Surrey County Council: Safeguarding Adults Board
The death of Mrs S
A Serious Case Review

Margaret Flynn

EXECUTIVE SUMMARY

Introduction

1. Mrs S died during June 2012 at East Surrey Hospital, Surrey and Sussex Healthcare NHS Trust. A patient at Shrewsbury Court Independent Hospital1 since March 2007, Mrs S was 75 when she was admitted to Intensive Care in East Surrey Hospital on 17 May 2012. Mrs S had been *clearing her plate away* when *she was spoken to by a member of staff.* She *was unable to respond and found to be choking. CPR…commenced. Paramedics managed to dislodge the food.*[2] Mrs S was subsequently found to have had achalasia.[3]

1. In terms of her mental health, Mrs S had been diagnosed with an *unspecified bipolar affective disorder* and *endogenous depression* during 2003, the year her husband died. The following year Mrs S was diagnosed with *generalised anxiety disorder* following *intentional self harm.*[4] Mrs S's behaviour was associated with an *abnormal bereavement reaction.*[5] Prior to her death, Mrs S's two daughters were exploring *suitable community placements for their mother.*[6]

2. Mrs S's family explained that Mrs S and her husband had lived in Spain for many years. Mr S was a lot older than his wife and he had been the principal decision-maker in their marriage. When Mr S became physically ill, it became clear to their daughters that he could no longer manage and that he had been providing more support to their mother than they had fully appreciated. Their mother was severely depressed. She became yet more so when her husband was diagnosed with a terminal illness. Within a two year time frame, Mrs S developed behaviour which was incomprehensible not merely to her family but also to mental health services. When her husband died, she could not manage and her mantra became, "I don't want to be lonely. I don't want to be on my own." However, being with her daughters and their families did not address Mrs S's sense of aloneness. Mrs S's daughters recall that in the 18 months she lived with their families their understanding of what was "normal" became skewed. There were occasions when she drank white spirits, she sought to harm herself using knives and she took Paracetamol tablets. Her suicide attempts involved jumping from a window, lying across a road and drinking bubble bath (the latter occurred prior to and when Mrs S was a patient at Shrewsbury Court Independent Hospital). It appeared that there was "nowhere suitable" in terms of accommodation, treatment and support for Mrs S.

3. For the duration of Mrs S's admissions to Shrewsbury Court Independent Hospital she had regular contact with her daughters.

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[1] Shrewsbury Court Independent Hospital provided a *Mental health, learning disability or substance misuse hospital service.* During 2013 it specialised in *Dementia, Diagnostic and/or screening services, Mental health conditions, Physical disabilities, Caring for adults under 65 yrs, Caring for adults over 65 yrs, Caring for people whose rights are restricted under the Mental Health Act.* It was registered to provide *Assessment or medical treatment for persons detained under the Mental Health Act 1983* and *Diagnostic and screening procedures.* In 2014, *Dementia* is not cited as a specialism and *sensory impairments, treatment of disease, disorder or injury* have been added. Shrewsbury Court Independent Hospital belonged to the Whitepost Health Care Group. The hospital's registration ended on 6 September 2012 (www.cqc.org.uk accessed on 16 April 2013 and 15 January 2014)

[2] Surrey Police IMR

[3] Achalasia is an uncommon condition. It refers to a condition whereby the gullet has lost its ability to move food along and the valve at the end of the gullet fails to open to allow food to pass into the stomach…As a result, food gets stuck in the gullet and is often brought back up…most people with achalasia have dysphagia, a condition where they find it difficult and sometimes painful to swallow food. This tends to get worse…bringing up undigested food can lead to choking and coughing fits, chest pain and heart burn http://www.nhs.uk/conditions/achalasia/Pages/Introduction.aspx (accessed 1 October 2013)

[4] GP chronology

[5] Surrey County Council IMR

[6] Surrey County Council IMR

About this SCR

4. The SCR was commissioned by Surrey's Safeguarding Adults Board and is based on information from: East Surrey Clinical Commissioning Group; Shrewsbury Court Independent Hospital; Surrey Borders and Partnership NHS Foundation Trust; Surrey and Sussex Healthcare NHS Trust; Surrey County Council; Surrey Police; and Surrey Primary Care Trust. In addition
   - Mrs S's family provided detailed information concerning Mrs S's care and treatment at Shrewsbury Court Independent Hospital i.e. clinical records, incident records, minutes from team meetings, CPA records and reports provided to the First Tier Tribunal: Mental Health
   - A DVD of the inquest proceedings of July 2013 was provided by the Coroner's Court during September 2013
   - Shrewsbury Court Independent Hospital provided documentation concerning treatment and consent matters; information concerning Mrs S's consent to a change in her medication; a review of her detention, including consent to remain in hospital as an informal patient; and capacity and consent interviews during November 2013. Shrewsbury Court Independent Hospital also provided information prior to and at a meeting during January 2014.

The Surrey Safeguarding Adults Board determined that the Terms of Reference required the seven agencies to provide a chronology and analysis of Mrs S's contact with each between January 2007 and June 2012.

The Records

5. The content of the Shrewsbury Court Independent Hospital records shared by the family is reflected in the following section. However, some caveats are merited. The nursing records spanning March 2007-June 2011 are photocopies, some of which are faint. Further, the handwriting of some staff is difficult to read. The use of electronic records began during 2011. Mrs S's family recalled their long standing concerns about Mrs S's eating and the occasions when she refused to eat; her fluctuating weight; her incontinence; factors which compromised her eating; her falls; and glimpses of perplexing behaviour – including periods of emphatic disengagement. In turn, the records highlighting such concerns have been summarised in tables, on a year by year basis[7].

Summary of Pivotal Events

6. Mrs S was detained under S.3 of the Mental Health Act 1983 during **2004**, since her family feared that she would take her life.[8] Mrs S's self harm continued and by **2006**, she became a patient once again at West Park Hospital.[9] Whilst there she made *several self harm attempts which included swallowing substances that once resulted in aspiration pneumonia.*[10] Mrs S was subject to *repeated chest infections following toxic ingestion of bubble bath liquid.*[11]

   During **2007** and prior to Mrs S's transfer to Shrewsbury Court Independent Hospital, risk assessments concerning her self-harming determined a "high" *overall risk rating.* Mrs S *transferred under S.3 (via S.19)* to this hospital.

[7] The process of scrutinising records led to questions about the adequacy Mrs S's physical health care and the reach of the GP/ Medical Officer's remit.
[8] Surrey Police: email of 23 April 2013
[9] Registered to provide *Treatment of disease, disorder or injury…Assessment or medical treatment for persons detained under the Mental Health Act 1983* (www.cqc.org.uk accessed on 16 April 2013)
[10] Shrewsbury Court Independent Hospital IMR
[11] Surrey and Borders Partnership chronology

The following six tables capture something of Mrs S's circumstances as a detained patient between 2007 and 2012.

