Hillingdon SCP safeguarding children partnership

Hillingdon Safeguarding Partnership

Hillingdon safeguarding adults board

Rachel

Safeguarding Adults Review

March 2025

Contents

Introduction

The purpose of this mandatory Safeguarding Adults Review is to identify systemwide learning in respect of Rachel, following her death from Sepsis, secondary to Osteomyelitis[1], which was in turn secondary to an unstageable[2] sacral pressure ulcer.

Rachel passed away at 85 years old. At the time of her death, she was in Hillingdon Hospital, but prior to this she had been at home from 7th December until 17th February 2023. Concerns about neglect, by a range of health and social care organisations and providers, during this period at home, have informed the decision to undertake this SAR pursuant to section 44 of the Care Act 2014. The criteria for a mandatory review were determined to be met in Rachel's case by the Safeguarding Adult Review Panel on 5th December 2023.

Reviewers

The Safeguarding Partnership Team led the review in consultation and quality assurance from suitably independent representatives from the key statutory partners: London Borough of Hillingdon, Metropolitan Police Service, and the North West London Integrated Care Board, and a panel of clinical experts in Tissue Viability Nursing who were independent of the care and treatment Rachel received.

Statement of Good Practice

The approach taken within this review has been proportionate to the issues arising. It has been led by individuals who are independent of the practice and decisions made for Rachel both before and after her death. Relevant professionals have been able to contribute their perspectives without fear of blame; and family members have acted as representatives, consistent with section 68 Care Act 2014 and have

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[1] Osteomyelitis is a painful bone infection. It usually goes away if treated early with antibiotics. It can cause serious long-term problems if it's not treated Osteomyelitis - NHS

[2] Unstageable Pressure ulcer: Full thickness tissue loss in which the base of the ulcer is covered by slough and/or eschar in the wound bed. https://www.nationalwoundcarestrategy.net/wp-content/uploads/2021/07/Pressure-ulcer-categorisation-poster.pdf

contributed to the review. The review has been undertaken in line with the SAR Quality Markers as developed by the Social Care Institute of Excellence.

Criminal and Other Legal Proceedings

There are no ongoing criminal or coronial proceedings relating to Rachel.

Methodology

- Desktop review of existing information from internal investigations: CNWL's Serious Incident Investigation report, a Safeguarding Enquiry report pursuant to s.42 Care Act 2014, the Coroner's Record of Inquest, and a review of the social work input that fell outside of the s.42 enquiry.
- Interviews with family members
- Expert input in respect of tissue viability
- Reflective discussion with representative from Adult Social Care

The agencies whose information has been taken into account in the review are:

- London Borough of Hillingdon, Adult Social Care
- The Hillingdon Hospitals NHS Foundation Trust
- Mountwood Surgery GP surgery
- Central and North West London NHS Foundation Trust
- Clayponds Rehabilitation Hospital, West London NHS Trust
- North West London Integrated Care Board
- Comfort Care Services Ltd
- West London Coroner's Court

Rachel

Rachel's family have kindly supplied information about Rachel's life and character.

Rachel started life in Ilfracombe, Devon. The ninth child in a family of 10, the family lived a good life. This was a family that knew how important it is to help each other and support each other.

Rachel left school and joined college to train as a teacher in cookery. Unfortunately, Rachel did not want to leave home on her own to complete the course so, although she never lost her cooking skill, she took up clerical work instead. She worked in Woolworths in Devon, and then she worked in a film company in

Perivale when she came to London following three of her sisters. Rachel enjoyed her working life and continued until it was time for her to retire. She was a very good cook and continued to enjoy catering for friends and family.

The sisters all remained close and looked out for each other. Rachel was a strong and respected presence within her family and remained a very independent person.

Never having children of her own, Rachel was a caring godparent and tremendous loving aunt and great aunt to many of the family's children. Rachel was always up for a laugh, for fun and games, and she relished telling stories. Rachel moved to a home in Ruislip where she lived in for 40 years. With natural green fingers, Rachel would plant and tend to the flowers and shrubs in the communal gardens, and even when a caretaker was appointed to take over this responsibility Rachel continued to help out. Rachel was a popular member of the local community.

Rachel liked to help others and for several years she volunteered at a local charity shop, sorting out donations and working behind the till, engaging in the banter with other volunteers as well as the customers.

Her spirit for fun, and her generosity and devotion to her family will be much missed but will act as an inspiration of how to share love, support each other and her example of how to catch a ball in a hat, balanced on your head will never be forgotten!

The family submitted a statement to the coroner, an excerpt of which they have agreed can be reproduced here to summarise their views about the support Rachel had received and the impact that it has had on the family:

> *The outcome from Hillingdon Social Services Safeguarding Meeting concludes that "There was system failure from all professionals involved from the start of [Rachel's] discharge from Clayponds rehabilitation hospital". However, we the family already knew this, we lived it alongside Rachel. We all felt the same sense of hopelessness, anxiety, anger and uselessness in trying to obtain best outcomes for Rachel. Liaising with health professionals and care workers/managers, most of the time, resulted in apathy; even in times of desperation when Rachel was begging to die, no health professional would visit. What more does one have to say or do to obtain a service from the GP, district nurse, etc in a situation such as this?*

We are a small, but close family; together we have been diligent in caring, aiding and advocating for Rachel. We have been left traumatised by witnessing Rachel's desperation, agony and utter despair. We all know that we are going to die, it's not the act of dying, but the journey of how we get there that is the most terrifying aspect of death, especially if all the services put in place to protect and safeguard us…fail.

We have watched Rachel suffer unnecessarily, terrified as her cognitive abilities and capacity to make informed decisions evaded her. The family all knew that Rachel's capacity to make decisions to protect her best outcomes was eroding and the best option was for Rachel to move to a residential nursing home, yet trying to obtain an assessment of Rachel's mental capacity proved fruitless.

No single person is culpable, yet every single agency assigned to Rachel is. As a family. We hear lessons have been learned so this won't happen again and how sorry agencies are. We hope this is true.

Protected Characteristics

Rachel was 85 years of age at her death. She was a white British female. She was heterosexual.

