rang the CWPT Acute Liaison Learning Disability link person to request a review, and appropriate discharge assessments and equipment were discussed.

5.15. **December 2022**

5.15.1. John died in hospital on 02/12/22, aged 77. A Protecting Vulnerable Persons referral was sent to the Police on 06/12/22, representing a delay. A forensic post mortem on 08/12/22 found the cause of John's death to be 'unascertained pending investigation.' The

Pathologist report identified pneumonia as the provisional cause of death. Concern was noted regarding the condition of John's bedroom (including faeces on his chair), a crash mat without sensors, the absence of a hoist, and the lack of a falls risk assessment. On visiting, the Police also report that the room was unclean, including faeces on a chair.

6. Analysis & findings

6.1. Overview and positive practice –

6.1.1 The main system and practice concerns arising from this review cover two main aspects. Agencies did not fully assess and escalate concerns about increasing health needs and a risk of falls, or provide a coordinated, proactive approach towards improving John's wellbeing. Also, the Care Home did not seek prompt medical attention or provide reasonable care and dignity on the night of John's final hospital admission. More specifically, concerns related to multi-agency risk management, trauma informed practice, hospital discharge, referral pathways, falls risk assessments, mental capacity and personalisation.

6.1.2. There were examples of positive practice and, in particular, instances of attentive, personalised and prompt support to John. Specific examples include the hospital discharge meeting and Mental Capacity Assessment in December 2021, an appropriate and personalised placement, prompt Social Care and Support Social Work review visits, and prompt and attentive GP and District Nursing visits. The Care Home did raise concerns about John's deteriorating mobility and requested support. Ambulance visit were generally prompt, prior to two later responses to falls. Also, contact was maintained with John's brother and the advocate about changing circumstances. There was also evidence of agencies communicating with each other about day to day care and treatment, although this did not amount to coordinated multi-agency practice.

6.2. Multi-agency needs assessment and risk management –

6.2.1. Hospital discharge: The Care Home did not consider that comprehensive hospital discharge information about John's needs was forthcoming in December 2021. The discharge summary in December 2021 contained limited information, all relating to John's health condition and medication, without consideration of care needs. A summary in September 2022 also contained sparse information. However, this responsibility was shared by the Care Home, which was represented at the hospital discharge meeting.

John experienced nine unplanned hospital admissions in the six months between July and December 2022, for a range of medical concerns. These included five due to falls between late October and late November 2022. By late October, the Home were reporting to the Hospital and community agencies that John's mobility was deteriorating, although not clearly that they were experiencing difficulty in managing his care needs. By this stage, there should have been sufficient concern about the number of falls and admissions, aligned to

John's complex needs, to convene a multi-agency hospital discharge meeting and a falls management approach, with increased support to the Home (including a hoist) or a move to a nursing home.

The Complex Discharge Team, which coordinates discharge assessment and planning in complex circumstances, was not involved in John's discharges. Acute Leads and Learning Disability Nurses were involved in the final but not previous Hospital admissions. The team is small and meets regularly with ward nurses, who provide social care or safeguarding referrals, without a formal written procedure in place. It does seem that a complex discharge planning meeting would have been beneficial in the latter months 2022, in view of John's needs, multiple falls and admissions. This might have involved the Complex Discharge Team or have been initiated separately by the Acute Liaison Nurse for Learning Disability or another professional. In the absence of escalated concerns from the wards or other agencies, John was not on their radar to review and make recommendations.

The Ambulance Service clinicians (not call handlers) have the facility to check if there have been previous hospital attendances. They also have access to a High Intensity Service User Team Monitoring process, which flags if there have been frequent emergency calls. However, these monitoring provisions were not established until October 2023, after the review period. It is notable that some 999 calls following falls were addressed via telephone consultations and, whilst John was not directly involved, it is recognised that his ability to engage in explaining symptoms was limited. However, the Ambulance Service representative clarifies that all calls are triaged in the same way and that delays are a consequence of demand outstripping resources.

6.2.2. Referral pathways: There was consistent involvement of the CWPT Learning Disability and Autism multi-disciplinary team, which was appropriate as his learning disability presented as a primary need. However, there were examples of agencies not being clear whether to refer to this service or Social Services for Occupational Therapy and Physiotherapy appointments, and for ordering equipment. This may have contributed to delays in assessment, particularly from late October 2022, and there is a need to ensure that all agencies are clear on the roles and referral pathways for these services. The Care Home senior managers express that the referral pathway for Occupational Therapy can be difficult to manage if the resident has multiple health conditions.