Occasions when Mrs S refused to eat (**2007**)	x146 – including 55 days with no meals;[12] refused medication x29 days
Recorded weight during the year	8 stones; 8 stones, 2lbs; 7 stones, 5lbs; 7 stones; 8 stones; 8 stones 1lb; 7 stones 9lbs
Occasions when Mrs S was incontinent	x7
Factors which compromised Mrs S's eating/ swallowing	Attempted to swallow glasses' lens; ***tried to choke herself with a pillow****…swallowed a pen cover; producing green sputum daily;* feeling *dizzy and sick; disturbed night because of cough; painful swallowing; eating soap;* **drank a hot chocolate – choking**; *agitated and shaky;* being assaulted by a peer who punched her in the face – *swelling on side of face*
Falls and risk factors	x7 *has fallen a couple of times; dizziness; complaining of room spinning;* 6 occasions when she was *unsteady on her feet*; *Found on floor; lay on floor outside her room…could not give an account; She continues to be at risk unless supervised*[13]*; Too weak for physical exercise;* a *peer pushed her to the floor; shaking while standing*
Examples of perplexing behaviour	*pulled her hair and banged at windows; wanting to die…not eating to this end; urinating in sink; put bin liner over her head; hid in wardrobe/ laundry; refused to get dressed;* refused to take a drink as part of an A&E medical assessment; tried to tie a ligature with tights; *Came out naked in corridor;*

During 2007, Mrs S received 10 visits from the GP/ Medical Officer. These were occasioned by *inter alia,* Mrs S's poor nutritional status, cough crackles and falling. When Mrs S was admitted to A&E (having swallowed glass) she was found to be dehydrated. Thus in the months immediately following Mrs S's admission to Shrewsbury Court Independent Hospital, she was conspicuous because of (1) her refusal to eat and her compromised nutritional status (2) her perplexing behaviour (3) her chest problem.

During **2008**, the GP/ Medical Officer's records referenced 11 visits due to Mrs S's asthma, chestiness and coughing, reflux and occasional faecal incontinence. Ultimately Mrs S was diagnosed with bronchiectasis,[14] mild asthma and gastro-oesophageal reflux.[15] Mrs S's Care Plan, which was drafted during 2007, associated her refusal to eat with her *presenting mental health difficulties.* Mrs S Did Not Attend a follow-up appointment with the chest physician. Correspondence to the GP/

[12] Mrs S's records contain statements concerning her food and fluid intake, including the occasions when she refused meals for whole days and when she declined to drink and take her medication

[13] Report prepared for Manager's Hearing 23 October 2007 by *Continuing Care Nurse Specialist, Surrey Primary Care Trust"*

[14] A long term condition where the airways of the lungs become widened leading to a build up of mucus that can make the lungs more vulnerable to infection.

[15] The symptoms of which include pain and difficulty swallowing

Medical Officer included *a copy of* Mrs S's *CT chest scan…and* an offer *to participate in her care as and when required.*

Occasions when Mrs S refused to eat (during **2008**)	x116 –including 51 days with no food; refused medication x42 days - *Has been missing medication on the mornings that she stays in bed had to switch to tea time dose…to stop her missing so much*
Recorded weight	A weight loss of 4 stone was noted during 2008
Occasions when Mrs S was incontinent of faeces	x21 *wanted to wear a continence pad;*
Factors which compromised Mrs S's eating/ swallowing	*Bronchiectasis; Complaining of not feeling well; abdominal pain; producing green sputum; shaking all the time, not eating a lot;* Mrs S was told that if she continued to refuse fluids she would be taken to hospital for rehydration; *went to dentist – broken tooth; Still experiencing hyper salivation; breathing difficulty, chest pain; very vulnerable to stress; asking to stay in bed; daughter reported that her cough seems worse; hit by peer – swelling on side of face; vomited partially digested food*
Falls and risk factors	x2 *Unsteady on feet…fell on floor; unsteady gait*
Examples of perplexing behaviour	*During board games she threw items at the wall;* refused to get up…*staff physically got her out of bed*; Urinating in sink; threw seats upside down; found hiding in the wardrobe of another patient/ in her own room; *put plastic bag over her head; Lying in bed pretending to be asleep…is becoming a daily occurrence*; wanted to use the men's bathroom; *evidence of self harm*

Mrs S was assaulted by another patient during 2008. The assault was similar to that which she sustained during 2007 i.e. a punch to her face.

During **2009**, Mrs S did not see the GP/ Medical Officer as frequently as her health status would appear to necessitate i.e. on three occasions. Her eating problems persisted. The GP/ Medical Officer's notes question whether there was an *organic course for confusion…*However, the period during which Mrs S was confused is not specified in the Shrewsbury Court Independent Hospital notes. In their clinical records it is noted that Mrs S *tends to relapse into a sick role.* Mrs S sustained four falls in a single month, one of which resulted in suturing. The clinical records note Mrs S's *ongoing assessment of memory…signs of early dementia are marked* and that her *memory assessment shows marked difficulties.* A brain scan confirmed that there was a *sudden degree of cognitive impairment but no evidence of neuro-degenerative process.* Mrs S herself noted that she *feels she has memory problems.* Towards the end of the year, the clinical records note that Mrs S *is having to be dragged out of bed.* On one occasion during 2009, Mrs S had water thrown over her by a peer.

Occasions when Mrs S refused to eat	x140; including 29 days with no food; refused medication x14; it was noted that *prompting* Mrs S to eat is *ineffectual*

(during **2009**)	
Recorded weight	10 stones 5lbs; 8 stones 9lbs x2; 10 stones 3lbs
Occasions when Mrs S was incontinent	x7
Factors which compromised Mrs S's eating/ swallowing	*Bronchiectasis* (the diagnosis was known to Mrs S's GP[16]); gastro-oesophageal reflux; *sore red throat; Chest pains; feeling less hungry and less salivation since dose of Olanzapine was reduced; deterioration of mental state; very distressed today…can't account for her distress;* 3 sutures in her chin; *coughing yellow phlegm;* A broken tooth, on visits to a dentist she was supported by hospital staff
Falls and risk factors	x6 Mrs S stubbed her toes which were x-rayed - *indicating fractures to little toe and fourth toe; some postural hypotension; "I was trying to get up and I fell…lost balance on way into bedroom – fell and hit head on wall;" fell and hurt knee*…A&E
Examples of perplexing behaviour	*Started to cry and shake* at the prospect of an outing with peers; *eating all foods and eating more if you would give her; Mrs S addressed the Registered Manager as "My Commandant"; refused to attend to hygiene;* naked in the hallway; *kept throwing herself on the floor;* kicked and scratched staff

During **2010**, it was noted that Mrs S was *on severe mental illness register*. The GP/ Medical Officer saw Mrs S on five occasions because of *pain in left hip…for x-ray.* Mrs S's weight continued to fluctuate. The clinical records note that Mrs S's daughter expressed concern that her mother was *not eating* and that she appeared *over-sedated.* A spine x-ray during the year revealed a *partial collapse* of the *L1 vertebral body.*[17] Mrs S would have been in a great deal of pain. Although she continued to refuse meals she was known to be buying snacks from the hospital's tuck shop. Mrs S sustained *bruising to right side of mouth following assault by another client.*