Summary of Concern

Rachel was discharged from the Clayponds Rehabilitation Hospital on 7th December 2022 following a period of inpatient rehabilitation, which followed an admission to Northwick Park Hospital from 6th October 2022 – 16th November 2022. She was discharged on the 'Discharge to Assess' pathway to the CNWL Community Health Service Rapid Response Team and Adult Social Care, and a care package from Comfort Care Services Ltd was arranged by Adult Social Care, based on information provided by Clayponds Rehabilitation Hospital. She was provided with the following equipment on discharge by Clayponds: a key safe, static commode, raised toilet seat, and a bed-lever. Her care package was initially a single carer to visit 4 times per day to help with personal care, toileting and meal preparation. Comfort Care informed Adult Social Care, on 9th December 2022, that one carer was not sufficient and that two carers was required because of severely limited mobility, and this was arranged on the day.

From 7th December 2022 until 17th February 2023 Rachel remained at home, receiving care from Comfort Care Services Ltd, arranged by Adult Social Care, and clinical input from a range of CNWL community health services.

Throughout this period, Rachel's skin integrity, mobility, mental wellbeing, and physical comfort deteriorated, from what appears to have been an already low baseline on discharge from hospital. Clinicians have described her as experiencing pain affecting her quality of life and her ability to mobilise, as soon as she returned home. Her pain made it hard for her to engage with some of the care provided and made it hard for her to manage to position herself in line with advice from community nurses to protect her skin integrity. Rachel's cognitive impairment made it difficult for her to act on advice given to her about repositioning to protect her skin and increasing her fluid intake. It may also have affected her ability to feed herself.

Throughout the period of care at home, Rachel's family raised concerns multiple times, with all involved agencies, about the sufficiency of care, and expressed a view that Rachel needed to receive 24-hour care.

Rachel's complaints of pain and distress, and her family's attempts to convey these to professionals, appear not to have been given adequate weight or attention by any organisation making decisions about her care arrangements nor her medical treatment.

As a result of deterioration in a sacral pressure ulcer, Rachel was admitted to hospital on 18th Feb 2023. She died on 28th February 2023.

Evidence presented to SAR Panel indicated that Rachel was neglected and that partners could have worked together more effectively to safeguarding her from neglect; this applies to all the organisations who were in contact with Rachel from and including hospital discharge from Clayponds Rehabilitation Hospital up until her re-admission to hospital on 18th February 2023.

Existing Information from Other Investigations

Some learning about the way that partners worked to safeguard Rachel has already been identified within the coroner's inquest, the CNWL Root Cause Analysis and the Safeguarding Enquiry led by Adult Social Care. Unfortunately, Clayponds Rehabilitation Hospital appear not to have been consulted for, nor notified of, the safeguarding enquiry, nor the root cause analysis, so were unaware of the concerns identified in both about the discharge process until this Safeguarding Adults Review was commenced.

They undertook an internal review of their records and provided feedback to the SAR reviewers once they were notified of the concerns.

Coroner's Inquest

The West London Coroner's Court concluded that Rachel died from Sepsis, secondary to Osteomyelitis, which was in turn secondary to a sacral pressure ulcer. The coroner also identified that dementia and frailty of old age were contributory factors. The coroner also commented that when Rachel was discharged home from Clayponds Rehabilitation Hospital in December 2022 she was provided with an inadequate package of care and insufficient equipment to allow for her to be safely cared for. The coroner's view was that a hospital appointment for which unsuitable transport provision was made was a pivotal turning point in the deterioration of her skin integrity, and thereafter only 24-hour care could have provided any chance of recovery.

CNWL Root Cause Analysis

A Root Cause Analysis undertaken by CNWL, concluded on 27th November 2023, identified a range of issues with the clinical care Rachel received. The analysis identified missed opportunities to:

- appropriately report and record skin damage and swab the wound for infection,
- correctly share care contracts with the care agency so that those providing care day to day knew what needed to be done to care for Rachel's skin,
- escalate health concerns to the GP, and
- recognise and respond to grounds to doubt and assess Rachel's mental capacity.

The key findings can be found in appendix 1.

This incident has prompted CNWL trust-wide training with recommendations to improve clinical practice and rectify concerns identified from the gaps in care received by Rachel. Bespoke training has been provided by Tissue Viability Nurse specialists to all the teams involved in Rachel's care to improve patient and family experience and outcomes. There has also been a concerted effort by the CNWL Adult Safeguarding and Mental Capacity Specialist for the Goodall Division to increase knowledge and skills in the application of the Mental Capacity Act 2005.

Safeguarding Enquiry Pursuant to s.42 Care Act 2014

The Adult Safeguarding Enquiry, undertaken between 16th March - 6th June 2023, concluded:

> *The safeguarding concern is substantiated for neglect and acts of omission. The safeguarding concern relates to all those involved in supporting Ms Smith with her care and support needs in the community including the GP, Comfort Care agency, adult social services, Claypondsrehab hospital and the district nursing service. There was a system failure from all professionals involved from the start of her discharge from Claypondsrehab hospital.*

More detail of the concerns identified by the safeguarding enquiry can be found in the appendix 2.

Adult Social Care also reviewed the social work input undertaken at and soon after Rachel's discharge from hospital and shared findings with the reviewer. The findings have been considered through the SAR process.

Claypondsrehabilition Hospital, West London NHS Trust

An internal review was undertaken over a year after the period of concern because Claypondsmanagement and the adult safeguarding lead were unaware of the concerns until the SAR began.

They identified learning related to the accuracy of documentation shared with other agencies at the point of discharge, and some issues in relation to the clinical response to Rachel's difficulties following repositioning advice and guidance.

The trust has introduced a new Waterlow Care Planning Matrix since the period of concern, intended to enhance clarity and consistency of identifying, recording and responding to pressure ulcers, or the risk of them developing, for any given patient.

Areas of Concern in Practice

Through the review process a range of examples of good practice have been identified across all involved agencies. Caring and responsive work was undertaken by a number of community- and hospital-based clinicians, social workers and care providers who encountered Rachel and her family. However, the review has identified five main areas where there are opportunities for practice improvement:

- Skin Integrity Preservation and Management of Skin Integrity Risks

- Provision of Hospital Transport
- Application of the Mental Capacity Act 2005
- Quality of Care Act Assessment
- Application of Section 42 Care Act 2014

Skin Integrity Preservation and Management of Skin Integrity Risks

Rachel was suffering from Moisture Associated Skin Damage (MASD)[3] prior to discharge from Clayponds Rehabilitation Hospital. The MASD was improving by the time of discharge but was still present; it deteriorated during her period of home care until it became an unstageable[4] pressure ulcer and became infected.

