Kingston Safeguarding Adults Board

Safeguarding Adults Review in respect of Connie

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Date: September 2022

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1. Foreword by the Chair of the Safeguarding Adults Board

1.1. The Kingston Safeguarding Adults Board has accepted the full Safeguarding Adults Review in respect of Connie, completed by an experienced reviewer who is totally independent of agencies in Kingston.

1.2. The purpose of a Safeguarding Adults Review is not to reinvestigate or to apportion blame but to establish where and how lessons can be learned and services improved for all those who use them and for their families and carers.

1.3. Kingston Safeguarding Adults Board commit to take forward the learning identified in the report and will consider the recommendations made by the reviewer.

2. Introduction

2.1. The Care Act 2014, Section 44, requires that a Safeguarding Adults Board must arrange a Safeguarding Adults Review when certain criteria are met. These are:

- When an adult has died because of abuse or neglect, or has not died but the SAB knows or suspects that the adult has experienced serious abuse or neglect, and;
- There is a reasonable cause for concern that partner agencies could have worked more effectively to protect the adult.

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

2.3. The aims of this Safeguarding Adults Review are to contribute to the improved safety and wellbeing of adults with care and support needs and, if possible, to provide a legacy to Connie and a support to her family and to practitioners.

2.4. There are clear review objectives which have been addressed to achieve these aims. Through a shared commitment to openness and reflective learning, the agencies involved have sought to reach an understanding of the key facts (what), an analysis of the facts and findings (so what), recommendations to improve services and to reduce the risk of repeat circumstances, and a shared action plan to implement these recommendations (now what).

2.5. 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 relevant records held by involved agencies and by interviewing representatives and family; culminating in a planned Safeguarding Adults Review Outcome panel meeting and presentation to the Kingston Safeguarding Adults Board.

2.6. The independent reviewer is aware that there are other formal processes relating to the care of Connie. This is a learning review and as such is independent of any other processes.

2.7. The independent reviewer has conducted interviews with the following agencies representatives, either by face to face or online meetings (unless otherwise stated).

- Corporate Head of Service, Safeguarding Adults, Hospital Discharge, Access & Occupational Therapy – RBK Adult Social Care
- Senior Practitioner, Safeguarding Adults – RBK Adult Social Care
- Head of NHS Continuing Health Care – Kingston & Richmond Boroughs CCG (name at time of the review)
- Designate Nurse Safeguarding Adults, Kingston – NHS South West London
- Safeguarding Adults & Prevent Lead – South West London & St George's Mental Health Trust
- Team Manager – Community Mental Health Team (CMHT), Older Adults, South West London & St George's Mental Health Trust
- Adult Safeguarding Lead – Kingston Hospital NHS Foundation Trust
- General Practitioner, Safeguarding Lead – Canbury Medical Centre
- Detective Inspector – South West BCU, Public Protection Unt Investigations
- Director – Milverton Nursing Home
- Manager – Milverton Nursing Home; also members of staff
- Inspection Manager – Adult Social Care, CQC London

3. Circumstances leading to the review

3.1. Connie experienced a long-term history of depression. She lived independently in her home after the death of her husband in 1993, with regular visits by her daughter. Connie fell in her garden in March 2019 and was admitted to Kingston Hospital with an inoperable fractured left hip, following which she transferred to Milverton Nursing Home in May 2019 with high dependency care needs and pain management. In late June 2019, Connie was discovered by carers with the call bell cord round her neck and she resisted its removal. The incident came to the attention of her family, Adult Social Care (ASC), Continuing Health Care (CHC) and Connie's GP in late July 2019 and a safeguarding adults enquiry was undertaken by Kingston CCG, CHC Team into the incident and other concerns. Connie died on 03/08/19, unrelated to the concerns in this report.

4. Key Themes identified for the review

4.1. Risk management and suicide prevention emerge as overriding themes in this review and practice learning from relevant national reviews has contributed to

the recommendations within this report. NICE guidance on the assessment of risk in people who may be contemplating suicide (Nov. 2021) identifies certain principles for agencies to take on board:

- 'Be aware that all acts of self-harm in older people should be taken as evidence of suicidal intent until proven otherwise.' [CG133]
- 'Always ask people with depression and a chronic physical health problem directly about suicidal ideation and intent.' [CG90, 91, 123]
- 'If a person with a common mental health disorder presents a considerable and immediate risk to themselves or others, refer them urgently to the emergency services or specialist mental health services.' [CG123]

4.2. The Metropolitan Police Service (MPS) representative points to learning from a review in Richmond (Michael, 2020), in which the MPS was asked to clarify the process for engagement in safeguarding adults enquiries and to publish contact arrangements with all borough SABs. It is understood by the independent reviewer that there are close links between Kingston Adult Social Care (ASC) and the Borough Police, aligned to MPS policy.

4.3. The following key themes of the review were agreed by agencies and Connie's family from the outset and form a thread through the analysis, findings and recommendations in the report.

4.4. (i) How effective was multi-agency risk management and information-sharing; particularly in relation to a history of depression, hospital discharge and consideration of home transfer?

4.5. (ii) How effective was the care provided by the Nursing Home and other agencies, including end of life care?

4.6. (iii) How effective was consideration of mental capacity and personalisation, including Lasting Power of Attorney?

4.7. (iv) How effective was the conduct of the Safeguarding Adults Enquiry?

4.8. (v) How did resources and environmental factors impact on care?

4.9. (vi) How compliant were agencies with legislation, policy, procedures and practice guidance?

5. Pen picture of Connie

5.1. Connie lived in Hook, Chessington and was an only child. Her father was Irish. She received an award for her service to the land army. On meeting her future husband at a dance, they married in 1952 and had a son and a daughter who survive her. She worked part-time at a plumbers merchants, supported the

scouts and tended an allotment. Her daughter recalls from childhood that Connie had experienced depression and anxiety from at least her 40's and this worsened on the death of her husband in 1993. She adored animals, enjoyed watching and feeding birds in her garden, reading and watching television. Connie lived in her home for 55 years. She is described by her daughter as a no nonsense, independent and friendly person.

6. Engagement with Family

6.1. The independent reviewer met with Connie's family on two occasions prior to meeting with agencies representatives and again after meeting with the agencies, to ensure that the family perspective is fully understood and incorporated within the review terms of reference and this report. Connie's daughter and son-in-law are very supportive of agencies learning, in order to prevent the abuse and neglect of other adults at risk. They consider that agencies did not work together and that multi-agency learning had not been fully explored in the Safeguarding Adults Enquiry. It is evident that Connie shared a very close relationship with her daughter, who regards the review as an opportunity to achieve partial closure for family.

7. Key facts

Contextual information prior to March 2019

7.1. There had been Kingston Community Mental Health Team (CMHT), GP and Kingston Hospital support to Connie in the years preceding 2019 in managing her clinical depression and physical health concerns.

7.2. Connie received outpatient support in managing her depression from the CMHT between 2001 and 2011. Consultant Psychiatrist letters to her GP in 2002 noted that she felt frustrated and tired due to her physical health but was not feeling suicidal. She was seen again in August 2007 and discharged as she did not present as depressed. A GP referral for a medication review in February 2010 noted that she was lethargic and spending a lot of time in bed, with the Consultant Psychiatrist concluding in July 2010 that she was not presenting as depressed. In July 2011, Connie was discharged to the care of her GP and Mirtazapine anti-depressant medication (30 mg) was continued, as her mental health seemed to be stable. There was no further CMHT involvement until July 2019 and it seems that her depressive illness was stable and primarily managed in the community with GP and family support during these years. Her daughter recalls that Connie's depression appeared in waves.