Mrs S was admitted to Hospital *following a respiratory arrest after allegedly choking on a piece of bread…obstruction removed at the scene by attending ambulance crew, arrived…with an oral airway in situ and a Glasgow Coma* (Scale) *Score of 3 (normal score 15)….it was reported that she ate too quickly and too much and then choked.* When Mrs S's daughters were informed they *acknowledged that she has been doing the same thing at home* (with them). *Medical Registrar review noted decreased facial tone and possible early Parkinson's, slight bradykinesia*[18] It is most likely that these resulted from her psychiatric drug therapy for mania.[19] During 2010, Mrs S *complained of dizziness and chest pain. Observations were stable, crackles at the right base of her chest…Nutrition Nurse performed a water swallow test…The Nurse suggested a puree and liquid diet…fibre optic endoscopy…showed a hiatus hernia and mild gastritis but no cause for dysphagia.* Mrs S explained to the nutritional nurse specialist that she had problems swallowing "big bits of solid food." She tolerated a soft diet without difficulty.[20] When Mrs S *was discharged from Hospital the risk of*

[16] Although the SASH chronology states, *results reported showing bronchiectasis* during July 2008, it is not known why it took almost six months for this to be communicated to the GP/ Medical Officer
[17] The uppermost part of the lower back and likely to be osteoporotic in nature
[18] Slowness of movement – the early signs of an illness or movement disorder such as Parkinsons
[19] For example, Carbocistine , Loperamide, Olanzapine , Diazepam, and Escitalopram
[20] Information from East Surrey Hospital – March 2013

choking was identified and a care plan was initiated from August ***2010****…as a precautionary measure…and evaluated on a monthly basis*. Mrs S had *a video swallow test. This found her swallow mechanism was intact, but the lower two thirds of the oesophagus showed an extremely sluggish passage of contrast into the stomach…diagnosis was dyskinesia of the lower oesophagus…extremely retarded stripping waves in the lower two thirds of the oesophagus.*
Mrs S *was supervised during scheduled meal times as part of her care plan. She was also commenced on the normal diet progressively.* Shrewsbury Court Independent Hospital note that *There was no reason, and there has never been any doubt by the people present at the meeting about Mrs S's capacity to make an informed decision in this case.*[21] The Clinical Team Meeting at Shrewsbury Court Independent Hospital determined that Mrs S *will be gradually introduced to more solid diet on supervision.* Mrs S requested to come off her semi-solid diet and it was agreed that she could do so since Mrs S had been discharged from Section 3. Crucially, three months after the decision to "gradually" introduce Mrs S to a more solid diet there are over 13 references to her having sandwiches. During December, Mrs S ate a *mince pie and biscuits* and on 31 December it was noted that Mrs S was *back to her regular diet i.e. vegetarian meals.*

Towards the end of 2010, Mrs S did not attend *an Outpatient appointment with the Gastroenterologist.* A letter to Mrs S's GP/ Medical Officer stated *I hope this means her symptoms have resolved as I have not arranged any further follow up.* Later, and during an outing from Shrewsbury Court Independent Hospital, *she appeared to be choking but the problem resolved and she continued to eat.*[22] Occupational Therapy information concerning Mrs S during 2010 confirmed that she was *clumsy, unsteady and needed a lot of reassurance* while ostensibly able to manage her laundry, eating, dressing and bathing unaided for example.

Occasions when Mrs S refused to eat (during **2010**)	x136 – including 47 days with no food; refused medication x3 – during one month it was noted that Mrs S *has a tendency of refusing meals but complies with her medication;* it was noted that Mrs S *is not eating well*
Recorded weight	9 stones 12lbs; 9 stones 6lbs; 9 stones 3lbs; 8 stones 12lbs; 9 stones 11lbs; 8 stones 8lbs; 8 stones 7lbs
Occasions when Mrs S was incontinent	x2
Factors which compromised Mrs S's eating/ swallowing	*Bronchiectasis;* gastro-oesophageal reflux; *Tremors, shaking of hands; daughter concerned…not eating…over sedated;* ***She allegedly choked on toast bread; got choked on toast at breakfast time. She started to turn blue…was given oxygen;*** *eating a pureed diet*; *dyskinesia of the lower oesophagus… coughing purulent sputum;* The clinical notes state *videofluoroscopy showed evidence of increased motility*[23] *in her lower oesophagus* ***we have advised*** **Mrs S** ***to try to eat more slowly and chew her food***; *was sick…in my opinion this is attention-seeking behaviour; will be gradually introduced to a more solid diet on supervision*; *dyskinesia of the lower oesophagus;* ***At dinner time*** **Mrs S** ***tried to force a whole banana into***

[21] Information provided on 7 May 2013
[22] Shrewsbury Court Independent Hospital IMR
[23] Motility is a term used to describe the contraction of the muscles that liquefy food in the gastrointestinal tract

	her mouth at once. Staff intervened so she did not choke; ***at 23.00 hrs…snatched three sandwiches in each hand ready to munch them. Same retrieved to prevent choking***; *the Clinical Team Meeting noted that* Mrs S *needs to swallow more slowly and chew her food properly before swallowing*
Falls and risk factors	x7 Mrs S fell in her bedroom whilst using the hand basin. She sustained a small bruise. Although her BP was *ok* she was thought to be unsteady on her feet because of her *constant refusal to eat*; *fell over in shower room, being assisted to dress. No visible injury…frail and slothful; fallen out of bed – banged head;* Mrs S was osteoporotic;[24] Mrs S *had a tooth extracted…she pretended to collapse when anaesthesia administered;* At the dentist…*standing up she fell on the floor slowly*
Examples of perplexing behaviour	Refused to get up; scratched nurse; Refusing to dry herself after a shower; very selective with medication; *Rocking…whilst standing*

During **2011**, the GP/ Medical Officer visited Mrs S on two occasions. Although she was referred to a Colorectal surgeon, Mrs S did not attend the *appointment with Colorectal surgeons.* During May a Risk Management Plan noted that Mrs S "is now on a solid diet." Towards the end of 2011, Mrs S's daughter confirmed to staff that the pace of her mother's eating was a problem when she was with the family. Also, it was acknowledged that Mrs S had been *ready for discharge for some months*. She was reported to be looking forward to moving on. Although it was determined that Mrs S was not eligible for Continuing Health Care, Mrs S had oesophageal dyskinesia i.e. a permanent condition which does not resolve. She had been discharged from hospital on a soft diet, with Parkinsonian symptoms, confusion, recurrent chest infections, poor mobility and low blood pressure, and she was no longer independent in Activities of Daily Living. An alternative placement was sought for Mrs S since *she appears physically frail and highly dependent on nursing staff.* A psychologist wrote of Mrs S's *neuro cognitive assessment…scores are extremely low on the indices of working memory…requires an environment supporting for her memory functions.*

Occasions when Mrs S refused to eat during **2011**	x52 – including 11 days with no food
Recorded weight	8 stones 10lbs; 9 stones 8lbs; 9 stones 1lb x2; 9 stones 3lbs; 9 stones 2lbs; 9 stones 6 lbs
Occasions when Mrs S was incontinent	x25
Factors which compromised Mrs S's eating/ swallowing	*Bronchiectasis;* gastro-oesophageal reflux; Mrs S's chin was bruised and bleeding; *nose bleed; dyskinesia of the lower oesophagus;* Mrs S *was* ***pushing her food down her mouth – every mouthful of food staff had to speak to her; Problems with swallowing***; *confusion*; Mrs S *try to induce herself to vomit*; assaulted – struck on head; *small laceration on lower lip said she might have accidentally bitten it when still numb after visit to dentist;* Mrs S