MASD results from prolonged exposure to fluids, including urine and/or faeces. It can cause pain and makes the skin much more vulnerable to pressure ulcers and infection. Damage to very high-risk skin, such as Rachel's, can happen rapidly where sustained pressure from lying or sitting down and/or corrosive fluids, such as urine or faeces, are present against the skin. The risk is also heightened where someone may be under-nourished or insufficiently hydrated, and where they have very limited mobility. Multiple high-risk factors were present for Rachel when she was discharged home. On the date of discharge Rachel's skin was at very high risk of breakdown, as evidenced by a Waterlow score[5] of 23 documented on Clayponds' records. Preventative management of the risk of pressure damage and MASD was therefore indicated.

In hospital, the MASD was treated through regular use of a barrier cream. Risks to Rachel's skin were well managed through regular support to access the toilet, day and night, regular repositioning to reduce pressure on bony prominences, and nutritional support through a fortified diet. However, these risk management strategies were discontinued on discharge. Discharge information provided to community health services and adult social care stated Rachel's skin was intact, gave no Waterlow score or other skin

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[3] MASD can occur due to the presence of any type of moisture on the skin, including incontinence, leakage from stoma, saliva, wound exudate and sweat https://www.nationalwoundcarestrategy.net/wp-content/uploads/2021/07/Pressure-ulcer-categorisation-poster.pdf

[4] Unstageable Pressure ulcer: Full thickness tissue loss in which the base of the ulcer is covered by slough and/or eschar in the wound bed, therefore extent of damage is not visible. https://www.nationalwoundcarestrategy.net/wp-content/uploads/2021/07/Pressure-ulcer-categorisation-poster.pdf

[5] Pressure ulcer risk assessment tool that identifies a person's level of risk of developing pressure ulcers.

integrity risk assessment information, and stated incorrectly Rachel did not require any interventions to maintain skin integrity.

No preventative pressure relieving equipment was provided by Clayponds at the point of discharge. The foreseeable risks from sustained pressure to her skin from remaining in an ordinary bed or chair, throughout the night and between care calls, and without professional support to reposition, were not shared, nor acted upon, at the point of discharge.

No continence products were provided on discharge by Clayponds to manage risk to her skin from functional incontinence[6], which could have been reasonably anticipated. The inability to transfer independently meant she couldn't access the toilet or commode all night nor in between care calls during the day. Clayponds have informed the reviewers that on discharge Rachel was expected to only pass urine or open bowels during care calls, which were only 4 times per day and none at night. This was unrealistic.

Her family did their utmost to support Rachel to the toilet between care calls when they were present, though as she lived alone she was alone at night. Recognising the need for continence management as soon as she returned home, her family were only able to purchase non-specialist incontinence pads for her from 7th December 2022 until 11th January 2023 because more absorbent pads were not being provided by health services. As of 11th January 2023, appropriately absorbent incontinence pads were provided by community health services following the bladder and bowel nursing assessment on 4th January 2023.

Comfort Care identified that Rachel was incontinent and requested a continence assessment on 9th December 2022. A district nurse documented double incontinence on 14th December 2022. Because of a waiting list, a bladder and bowel assessment was carried out on 4th January 2023.

There is no indication that any organisation involved in her care or treatment took account of potential nutritional or fluid intake difficulties, and the associated risks to her skin, after her discharge from hospital. Rachel's need for a fortified diet was included in the discharge information shared with community health and Adult Social Care. Unfortunately, this was not reflected in the social care assessment of need and wasn't therefore communicated to the care agency who were preparing her meals. There was no follow up with a community dietitian. Her family have raised concern with the reviewers that she was not eating well and required more support and prompting to eat following her return home; they describe

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[6] Functional incontinence relates to that which arises when a person cannot access the toilet, rather than because of any other clinical reason.

repeatedly finding uneaten food beside her long after a carer had left. The continence nurse noted, on 4th January 2023, that she needed to increase her fluid intake.

Community health clinicians became aware of the skin damage on 9th December 2022, two days post discharge, where a grade 3 pressure ulcer[7] was suspected. This transpired to be MASD, deteriorated since being in hospital. It required dressing at this point.

There was a period of two nights, from 7th – 9th December, where Rachel slept on an unsuitable mattress, with no pressure relieving equipment, incontinence of urine, and without barrier cream or other strategies to protect her skin; this had had a predictable detrimental effect on her skin.

The need for some form of pressure relief was identified on 9th December and a mattress overlay was ordered but it did not arrive until 13th December, at which point it was identified as a falls risk and immediately removed. On 11th December the need for a hospital bed was identified but there was insufficient space in the property, and the family were asked to move furniture to allow for one. In the meantime, she was still without pressure relief whilst in bed for long stretches. By 13th December Comfort Care contacted community health services to raise concern about the damage to her sacral skin, describing it as "*a bad pressure sore on bottom*", repeatedly saying it was "*really bad*'. On 14th December 2022 Rachel was documented as agreeing to a hospital bed being ordered but this was not ordered until 16th December. The mattress ordered was a static mattress intended for people at high risk of developing pressure ulcers and those with ulcers up to category 2[8].

Unfortunately, from 28th December 2022 until 19th January 2023 there was no community nursing input for Rachel's sacral skin because of an administrative error that resulted in the withdrawal of Rachel's name from the district nursing caseload. This may have contributed to the deterioration of her skin during that time.

The family repeatedly raised concerns about her skin integrity, describing it as "broken and bleeding" (28th January 2023) and "black and blue" (10th February 2023). The care agency reported to the district nursing

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[7] Category 3: Full thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. https://www.nationalwoundcarestrategy.net/wp-content/uploads/2021/07/Pressure-ulcer-categorisation-poster.pdf

[8] Category 2. Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. https://www.nationalwoundcarestrategy.net/wp-content/uploads/2021/07/Pressure-ulcer-categorisation-poster.pdf

service that Rachel's sacral skin was "bleeding and very sore" (1st February 2023). Rachel sometimes cried in pain when using the Sara Stedy hoist[9] as the supportive seat rubbed her sacral skin.