6.2.3. Falls risk assessments: Mobility assessments were undertaken both in the community and in hospital, as John's condition deteriorated. However, it is not evident that the Care Home or Occupational Therapy completed a comprehensive and outcome-focussed falls risk assessment at any time, or referred him to a falls assessment clinic, although there is documentation within the Home of a mobility and falls assessment in May 2022. An assessment could potentially have uncovered an underlying health condition and informed consideration of falls prevention and equipment, including a hoist in latter months. There is evidence of accident reporting at the Home and of falls being recorded in relation to John.

Also, there are Care Home records on 03/11/22 and 21/11/22 that John was awaiting an Occupational Therapy assessment with regard to poor mobility and falls.

6.2.4. Risk management: Transfer to a small, local, specialist care home was an appropriate and personalised placement on hospital discharge in December 2021. However, John's mobility deteriorated from around April or May 2022 and significantly from October 2022 when it is understood that he was unable to stand independently. A coordinated, multi-agency risk assessment and management plan should have been in place. Currently practitioners can trigger a multi-agency risk management meeting, although the 'Social Care and Support Risk Management Framework' (updated July 2020) can more clearly emphasise the responsibility of all agencies to trigger a practitioner-led, multi-agency risk management meeting in high risk circumstances, even if the safeguarding threshold is not met. This is also a single service document, rather than a shared protocol. There is also a strategic risk management panel in place since February 2024, although John would not have met the criteria for escalation to this level. There was insufficient urgency by the Care Home and involved agencies in recognising and escalating concerns, with missed opportunities to arrange a multi-agency risk management meeting from around April or May 2022. This could have enabled the development of a coordinated plan, including the provision of a hoist and other interventions, or transfer to a nursing home. A review participant suggests that multi-agency reviews should become standard practice a month after patients with complex needs are discharged from hospital, which the WSAB may wish to consider. At the CWPT Learning Disability review in May 2022, it was recognised that John was unsteady, prone to falls, and was not sleeping on his bed. This further illustrates the importance of agencies sharing information and jointly risk managing in complex situations.

6.2.5. Crisis intervention: By late October 2022, John was experiencing multiple falls and hospital admissions. It was reported by the Care Home that he was no longer weight-bearing, which meant that he could not be lifted when he regularly slid out of bed and onto the crash mat. An urgent risk management meeting or hospital discharge meeting would have been appropriate to consider whether John's placement remained viable and what additional support was needed. An Occupational Therapy assessment was requested in mid- October and was not completed, which may have been impacted by the disruption of hospital admissions in early and late November 2022. District Nurses were involved in early November 2022 and did not escalate concerns. John was admitted to Hospital around this time, after 3 falls in the period of 7 days, without an urgent escalation by the Hospital or community agencies, including the Care Home. The Home Manager stated in November 2022 that a referral had been made to Social Services and a Social Worker had not been assigned, and it would have been appropriate for a Social Worker to coordinate a multi-agency risk management response, but Social Care and Support do not have a record of receiving a referral to say that the Home was not managing John's needs.

6.2.6. Safeguarding Adults Concerns: A Safeguarding Adults concern was raised on 19 November 2022 and closed four days later by Social Services, on the basis that staff had stayed with

John and monitored him during the wait for an ambulance and had not felt they could move him in case he was injured. This decision seems to have been made without knowledge that John was experiencing multiple falls and hospital admissions. It seems to the reviewer that there may have been grounds to have been concerned about a potential risk of neglect and injury at this time. Whilst this might have presented a further missed opportunity to consider a proportionate multi- agency risk management response, John was admitted to hospital soon afterwards in late November 2022, with two further Safeguarding Adults concerns being raised. It seems clear that a risk management plan was needed, regardless of whether the safeguarding threshold was met.

6.3. Care provided by the care home and other agencies –

6.3.1. Care Home standards: Care Quality Commission (CQC) inspections in February 2023 and January 2024 found that the Care Home improved from 'Inadequate' to 'Requires Improvement'. Care Home managers have contributed to this review and have introduced quality assurance measures. These cover an open culture with prioritisation of governance and lessons learned meetings, buddying at staff induction, manager walkarounds, supervision, life stories, internal risk assessments and support plans, internal peer reviews and safeguarding training. Further developments under consideration are staff champions and an expanded key worker system. Training is provided to staff in using hoists and, if required, they will provide hoist availability. The Care Home has provided copies of procedures relating to health and safety, incidents and accidents, managing stress, moving and handling, whistleblowing, falls risk management and care planning, person-centred care and auditing, and raising concerns.

A comprehensive quality assurance plan has been maintained by Warwickshire County Council, through a Service Escalation Panel, which continues to involve regular monitoring, alongside CQC checks. A report in February 2024 noted improvements in medication audits and in supervision, training and appraisals, that daily record forms are more detailed, and that Mental Capacity Assessments and Best Interest Decisions are in place.