[24] Osteoporosis is a condition that affects the bones causing them to become weak and fragile and more likely to break

	experienced discomfort with *sharp teeth;* Dental visit; *staff asked* Mrs S *why she eats a varied diet when out of the hospital but only cheese sandwiches in hospital. She said if she eats anything else then she might be incontinent of faeces…;* ***has not been using her inhaler properly****, has developed some crepitations at the base of her lungs*
Falls and risk factors	x6 Mrs S *bruised right knee and arm - said she fell*
Examples of perplexing behaviour	Mrs S *gets very distressed when she has to do her washing… crying and resisting staffs' explanations and instructions; told staff she wanted a pamper because she is a two year old; kicking off during shower time; Wearing her clothes the wrong side out; Child-like, attention seeking behaviour; very upset and insisted she was not going to eat;* went into the *communal area half naked*

During **2012**, it was recommended that although Mrs S was *not eligible for NHS Continuing Healthcare,* she was *eligible for funded nursing care.* The psychiatrist at Shrewsbury Court Independent Hospital *advised that Mrs S did have capacity to decide her future accommodation.* Belatedly, the PCT informed Surrey County Council that Mrs S had been discharged from S.3 MHA 1983. During early **2012**, negotiations began to discharge Mrs S from Shrewsbury Court Independent Hospital. These involved Mrs S's daughters. A vacancy in a shared room was identified at a nursing home and Mrs S visited with her daughter. Later, Mrs S expressed her misgivings about moving. During **May 2012,** Mrs S was *eating cheese on toast for lunch* and ***was seen by staff to be choking.*** *First aid was applied and the obstruction was cleared. She was seen by the ward doctor.*[25] Also during **May 2012**, Adult Social Care contacted the nursing home for *assessment feedback* and they confirmed that they were *happy to accept Mrs S.* However, at a CPA meeting on **10 May 2012**, Mrs S was *adamant* that *she did not want to move to the nursing home.* A documented account of the meeting (on **24 May 2012)** noted that Mrs S was *angry, stating* that *she has capacity to decide where she lives.* A "CPA medical report" noted that *Attempts have been made at placement in two residential homes…and a nursing home. On each occasion Mrs S's behaviour has deteriorated prior to visits and the homes have felt unable to cope with the level of disturbance.*

On **14 May 2012**, Mrs S *went on a trip and for a meal with the OT department and was found to be eating too much food very quickly. The food was taken from her for a brief period of time.* Concerns about S.117 funding were overshadowed by Mrs S's admission to Surrey and Sussex Hospital on **17 May 2012.** Mrs S was *reported to have choked on food…at care home. Hypoxic cardiac arrest with 24 minute down time before clearance of airway and successful resuscitation by paramedics. Glasgow Coma Score=3. Arrived intubated and ventilated. Admitted to ICU. Therapeutic hypothermia commenced with sedation.* The discharge letter from A&E noted the *difficulties sighting NJ tube oesophagogastroscopy revealed oesophagus full of food*[26]*…for Liverpool Care Pathway.* Later the *Gastro-enterology team performed OGD and passed NG tube. Found achalasia*[27] *no other*

[25] Shrewsbury Court Independent Hospital IMR
[26] The accumulation of food was not a sudden event and is likely to have been present for a number of weeks.
[27] Achalasia is an uncommon condition. It refers to a condition whereby the gullet has lost its ability to move food along and the valve at the end of the gullet fails to open to allow food to pass into the stomach…As a result, food gets stuck in the gullet and is often brought back up…most people with achalasia have dysphagia, a condition where they find it difficult and sometimes painful to swallow food. This tends to get worse…bringing up undigested food can lead to choking and coughing fits, chest pain and heart burn http://www.nhs.uk/conditions/achalasia/Pages/Introduction.aspx (accessed 1 October 2013)

abnormality.[28] Mrs S deteriorated and by **20 May 2012,** she required *cardiac and respiratory support* with *no signs of neurological recovery.* Mrs S died during **June 2012.**

Occasions when Mrs S refused to eat (during **January-April 2012**)	x15 – including 5 days with no food; refused medication x1
Recorded weight	10 stones and 7lbs; 9 stones 11lbs; 9 stones and 12lbs
Occasions when Mrs S was incontinent	x3*; assisted with personal hygiene, staff have to do it for her*
Factors which compromised Mrs S's eating/ swallowing	*Bronchiectasis;* gastro-oesophageal reflux; *Mrs S said she had a lump in her throat; Been sick; small upset tummy; dyskinesia of the lower oesophagus; bronchiectasis; producing green sputum?*
Falls and risk factors	x2 *as she was putting on her nightdress – fell onto the toilet and hit her back on the wall*
Examples of perplexing behaviour	*Refusing to leave room* when fire alarm went off; *continues to ask repetitive questions that she already knows the answer to*; *putting clothes on back to front;* said *she would be "on fast" tomorrow; Activated the call bell several times…child like behaviour;* Refusing to have ECG; *she was very difficult – shouting; does not want to have her cataracts removed*

The Family Perspective

7. The family recalls that they had no choice concerning Mrs S's transfer to Shrewsbury Court Independent Hospital. Mrs S had once been a solidly built and physically strong woman. For example, she did not hesitate to carry heavy objects and would insist on carrying the shopping bags when she was with her daughters' families. She lost a great deal of weight when she was at Shrewsbury Court Independent Hospital and her daughters believe that the origins of her considerable weight loss were fourfold:
   - She choked/ struggled as she ate and this was "an everyday occurrence"
   - Her shaking and tremors meant that it was difficult for her to manage eating and drinking
   - From having enjoyed a varied and nutritious diet throughout her life, Mrs S found the food at Shrewsbury Court unappetising and she would go to bed for days
   - She informed the hospital that she was a vegetarian having "moaned" to her daughters that the food there was "hospital food at its worst." However, she was most concerned that her daughters should not "say anything."
8. Mrs S's daughters recall that their mother was "starving hungry" when she visited from hospital and "ate large quantities greedily, gulping and guzzling." In contrast, there were occasions when she seemed to go on "hunger strikes" which her family believe may have had origins in her physical discomfort when "eating became a real issue" and her mental deterioration. With her family and their friends, Mrs S was "always told to slow down…don't gulp…She was always being patted on her back because otherwise she choked. It was made worse because she had a really bad cough and she retched with lots of mucus. She was breathless with a lot of dribbling issues." The family learned not to prepare any food containing nuts and they avoided cooking anything

[28] The lack of peristalsis in the lower two thirds of Mrs S's oesophagus was known during August 2010. There was no underlying malignant abnormality

with skins. On one occasion Mrs S choked on an orange. Her daughters told a nurse about this because it had been so shocking watching her struggle. Mrs S's coughing became worse after she swallowed bubble bath and this damaged her lung. Her family were bewildered when she stopped having a soft diet. Although Shrewsbury Court Independent Hospital believed she was able enough to make her own decisions concerning her diet, her family did not. Every evening the patients were given sandwiches and Mrs S's daughters knew that often she "shovelled them down" since they were the only things that she enjoyed eating.