On 10th February 2023 the district nursing service identified that the MASD had deteriorated to an unstageable pressure ulcer. The nurse recommended at that visit that Rachel should be repositioned in bed every 2-3 hours to offload pressure to her sacral area; this was discussed with Rachel again on 11th, 14th, and 15th February 2024. That she was not adhering to repositioning advice was also clearly documented by a nurse on 10th February 2023. Her care package was only 4 times a day, she lived alone and was demonstrably unable to reposition alone as she was not doing so, so this was not achievable without increasing her care package to include 2-3 hourly visits day and night or placing her in a 24 hour care setting. However, the need for someone to ensure 2-3 hourly repositioning was not communicated to Adult Social Care by a community health clinician nor Comfort Care until after she was readmitted to hospital.

On the 10th February 2023 a decision was made that she required an air mattress rather than the static mattress she already had; this had still not arrived a week later when she was admitted to hospital. Opportunities to identify the infection in the wound prior to hospital admission and commence treatment at an earlier stage were missed as the wound was not swabbed, nor was the possibility of infection escalated to the GP. This was despite the high risk of infection in such a wound, when combined with double incontinence and a reported issue of soiled/removed dressings, and malodour from the wound.

The CNWL Root Cause Analysis asserts family removing dressings to have been a complicating factor in her care. The family firmly deny they ever removed dressings applied to her sacral wound. It is unclear what the assertion in the Root Cause Analysis was founded upon.

Provision of Hospital Transport

On 25th January 2023 Rachel had an outpatient's hospital appointment at the Eye Clinic at Hillingdon Hospital. The GP surgery booked hospital transport and stipulated a carry chair was needed for the transfer from her flat and she would need to be moved onto a hospital wheelchair once at the hospital. No instructions or concerns about pressure care were communicated.

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[9] Standing and transfer aid designed to assist caregivers with transferring patients with varying degrees of ability.

Rachel was picked up from home at 12:15. She was transferred to a seat in the transport vehicle. Once at the hospital she was moved onto a hospital wheelchair where she remained until she was picked up again by hospital transport at 16:04. She arrived home at 17:30. This means she was sitting up in a chair for 5 hours and 15 minutes with no pressure relieving cushion or other equipment. Throughout this long stretch of time, and in the immediate aftermath, there was no incontinence care provided, so Rachel's skin would likely have been further exposed to corrosive fluids.

Subsequently on 9th February 2023 Rachel had an outpatient appointment scheduled at Mount Vernon Hospital Vascular Clinic. The GP surgery had made a booking for transport as before, with a request for a carry chair and transfer to a wheelchair, with no information about skin integrity management. Two transport officers arrived with the carry chair but determined on arrival that Rachel was bed bound and not safe to transport in a carry chair or wheelchair. The transport officers aborted the conveyance to hospital. The appointment was therefore not attended.

The GP surgery had access to information about skin integrity concerns. The GP was contacted by the family on 19th January 2023 raising concern about unmanaged skin integrity concerns and discomfort from sitting.

If hospital transport arrangements take account of skin integrity and other health issues, they can avoid causing avoidable pain and deterioration in skin integrity and overall physical safety and wellbeing.

Application of the Mental Capacity Act 2005

The family have expressed to the SAR that they believed Rachel lacked mental capacity to make decisions about her care arrangements before she was discharged from Clayponds Rehabilitation Hospital and they expressed this to multiple professionals during the period of concern. They firmly hold the view that Rachel did not regain capacity to make decisions related to her care arrangements at any time during or after her time at Clayponds.

There is significant evidence that it was appropriate to assess Rachel's mental capacity during this time. Clayponds' records show that when Rachel was admitted she was assessed using the Six Item Cognitive Impairment Test (6CIT)[10], which was good practice. She scored within a normal range. However, she was repeatedly described as "*confused*" throughout the admission and, on 23rd November 2022, reportedly "*recalling events that have not actually happened*". She was routinely documented as having difficulties

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[10] 6CIT.pdf (mindwell-leeds.org.uk)

remembering advice on hand positioning for transfers during her admission. She was also referred to "*not complying with repositioning*" to reduce risk to her skin integrity. However, there is no evidence of any reassessment of her cognitive function, such as a repeat of the 6CIT, during the admission. The family say that they raised concern about her cognitive function with the hospital and were told that she may be in the early stages of dementia.

Rachel's persistent confusion was not reflected in the discharge notification which was sent to CNWL and to Adult Social Care, nor the discharge summary to the GP. Instead, the report said *"assumed cognition intact".* This informed the social care planning at the point of discharge and also the dependence on her self-report by community health services.

During the first care call from Comfort Care Services on 7th December 2022 she was described by the care worker as *"very confused".* On 14th December 2022 a District Nurse documented that they discontinued a dementia screen because Rachel *"kept repeating the same questions".* On 15th January a physiotherapist contacted the GP requesting a memory clinic referral, indicating concerns about Rachel's cognitive function. On 18th January 2023 a visiting physiotherapist documented that Rachel was "*talking about irrelevant things and unable to follow instructions at times"*.

CNWL community health professionals did not undertake an assessment of her mental capacity, in relation to any aspects of her treatment, throughout the period at home. Family reported to the SAR that health professionals seemed wary of challenging Rachel or questioning her capacity as they seemed worried about getting it wrong and breaching her rights.

Soon after discharge, on 20th December 2022 a social worker correctly identified that there were grounds to doubt Rachel's mental capacity and she undertook an assessment of capacity adherent to the functional test set out section 3 Mental Capacity Act 2005. This was good practice.

The assessment concluded that Rachel lacked mental capacity to make decisions about her care arrangements and provided evidence to support this conclusion. This was good practice.

The care and support needs assessment document posted to Rachel's home on 23rd December 2022 made this brief mention of the assessment of capacity:

> *MCA carried out on the 20.12.2022. Despite Ms Smith showing some insight into her care needs. She presents with confusion. She lacked capacity regarding her care needs/care arrangements.*

Unfortunately, Rachel’s family have no recollection of being informed of the outcome of the mental capacity assessment and expressed surprise and frustration when told about this during the SAR. The information clearly was conveyed in the assessment report sent to her home, as shown in the excerpt above. However, it would have been helpful to ensure family fully understood this information, its implications and where it was documented, as it could have empowered the family and influenced the response of other professionals to Rachel’s deterioration.