6.3.2. Pressure ulcers: John developed pressure ulcers in December 2021 and in March and August 2022. In difficult circumstances, due to John's distress, District Nurses provided prompt and attentive wound care, working effectively alongside Care Home staff. SWFT consider that the Care Home was managing skin care, as John's wounds had healed. A profiling bed was provided and a plan of applying barrier cream, repositioning and monitoring was in place. By March 2022, John was declining to use the pressure relieving mattress and a risk management plan should have been considered. The reviewer has not been able to clearly establish exactly when John had a profiling bed and pressure relieving mattress, when he was using this equipment, and any direct relationship to the periods in which he had pressure ulcers.

6.3.2. Epilepsy and seizures: John had experienced epileptic seizures since childhood and these continued into his stay at the Care Home. There were occasions in which his medication ran out and the Home inappropriately used the 111 service to access repeat prescriptions, including anti-epilepsy medication. It is therefore apparent that there were occasions in which he did not receive this medication promptly, and the regularity and impact of this occurrence is unclear, although MAR charts seen by the reviewer indicate correct administration for the weeks viewed. There was also a reported minor medication error in October 2022.

6.3.3. Dysphagia: A SALT assessment was completed in February 2022 and concern was raised that carers were not following the requirements for safe dietary and fluid intake. The Care Home did not consider that requirements were adequately communicated on hospital discharge and, as aforementioned, this was a shared responsibility.

6.3.4. Pain relief: There was a clear indication that John was at times experiencing considerable pain, with his knees drawn up and his fists clenched, and he did not have the ability it seems to verbally state that he was in pain. Pain relief was also recommended after some of his falls and it is unclear whether this was always administered. The Hospital Discharge Summary in December 2021 did not refer to pain relief. Also, the Care Home medication administration record (MAR) chart did not include pain relief and records of paracetamol administration indicate only minimal medication, mainly relating to colds and not aligning with the dates of falls. Furthermore, whilst lying on the floor before his final hospital admission, John did not receive any pain relief and he was likely to have been in considerable pain and discomfort.

6.3.5. GP annual health check for people with a learning disability: The ICB representative has clarified that a learning disability annual review was scheduled for June 2022, but that John did not attend the appointment and no reason was apparent. A further review was booked for October 2022 and a telephone call was made, but there was no reply.

6.3.6. Critical incident, basic care and emergency contact on final admission: On admission to Hospital on 26 November 2022, after a fall from bed, John was left on the floor for around 16 hours (14 hours until a 999 call was made) without medical attention or basic personal care. Whilst it is acknowledged that carers did not have a hoist, were not aware that he had a fractured hip, and were concerned about not causing an injury, it is a significant concern that John was left without basic care, comfort and dignity for such a considerable time, and that an emergency ambulance was not requested. It should also be noted that John was on the floor for at least 7 hours on two occasions earlier in the same month, awaiting the arrival of an ambulance.

6.4. Mental capacity and active listening –

6.4.1. Learning disability & autism: John was known to have a learning disability from a young age, although there is no evidence that this was assessed at any time. The CQC inspectors found that staff at the Care Home had received training in understanding autism.

6.4.2. Cognitive impairment: John experienced cognitive impairment as a consequence of a brain operation in 2005. A dementia questionnaire could not be satisfactorily completed in June 2022, at least in part due to the Home having insufficient knowledge of John's history. The GP added dementia to the patient record in April 2022, based on Care Home and Hospital records, and without a formal assessment. A CWPT assessment in June and November 2022 revealed increasing cognitive impairment. It is not clear that sufficient weight was placed on understanding the impact of cognitive decline on John's functioning.

6.4.3. Mental capacity: Mental Capacity Assessments were carried out appropriately in December 2021 and November 2022, with the former leading to a personalised, less restrictive placement outcome. However, there should have been consideration of a further Mental Capacity Assessment by March 2022, when District Nurses were made aware that John was declining to use pressure relieving equipment. The Decision Against Advice form was completed, recognising his right to choice, without evidencing a risk assessment on whether he may have lacked the mental capacity to make this decision, warranting completion of an MCA. This was a missed opportunity to more fully understand and respond to John's reasons for declining this support.

6.4.4. Deprivation of Liberty Safeguards (DoLS): A standard application for a DoLS assessment was submitted by the Care Home in December 2021, and John was placed on a waiting list. There were also standard applications by George Eliot Hospital in November and December 2022. A DoLS assessment was not completed and, whilst it is recognised that a backlog of these assessments is a national issue, this represented a missed opportunity to consider in depth how well the placement was meeting John's needs.