9. Ultimately, Mrs S ceased to self-harm when she was at Shrewsbury Court Hospital. She seemed to become more manageable when the hospital ceased to expect her to look after herself. It was clear that she could not do so. From being someone who had been able to use public transport to meet her daughters, for example, more and more responsibility had to be assumed for her. She even ceased to put her washing in the washing machine and the day a week when she was assisted to prepare her own food was set aside in favour of doing it for her. At this stage Mrs S "plateaued and she became relatively stable."
10. Mrs S hated being returned to the place she referred to as "Slade Prison." Mrs S's deterioration led her daughters to observe that "By then, she was definitely not our mum." Mrs S disclosed that she was hearing voices during 2008, and her steady deterioration was conspicuous to them. They were very troubled that Mrs S reported feeling "giddy all the time," she lost her balance a lot and they believe she had many falls.
11. Mrs S's family remain disappointed that (i) her dental problems were poorly attended to (in the end they took her to their own dentist for treatment) and (ii) that there was no sense of urgency in finding an appropriate place where she would be looked after, irrespective of the fact that they had long believed that she was inappropriately placed. They shared their mother's view that Shrewsbury Court Independent Hospital was unsuitable and that Mrs S had been harmed by some patients, and yet the family recall being told that there was nowhere else. Mrs S's daughters very much wanted their mother to sample a completely differently environment where she would be looked after with compassion. [29]

The Inquest

12. The Inquest of **July 2013** heard the evidence of; *inter alia,* Mrs S's daughter, the Shrewsbury Court Independent Hospital staff and the written evidence of Mrs S's GP/ Medical Officer. This established that Mrs S's family accepted that she was *often nasal and chesty* and that it was easier for her to manage soft food. She would *always cough, choke, spluttering, regurgitating…always a fussy eater…not good at eating her food.* The family were concerned that Shrewsbury Court Independent Hospital appeared dismissive of manifestations of Mrs S's distress and confusion.
13. The Inquest heard that Mrs S did not want to leave Shrewsbury Court Independent Hospital. On 17 May, the date of a meeting concerning her transfer to the nursing home, she was "very calm and not agitated." Although the planning process had been protracted, "the funding was by then in place" and it was "fairly certain" that Mrs S would be leaving. Mrs S was reported to have "always worried that people would make decisions on her behalf." It was the view of the psychiatrist that Mrs S had the capacity to make a decision concerning her post hospital

[29] Aspects of the family's understanding of events are disputed by Shrewsbury Court Independent Hospital – January 2014

placement and that while "there were always some fluctuations in her mood and thoughts, there were no major changes during that week."

14. It was difficult to discern the exact date when Mrs S's soft diet was discontinued and which of her two care plans was active. The Inquest heard that since Mrs S had been discharged from Section 3 of the MHA 1983, she was able to determine the diet she wanted. Subsequently, Shrewsbury Court Independent Hospital undertook to "observe" Mrs S during meal times i.e. on the occasions when she was in the dining room. However, such observations would not impact on Mrs S's eating both outside the dining room and away from the hospital. Mrs S's daughter expressed concern that Shrewsbury Court Independent Hospital did not take account of her mother's eating problems as reflected in her fluctuating weight and what they construed as her "hunger strikes." The family learned to offer her food which was easy to eat. There were "quite a few occasions" when Mrs S was with her family and she choked. One occasion was reported to the nurse with lead responsibility for Mrs S. This nurse noted that on 17 May 2012, Mrs S was eating cheese on toast, since "she was not on a soft diet so no reason why staff couldn't serve her cheese on toast."
15. Shrewsbury Court Independent Hospital reported that they had sought to "educate" Mrs S about the dangers of choking by explaining these, encouraging her to take her time eating and chew her food properly. She was "always reminded."
16. Mrs S's psychiatrist confirmed that Mrs S had had an unusual, abnormal bereavement reaction in terms of its severity and length. Although Mrs S experienced some psychotic episodes, e.g. hearing staff saying derogatory things about her, "since these came on late there was a degree of uncertainty." Mrs S was taking antipsychotic medication (Olanzapine) to address the voices she was hearing. She was taking anti-depressants, diazepam for her anxiety and medications for her physical conditions. The psychiatrist did not believe that these compromised Mrs S's swallowing ability. Neither did the psychiatrist associate episodes of choking at Shrewsbury Court Independent Hospital with Mrs S's mental state. It was the psychiatrist's belief that overall, Mrs S was "improving" and thus ready to leave. The psychiatrist responded to a question concerning Mrs S's diet with the observation that the psychiatrist's role was "mainly around the psychiatric issues the mental health issues but being aware of the overall picture." The psychiatrist was asked whether or not there was clinical evidence that Mrs S had an eating disorder.[30] "I wouldn't go so far as to say it was an eating disorder…in the context of a depressive illness, there were times when Mrs S didn't eat and she took to her bed." The psychiatrist did not recall any discussion concerning Mrs S's capacity to make a decision about discontinuing her soft diet. "I don't recall a discussion. I think she probably would have had capacity."

The Terms of Reference

1) With reference to work undertaken with Mrs S between January 2007 and June 2012, identify the role and responsibility of (i) your agency and (ii) lead professionals within your agency, specifying timescales of their involvement

17. **East Surrey Clinical Commissioning Group** note that the GP *visited weekly and on request to see patients at Shrewsbury Court Independent Hospital.* The latter confirmed that the GP looked after *the physical health of the patients.*

[30] An eating disorder is characterised by an attitude to food that causes a person to change their eating habits and behaviour leading them to make unhealthy choices about food with damaging consequences for their health