The determination that Rachel lacked capacity to make decisions about her care arrangements was not shared with community health services nor with the GP.

Instead, Rachel’s family report they were repeatedly told by multiple other professionals throughout the period of care at home that there was no reason to doubt Rachel’s mental capacity and therefore she was entitled to make her own choices about her care, despite the risks she was facing. Rachel’s family were reportedly told, incorrectly, by multiple professionals that without a diagnosis of dementia it was not possible to assess her mental capacity.

Some professionals appear not to have understood that if family members are raising concern about someone’s mental capacity, this is grounds to doubt capacity; as is behaviour or circumstances that indicate the person might have difficulty making decisions, such as repeatedly appearing confused or making choices which place them at risk. This is clearly set out in the Mental Capacity Act 2005 Code of Practice, paragraph 4.35.

Instead, the family report that they were repeatedly warned by professionals that if they overrode Rachel’s wishes and moved her to a care home, they would be considered to be posing a safeguarding risk to Rachel because they would be breaching her rights.

Despite seemingly agreeing that Rachel required placement in a care home, documented on 23rd January 2022, a clinician from the Community Rehabilitation Team assumed her capacity, despite reason to doubt it:

> *Family feel the best place for Rachel is a care home but Rachel does not agree…Family understand and feel that if Rachel agrees, the safest place for Rachel will be a care home*

On the same day, the GP documented *“significant cognitive impairment*”.

It was noted on 10th February 2023 that Rachel was described as “*non-compliant*” with advice on turning and changing position, every 2-3 hours, to relieve pressure on bony prominences. This ought to have prompted doubt of mental capacity and further exploration of her reasoning and understanding; it did not. Instead, the language of ‘*non-compliance*’ appears to imply that Rachel was *choosing* not to follow instructions, when in fact she was unlikely to have been able to do so.

If the clinicians had known about the determination by the social worker in December 2022 that Rachel lacked mental capacity to make decisions about care arrangements, perhaps the response to her clinical deterioration would have been different.

Following the determination that Rachel lacked mental capacity to make decisions about her care arrangements, there was no clear best interests decision recorded, pursuant to s.4 Mental Capacity Act 2005, about her care arrangements. The documentation of the best interests decision making process does not evidence the views and wishes of Rachel, her family, nor the views of interested others such as involved community health clinicians nor her paid carers, nor how these views were taken into account in best interests decision making, as is required by law. The documented assessment appears to, inappropriately, defer the best interests decision making to her family:

> *As Ms Smith is a self-funder family will make private plans when they make the decision on her long term placement.*

and

> *family continues to support with welfare and financial decisions.*

Whilst the family had commenced an application for Lasting Power of Attorney (LPA) this had not concluded before she passed away.

The family have articulated to the SAR their view that, throughout her hospital admission and period of care at home, it was in Rachel’s best interests to be in a care home with 24-hour availability of care. The family’s account is supported by documentation of their concerns expressed to the social worker about the care she required between care calls, as early as 20th December, and later communication with community health professionals. The family say they were told by the social worker on 20th December that Rachel wasn’t yet in need of 24-hour care.

Given Rachel was assessed as lacking capacity at this time and there was a notable difference of opinion about what was in her best interests this should have been addressed as a dispute between involved parties and, if unresolved at a local level, may have required arbitration in the Court of Protection. However, the dispute was not addressed nor clearly documented.

Quality of Care Act Assessment and Review

There were two Care Act assessments recorded during or close to the period of concern. The first was completed on November 22nd 2022 whilst Rachel was in Clayponds Rehabilitation Hospital; the second was completed during a home visit on 20th December 2022.

The assessment completed in November was undertaken through telephone contact between a social worker and a member of clinical staff at Clayponds. The assessment documented that it was not possible to gather the views of family members though there is no record of efforts having been made to do so. It also incorrectly stated that there were no skin integrity issues.

The assessment completed following a home visit to Rachel on 20th December 2022 contains inaccurate information on which decisions were based about care provision. The documented assessed needs appear inconsistent with the facts known to Comfort Care and to community health services at the time and is inconsistent with the concerns expressed by the family to all involved.

The assessment does not reflect the known extent of the Moisture Associated Skin Damage. The effect of her functional incontinence, severely limited mobility, and lack of appropriate pressure relieving equipment on the risks to her already compromised skin integrity was not accurately reflected in the assessment nor considered in care planning or assessing risk.

The social work records state that at a home visit on 20th December 2022 the *"family shared their concern about the support they were providing in-between care calls*." Indeed, the mental capacity assessment recorded on the same date includes reference to family members providing frequent support with toileting in between care calls. Her family were also regularly picking her up after falls off her chair, and they were feeding her. However, the Care Act assessment stated Rachel would *not* be receiving support from family and friends. Also, there is no evidence the reasons for the support needed in between care calls was considered in determining what level of care Rachel needed to remain safe.

On the assessment record, there is a section to record family and carer views and this is what was documented:

> *Allocated worker explained the Checklist, LPA, Deputy, Extra Care, DST, Nursing Dementia and Residential Dementia Placement to her family. Contact for CHS provided for when family are ready to arrange private placement.*

This doesn't set out the family's views; it documents information provided *to* family. The family views at the time, according to what has been reported to the SAR, were very clear that Rachel was unsafe at home and needed 24-hour care.

There is no evidence of liaison between the social worker and the actively involved community health professionals or Comfort Care in completing the assessment, contrary to the requirements of section 9(5) of the Care Act.