7.3. There had been Kingston Hospital admissions from 2013 to 2016, with diagnoses of atrial fibrillation, diabetes, depression and bruising to her legs and buttocks (which the Kingston Hospital representative considers may have been due to minor trauma or Warfarin medication). In June 2015 and April 2016,

Connie attended the Cardiology Clinic and long-term management through monitoring and medication were recommended. She fell in October 2015 and experienced minor right hip and knee pain.

7.4. A GP from the Chessington Park Practice visited Connie at home in December 2016. She presented as 'teary', described having an empty feeling and was worried about her daughter possibly moving further away. Mirtazapine (30mg) was continued.

7.5. A Your Healthcare Occupational Therapist (OT) developed a reablement care plan in 2016, supporting Connie's independence through recommending the provision of a Careline alarm and weekly Staywell cleaning support. The alarm installation and private cleaning service were arranged by family.

Hospital admission from March to May 2019

7.6. **Significant incident:** On 10/03/19, Connie slipped and fell whilst feeding birds in her back garden. She activated her call alarm and waited in wind and heavy rain for about ninety minutes until an ambulance arrived.

7.7. Hospital admission and inpatient stay: Connie was admitted to Kingston Hospital, with a fractured left neck of femur and myocardial infarction diagnosed. Her history of low mood and independence were noted. Medical staff consulted with Connie and her family during March 2019 on the feasibility of operating on her hip, balancing the high risk of mortality due to her heart condition with the high risk of long-term conservative management (care in bed with pain management). Connie felt 'between the devil and the deep blue sea' and decided against an operation. She consistently accepted painkillers prior to repositioning and movement. On 21/04/19, there is a record of ongoing left hip pain and bruising and at times she declined the use of a hoist. She sometimes presented as tired, fed up, agitated and confused. There are records in early to mid-April 2019 of bruising to her buttocks, lower back and arms, which were attributed to pressure, excess water in her body and Warfarin medication.

7.8. Hospital discharge planning: An Occupational Therapy (OT) assessment was completed at Kingston Hospital on 26/03/19 and, whilst there was a focus on her physical health, low mood and episodes of crying were noted. The OT discussed discharge needs with Connie and her family in this meeting and subsequently until Connie and her family agreed on 02/04/19, in discussion with the Discharge Coordinator, to a four week nursing home admission 'without prejudice' (receiving CCG funding, pending a CHC assessment). A CHC checklist was completed on 04/04/19 in a meeting with the family to process this arrangement. This referred to a long history of depression and, whilst Connie said that she was not depressed, episodes of low mood and crying on the ward, due to frustration at her limited physical ability and resignation to Nursing Home admission. A Consultant Psychiatrist contributing to this review considers that Connie's presentation indicated a reaction to loss, but not a recurrence of depression. Whilst acknowledging this expert opinion, the independent reviewer

considers that depression or a risk of depression cannot be excluded from this point onwards. Her family consider that she was depressed during this period. Until this time, Connie had consistently expressed a wish to return home and accept the risks associated with her high dependency and she had a negative view of Nursing Homes; whilst her family, the OT (who visited Connie's home as part of her assessment) and the Discharge Coordinator clearly relayed their view that she required care in a Nursing Home. An Adult Social Care (ASC) Social Worker (based at the hospital) advised the OT that up to four visits would be possible in the day, but no visits overnight, and that discharge home was not suitable. A Social Work assessment was not undertaken by ASC or CHC. On the day following her decision to accept Nursing Home admission, Connie became very distressed, tearful and frustrated at the possibility of living in a Home. She also became acutely unwell in April 2019 and had a reduced food and fluid intake, attributed by doctors to infections. On 22/04/19, Connie said that she was unhappy because of her fall and she was provided with reassurance.

7.9. Mental Capacity Assessment: Aligned with the functional assessment, the OT completed a Mental Capacity Assessment on 28/03/19, concerning Connie's capacity to make a decision about her discharge options, and she was considered to have the mental capacity to make this decision. Further Mental Capacity Assessments were initiated by a Doctor and the Discharge Coordinator and Connie was not deemed to have a disorder of the mind or brain, so the assessments could not progress. Connie said that she wished to return home but did not want to take the risks involved. She was asked if she would consider a Nursing Home and responded; 'I guess so, as I don't have any other choice.'

Nursing Home admission from May to June 2019

7.10. Admission to Milverton Nursing Home: Connie transferred to Milverton Nursing Home on 01/05/19, initially for 28 days on a 'without prejudice' pathway. This is a national arrangement to support timely hospital discharge, whereby NHS funding is provided until a Continuing Health Care (CHC) assessment is carried out to determine funding responsibility. The Nursing Home is registered to meet the needs of 29 people aged 65 and over, living with dementia or a physical disability. Connie had a single room, next to a busy lounge and with a window overlooking the garden. There are 6 carers on duty in the day and 3 carers at night; as well as 2 nurses covering 12 hours each and an additional nurse for mornings and early afternoons. A pre-admission assessment had been completed by the Home Manager on 29/04/19. Connie's family were initially positive about the placement and had a good rapport with members of staff.

7.11. Hospital Discharge Summary: The summary, received by the Nursing Home and Berrylands GP practice (aligned to the Nursing Home) noted the hip fracture for conservative management and acute myocardial infarction. There was no reference to her history of depression or distressed presentation, although her anti-depressant medication was listed and that she may be confused at night. The summary contained a recommendation for the GP to review medication and also 'if memory issues to continue, to consider Memory Clinic referral'. A body

chart referred to her skin as 'bruised all over' and was intact on transfer; whilst a Nursing Home body chart on admission noted bruising to her hips.

7.12. End of life care: A GP prescribed end of life medication in May 2019, which included halving the Mirtazapine anti-depressant medication to 15mg and potentially lowering her mood, until this was reverted back to the higher dosage on 25/07/19. The Warfarin prescription was changed to Apixaban (requested by family) due to the extensive bruising. At a GP visit on 23/05/19, with Connie's daughter present, it was noted that chronic depression had worsened since her fall and Nursing Home admission and that she was in bed, in a low mood. She had also been prescribed Thyroxin due to a low thyroid function, a medication that can adversely affect mood but is very unlikely to cause depression. GP records show that the Home asked a locum GP about end of life care on 29/05/19 and the GP arranged an end of life prescription and chart on 30/05/19.

7.13. Mental health needs: A person-centred care profile was provided by Connie's daughter on 05/05/19, noting that Connie was cheerful with bouts of depression and only wished to have female staff to support her with washing. On 15/05/19, the Nursing Home emailed the GP practice with a request to refer Connie to the Memory Clinic, as she was presenting as confused, restless and not sleeping well. On the following day, the GP discussed the referral with the Home and organised tests towards a referral, although this was not progressed and she was not seen at the Memory Clinic. The Home did not follow up the referral with the GP and were focused on her physical health needs. Her family feel that she was isolated in her room and lacked stimulation. They also recall that she was often crying when they visited and would speak of feeling fed up and isolated. A comprehensive care plan completed on 23/05/19 referred to a history of depression and low mood; noting that she had recently been declining medication, meals and sitting out due to pain. Staff were encouraged to engage her in conversation at least every one to two hours to provide reassurance, ask her to express her wishes and rekindle her memories, and it is unclear whether this was met. The Home consider that staff were responsive to Connie's emotional needs, that the Activities Coordinator talked with her daily and placed food outside her window to attract squirrels and birds. Connie's family say that they never found a staff member with her when they visited, and her door was often closed.