18. Mrs S was transferred to Shrewsbury Court Independent Hospital from the Old Age Psychiatry Unit at the Meadows, West Park Hospital, Epsom where she had been a continuous in-patient since December 2004. Mrs S was cared for by Shrewsbury Court Independent Hospital's Consultant Psychiatrist from March 2007. The *day to day nursing, giving medication etc. was done by the nurses…health needs assessments were done and there were regular clinical team meetings.*
19. **Surrey Borders and Partnership NHS Foundation Trust** provided in-patient treatment under S.3 MHA 1983. Mrs S received nursing, Occupational Therapy, psychology, physiotherapy, psychotherapy and family psychotherapy between 2004 and 2007. During 2009, Mrs S was referred for a *second opinion with regard to her memory* when *no significant cognitive decline was* identified. During September 2010, Shrewsbury Court Independent Hospital sought *a cognitive assessment.* Although the Hospital had *no concerns about decline in Mrs S's cognitive functioning…the problem…related to behavioural problems…*it was believed that *Mrs S's problems were more of a physical and behavioural nature and were not due to a decline in her cognitive functioning.*
20. **Surrey and Sussex Healthcare NHS Trust** have recorded 15 contacts with Mrs S up to and including her admission to A&E on 17 May 2012. Mrs S was admitted during September 2007, since she was reported to have swallowed glass. She was x-rayed and discharged. During 2008, she was referred because of a *persistent chesty cough.* During 2009, Mrs S's GP was advised (i) that she did not attend her appointment and a copy of her CT chest scan was included in the correspondence and (ii) that she had fractured two toes. During 2010, Mrs S was admitted *after allegedly choking on bread…it was reported that she ate too quickly and too much.* She remained in hospital for seven days during which time she was reviewed by the Intensive Care Unit and the Medical team; she was diagnosed with *aspiration pneumonia/ pneumonitis with negative pressure pulmonary oedema;* she was supervised when eating; a swallow test was undertaken and the Nutrition Nurse *suggested puree and liquid diet;* and an ECG and fibre optic endoscopy were performed.
21. **Surrey County Council**'s locality social care team *received a referral to identify an appropriate community placement for Mrs S…on 29 February 2012.* The practitioner responsible *remained with the case up to Mrs S's death.*
22. **Surrey Police** had three contacts concerning Mrs S. The first occurred during February 2006, when it was reported that Mrs S had absconded from the hospital. She was located before an investigation commenced. The second occurred during January 2007, and arose from a referral about an overheard telephone conversation. Finally, the police were informed of Mrs S's death.
23. **Surrey Primary Care Trust** confirms that Mrs S *was referred to the NHS Funded Healthcare Team* during December 2011. Subsequently she was referred for a CHC assessment.
24. It should be noted that Shrewsbury Court Independent Hospital's own records tracked a halting "moving on" process for which no agency assumed lead responsibility. Mrs S and her family believed that a Registered Mental Health Nurse, who was known to them prior to Mrs S's placement at Shrewsbury Court Independent Hospital, was her "Care Manager" who signed correspondence as "Continuing Care Nurse Specialist, Surrey Primary Care Trust." It was noted at a CPA review during May 2008 that the "Care Manager not present…difficulties will be apparent moving on as she will not want to be in EMI provision." During June 2008, Mrs S's family were keen that Mrs S should leave the hospital and they were advised that contact would be made with the Care Manager. During July 2008, Shrewsbury Court Independent Hospital noted that

they "need to chase Care Manager…still no news…re possible future placement." During September 2008, although Surrey PCT sought an assessment of Mrs S, it was noted that "we cannot locate her Care Manager." During October 2008, Shrewsbury Court Independent Hospital noted that the Care Manager would be looking "at places that will take S.17 leave…will make a list…Care Manager needs to communicate plans for the future to Mrs S's daughter."

25. There was no reference to plans for Mrs S's future placement during 2009 or 2010.

2) Evaluate the adequacy of assessments undertaken, the decision-making and planning by your agency concerning Mrs S and members of her family

26. **East Surrey Clinical Commissioning Group** state that the GP's role *did not include assessment or treatment of Mrs S's mental health* and that the GP *was never involved in decision-making by* Shrewsbury Court Hospital *staff.* This is troubling since "carving out" physical health care from mental health care would appear to preclude discussion concerning the impact and interaction of medication regimes e.g. antipsychotic medication impacts on swallowing. Neither does it appear that the GP/ Medical Officer was assisted by discussion with Mrs S's family.
27. **Shrewsbury Court Independent Hospital** asserts that initially, Mrs S was appropriately placed. However, latterly, they acknowledge that *Mrs S should not have been in Shrewsbury Court.* A social worker noted during November 2008, that although Mrs S's family wished Mrs S to leave the hospital and return to more independent accommodation, the Clinical Team did not share this aspiration. It was noted that "A major difficulty has been the lack of consistent input from Mrs S's Care Manager[31] and on a number of occasions…has failed to attend CPA meetings causing the CPA to be cancelled…I understand that the Care Manager was looking at a possible placement in the Kingswood area but more recently I have learned that this is on hold as he feels Mrs S is currently appropriately placed at Shrewsbury Court."
28. It was during May 2011, that Mrs S's transfer from Shrewsbury Court Independent Hospital was considered once again during a CPA meeting. Mrs S would require "a structured, secure, 24 hours supported environment." During June 2011, Mrs S was advised to discuss her preferences with her Care Manager. The latter reported during August 2011, that although a placement had been found, it was "not appropriate." During September 2011, the Care Manager "proposed The Beeches for her" and the following month declared that there was "a vacancy at a home in Wandsworth…awaiting word from PCT" and separately, that the hospital was "waiting for Care Manager to arrange funding for her to move to the nursing home." The Care Manager "submitted assessment form on 14 November 2011 and now awaits feedback." Irrespective of this person's role, he was only ever known to Mrs S's family as the Care Manager.
29. This sequence of events is barely coherent. It appears to hinge on the intermittent availability of nurse who was not a Care Manager whose decision-making was unduly influential.
30. **Surrey Borders and Partnership NHS Foundation Trust** states Mrs S's daughters were *involved in ward rounds, reviews and their views were taken into account when care plans were decided. The daughters were also included in some of the psychotherapy sessions.*
31. **Surrey and Sussex Healthcare NHS Trust** responded appropriately to Mrs S's two choking episodes. *Both required resuscitation by paramedics and admission to the Intensive Care Unit.*

[31] The "Care Manager" signed correspondence as the "Continuing Care Nurse Specialist, Surrey Primary Care Trust" during 2007. During two months in 2011, this person signed correspondence as the "Care Coordinator, Older Adults Mental Health Service; Continuing Care Advisor, Surrey and Borders Partnership NHS Trust; and Continuing Care Advisor, Surrey and Borders Partnership NHS Trust, Older Person's Team"

Investigations into Mrs S's *swallowing difficulties* arose from the initial admission. *Written confirmation that Mrs S had not attended* subsequent appointments was *sent…to her GP on all but one occasion. Because Mrs S was considered to have mental capacity, letters* were *sent directly to her* and *not to those caring for her to ensure her attendance.* Surrey and Sussex Healthcare NHS Trust acknowledge that this represents *a gap in the care pathway.*

32. **Surrey County Council** note that from the date of referral, 29 February 2012, the assessments and decision-making of the social worker hinged on securing the *right outcome* for Mrs S. The social worker acknowledged the frustration of Mrs S's daughters who had believed that the "Care Manager" with whom they had been in contact for six years was responsible for identifying a suitable placement. The social worker clarified funding responsibility since Mrs S was subject to S.117 MHA 1983. Funding was discussed with the family on three occasions during March 2012 and Mrs S completed a supported self-assessment in the same month. The family were kept informed of progress in identifying a placement and were reassured during the process by the social worker because Mrs S appeared anxiously ambivalent about moving. Also *she kept the daughters involved and informed as the case progressed,* albeit within a brief timeframe commencing 29 February 2012.
33. **Surrey Police** investigated the information concerning Mrs S's telephone conversation about her finances. Their *enquiries established that* since *Mrs S was deemed to have capacity to manage her own finances* and *did not want to make a formal complaint, the investigation was closed.*
34. **Surrey Primary Care Trust** oversaw the completion of the CHC. The Decision Support Tool was completed by a multi-disciplinary team and *included information provided by and discussed with the team involved in* Mrs S's *care.*

3) How were Mrs S's (i) medical diagnoses, (ii) mental health and (iii) risk of choking addressed by your agency?

