Safeguarding Adults Review: Case Nancy
Executive Summary

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Summary - Safeguarding Adults Review concerning the death of Nancy at her home in Bolton.

In July 2022, Nancy passed away in hospital. Nancy received care from her sister, who lived nearby and Care providers who attended to her three times daily. During Nancy's sister's holiday, there was an assumption that the carers would continue their support. Unfortunately, due to a breakdown in communication, the Care providers discontinued the care package, unbeknown to both the family and professionals involved. This lack of oversight resulted in Nancy being left in a state of neglect, a factor that ultimately contributed to her passing the following month. This review examines the systemic issues that led to the cessation of the care package and the subsequent breakdown in communication with the family and professionals collaborating in Nancy's care.

1. The background to the review

Nancy was an elderly single female who died in July 2022. She lived on her own in a semi-detached 2-bedroom bungalow, which she owned, in Bolton. Nancy's family lived nearby and provided support, her sister lived across the road and her son lived locally.

Nancy suffered from complex physical and mental health issues as well as being diagnosed schizophrenic. These meant that she required regular support with everyday living and since May 2017, carers from a local provider attended up to 3 times a day.

Nancy sometimes would become confused and forgetful, and an assessment showed she had cognitive impairment. On two occasions, when Nancy was in hospital, there were reports of attempted burglaries at her home. Both events caused distress to the family and were investigated fully by local Police. Nancy had good support from her GP at the local Health centre as well as the carers from her Care provider and the Older Adults Community Mental Health Team (OACMHT).

In June 2022, her sister discovered Nancy in a neglected and distressed condition upon returning from a family holiday. It was initially assumed that the care company had been attending to Nancy daily, but this was not the case. It appeared that there was confusion between the Local Authority and the Care provider regarding the renewal of Nancy's care package, three weeks previously.

Tragically, Nancy passed away on July 22, 2022, following a month-long hospital stay.

2. The key lines of enquiry in this review.

Four key lines of enquiry were identified by the review panel, these were:

- Did agencies work effectively together to respond to safeguarding concerns from September 2019?
- Was there effective information sharing between agencies, particularly when concerns were raised, and safeguarding risks started to escalate?
- Did the Care providers adequately meet Nancy's needs and respond to any safeguarding concerns?
- Were Nancy's family kept informed of escalating risks and involved in decision making at key stages?

3. The multi-agency review panel for this review.

The panel met four times for this review.

The panel was made up of representatives from Greater Manchester Mental Health Trust, Bolton NHS Foundation Trust, Greater Manchester Police, Adult Social Care (including the Quality Assurance Team and Commissioning Teams), Greater Manchester Integrated Care Board, the Care provider, Bolton Home Care Bookings Service, Northwest Ambulance Service, and the Independent Living Service.

The review used a **signs of safety methodology** to identify, what went well, what could have gone better and what was the learning for each of the key lines of enquiry.

4. The four key lines of enquiry

4.1 Did agencies work effectively together to respond to safeguarding concerns from September 2019? And was there effective information sharing between agencies, particularly when concerns were raised, and safeguarding risks started to escalate?

Nancy had been receiving a care package from a Care provider Company for 5 years prior to her death. In September 2019, Nancy's mental health declined, leading to a referral to the Older Adults Mental Health Team (OACMHT) and the appointment of a care coordinator.

Further concerns for Nancy were further raised in September 2019 following a call to Police who found Nancy to be 'very confused' when Police attended. They made a referral to adult safeguarding. Nancy suffered a serious fall, in early January 2021 which resulted in admission to hospital, where she would stay for 2 weeks. In January and February 2021 Police investigated two attempted break-ins at Nancy's home, both were investigated, and no arrests made.

There was a concern that there was no consideration given at this point to Nancy's Protected characteristics, under the 2010 Equality Act – *(The 9 characteristics that are protected by the Equality Act 2010 are: **age, disability**, gender reassignment, marriage or civil partnership, pregnancy and maternity, race, religion or belief, sex, and sexual orientation*). In actively considering Nancy's protected characteristics, there may have been a motivation for the attempted burglaries and why Nancy was possibly targeted in the community and therefore better safeguarded.