7.14. Physical health needs (eating and drinking): The Care Plan also covered eating and drinking. It was recognised that Connie had a poor appetite and staff were encouraged to offer fluids and monitor weight. On 30/05/19, the Home referred for dietician and Speech and Language Therapy (SALT) support. A Care Plan Evaluation Sheet on 23/06/19 recorded that Connie had lost about 6kg in weight since admission, with encouragement to eat and more frequent weight monitoring advised. The Dietician prescribed a dietary supplement on 28/06/19, due to weight loss and difficulty in swallowing. The Consultant Psychiatrist contributing to this review suggests that factors such as significant weight loss may have indicated a recurrence of depression. Connie's family recall that she had an excellent appetite when living in her home. The care plan was updated on or after this date to require supervised dining and only the use of plastic utensils. Connie's family say that they did not sign the care plan, as they

considered it to be incomplete. A Moving and Handling Assessment and an Activities of Daily Living Assessment on 16/05/19 referred to the need for hoist support with transfers and also support with repositioning and personal care. A Risk Assessment on 29/05/19 noted high risk areas as falls, moving and handling, personal care and skin integrity.

7.15. Physical health needs (medication): There were five GP visits in May 2019 to review medication, mostly attended by family, and one visit in June 2019 (as well as a review phone call). The visit notes indicated a deterioration in Connie's 'confused' presentation, lower mood and poor appetite. Connie's family believe that Warfarin medication was not managed correctly (referred to in 7.33), resulting in an emergency admission to Kingston Hospital on 03/06/19 due to a high INR level, and that left hip pain management was not administered for weeks. The Home representatives state that medication was managed and that Connie often declined pain relief. Administration of Warfarin or Apixiban increases the risk of bruising to the skin or bleeding under the skin, although Connie's family say that she did not have bruising when in her own home and receiving this medication. Hospital records show that she had experienced significant weight loss. Her daughter said that she would sometimes attempt to climb out of bed when confused.

7.16. Physical health needs (manual handling & bruising): The Care Plan covered mobility and noted that Connie was not able to weight bear, was cared for in bed by two carers and the use of a hoist for transfers, required four hourly repositioning with the use of sliding sheets, and staff were to be gentle and offer reassurance. A Physiotherapist attended to Connie on four occasions in May 2019 and once in June 2019, with an emphasis on supporting and encouraging daily transfers from bed to a reclining chair. Connie's family state that they noticed poor manual handling and bruising from 07/05/19, when they observed red marks to Connie's left lower leg, and subsequently observed increased bruising to her arms and legs, including a finger-print size bruising to her arms. They say that they discussed bruising and marks with staff on 05/06/19 and raised these as a concern about manual handling on 26/07/19, after the Decision Support Tool (DST) meeting. Also, Connie would apparently knock the bedside table with her hand and the padded bed rails with her arms and legs. The Nursing Home representatives attribute bruising to medication and these causes. Connie's family consider that she would not have knocked the table with her arm if the call bell had been in reach, that she would not have been able to kick out with her left leg, and they do not feel that the padded bed rails would have caused the bruising.

7.17. Physical health needs (skin integrity): The Care Plan noted a high risk of developing pressure ulcers due to her immobility and it stipulated support with transfers, repositioning, bed rails and bumpers. On 23/06/19, the Care Plan Evaluation Sheet referred to a skin tear below her left elbow, which was reported to family; and on 29/06/19 a skin tear to her left shin, without an explanation.

7.18. Physical health needs (other concerns raised): Connie's family relayed other concerns about the care she received at the Nursing Home. They said that her call alarm was at times out of reach. Connie only wished to be supported by female carers and this was recorded in the 15/05/19 daily record, but her family recall that she was frequently supported by male carers and felt that some were rough in caring for her. They say that a male carer showed them a day chart in July 2019 that indicated female and male carers. Also, the CHC social worker had noted in July 2019 that a staff member he spoke to was unaware of the requirement. Her family observed a shredded dirty pad on her bedroom floor when Connie was present and felt that a category 2/3 sacral pressure ulcer could be attributed to being left wearing dirty pads.

7.19. Mental Capacity Assessment: On 29/05/19, an RGN at the Nursing Home completed a Mental Capacity Assessment concerning her activities of daily living and Connie was considered to lack mental capacity with regard to all activities of daily living. The assessment record does not state an impairment in the functioning of the brain or mind but refers to disorientation. A Covert Administration Medication Record Form on 02/06/19 recorded that Connie had been spitting out tablets, that she lacked mental capacity and that covert medication was required as a best interest decision by the RGN, other nursing staff and a Pharmacist. The Mental Capacity Assessment record was signed by her daughter, who had LPA status, on 16/06/19.

7.20. Lead up to significant incident: On 25/06/19, a Behaviour Record Chart was completed in the early afternoon, stating that Connie was pulling the curtains and shouting that someone was walking on the wall. Staff provided reassurance. On 28/06/19, family say that Connie commented in the presence of a Dietician that she felt suicidal, repeating this comment when a nurse was called into the room. They say that the nurse commented that Connie had made similar comments, at times crying and saying that she had no life. The staff recollection is that Connie did not specifically state an intent to take her own life. An entry in the daily care progress report for 28/06/19 refers to Connie feeling depressed, having suicidal thoughts and that the GP was informed.

7.21. **Significant incident:** On 29/06/19, staff heard a noise from Connie's room and, on entering at 17.40, found her lying on her bed and holding the call bell cord loosely round her neck (twisting the cord but not touching the front of her neck). Staff believed that she had fallen out of bed. A Behaviour Record Chart was completed at around 17.40, stating that Connie 'was found with the call bell cable/wire around her neck which was knotted' and that she had told staff not to remove it. She presented as restless and confused. Reflecting on the experience of visual hallucinations and confusion, the Consultant Psychiatrist contributing to this review considers that delirium may have been a factor. Three staff removed the cord and provided reassurance. A nurse returned ten minutes later and observed a skin tear to Connie's leg. An Accident Report was then completed by a nurse at 18.00; stating that carers had found Connie with her legs up the bed and with a skin tear, that the wound was dressed and family were informed. The incident was not recorded in daily records and there were inconsistencies in the recording. The managers and staff at the Nursing Home

did not consider the possibility of a premeditated and deliberate act by Connie and the incident was not reported to any agency, including the GP, to trigger a suicide risk assessment. The room was not made safe, aside from the removal of the call alarm cord. There were cushioned bed rails, which the nurse considered were hard enough to cause bruising on impact. Family say that a nurse, on ringing them on the same day, said that the call bell cord was wrapped around her leg. The nurse in a statement said that she told the daughter that the call bell was round her neck and there was a skin tear to her leg, that it may have been misheard due to her accent, and another nurse said that she discussed the incident with family on the following day. Connie's family say that they were unaware that the cord had been round her neck until this was disclosed at the Decision Support Tool (DST) meeting in the following month.

Safeguarding Adults Enquiry from July to November 2019

7.22. Reporting of serious incident: On 19/07/19, Connie was observed hugging the curtains in her bedroom. On the same day, a Decision Support Tool (DST) meeting was held (postponed from 12/06/19) to complete the Continuing Health Care (CHC) assessment. Kingston Adult Social Care (ASC) assigned a Social Worker on 16/05/19 (the first ASC contact relating to Connie) to attend the meeting, which was also attended by family and a CHC advocate. Connie's family say that there had also been a consideration of holding the meeting on 17/06/19 and 20/06/19, without inviting them. The incident on 29/06/19 was disclosed by the Nursing Home, the first disclosure to any agency. Connie's family expressed their shock and upset about the incident and the reporting to them. The ASC Social Worker advised on safety in the room and the CHC Social Worker and nursing representatives continued with the DST meeting.

7.23. Reporting to external agencies: CHC raised a safeguarding concern with the ASC Contact Centre on the same day. Connie's family notified the GP about the incident on 22/07/19 and the GP recorded that there may be an ongoing suicide concern. There were six GP visits during July and the start of August (as well as two review phone calls). The family also rang the ASC Contact Centre to raise a safeguarding concern about this and other aspects of care, including alleged rough handling and Connie's wish to move.