No review of Rachel's needs was undertaken by Adult Social Care during the period of concern. This is despite new information being communicated to Adult Social Care. On 10th January 2023 Comfort Care Services raised these concerns to Adult Social Care:

> *"Care workers are reporting that Rachel's mobility has deteriorated, I spoke with the family and they confirmed that they have seen a decline daily. The carers are saying that she is stumbling and falling sometimes, and they just manage to stop her. Spoke to her sister June and she said she cannot live on her own she needs constant care. Family would like to have information with regards to Rachel going into a home."*

However, in response to the concerns from Comfort Care and from a local authority commissioned Occupational Therapist, there was liaison between Adult Social Care and Comfort Care on 18th January 2023 to try to bring the morning call as early as possible to reduce the duration she was spending soiled in bed. There was also an Adult Social Care decision to increase the amount of time the care agency were commissioned to provide care to Rachel in the mornings as of 25th January 2024. Given the information provided by family to Adult Social Care about her pressure sores, it may have been proportionate to contact community health services to gather more information to inform care planning. This may have enabled richer information and more thorough understanding about the risks she was facing at the time as a result of pressure on her skin and incontinence. However, it was not unreasonable to have expected community health clinicians to have proactively shared concerns if they developed a view that care provision was not managing the risk.

Application of Section 42 Care Act 2014

An adult safeguarding enquiry, pursuant to section 42 Care Act 2014 was undertaken between 16th March and 6th June 2023. The enquiry was detailed and thorough, multiagency in nature, and effectively engaged family members. This is an example of good practice. However, there were missed opportunities to ensure the learning was used to safeguard other people in future.

Clayponds Rehabilitation Hospital was included in the list of agencies implicated in the substantiated allegations of neglect, but their staff were not part of any planning or round table meetings of the safeguarding enquiry. The enquiry officer did attempt to engage the occupational therapist who wrote the discharge information but got no response. This could have been escalated to the adult safeguarding lead within the hospital and/or the relevant ICB lead for Ealing, where the hospital is located.

Social Care records state that the enquiry report, at the conclusion of the process, was shared with the Clayponds Rehabilitation Hospital ward manager on 6th June 2023. However, current Clayponds management and the adult safeguarding lead for the hospital have no record of the safeguarding enquiry, so were not aware of concerns about the discharge process identified in the safeguarding enquiry. This has delayed action being taken to remedy the identified issues. It also potentially undermined the accuracy of the enquiry itself. It is not clear what happened to the enquiry report once it had been shared on 6th June 2023 with a manager at Clayponds.

Enquiries under section 42 of the Care Act 2014 are necessarily led by Adult Social Care. The Safeguarding Adults Manager supervising the enquiry was also a manager responsible for overseeing some of the decisions about Rachel's care during the period of concern. Whilst the enquiry report clearly identifies missed opportunities by Adult Social Care to safeguard Rachel, and the SAM has demonstrated openness, honesty and critical reflection about Adult Social Care actions, there is a clear conflict of interest in the process. Such a conflict of interest could pose a risk in the application of section 42 in other such situations. It is arguably unfair and unreasonable to expect Adult Social Care staff to fully scrutinise and challenge practice by themselves, their peers and managers. The potential for conflict of interest should inform the allocation and support of SAMs and enquiry officers in safeguarding enquiries where Adult Social care involvement is of concern.

Key Thematic Learning and Recommendations

Skin Integrity Preservation and Management of Skin Integrity Risks

Department for Health and Social Care guidance on safeguarding adults from pressure ulcers[11] makes clear that joint working between all involved professionals is the key to prevention and risk management related to skin integrity:

> *While the treatment and response to pressure ulcers is predominantly a clinical one, the prevention of them - our ultimate goal - is a shared responsibility...The reality is that many people at risk of pressure ulcers are receiving services that are commissioned, arranged and provided by non-clinical staff in the social care sector...It is vital that any assessment addresses the likelihood of pressure ulcers developing and what action must be taken to prevent them... Those responsible for carrying out assessments and arranging services need to be alert to this issue and have easy access to clinical advice to support care planning.*

When someone is at high risk of skin breakdown preventative steps including pressure relieving equipment and care planning to manage risks are necessary to prevent harm. Maintaining a healthy skin integrity and reducing the risk of skin damage from pressure ulcers or moisture associated skin damage (MASD) is achieved with regular repositioning to offload pressure, well managed incontinence, good skin care, such as barrier cream, and use of appropriate pressure relieving equipment.

Irreversible pressure damage due to the application of constant, unrelieved pressure can result in cell death and tissue necrosis. This can occur within as little as 20 mins depending on skin integrity and surface. Any previous skin damage increases the risk of recurrent damage due to skin maturation and process of healing and so is important information to inform subsequent risk assessment.

If a patient has incontinence, appropriate skin care and incontinence management is recommended to reduce the risk of moisture associated skin damage. This includes the appropriate use of incontinence pads to better manage moisture contact to the skin and the use of a barrier cream for both prevention and treatment of MASD.

Even where preventative measures are not implemented by hospitals on discharge, timely and thorough communication between hospital and community health clinicians and social workers, with accurate

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[11] Safeguarding adults protocol: pressure ulcers and raising a safeguarding concern - GOV.UK

discharge summary, including previous skin damage, can prompt community teams to provide preventative measures to reduce the risk of deterioration of skin integrity with MASD and pressure damage, with quicker assessment for equipment, care planning, barrier creams and repositioning advice.

Recommendations – Skin Integrity Preservation

- Relevant partners should review hospital transport booking processes to ensure that they do not place any patients at avoidable risk.
- Care Act assessments should include explicit consideration of the risks to skin integrity and social workers should have ready access to clinical advice.
- SAB to seek assurance from CNWL that recommendations from their single agency Root Cause Analysis have been implemented.

Partnership Working and Information Sharing

Care and Support Statutory Guidance sets out how the Care Act 2014 should be applied in practice. The following excerpts emphasise the importance of ensuring assessments of need include consultation and collaboration with clinicians. These excerpts are highly relevant for working with frail elderly people who often are receiving a range of clinical and social care inputs:

> *Where an adult has a need… the local authority… must… consider whether their need(s) have… consequences on their… personal health. The local authority must also consider whether the individual's needs impact upon their wellbeing beyond the ways identified by the individual.* (paragraph 6.14)
>
> *Where more than one agency is assessing a person, they should all work closely together to prevent that person having to undergo a number of assessments at different times* (paragraph 6.77)
>
> *Where a person has both health and care and support needs, local authorities and the NHS should work together effectively to deliver a high quality, coordinated assessment* (paragraph 6.78)

Effective consultation, collaboration and accurate information sharing by all involved organisations in the completion of assessments, and care and treatment planning, better enables effective identification and management of risk. Section 7 of the Care Act 2014 requires relevant organisations to cooperate with each other in assessments and care and support planning for individuals with care and support needs;

working in isolation from each other hinders effective assessment and risk management, as it did for Rachel.