35. **East Surrey Clinical Commissioning Group** notes that the GP's role *did not include assessment or treatment of Mrs S's mental health.* Further, between October 2010 and June 2012, the GP was *not informed by the patient or any member of staff of any swallowing difficulties or choking episodes.* This is troubling in the light of Shrewsbury Court Independent Hospital's daily records i.e. during August 2010 a "consultant review suggested Olanzapine could possibly be contributing to poor swallow" and between October 2010 - the end of March 2012, there were 15 whole days when she ate nothing, almost 100 occasions when she declined to eat at least one meal and Mrs S had eight falls. Further, problems with swallowing were noted during April 2011 and Mrs S's behaviour concerning her eating required staff to be vigilant.
36. **Shrewsbury Court Independent Hospital** state that *the mental health care of patients is very adequately addressed in the regular clinical team meetings and the CPA meetings where reports are received and discussed and care plans made.* The risk of Mrs S choking *was identified as an active risk following her admission to East Surrey Hospital in August 2010.* Accordingly, Mrs S had *a semisolid diet* and staff sought *to educate* her *regarding the risk so she was aware of it.* Further, staff were instructed in *how to mitigate the likelihood of choking and how to respond to any* such *incident.*
37. The debriefing with patients following Mrs S's choking, led them to comment that she was *her usual self, eating hurriedly and stuffing food into her mouth* i.e. Mrs S's peers were attuned to the way in which she ate. This would appear to confirm her family's observation that she "ate large quantities greedily, gulping and guzzling." It should be noted that on 30 September 2010, Mrs S

was removed from S.3 of the MHA 1983. It would appear that this was a factor in the decision-making concerning Mrs S's solid diet i.e. *no additional measures were taken with regards to Mrs S, especially as she was an informal patient and was able to access food and drink without supervision.*

38. In Shrewsbury Court Independent Hospital's *Full Assessment of Risk Form* (of 10 October 2011), it is noted that Mrs S's food intake and weight should be monitored regularly. However, the same document contains contradictory statements, *She is currently on a semi-solid diet due to an episode of choking in August* and *Mrs S is now on a solid diet.*
39. Mrs S's leave from Shrewsbury Court Independent Hospital appeared to hinge on her eating i.e. although the Multi-Disciplinary CTM of 8 November 2011 noted that Mrs S's *eating habit is good,* the Risk Management Plan noted of her *day leave with family* that this depended *on adequate food intake.*
40. **Surrey Borders and Partnership NHS Foundation Trust** responded to two referrals concerning Mrs S's memory and *behavioural problems* and declined to accept a Speech and Language Therapy referral.
41. **Surrey and Sussex Healthcare NHS Trust** were responsible for diagnosing Mrs S's *swallowing difficulties* and initiating clinical investigations. Their *Nursing records* confirm their reliance on Mrs S's carer from Shrewsbury Court Independent Hospital. The records *note that Mrs S was being provided with one to one care by her carer as she was under S.3. The carer would therefore be expected to have had communication and awareness of her condition and treatment plan throughout.* Following Mrs S's initial admission, *nursing records state supervision was provided when eating.* With reference to clinic appoints, it was noted that, *because Mrs S was considered to have mental capacity, letters would have been sent directly to her but not to those caring for her to ensure her attendance.*
42. **Surrey County Council**'s adult social care practitioner was *not involved in the diagnosis or the risk assessment.* However, the social worker did not have *full sight of reports dealing with Mrs S's problems with choking.* Had these been accessed it is possible that a safeguarding alert may have resulted.
43. **Surrey Police** note that "it would seem that Mrs S had been on a food care plan due to previous choking incidents but this plan appears to have been rescinded in May 2011 following a 'video swallow' test carried out by the GP."
44. **Surrey Primary Care Trust** state that Mrs S was *assessed holistically* insofar as *the* Decision Support Tool includes *behaviour, cognition, psychological and emotional care domains.* The risk of choking *was assessed...and following discussion with the professionals involved in* Mrs S's *care…it was considered not to be an issue at the time.* This observation is extraordinary since a holistic assessment must take account of medical information. Mrs S had eating problems, significant upper gastrointestinal tract pathology, respiratory problems, she was intermittently compliant with her medication and she had made numerous attempts at self harm, including the deliberate ingestion of foreign objects.

4) Comment on the effectiveness of information sharing (i) within your own organisation (ii) with other agencies, (iii) with Mrs S and (iv) with her family

45. It cannot be asserted that collaboration was central to the ways in which practitioners worked with and on Mrs S's behalf. Mrs S's family were bewildered by the limited progress of a Care

Manager who was not a Care Manager in identifying and securing a post Shrewsbury Court Hospital placement for Mrs S.

46. **East Surrey Clinical Commissioning Group** assert that the GP/ Medical Officer relied on the fact that *every consultation with patients at Shrewsbury Court was attended by a member of the nursing staff…to facilitate communication and provide an opportunity for issues of health concerns to be raised.* It is regrettable that the GP had no contact with Mrs S's daughters and that the GP/ Medical Officer did not assume a more forthright role in teaching staff about the management of this medically complex woman, not least in terms of her gastrointestinal tract pathology.
47. **Shrewsbury Court Independent Hospital** states that latterly, Mrs S *should have been placed in a care home and that there were issues regarding family agreement and funding problems.*[32] The Hospital acknowledges that *there appears to have been a breakdown in communication between the various services and agencies involved in the care and treatment of Mrs S as well as with her family.* For example, Mrs S was offered an appointment to see a gastroenterologist during October 2010. This letter was copied to her GP. Mrs S did not attend the clinic and no follow up appointment was made. The failure to keep the appointment *was not chased up by the GP or the* East Surrey *hospital.* As a clinician noted, *the situation concerning GP cover was not ideal.*[33]
48. **Surrey Borders and Partnership NHS Foundation Trust** states that it *supports multi-agency working and has many examples of liaising with other services.*
49. **Surrey and Sussex Healthcare NHS Trust** acknowledge that *upon discharge from hospital in 2010 there was no evidence of nursing handover of information given to the home regarding ability to swallow and appropriate advice relating to this…communication with Mrs S's family and her care within the Intensive Care Unit is deemed appropriate.*
50. **Surrey County Council** state that the social worker *kept all partners informed of progress,* most particularly *Mrs S and her daughters.*
51. **Surrey Primary Care Trust** states that information sharing was effective as evidenced by the *joint Surrey NHS and Surrey CC panel and the S.117 panels.* Also, *information was shared between the doctors and other professionals at Shrewsbury Court Independent Hospital and Surrey Social Services to organise the Decision Support Tool and subsequent panels.* It is noted that although *Mrs S was offered the opportunity* to be accompanied by a representative such as a relative, *it is not known if they were invited.* This claim conflicts with the facts. During September 2008 an "assessment" was required. It does not appear that any effective action was taken until May 2011.