7.24. Bruising: Connie's family observed a bruise to her cheek and cuts and bruising to her forearm on 20/07/19. They state that Connie had told them that staff had dug their fingernails in when supporting her with repositioning; and that they observed rough handling during repositioning without the use of a sliding sheet. There had been four Physiotherapy visits to Connie in July 2019, without any concerns arising.

7.25. Safeguarding Adults Enquiry and Safeguarding Plan: On 22/07/19, an ASC Social Worker completed an unannounced visit to the Nursing Home; and Connie's family were present. She noted concerns regarding male carers;

Connie's disclosure that a couple of male carers 'throw her about' and carers roll her over too quickly; recording of bruising; and noticed that the call bell was out of reach and there was no water jug in the room (on a hot day). Connie presented as bright and alert in bed and commented that there was a generally hostile environment. The Social Worker reviewed the case records and there was no available risk assessment, incident report or behaviour chart relating to the incident. There was a body chart showing the skin tear to her leg. The Social Worker advised the family that the enquiry would be led by the CCG, as the funding authority, and recorded an action on the following day to refer to the CCG safeguarding lead. It is noted within this review that there was a daily care progress report in early May 2019, recording a discussion with family that there might be occasions in which male carers change Connie's pad, but this conversation is not otherwise verified.

7.26. CMHT involvement: On 23/07/19, the GP referred Connie to the CMHT for a suicide ideation review, due to her acute mental health presentation. The Consultant Psychiatrist contributing to this review notes that Connie appears to have experienced distress and a deterioration in cognition whilst in hospital, with a deeper decline whilst in the Home; that her presentation suggests a chronic mixed delirium. The GP referral noted that 'it appears she may have tried to take her life two times in the past three months' (referring to her hugging curtains and the incident with the call bell cord) and that there was a moderate risk of Connie attempting suicide. A GP visited on the same day and noted continued cognitive impairment. Connie said that she was feeling low, was lonely at times, had thoughts of dying a few weeks before (without elaborating on this), that the cord round her neck related to her night terrors and she was not feeling that way now, and that her daughter gives her a reason to live. Mirtazapine was maintained at the lower dosage (15mg) and the plan was to await the CMHT review. A Risk Assessment was completed by the Nursing Home on the same date, relating to suicidal thoughts. This stated that Connie had at no time conveyed an intention to commit suicide but had said 'I am fed up with everything and once said I want to die'. It also referred to the incident with the cord round Connie's neck. The plan was for staff to sit with Connie at least every one to two hours and chat with her to relieve anxiety, access to a wireless call bell and the curtains to be kept out of reach. Connie's family consider that the safety plan was not always followed.

7.27. A CMHT CPN visited Connie on 24/07/19, with her daughter present, and separately spoke with an agency nurse. Connie presented as underweight. It was noted that she appeared to be low in mood and that 'there is a risk she may try to harm herself', particularly if she regains her strength; that she 'admits to feeling down and wishing she was no longer alive. Could not recall attempting to take her life.' The CPN was concerned that a nurse did not recognise the risk of suicide or the need to speak with Connie; 'the agency nurse expressed scepticism that it was suicidal intent saying "I don't think she meant to do it", and didn't appear particularly concerned about this'. She was also concerned that Connie did not have access to a call bell to summon assistance and that she was isolated, to which the nurse responded that she is "pretty vocal." She asked if staff do multiple checks per hour (for safety and to reduce isolation) and the nurse responded that staff check when passing the door. The

CPN recommended removing items from her reach and completing 15 minute checks. She contacted the CCG Safeguarding Manager on the following day to raise a concern about the Nursing Home response, but a Safeguarding Concern had already been raised.

7.28. Connie was seen by a CMHT Consultant Psychiatrist on 25/07/19, who subsequently wrote to the GP to revert the Mirtazapine prescription to 30mg and noted a 'recurrent depressive disorder' that was currently moderate and possible delirium. The GP representative in the review believes this will probably have been in order to treat her depression. The Psychiatrist interviewed Connie, who said that two weeks earlier she had felt like committing suicide, but denied trying to harm herself and could not recall the incident in late June. She said that some staff were spiteful to her, she was unhappy with attendance by male carers and she was unable to say how her future looked. Her appetite was poor and she had lost weight. Also, her sleep was disturbed. Connie's daughter felt that she was more confused in the previous few days and this was also evident to the Psychiatrist. A nurse confirmed that Connie's mood had been fluctuating since admission and she often said that she felt fed up and wanted to die (expressing these thoughts more significantly on admission and still expressing them at times). The Psychiatrist concluded that the incident was a possible attempt at self-harm and that staff had thought at the time that she had become confused and accidentally wrapped the cord around her neck. She recommended safety measures; ensuring that there were no knives in her bedroom and to support her to the lounge to avoid isolation. Her family say that they witnessed metal cutlery being used on 29/07/19. Connie was to be reviewed by the CPN on a weekly basis. The Consultant Psychiatrist contributing to this review considers that the clinical history and lack of recall point more to delirium than depression.

7.29. Safeguarding Adults Enquiry Visit: The CHC Social Worker (Enquiry Officer) visited the Nursing Home on 26/07/19. There was a brief telephone call, initiated by family who felt that they were not being listed to, and their concerns were noted. The Social Worker met with Connie, who appeared to be in a good mood. A behaviour record referred to the cord around Connie's neck and an accident report completed shortly afterwards referred to a skin tear to her leg. The Social Worker considered that there were inconsistencies in the recording of the incident and the cause of the skin tear. The communication book did not indicate the content of the message to family. He asked the nurse to explain why the only safety action taken had been to remove the call bell from the room and replace it with a cordless call bell and why the risk assessment had not been reviewed. The nurse responded that "maybe (the) nurse on duty didn't fully appreciate the seriousness of the incident or that (the) incident was of a suicidal nature". He noted that Connie had expressed a wish for attendance by female carers only and also that the CPN had requested 15 minute checks and the Nursing Home was completing 30 minute checks. A decision was taken to progress to a Safeguarding Adults Enquiry, with the Safeguarding Adults Manager (SAM) and Enquiry Officer (EO) roles delegated to the CHC Team. The enquiry actions involved the CHC Social Worker checking documents and a Nursing Home internal enquiry that was to be completed by 29/07/19. An interim Safeguarding Plan involved the CPN and Consultant Psychiatrist visits,

with safety in the room and checks covered but not external monitoring of the plan. The Nursing Home representatives state that 30 minute observations involved entering the room, acknowledging that Connie could not have been seen from the doorway.

7.30. Nursing Home Enquiry report; A timely report by the Nursing Home was completed by 29/07/19. It covered the incident and also wider issues. The staff view that the incident was not a suicide attempt was accepted and that the risk was addressed by removing the cord. The Safeguarding Plan actions made reference to the call bell (accepting that it was not consistently kept within her reach) and documentation (that the nurses should have documented that they did not think there was a suicidal risk). It was not recognised that a report should have been made to the GP to request an urgent suicide risk assessment. A GP visit record on the same day noted that Connie was unwell, feeling short of breath and in a low mood.

7.31. Report to Police (MPS): Connie's family reported their concerns about unexplained injuries to the Police on 29/07/19. They accompanied the Police on an unannounced visit to Connie on the same day to observe the injuries. Connie's family were subsequently advised that the investigation would be closed as there was no evidence of a crime, and they say that this notification was received in December 2019. The MPS Merlin Report was received by Adult Social Care on 30/07/19 and the Home states that this information was not shared with them.

7.32. LAS attendance: An ambulance crew attended on 31/07/19, requested by family, as Connie's end of life condition had declined and she was experiencing difficulty in breathing. It was agreed that she would remain at the Nursing Home in the care of her daughter and the staff, rather than be admitted to Hospital.