Accurate and up to date clinical information, and a shared understanding between informal carers, formal care providers and other professionals delivering care and treatment is necessary for an effective assessment and therefore safe care, support and treatment planning, including hospital transport and hospital discharge.

Discharge to Assess arrangements from hospital can only work if community-based and hospital-based clinical and social care services are in meaningful dialogue and share accurate and thorough information with each other. Failure to share accurate information between organisations delivering health and social care can result in increased risk of neglect.

In a safeguarding enquiry under section 42 Care Act 2014 relevant partners should work together, coordinated by Adult Social Care. Where concerns arise about actions or policies of a particular organisation, it is important that that organisation is included in the safeguarding enquiry and any difficulties in engaging them in the enquiry should be escalated using the Safeguarding Partnership Escalation Policy. It is important that any findings of concern about any partners are clearly and robustly communicated to that partner to enable actions to be taken to redress the concerns.

Recommendations – Care Act 2014

- Adult Social Care should provide assurance as to how care act assessments are quality assured for accuracy and thoroughness, and their consultation with carers and other interested in the welfare of the subject adult.
- Safeguarding enquiries or internal agency investigations should always ensure that agencies implicated by findings are involved in the enquiry and informed about the findings.

Lived Experience and the Voice of the Person and their Representatives

In order to offer quality services and effective safeguarding, the lived experience of the people concerned must be heard and taken into account in assessing the care and treatment they need.

Professionals should think about the day-to-day experience of people in need of support, and think about how pain, loss, frailty and disability affects them, and factor this in to any assessment.

Families need to be heard and taken seriously when they raise concerns about their loved one's safety and dignity. Their views should be clearly documented, and differences of opinion ought to be documented and collaboratively resolved. People's rights to appeal to the courts when disputes about unmanaged risks go unresolved at a local level should be explained to them.

There should be routine quality assurance of the recording of the views of adults at risk and their families throughout assessment and care and support planning and best interests decision making. Differences of opinion should be clearly highlighted and responded to in accordance with the law.

Recommendations - Lived Experience

- Adult Social Care should provide assurance as to how the views and wishes of adults and their family members and informal carers are recorded in assessments.

Legal Literacy

There was evidence that professionals providing support, care and treatment to Rachel lacked understanding of their relevant legal duties and this was not picked up through management oversight of the direct work undertaken. There is a need across the professional network to support legal literacy for those that are undertaking work that includes discharge of legal duties.

Care Act 2014

Section 18 Care Act 2014 is clear that a local authority must meet eligible care needs "where *the person lacks capacity to arrange provision for care and support, but there is no person authorised to do so under the Mental Capacity Act 2005 or otherwise in a position to do so on the adult's behalf*" regardless of financial resources. It is important that people who have sufficient financial resources to fund their own care are not discriminated against when they are in need of 24 hour care.

Section 9(5) and section 27(2) Care Act 2014 state that in carrying out, respectively, a needs assessment or a review, where the person lacks mental capacity, the local authority *must* involve any person who appears to the authority to be interested in the adult's welfare. This would include care providers, family members and involved healthcare professionals.

Since the period of concern addressed within this SAR, clear communication pathways have been established to enable social workers to consult community health clinicians more easily, both for assessments and best interests decision making, and vice versa.

Mental Capacity Act 2005

If a person lacks capacity to make specific decisions, they might make decisions they do not really understand, causing potential harm or an increase in risk. Timely and thorough assessments of capacity are an important intervention to safeguard people. Best interests decisions, made in accordance with section 4 of the Mental Capacity Act 2005, are also a safeguard to protect people who lack mental capacity from placing themselves at risk by making ill-considered and ill-informed decisions.

Assessing Capacity

The Mental Capacity Act Code of Practice clearly states the grounds for doubting capacity are:

- the person's behaviour or circumstances cause doubt as to whether they have the capacity to make a decision; or
- if somebody else says they are concerned about the person's capacity; or
- the person has previously been diagnosed with an impairment or disturbance that affects the way their mind or brain works, and it has already been shown they lack capacity to make other decisions in their life.

It is clear in the Code of Practice a diagnosis of a mental disorder is *not* a precondition to doubt nor assess capacity. Furthermore, recent caselaw[12] has clarified neither is it necessary to have a formal diagnosis of a mental disorder before determining that someone lacks mental capacity:

> *The words "impairment of, or a disturbance in" are not further defined elsewhere in the [*Mental Capacity*] Act ... there is no basis for interpreting the statutory language as requiring the words "impairment of, or disturbance in" to be tied to a specific diagnosis. Indeed, it would be undesirable to do so. To introduce such a requirement would constrain the application of the Act to an undesirable degree, having regard to the complexity of the mind and brain, to the range of factors that may act to impair their functioning…* (Justice MacDonald, [2023] EWCOP 5)

When families express doubts about mental capacity this should be taken seriously and is a ground, in and of itself, to set aside the assumption of mental capacity and explore further someone's reasoning and understanding. It is necessary at this point to ensure that the relevant information to the decision at hand

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[12] North Bristol NHS Trust v R | 39 Essex Chambers

is provided to the person and to support them as far as possible with making the decision themselves. If there is still doubt, then their capacity needs to be formally and thoroughly assessed.

When undertaking an assessment of mental capacity, there must be a determination as to whether someone has difficulties retaining, understanding, or weighing or using relevant information; and if so, whether that person has an *impairment or disturbance* in the functioning of their mind or brain which is causing the difficulties in decision making. The threshold for a formal diagnosis of a particular mental disorder is higher than for determining the presence of an '*impairment or disturbance*'.

There is great importance in sharing the outcome of any mental capacity assessment with families and professionals involved in the delivery of care and treatment to ensure that people unable to make decisions for themselves are not inappropriately left to decide important decisions for themselves.