6.4.5. Personalisation and active listening: John had a reserved and quiet temperament since childhood. He also demonstrated that he had an independent and determined mind. Whilst he was labelled as non-verbal and there was a tendency for practitioners to speak to carers rather than directly to him, his views about care do seem to have been sought at times and he was shown empathy. Also, CWPT were commended in the Rapid Review for providing a positive pen picture of him. However, practitioners should have further explored John's communication needs (using creative tools such as picture boards), to try and reach a deeper understanding of what he felt about his care and what a good life meant to him. In 2005 he lost his mother, much of his cognitive ability and also his job, and these losses and potential trauma were not fully recognised or grief counselling considered.

6.5. Resources and environmental factors –

6.5.1. Resources: The reviewer recognises that all service delivery is impacted by limited resources and that workload pressures are high nationally. Within this context, Ambulance response times were variable and John waited for many hours on two occasions in November 2022, reflecting a national resourcing concern.

6.5.2. Care home environment: John was in a setting which initially was able to meet his needs in a personised way, but his mobility needs and risks increased and further support or a move to an alternative care home environment should have been considered.

6.5.3. Covid pandemic: A SALT appointment was postponed in January 2022 due to Covid, but was completed the following month, so there was no impact on John. Also, whilst some assessments were completed via video, practitioners were regularly visiting John and he was in a care home setting.

6.6. Key legislation, policies, procedures and practice guidance

6.6.1. Legislation: The Care Act 2014 requires that appropriate needs assessments and care plans are in place and, for some months, John was provided with a placement that both met his needs and was personalised. However, there was a need for coordinated reassessment, risk management and possibly safeguarding as his needs increased, which was not provided. There were appropriate Mental Capacity Assessments, but there should have been consideration of mental capacity from March 2022, when he was declining pressure relieving equipment, and a DoLS assessment should also have been undertaken. Whether unconscious bias in relation to John's learning disability was a factor in the aforementioned gaps and delays is not possible to establish, but this should provide reflection for all health and social care staff, in accordance with the Equality Act 2010. This is very significant in reflecting on the reason for leaving John on the floor for many hours without reasonable care and dignity, when he was not able to express whether he was in pain.

6.6.2. Policy, procedures & practice guidance: There is a need to consider whether risk management, referral pathway and hospital discharge procedures are sufficiently robust and understood across agencies. Whilst John would not have met the criteria for the recently established risk management panel, this is a positive strategic development.

7. Recommendations

7.1. **Practitioner-led risk management:** Warwickshire SAB (WSAB) to oversee a review and creative promotion of the multi-agency risk management procedure. The review should focus on ensuring that professional curiosity and escalating concerns (triggering risk management meetings) are embedded in practice across agencies; with consideration of GP-linked MDT meetings as a potential vehicle for meetings.

7. 2. **Training programmes on risk, safeguarding adults, mental capacity, learning disability and autism:** WSAB to seek assurance on compliance with training provision, commensurate with specific roles. Training should include risk management, aligned to a multi-agency procedure and incorporating professional curiosity, creative communication, active listening and trauma-informed practice; Mental Capacity and DoLS assessments, incorporating risk-based and decision-specific judgements; and learning disability and autism training, incorporating mandatory Oliver McGowan attendance.

7.3. **Referral pathways:** Warwickshire Social Care and Support, CWPT and SWFT to review referral pathways and responsibilities in relation to people with complex co-morbidities. This should ensure there are include clear and transparent referral pathways with no gaps to ensure understanding across agencies; with particular attention to Occupational Therapy, Physiotherapy, falls risk assessments and ordering equipment. The procedural review should also incorporate expectations on staff across agencies in undertaking holistic, multi-agency assessments, collaborating and engaging all relevant professionals.

7.4. **Hospital discharge procedures and practice:** George Eliot Hospital to review procedures and audit practice to ensure that discharge arrangements for people with complex needs are consistently robust and coordinated, with clear responsibility and consideration of a risk tool to take account of repeat admissions due to complex and high risk needs. To consider a formal written procedure for ward nursing referrals to the Complex Discharge Team, including thresholds, as well as guidance for care homes and community agencies in escalating concerns to ward nurses and/or the team.

7.5. **Ambulance response times:** WSAB Independent Chair to raise ambulance response times, due to a national issue of demand outweighing resources, via the national SAB Chairs network.

7.6. **Care Home procedures and practice:** The Care Home Provider to continue to produce evidence to Warwickshire County Council and the CQC of improved procedures and practice, in relation to the escalation of concerns, personalisation, dignity in care, falls risk assessments, ordering repeat prescriptions on time and recording medication administration, particularly relating to pain relief. It is recognised by the independent reviewer, as covered in the previous section of the report, that considerable quality assurance has already been undertaken and progress evidenced.

Clive Simmons
Independent Lead Reviewer
March 2025