7.33. Safeguarding Plan and Review Meeting: A meeting was held on 27/08/19. The meeting was chaired by the ASC Head of Safeguarding and was attended by family, the CHC Team, CCG, Nursing Home, CQC and CMHT. The Police did not attend. The purpose of the meeting was introduced as to share information on a concern that Connie was abused by staff at the Nursing Home. It did not cover wider risk management by other agencies. Family reported having a good impression of the Home when Connie moved there, but that this changed to being dissatisfied, as they felt that care and safety were lacking. The CHC Social Worker provided a summary of his report to the meeting, based on his visit to the Home, the Home internal investigation and the CPN and Consultant Psychiatrist visits. He found inconsistencies in the reporting of the incident, incomplete and false reporting of the incident to the family, non-reporting to the GP and CQC at the time, no recognition of suicide risk, the risk assessment was not reviewed after the incident, and Connie was provided at times with male carers. The family believed that Connie was being turned incorrectly onto her left side and that there was rough handling; the bed had padded sides to prevent bruising; and it was recorded that the Home was to contact the family to 'calm them down'. It is understood by the independent reviewer that this

wording was not conveyed accurately in the report to meeting. The Consultant Psychiatrist had made recommendations regarding a safe bed area and 30 minute checks. Family noted that they had not received a CCG response to the request for a move; no explanation of the call bell and water jug being out of reach; or a soiled continence pad scattered on the carpet in the room; that they had witnessed staff back-dating information on charts; and they were concerned about the INR level. CQC found errors in the Home notification about the incident. Connie had been assessed as not requiring a Deprivation of Liberty Safeguards (DoLS) application. The agreed enquiry outcome was that 'on the balance of probabilities it was likely that harm had occurred'. A Safeguarding Review was to be arranged on receipt of a draft action plan from the Nursing Home. The Home responded in writing that documentation on the incident was correct, Connie received stimulation, nurses were competent in medication administration and the raised INR was correctly addressed, staff denied backdating information, the pad left on floor should have been cleaned, the call bell was at times out of reach, the fluid chart shows regular encouragement to drink, Connie was not handled roughly, and issued an apology regarding the attendance of male staff. Connie's family say that they were unaware of the meeting outcome, disagree with most of the findings, and have not received an apology from the Home.

7.34. Safeguarding Plan and Review Meeting: A further meeting was held on 08/11/19, to review progress with the actions of the previous meeting. The meeting was attended by a Safeguarding Adults Senior Social Worker, CCG Designated Safeguarding Adults Lead, Nursing Home Managing Director and Home Manager. Family members were not invited. It was acknowledged by all parties attending that staff made assumptions that the incident with the call bell cord was not a suicide attempt and that training had been provided on suicide risk and prevention. It was further acknowledged that there were errors in reporting and that the incident should have been recorded on an accident reporting form, not only on the behaviour chart. The Nursing Home reported that all care plans were switching to an electronic system, including information on suicide risk, to improve assessment in this area. With regard to bruising, the Home pointed to the fragility of Connie's skin and the Warfarin medication, that she refused pain relief medication, and that concerns had not been raised about her care by the GP, Physiotherapist and Your Healthcare. The ASC and CCG representatives could not find evidence of rough handling and obtained a log of staff who have received manual handling training. There were occasions in which Connie received support with personal care from male carers, against her wishes. The Home stated that the family had been advised that this may happen on rare occasions, but there was no evidence of this conversation and it was agreed that these matters should be documented and signed by families. The Home stated that Connie was supported with drinking and at times spilt liquid from the jug, that fluid charts were maintained, and that the activities coordinator did engage with Connie. It was accepted that a pad was left on the bedroom floor by a carer, not meeting the Home's clean as you go policy. The ASC and CCG representatives accepted, on the basis of the internal investigation and the information in this meeting, that a robust action plan was in place to address the safeguarding enquiry findings and other concerns. A copy of the report was provided to the family, CQC and ASC Commissioning.

7.35. End of life care: A GP visit record on 01/08/19 noted that Connie's preferred place of care was at the Nursing Home and that she was receiving end of life care. The CPN (Care Coordinator) visited Connie on 01/08/19 and was advised that end of life medication had started and anti-depressants had ceased. She was therefore discharged by the CMHT on 02/08/19.

7.36. CQC inspection: A CQC unannounced inspection on 02/12/20, brought forward in view of concerns raised by Connie's family, found no concerns about the Nursing Home and a 'Good' rating was received overall and across all domains. The inspection incorporated speaking with relatives of residents and no concerns were raised.

8. Analysis of Key Facts

8.1. **Overview:** It is important to note that there is, in the view of the independent reviewer, evidence of all agencies endeavouring to address Connie's complex needs in a sensitive and personalised manner. No agency set out to neglect or avoid addressing her needs and risks. However, there is a sense that agencies may have regarded loss as a natural and expected part of the ageing process, thereby limiting professional curiosity in actively considering Connie's individual experience of depression (or risk of depression) and trauma on a par with her physical health needs.

How effective was multi-agency risk management and information-sharing during hospital inpatient stay and discharge

8.2. General: Connie experienced a long history of depression and her physical health was a contributory factor to her condition, even when managing independently. She experienced the trauma of a fall and serious injury, permanent and debilitating pain, the loss of her independence and the loss of her home. On occasions she presented as sad and distressed about her circumstances and latterly expressed at times that she wished to die.

8.3. Hospital admission and discharge: There are occasions in which Connie was observed on the ward in a tearful and frustrated state as a consequence of her fall, with an apparent increase in her distressed presentation when resigned to Nursing Home admission. Whilst she was provided with reassurance, it is not clear that Hospital staff demonstrated professional curiosity and entered into a meaningful conversation with her on how she felt about her life. There was also a missed opportunity for a Social Work needs and risk assessment to be undertaken. Whilst the functional assessments underpinning Hospital discharge planning were thorough and personalised, the Hospital discharge information to the GP and the Nursing Home did not indicate that her history of clinical depression, current trauma and distressed presentation were a primary concern. The independent reviewer acknowledges that discharge arrangements were a Hospital responsibility and that there was no indication of trauma in the Continuing Health Care (CHC) checklist. However, the Clinical Commissioning

Group (CCG) also monitors discharge plans within its commissioning responsibility and did not question the low priority afforded to the history of depression and the traumatic circumstances.

8.4. Nursing Home admission and stay: Connie's family are concerned that the Nursing Home is not registered to provide care for specialist mental health needs. The CQC representative considers that, whilst Connie's presentation may have warranted consideration of mental health support, her needs were not untypical for a registered Nursing Home to manage and that she did not require a specialist Mental Health Nursing Home. This view is also expressed by the CCG, Kingston Hospital and Nursing Home representatives. Connie's family point to CQC correspondence in December 2020 that the Nursing Home does not specialise in identifying or responding to serious instances of mental ill health. It is the view of family that Connie should have resided in a Nursing Home with a registered care category of 'mental health condition.'

8.5. On admission to the Home, it was not questioned that the Hospital discharge summary did not comment on a history of depression and the traumatic circumstances as a primary concern. The Home confirms that detail on the history of depression would have been helpful in care planning. Connie had expressed thoughts of feeling fed up and wishing to die from the time of her admission to the Home. It is not clear that this prompted professional curiosity and meaningful conversations with Connie about her life and mental health, notwithstanding the priority of pain management. The Psychiatrist contributing to the review considers that Connie's presentation did not indicate a recurrence of depression at this stage, rather a reaction to loss, and would not have met the threshold for a referral to secondary mental health on this basis. The request to the GP in mid-May 2019 for a referral to the Memory Clinic would have engaged the CMHT in relation to her 'confused' presentation if progressed. A nurse, contributing to the review, recalls that Connie's daughter had provided information to staff about Connie's history of depression and that she was tearful at times during her stay. However, when staff asked Connie how she was feeling, she was reluctant to engage; mainly talking to the Activities Coordinator. The nurse feels, however, that staff could have been more proactive in sitting with Connie and asking how she felt about her life.