In August 2021, the OACMHT care coordinator completed an ACE III[1] assessment, first discussed in December 2020. This resulted in a score of 46/100, which indicated Nancy's cognitive impairment. It was unclear if the assessment resulted in any further plan of action.

March 2022 saw a call from Nancy's neighbour stating concerns that Nancy was outside, alone in the cold. Shortly after, new medication was prescribed for Nancy following a diagnosis of dementia and schizophrenia. In May 2022, problems arose due to miscommunication regarding the cessation of the package of care for Nancy, provided by the Care providers, (this is covered in more detail later in the report). Nancy was left without full time care for ten days and became severely neglected and was admitted to hospital.

[1] The ACE-III is a brief, bedside, cognitive screening test that takes approximately 15 to 20 minutes to deliver; it encompasses five major cognitive domains: attention, memory, language, visuospatial function, and verbal fluency (Hsieh 2013; Noone 2015; Velayudhan 2014)

Nancy was taken to hospital again on 20th June following further deterioration and a 999 call. A safeguarding referral was made by the Hospital Emergency Department and a section 42 safeguarding enquiry started. Over the next two weeks in hospital, Nancy was referred to Occupational Therapy and Physiotherapy, discharge plans were starting to be made. Things would take a turn for the worse when, in July 2022, Nancy suffered a fall on the ward and sadly died.

The considerations of Nancy's mental capacity

Despite concerns about Nancy's declining mental health, delays in responses and cognitive impairment, there is no record or mention of the need for a formal mental capacity assessment between September 2019 and early July 2022. There are numerous mentions in recordings of Nancy 'having capacity' or 'lacking capacity'. It appears that there were occasions when assumptions were made around Nancy's mental capacity, or lack thereof. These assumptions should not have replaced a formal assessment.

The main learning points from this key line of enquiry

- There is evidence that assumptions were made about Nancy's capacity. These assumptions should not have replaced a formal assessment.
- There was a delay in completing the ACE 111 assessment, identifying cognitive impairment, and no evidence of an outcome focussed plan, risk assessment and safety planning, following the assessment.
- Where there are several agencies involved in delivering care to a person in the community there should be a co-ordinated care plan, with an identified lead professional.

4.2 Did the care providers adequately meet Nancy's needs and respond to any safeguarding concerns?

Nancy was receiving care from the Older Adults Community Mental Health Team (OACMHT) and had a designated care coordinator who conducted regular visits. Also, a care package provided by the Care provider company who helped prepare meals twice a day, personal care, and medication administration (not injections). This increased to three visits a day in response to Nancy's discharge from hospital in January 2021.

There was some confusion in January 2020, when Nancy could not locate her keys or the key safe code, leading to some safety concerns from the OACMHT care coordinator. A falls referral was initiated by the OACMHT care coordinator in September 2020, following two falls that had occurred in the previous two months. This practice aligned with established protocols. Nancy's sister expressed further concerns in March 2021 about her potentially not taking her medication and concealing it. A co-ordinated plan was needed with the carers at this point.

In March 2022, a neighbour raised concerns that Nancy had been 'outside and undressed' for several hours. This may have been a missed opportunity to make a further safeguarding referral or adjust Nancy's care to better suit her declining needs.

The cessation of the care package from May 2022.

The Care providers experienced difficulties due to a shortage of staffing in some geographical areas in May 2022. On 17th May 2022, the registered manager sent a notification, requesting the re-commissioning of seven care packages, including Nancy.

Care providers recorded that written communication was not always consistent, and they usually made requests or updated information verbally. Home Care Bookings had no record of the request being made.

Nancy's sister was unaware the care package was about to cease and left a note on Nancy's fridge, for carers, on the 6th June 2022 stating that she would be on holiday for 2 weeks from the following day. The Care provider care workers visited Nancy on the 8th June 2022 and recorded as being no concerns.

The Care providers stated that Home Care Bookings advised them that all the care packages in the local area had been re-commissioned, and cancelled future care calls for Nancy. This left her without care from 8th June 2022 until 18th June 2022, so not supported with meal preparation, personal care, or medication.

On 14th June the OACMHT care co-ordinator visited Nancy at home to administer an injection and didn't check the carers record, therefore not realising carers were not attending. Nancy's son also didn't realise that carers were not attending when he visited.