Best Interests Decision Making

Once someone has been found to lack mental capacity about something for which a decision needs to be made, that decision must be made in a timely fashion following the best interests decision making process set out in Section 4 Mental Capacity Act. The law states the decision maker *must* take into account the views, wishes and feelings (past and present) of the adult, and the views of anyone caring for, or interested in, their welfare. This includes clinicians, paid carers and family members involved with someone, where it is practicable to consult them. Consultations should be documented clearly, as should evidence of taking them into account. If consultation has not been practicable this should be clearly documented. Documentation of best interests decisions should be quality assured against these legal requirements

Where there is a difference of opinion between interested parties about what is in someone's best interests this should be addressed through collaborative discussion and, if unresolved at a local level, may require arbitration in the Court of Protection[13]. Such differences of opinion about the level of care someone needs must be clearly documented. It is unlawful to simply acknowledge disagreement and override opposing views without resolving the dispute or seeking arbitration.

If the best interests decision making process is not adherent to the legal requirements, the decision maker may no longer be afforded the protections in section 5 Mental Capacity Act 2005 for actions carried out in relation to care or treatment.

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[13] Mental-capacity-act-code-of-practice.pdf (publishing.service.gov.uk), Paragraph 5.68

In any case where the local authority is the only body with the responsibility and authority to act on a best interests decision to arrange care, the decision maker needs to be a representative of the local authority.

Best interests decisions should be reviewed by an appropriate decision maker in response to new information such as concerns or changes reported by family or any other professionals, or changes of opinion expressed by anyone interested in the person's welfare about what is in their best interests. This would include, for example, where a family member contacts Adult Social Care to say that in their view the current care provision is no longer sufficient.

Recommendations – Mental Capacity Act 2005

- Partners to provide assurance as to how best interests decision making is quality assured.
- Mental capacity training should include when to set aside the assumption of capacity.

Appendix 1

CNWL Root Cause Analysis

A Root Cause Analysis undertaken by CNWL concluded, on 27th November 2023, identified a range of issues with the clinical care Rachel received.

Care and Service Delivery Problems

- *Incorrect categorisation of skin changes – Rapid Response Team and District Nursing teams to ensure MASDs or Pressure Ulcer damage is identified and categorised correctly. Refreshers training on MASD/Pressure Ulcer identification/categorisation needed for relevant District Nursing team and Rapid Response Team.*
- *Gaps in management of pain – failure to escalate concerns about pain and pressure damage to GP for advice and guidance.*
- *Gaps in management of skin damage – failure to escalate deterioration of MASD to unstageable to senior clinicians by agency Distict Nurse and wound swab not considered to confirm if infection present and GP referral required to assess need for antibiotics.*
- *Referral system error - the District Nurse and Bladder & Bowel electronic records are linked leading to risk of either service discharging patient from both caseload in error.*

- *Care contracts – District Nurse patient care contracts should be routinely signed and emailed to the care agency directly and a copy sent to GP. This did not occur as expected*

Contributory factors

- *Delays in medical & pressure relieving equipment provision – delay by Mediquip in delivery of air mattress from 10/02/23 up till admission on 17/02/23 to The Hillingdon Hospitals – a key period where there was deterioration in the pressure ulcer. Medequip no longer under contract for medical equipment and new provider in place.*
- *Gaps in supporting information provided by referring agency - Ealing Community Rehab Unit (Clayponds) did not refer to District Nurses for moisture lesion (MASD) as would be routinely expected Despite it being present prior to discharge. Nor was this information included on the Discharge 2 Assess referral.*

Lessons Learned

- *Assessment of skin - clinicians require ongoing training to maintain their skills and knowledge in assessment of skin and categorisation of skin changes.*
- *Pain management - clinicians should routinely seek advice and guidance from a patient's GP in the management of pain.*
- *Follow up and Management of skin damage - Datix should be completed same day when MASDs or Pressure Ulcers identified. Likewise, wound swabs should be considered to support confirmation of infection present in order to allow GP to assess need for antibiotics.*
- *Escalation of care - Handovers should use the Situation, Background, Assessment, Recommendation, Decision (SBARD) framework. This will support prioritisation of patients of concerns for allocation to senior nurses.*
- *Referral System error – for SystmOne to spilt the DN and B&B referral units so referrals across both teams are not closed in error for either team.*
- *Care contracts - DN patient care contracts should be routinely signed and emailed to the care agency directly and a copy sent to GP.*

Appendix 2

Safeguarding Enquiry Pursuant to s.42 Care Act 2014

The Adult Safeguarding Enquiry, undertaken between 16th March - 6th June 2023, concluded:

> *The safeguarding concern is substantiated for neglect and acts of omission. The safeguarding concern relates to all those involved in supporting Ms Smith with her care and support needs in the community including the GP, Comfort care agency, adult social services, Clayponds rehab hospital and the district nursing service. There was a system failure from all professionals involved from the start of her discharge from Clayponds rehab hospital.*

In addition to the concerns identified in the CNWL Root Cause Analysis the Safeguarding Enquiry identified the following concerns:

- *Comfort care have failed to keep daily records of the care calls so it is not possible to establish the level of care they were providing to Ms Smith.*
- *Despite numerous concerns being raised to social services about a deterioration in Ms Smith and the care agency reporting that they need an increase in the care package, social services did not carry out a reassessment. Social services were aware that Ms Smith lacked capacity regarding her care and support needs and reports were being made regarding Ms Smith not engaging with carers and repositioning. Requests were also made for a placement and these requests were not followed up by social services via a reassessment of care needs.*
- *Rapid response failed to report concerns to other agencies involved in the long-term care and support for Ms Smith regarding her being uncomfortable and refusing to sleep in the bed.*
- *The GP was aware that Ms Smith had a pressure sore and several concerns were reported to the GP regarding Ms Smith's pressure sore deteriorating. The GP was also aware that Ms Smith had an infection from the 25/01/2023. However, there was no follow up from the GP until the 15/02/2023 when the GP referred to rapid response. There is no evidence of the GP completing a face to face visit to assess Ms Smith during her period at home.*
- *District nursing service - There is a 20 day gap between district nursing calls between 28/12/2022 - 19/01/2023. GP records also note that family called on 19/01/2023 stating*

that the district nurses have not visited for 3/4 weeks. During this period there was no district nursing input. Family requested a district nurse visit on the 15/02/2023 due to concerns regarding soiled dressing after nurse had changed and cleaned the wound that morning. They agreed to visit the following day, however a visit did not take place by the district nurses on 16/02/2023. A nurse visited on 17/02/2023 and this is when Ms Smith was admitted to hospital.