8.6. The Home did not consider the possibility that the incident in late June 2019 may have been an act of self-harm and attempted suicide (possibly with confusion a contributing factor), and therefore did not request a GP referral to the CMHT for a suicide risk assessment and did not inform any other agency about the incident at this time. The CMHT representative confirms that a concern about suicide ideation would have warranted a referral to the CMHT, via the GP; that a visit would have been undertaken within 48 hours or an emergency ambulance called, dependent on the assessed urgency. The Home accepts that the possibility of self-harm and attempted suicide should have been recognised and reported. There was also a lack of clarity in the internal recording of the incident and in the reporting to the family.

8.7. The independent reviewer was invited to meet with nurses at the Home who knew Connie and this was helpful in gaining a perspective on the extent to which Connie was heard to express possible suicide ideation. A range of personal recollections give the impression that Connie was unhappy with her life, had expressed a wish to die but had not expressed an intent to take her own life. This should have prompted a consideration of possible suicide ideation. The nurses recollected Connie expressing that she was fed up and wanted to die, but not that she intended to take her life; that she wished to go home, but never said she had had enough and would take her life; that she was not happy with life, but never mentioned dying; that she generally talked about her past and perhaps once said she wanted to die, but never said that she wished to take her life; and that she had mentioned never having been happy and that she missed her daughter. The independent reviewer has a sense that nurses listened to and were concerned about Connie, but it is not clear that this amounted to active listening and exercising professional curiosity.

8.8. The CCG was the responsible agency in terms of commissioning the Nursing Home placement and did not undertake monitoring or a review from the time of admission in early May 2019 to the Decision Support Tool (DST) meeting in late July 2019. This was a possible missed opportunity, particularly in view of Connie's history of depression and traumatic circumstances, to have picked up on potential concerns and latterly to have requested a suicide risk assessment.

8.9. Involved agencies could also have considered the potential benefits of triggering a multi-agency risk management meeting at any time from the point of Hospital admission. This could have followed the existing structure for DMT risk management meetings or presentation at the KVAMA panel.

How effective was the care provided by the Nursing Home and other agencies?

8.10. Care planning: The independent reviewer considers that, overall, care plans and daily records held by the Nursing Home present as reasonably comprehensive and detailed; notwithstanding the apparent gaps noted in the family's comments, in the Safeguarding Adults Enquiry and in this review, particularly concerning the recording and reporting of the incident.

8.11. End of life care: The GP halved the dosage of Mirtazapine anti-depressant medication, which is understood to be common practice when patients enter the end of life phase. The independent reviewer is advised by medical and nursing representatives in the review that this is likely to reduce the fog of 'confusion', whilst increasing the risk of depressive symptoms, but can also worsen confusion.

8.12. Monitoring the causation of bruising: Connie experienced considerable pain when supported with repositioning and transfers. She felt that some staff at the

Nursing Home handled her roughly and increased her level of pain. Her family had concerns about bruising and other marks from admission and raised these with staff from early June 2019. In late July 2019, they raised having witnessed rough handling during repositioning and a suspicion that bruising and marks to the skin (including what they believed to be grip marks and cuts) were due to rough handling. The Home representatives stress that staff attended to Connie with care and sensitivity, including the offer of pain relief prior to repositioning, that was often declined. Connie was at an increased risk of bruising due to the administration of Warfarin and to her tendency to impact the bedside table with her hands and the padded bed rails with her arms and legs. A nurse relayed to the independent reviewer that staff would support Connie with moving by administering pain medication and placing their hands on her shoulder and hip, and that she did see red marks on Connie's skin which may have occurred during manual handling. Another nurse said that bruising was linked to medication and turning; that Connie would not take painkillers most of the time. Certainly, bruising was also evident whilst Connie was a patient in Hospital and body charts produced by the Hospital and Home record some similar markings. It is not within the scope of this review to establish whether rough handling occurred and this was not established within the Safeguarding Adults Enquiry. Clear information on the conservative management of an inoperable fractured hip within the Hospital Discharge Summary may have been helpful in supporting the Home with care planning.

8.13. Other care concerns: Connie's family raised other concerns regarding the provision of care whilst Connie was resident at the Nursing Home. They raised concerns that the call alarm was often out of reach; that fluids were often out of reach or not available; that male carers were supporting Connie with personal care despite her expressed wish for female carers only; that a soiled continence pad was left on her bedroom floor; and that raised INR level were not addressed correctly on three occasions. The Safeguarding Adults Enquiry (analysed later in this report) found that there were occasions that the call alarm was out of reach; there was evidence of fluids being made accessible to Connie (although not in reach during a CHC Social Work visit) and the Home commented on the risk of spilling and the painful task of changing soiled clothes; there were occasions in which male carers were supporting Connie and the Home did not have a record of clarifying that this was at times unavoidable; and that a soiled pad was left on the bedroom floor for cleaners (against the Home's clean as you go policy). The Home acknowledged these concerns and made a commitment to address them with staff.

8.14. Fast-track CHC funding: As discussed with CCG representatives, given that Connie entered an end of life phase from late May 2019, it would seem to have been reasonable to have considered fast-track funded nursing care instead of proceeding with a Decision Support Tool (DST) meeting in mid-July 2019. Unless there was a realistic prospect of CHC funding not continuing, the additional anxiety to Connie and her family may have been avoided. However, NHS funding was provided throughout Connie's stay in the Nursing Home and a CCG complaint response to the family in February 2021 stated that the response was in accordance with the CHC National Framework.

How effective was consideration of mental capacity and personalisation?

8.15. Mental Capacity Assessment in Hospital: An Occupational Therapist (OT) at Kingston Hospital completed a thorough and personalised Mental Capacity Assessment in March 2019 (on the assumption by the independent reviewer that the diagnostic test was valid). Whilst her recommended outcome of Nursing Home admission was clearly known to Connie, she also provided clear information on the option of returning home. This is a difficult balance of choice and advice that seems to have been handled with sensitivity and patience. It is unclear why another assessment was initiated by a Doctor on the same day and a further assessment by the Discharge Coordinator soon afterwards, when the circumstances and decision to be made were unchanged. Also, these assessments were halted on the basis of the diagnostic test; as Connie was deemed not to have an impairment or disturbance of the mind or brain. However, the Clinical Psychiatrist contributing to this review considers that her confusion may have indicated chronic delirium.

8.16. Mental Capacity Assessment in the Nursing Home: A further Mental Capacity Assessment was undertaken by an RGN (registered nurse) at the Home in May 2019. This assessment incorporated the diagnostic test in noting an undiagnosed impairment or disturbance in the functioning of the mind or brain; specifically disorientation to time, place and person. The functional test covered a range of activities of daily living, although this should have been more descriptive. Connie was considered to lack the capacity to make decisions in all aspects of her care needs. The assessment outcome was that staff should anticipate Connie's needs and that she is able to ask for fluids with prompting, which reads as personalised. The assessment was signed by the family over two weeks later in June 2019. As the family held dual Lasting Power of Attorney (LPA) status, this did not indicate close consultation in regard to best interests. Connie's daughter adds that she was asked questions about Connie's memory on signing the form and that the report was not presented to her as an MCA assessment. Connie's family relay that Connie told them in late July 2019, after she had been assessed as lacking capacity in relation to her care needs, that she had signed a 'big book' on the same day. They suspect that this may have been care plan related, although the independent reviewer has not verified this with the Home.

8.17. Deprivation of Liberty Safeguards (DoLS): Given that Connie was assessed as lacking mental capacity to make decisions regarding activities of daily living and that she was under continuous supervision and control and was not free to leave, an application for a DoLS authorisation should have been made by the Home in May 2019 and should have been advised by the CCG and latterly ASC. DoLS is due to be replaced by Liberty Protection Safeguards (LPS).