When Nancy's sister returned home on 17th June, Nancy was found to be in a neglected state and in poor physical condition. A call was made to the out of hours OACMHT team and ambulance service. A safeguarding referral was made by the OACMHT out of hours team on 18th June Nancy was admitted to hospital on 24th June 2022 and sadly died 4 weeks later.

The learning points from this key line of enquiry

- An updated and robust Local Authority protocol for external Care providers, outlining a clear process for the cessation of, or amendments to, care packages.
- Missed opportunities for the Care Co-Ordinator and Nancy's son to review the carer attendance records, realise they were not attending and raise the alarm.
- Multi-Agency Regular reviews of care need to routinely be undertaken – to ensure that new and emerging risks are risk assessed and reflected in the care plan.

4.3 Were Nancy's family kept informed of escalating risks and involved in decision making at key stages?

There was good evidence of interagency conversations involving Nancy's family as concerns started to intensify from September 2019. There was evidence of the family's active participation in decision-making during a critical point in November 2019 after Nancy's hospitalisation, during which the family expressed concerns about the continuity of care upon her return home.

The family actively participated in various discussions with the Police following a burglary and intrusion at Nancy's property. This situation led to a safeguarding referral by the Police, The GP practice regularly worked together with Nancy's family during crucial moments, especially when adjustments to medication were required.

When the Care providers, initially conveyed in May 2022 that they would no longer be able to continue providing care for Nancy, as well as for others, it is unclear how or whether this information was communicated to the family. There is no supporting evidence to confirm any communication with the family, at this stage, either from Care providers or the Local Authority, which was a concern.

The need for a carers assessment.

An area for consideration in this report is the question of potentially a missed opportunity for a carers assessment for Nancy's sister and son. The rationale for this line of enquiry would be the lack of care Nancy received when her sister went on holiday, albeit due to the confusion and subsequent lack of care from Care providers. A carers assessment would have given an informed view of how the family could be best supported, in the event of a crisis, which ultimately, this was.

The main learning points from this key line of enquiry.

- There needs to be a process for communication with the family when a care package is at risk of being re-allocated to another provider.
- A missed opportunity to conduct a carers assessment for Nancy's family, to ensure they would be able to continue with appropriate care in the event of a crisis.

5. The recommendations to effect change following this review.

There were ten recommendations following this review.

1. When changes are required to a home care package, a checklist/dialogue with the relevant care management team, across all agencies to ensure the care manager, relevant professionals and where appropriate, family members, are notified.

2. BSAB to convene a working group, within 6 months of the publication of this report to consider the development of a universal care log which would be signed by agencies following a home visit.

3. BSAB to lead on a targeted audit of the updated process for agencies involved in the commissioning of domiciliary care when care packages are to cease, or changes are required. This will happen within 6 months of this report publication.

4. As part of our Care Act duties, practitioners need to ensure Carers assessments are considered as part of standard operating procedure. This will build on and embed strengths and assets-based working. Adult Social Care to ensure their case recording systems record the active consideration of carers assessments so that this can be routinely monitored via case file audits.

5. When a Care provider, family member or social worker/ community assessment officer/ CPN provides concerns that the current support package is not meeting an individual's needs, a request would be made to the Social Worker (or allocated worker) to undertake an urgent review. This will take place within 28 days and form a re-assessment of the individual's needs.

6. The BSAB needs assurance that Care Act Assessments and Carers Assessments are undertaken in a timely manner resulting in an outcome focussed care plan, reviewed at least every 12 months, which responds to changing needs. The plan will be shared by all professionals and the family, in line with current protocols.

7. There needs to be consideration of Decisional or Executive capacity – as part safety planning and assessments to enable risks to be effectively managed. There needs to

be clear evidence of the person's voice, wishes and feelings in line with Care Act duties - Making Safeguarding Personal

8. The BSAB need to ensure a multi-agency training programme on discriminatory abuse is available across the safeguarding adult workforce.

9. BSAB partners will ensure that the learning from this review is shared with practitioners and the learning is embedded in front line practice.

10. The BSAB will ensure that the above recommendations are implemented within 6 months of the publication of this report and progress is formally reported back to the BSAB and its subgroups for scrutiny purposes.

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