8.18. Active listening: It seems that the practice of agencies was personalised at times but not always. Whilst involved agencies generally presented as sensitive and reassuring to Connie, it is not clear that they entered into meaningful

conversations on how she felt about her life. Hospital staff did spend time with Connie and her family in discussing Hospital discharge and Nursing Home representatives convey a concern for Connie in recalling the care provided. As aforementioned, the Home should have demonstrated more sensitivity and clarity in response to Connie's request for female carers. A CCG representative acknowledges that there should have been more empathy shown to Connie's family in the Decision Support Tool (DST) meeting in July 2019, when the incident of the cord round Connie's neck was disclosed, by considering the option of closing and reconvening the meeting to allow family the time to absorb the information. Following this meeting, the trust between family and the Nursing Home, as well as with other involved agencies, was severely strained. This was understandable. Whilst the independent reviewer acknowledges the Home comment that efforts were made to engage with the family, there was insufficient evidence of a concerted effort by the Home and other involved agencies to establish an open and meaningful communication channel, through structured meetings or perhaps mediation. As addressed in the next section, inclusion of Connie's family in the Safeguarding Adults Enquiry was patchy. This was not helped by an inappropriate comment about contacting the family to keep them calm, which was relayed in a report to family members, even if this was relayed inaccurately.

8.19. Nursing Home transfer: Following the disclosure in July 2019, Connie and her family requested a transfer to a different Nursing Home. Whilst Connie experienced considerable pain on moving and had entered an end of life stage, there do appear to have been grounds to have given serious consideration to this option. A transfer may have been supportive to Connie, her family and the Home, as trust had broken down. However, there is insufficient evidence of the CCG actively discussing the option with Connie and her family, or of updating the Home, until it was stated at a Safeguarding Adults Enquiry meeting that Connie would not be transferred. A CCG complaint response in February 2021 states that it was not in Connie's best interests to move her to another Nursing Home, as there were safety measures in place. It was also recognised that moving a frail person to another home may have increased the risk of a decline in physical and mental health. Whilst the independent reviewer respects the CCG rationale, safety measures could have been replicated elsewhere, Connie did not lack mental capacity regarding her place of residence, her family had LPA and both Connie and her family had requested a move because they had lost confidence in the placement. Connie and her family were understandably distressed at the circumstances and should have been involved in the decision-making.

How effective was the conduct of the Safeguarding Adults Enquiry?

8.20. Proportionality and personalisation: The Safeguarding Adults Enquiry was characterised by both strengths and areas for development. It reached a clear finding about the incident and addressed some of the wider concerns. Also, it led to further actions to reduce risk. However, it was not sufficiently proportionate or personalised and did not address multi-agency risk management.

8.21. Lead coordination: Responsibility to manage the Safeguarding Adults Enquiry was delegated by Adult Social Care (ASC) to the Continuing Health Care (CHC) Team; with a registered Social Worker who was inexperienced in safeguarding assigned as the lead Enquiry Officer (EO) and the Designated CCG Safeguarding Adults Manager adopting the role of Safeguarding Adults Manager (SAM). A revised local Safeguarding Adults procedure emphasises the lead coordinating role of ASC, which the independent reviewer considers to be an appropriate action.

8.22. Visits to Nursing Home: There were prompt visits to the Home by a range of agencies. These visits enabled an examination of records and the prompt reinforcement of what amounted to an interim Safeguarding Plan, which was positive practice. There was also prompt reporting by the CHC to ASC, but not to other agencies, such as the GP and MPS.

8.23. Safeguarding Adults Planning Discussion: The independent reviewer notes that the Safeguarding Adults Enquiry did incorporate a range of meetings, as is good practice. However, a Safeguarding Adults Planning Discussion is pivotal in establishing a proportionate and personalised enquiry. Whilst there was contact with family and agencies during the process, the enquiry actions were not agreed in a discussion with the family and all the key agencies of relevance to the incidence of the cord, the wider care concerns and the wider risk management context. The enquiry was heavily reliant on a Nursing Home internal investigation, which is not proportionate as a multi-agency response to serious safeguarding concerns was warranted. Attendance by ASC, CCG line management (possibly arranging independent checks of nursing records), the CMHT, a GP, OT or Physiotherapist, Kingston Hospital (for context), and possibly MPS (in view of Connie's lack of capacity regarding care needs and potential serious abuse), may have led to a more proportionate and personalised, multi-agency enquiry plan. The resulting report by the Home does not appear to the independent reviewer to have been adequately comprehensive or objective.

8.24. Safeguarding Plan: The plan to reduce the risk of self-harm was prompt and consisted of removing potentially harmful objects in the immediate environment and of undertaking regular safety checks. These appear to be proportionate measures, but their application was not independently monitored. The independent reviewer recognises that Connie was nearing the end of her life and there was only a two week period for monitoring to take place. It is further recognised that CPN visits, a key source of monitoring, could only be provided weekly in line with CMHT policy on the assessed high level of urgency. A Checking Chart at the Home was recorded throughout the placement and generally indicated hourly or more frequent checks. The independent reviewer checked five afternoon/evenings after checks were increased to half hourly. On 25/07/19 checks were not fully maintained (occurring every 10 minutes up to an hour); on 26/07/19 they were mostly maintained (with a one hour gap in the evening); and from 27 to 29/07/19 they were mostly maintained. Each recording included a brief observation of Connie, suggesting that staff had

entered the room. Family members have said that they observed records being updated retrospectively. The enquiry could not establish whether this had occurred.

8.25. Safeguarding Planning and Review Meetings: A Safeguarding Planning and Review Meeting in August 2019 was effectively chaired and well attended, including family participation. Whilst there had not been a coordinated planning discussion at the start of the process and enquiry actions should have been broader, the meeting did cover the incident and wider concerns and found on the balance of probability that harm had occurred. A further meeting was held in November 2019 and was attended by core agencies alone to monitor progress. There did appear to be evidence of Nursing Home actions, as endorsed by the ASC and CCG leads in attendance, but multi-agency risk management learning remained a gap.

9. Key Findings

9.1. **Overview:** Involved agencies endeavoured to meet Connie's needs in a sensitive and personalised manner.

How effective was multi-agency risk management and information-gathering:

9.2. Professional curiosity: Although involved agencies demonstrated sensitivity and provided reassurance to Connie, it is not clear that they applied professional curiosity in actively considering her mental health needs on a par with her physical health needs; prompting a meaningful discussion with Connie about her life. The risk factors comprised her history of depression, onset of trauma, distressed presentation in both Hospital and Nursing Home settings, and increasing confusion (particularly at night).

9.3. Risk management meeting: There were missed opportunities for agencies to have considered convening an MDT risk management meeting to ensure a coordinated, multi-agency response.

9.4. Social work allocation: A Social Work needs and risk assessment, either by ASC or CHC, should have been considered as part of Hospital discharge planning. The Hospital Safeguarding Adults Lead considers that there is now a cohesive relationship between the Social Work and Hospital Discharge Teams.

9.5. Hospital discharge: The Hospital Discharge Summary did not refer to Connie's history of depression, traumatic circumstances and presenting distress as primary concerns and was not subjected to sufficient scrutiny by commissioners or receiving agencies.

9.6. Serious incident: When Connie was found in her bedroom with the call alarm cord round her neck, resisting its removal, the Nursing Home staff did not recognise the possibility of self-harm and suicide ideation and therefore did not take proportionate action. This should have involved reporting to the GP for urgent referral to the CMHT for a suicide risk assessment; reporting to the commissioning, regulatory and safeguarding authorities; and initiating the safety precautions of removing or reducing access to potential means of self-harm and completing regular checks to monitor wellbeing. Recording of the incident was not sufficiently robust and there was a lack of clarity in reporting to the family and recording this contact.

9.7. Nursing Home placement: It seems from the perspective of the commissioning and nursing representatives in the review that a standard Nursing Home placement was appropriate to meet the presenting mental and physical health needs of Connie. The independent reviewer respectfully notes that this view is not shared by family members, who consider that a more specialist mental health setting was warranted.

How effective was the care provided by the Nursing Home and other agencies?

9.8. Hospital Pain Team: The Kingston Hospital Safeguarding Adults Lead considers that, as there was continued left hip pain at the same apparent level a month after hospital admission, with bruising still present, there should have been a referral to the Hospital Pain Team and that this did not occur.

9.9. End of life medication review: The GP Practice halved anti-depressant medication as a part of end of life care, which the independent reviewer understands is standard medical practice. This may have led to a reduced 'fog' of confusion and an increased risk of depressive symptoms. The impact of this should have been more closely monitored in view of Connie's history of depression and deteriorating cognitive functioning.

9.10. Bruising: Connie experienced considerable pain during repositioning and transfers, and it is understood that she was offered pain relieving medication in advance. It seems that Connie regularly accepted this medication in Hospital but not in the Nursing Home, and the reason for this is unclear. Her family believe that she at times declined medication because she did not like some staff members approaching her. She experienced bruising and marking to her skin whilst in Hospital and the Home. This is attributed by the Home to the administration of Warfarin medication and the impact of her hands and limbs on surfaces. It is attributed by Connie's family to rough handling by staff at the Home. It is not within the scope of this review to establish whether there was rough handling, but recommendations are made in the next section on the basis of this risk aspect.

9.11. Care planning and delivery: There is evidence of comprehensive care planning and recording at the Nursing Home. However, there is acknowledgement within the Safeguarding Adults Enquiry of concerns relating to the accessibility of the call alarm, the support of female carers, the accessibility of fluids, and a soiled continence pad left for cleaners.

9.12. Fast-track NHS funding: The CCG progressed a DST meeting for a decision on Continued CHC funding in July 2019, after Connie had entered an end of life phase in May 2019, and it may have been reasonable to have considered whether there were grounds to have considered fast-track funding at this point. However, Connie did receive NHS funding throughout her stay at the Home.

9.13. CQC inspections: It is notable that both Kingston Hospital and the Nursing Home held 'Good' ratings in the CQC inspections covering the period of this review; overall and within each domain.

How effective was consideration of mental capacity and personalisation?

9.14. Mental capacity: A Mental Capacity Assessment undertaken at Kingston Hospital in March 2019 appears to have been thorough and personalised. A further MCA assessment at the Nursing Home in May 2019 appears to have met legal requirements, although further description within the functional test and evidence of family consultation are areas for development. A standard Deprivation of Liberty Safeguards (DoLS) referral should have been initiated by the Home in May 2019. This should also have been advised by the CCG and latterly by ASC.

9.15. Active listening: Involved agencies on the whole demonstrated sensitivity towards Connie and provided reassurance. However, there was not a sense of engaging with Connie in a meaningful way on how she felt about her life. Engagement with Connie's family was variable and there was not a sufficient effort by involved agencies to build an effective channel of communication from July 2019.

9.16. Nursing Home transfer: The CCG did not appear to actively engage with Connie, her family (who held LPA) and the Home in considering the option of a transfer. The decision not to progress was presented at a Safeguarding Adults meeting without active consultation and without a sense of urgency.

How effective was the conduct of the Safeguarding Adults Enquiry?

9.17. Proportionality and personalisation: The Safeguarding Adults Enquiry should have been more coordinated, proportionate and personalised at the planning and enquiry stages. Key concerns were the decision to delegate lead coordination responsibility to the CHC; a planning process that did not engage Connie's family or partner agencies in a robust and independent enquiry that also covered the risk management context; and a safeguarding plan that was not externally monitored (albeit within a very limited timespan).

9.18. Strengths: Positive aspects of the Safeguarding Adults Enquiry include the prompt visits by agencies to the Home, the prompt Safeguarding Plan decisions, the conduct of the two closing meetings in reaching overall findings and outcomes, and the acceptance by the Home of learning regarding suicide ideation and wider concerns as the enquiry progressed.

How did resources and environmental factors impact on care?

9.19. Resources: Whilst all health, social care and service provider agencies are operating within a climate of increasing demand and diminishing resources, there is no evidence that any decisions were made, or actions taken on the grounds of financial considerations.

9.20. Environmental factors: Connie was managing independently at home and, on falling, was cared for in a Hospital and latterly a Nursing Home setting. Notwithstanding the family perspective on a specialist resource and the safeguarding concerns raised, there is not clear evidence that the type of resource contributed to the concerns. However, her family feel that she was isolated and lacked stimulation, contributing to her mental health decline.

How compliant were agencies with legislation, policy, procedures and practice guidance?

9.21. Care Act 2014: ASC and the CCG did not robustly carry out Care Act s42 requirements in terms of the accountability and delegated responsibility to conduct a proportionate and personalised enquiry, and to effectively monitor the Safeguarding Plan. The Making Safeguarding Personal (MSP) national policy guidelines, contained within the London Multi-Agency Adult Safeguarding Policy and Procedure, was also not always robustly applied.

9.22. Mental Capacity Act 2005: The MCA was on the whole followed on undertaking the Hospital and Home Mental Capacity Assessments, despite areas for development that are noted in this review. However, there should have been a standard DoLS application from the time that Connie was assessed as lacking capacity to make decisions about her care needs.

10. Recommendations

10.1. **General:** The following recommendations for the Safeguarding Adults Board and individual agencies relate directly to the findings of this review and also draw on recommendations from other contemporary national reviews concerning suicide prevention; the most relatable undertaken by Essex SAB (William, 2020).

10.2. **Recommendation 1**: Adult Social Care (ASC) should demonstrate how they gain assurance about the effectiveness of the multi-agency risk management arrangements.

10.3. **Recommendation 2:** SAB to commission a Subject Master Expert Programme session on multi-agency risk management training, incorporating self-harm and suicide prevention.

10.4. **Recommendation 3:** Kingston Hospital to work with partners to develop discharge grab guide to ensure that mental health concerns are assessed prior to discharge and shared effectively with care homes, to enable a care plan to be developed to support the individual.

10.5. **Recommendation 4:** The SAB should seek assurance that individuals who are discharged from hospital to care homes, on the end of life care pathway, have their care coordinated to ensure that there is a shared understanding of the person's holistic needs as set out in the NICE guidance (142).

10.6. **Recommendation 5:** ASC and CCG commissioners, CQC and Nursing Homes, to review expectations on the monitoring and recording of manual handling and bruising in regard to residents who bruise easily. The Nursing Home advises that the current internal procedure involves reviewing documentation with staff and family to discuss concerns.

10.7. **Recommendation 6:** Kingston Hospital to ensure that there is clear discharge information to care homes on the conservative management of inoperable fractured hips, including pain relieving medication and manual handling.

10.8. **Recommendation 7:** Involved agencies to evidence that staff have received appropriate training on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.

10.9. **Recommendation 8:** ASC should provide assurance to the SAB that safeguarding enquiries are undertaken in line with the Care Act 2014 and the London Multi-Agency Adult Safeguarding Policy and Procedure.

10.10. **Recommendation 9:** SAB training sub-group to report to the SAB on an analysis of the data from partner agencies in relation to the training provided on safeguarding adults, incorporating the six safeguarding principles.

10.11. **Recommendation 10:** The SAB should seek assurance from members as to how agencies learn from complaints when there have been safeguarding concerns, and how the views of service users and their families are heard and recorded.

References:

NICE, *Quality Standards and Indicators Briefing Paper: Suicide Prevention* [2019]

Care Act [2014]

Care and Support Statutory Guidance [DHSC, 2022]

London Multi-Agency Adult Safeguarding Policy and Procedure [ADASS, LGA, 2019]