5) Identify any organisational factors such as capacity and culture which may have impacted on practice in working with Mrs S

52. **East Surrey Clinical Commissioning Group** note that the GP *did not think that there were any organisational factors that impacted on working with Mrs S.*
53. **Shrewsbury Court Independent Hospital** suggests that their capacity may be enhanced by the appointment of a *physical health care liaison person.* They accept that *the situation regarding GP cover was not ideal.*

[32] Shrewsbury Court Independent Hospital IMR
[33] Shrewsbury Court Independent Hospital IMR

54. **Surrey Borders and Partnership NHS Foundation Trust** do not make reference to capacity and culture.
55. **Surrey and Sussex Healthcare NHS Trust** recognises that letters concerning clinic appointments are a limited means of engaging with patients and that these should be supplemented with timed telephone reminders.
56. **Surrey County Council** state that the social worker ensured that the psychiatrist had *advised that Mrs S had capacity to make decisions about her long term accommodation* and checked Mrs S's status vis a vis S.117 MHA 1983.
57. **Surrey Primary Care Trust** asserts that *there are no identifiable capacity or culture issues which may have impacted on practice.*

6) Consider the effectiveness of your agency's response – its practices and internal processes as measured against the expectations set down the multi-agency policies and procedures for safeguarding adults and (i) propose ways in which practice can be improved within your own agency; and(ii) specify how and within what timescales they will be enacted

58. **East Surrey Clinical Commissioning Group** do not make any reference to safeguarding and assert that the GP *was always available for medical consultations at the request of Mrs S or staff and…acted promptly on any information shared.*
59. **Shrewsbury Court Independent Hospital** does not make reference to adult safeguarding. This is surprising on two counts
    (i) Mrs S was punched in the face during December 2007 and during June 2010, sustaining bruising to her face and mouth respectively. Also, during April 2011, she was struck on her head.
    (ii) Mrs S's final hospital admission arose from choking. There had been at least five occasions between 2007 and 2012 when Shrewsbury Court Independent Hospital had documented choking events and this was acknowledged to be a risk unique to Mrs S.
60. Such events merited referrals to Surrey's safeguarding adults' personnel.
61. **Surrey Borders and Partnership NHS Foundation Trust** does not make reference to adult safeguarding.
62. **Surrey and Sussex Healthcare NHS Trust** *is confident of its robust safeguarding procedures.*
63. **Surrey County Council** does not believe that Mrs S's choking should have resulted in a safeguarding alert since their practitioner *had no reason to believe or suspect abuse.*
64. **Surrey Primary Care Trust** state that although the Continuing Healthcare Team were not directly involved with the safeguarding review, the lead nurse for safeguarding was invited to the strategy meeting at which *no subsequent CHC related actions or change to practice were identified.*

7) Identify the lessons to be learned from this case about the way in which professionals and organisations work individually and together

65. Although **East Surrey Clinical Commissioning Group** makes no reference to learning arising from Mrs S's care at Shrewsbury Court, it is asserted that *closer communication between* the GP *and the staff on Mrs S's choking episodes would certainly have led to further investigations and referral.*
66. **Shrewsbury Court Independent Hospital** proposes that there is merit in appointing *a physical health care liaison person who could take overall responsibility to make sure there are no lapses in the continuity of care of physically ill patients.*

67. **Surrey Borders and Partnership NHS Foundation Trust** does not cite any learning arising from Mrs S's circumstances.
68. **Surrey and Sussex Healthcare NHS Trust** acknowledge that there should be *a formalised care pathway that addresses the issues of vulnerable adults failing to attend follow-up appointments;* a means of ensuring that the handover of information to community providers should embed *hydration/ nutrition/ assistance required and feeding regimes;* and that the *provision of Speech and Language Therapy within the Trust requires review and consideration.* When a junior doctor referred Mrs S for speech and language therapy, the referral should have contained the contact details of a permanent post holder.
69. **Surrey County Council** advises in its IMR that Mrs S should have been referred to the social care team when she ceased to be subject to S.3 MHA 1983 during *late 2010.* However, Surrey County Council did not receive the referral from the Primary Care Trust until 31 January 2012. Agencies did not *work together in a timely manner.*
70. **Surrey Primary Care Trust** states that *the limitations of the Continuing Healthcare database have been highlighted…clinical and non-clinical* staff *are reminded...of the importance of ensuring relevant information is added to the database as well as patient records.*
71. It should be noted that this SCR would have been limited had it not been for (i) the family's Freedom of Information request, (ii) their willingness to make Mrs S's records available to the SCR and (iii) an extended timeframe within which to complete the work. The information shared by Shrewsbury Court Independent Hospital was partial because it did not take full account of its own records and disproportionate reliance was placed on its own Serious Untoward Incident report concerning Mrs S's final admission to hospital. Although a Safeguarding Adults Board has no power to compel any agency to contribute to a SCR – it is a voluntary process – learning is frustrated if relevant records are neither considered nor scrutinised.

Conclusions

72. Mrs S was very frail with ongoing respiratory problems - coughing and regular production of purulent sputum – and she was restricted in her mobility. She was medically complex as an older woman with a diagnosis of *abnormal bereavement* depression and a history of numerous attempts at self harm, including the deliberate ingestion of foreign objects. Mrs S had over 20 documented falls between 2007 and 2012 and yet she did not benefit from a referral to a falls clinic. Irrespective of prescribed medication for Mrs S to address her depression, for example, she appeared unable to break out of a compulsion to punish herself. Mrs S's experience confirms that she required a holistic approach to treatment i.e. one which did not separate her "physical health care" from her "mental health care" (e.g. Wade 2009).
73. It is not clear why the change in Mrs S's status from S.3 MHA 1983 to becoming an "informal" patient heralded evidence of her mental capacity to make decisions about her diet. Perhaps it was because, more generally, it was noted that *she seemed to have capacity to understand things*[34] and there was documented uncertainty about whether or not Mrs S was on a semi-solid diet (se para 43). Although Shrewsbury Court Independent Hospital documented discussions with Mrs S concerning her medication and her consent to taking particular medications, (which incidentally did not involve the GP/ Medical Officer who arguably should have explained the

[34] Shrewsbury Court Independent Hospital IMR

medical implications of Mrs S's oesophageal dyskinesia), the basis on which it was assumed that she could make a capacitated decision concerning her diet is unclear.

74. Mrs S was seen regularly by the GP/ Medical Officer for recurrent respiratory infections for which she received a number of different antibiotics with referrals to a respiratory physician (May 2008) and a chest physiotherapist (March 2011). A CT scan report eventually revealed evidence of bronchiectasis (see July 2008 and January 2009) in the *right upper, middle lobes and both lower lobes*, considered to be related to aspiration of ingested noxious substances (see Feb 2007). Also, Mrs S had long standing gastro-oesophageal reflux with severe sluggishness in her oesophagus. Chest infections would have aggravated Mrs S's swallowing problems which were ultimately attributed to achalasia.
75. Mrs S's risk of choking whilst swallowing was identified in August 2010, following an acute admission to hospital when it was noted that in the middle and lower thirds of the oesophagus, the passage of contrast media[35] was extremely sluggish. Mrs S was diagnosed as having oesophageal dyskinesia and this is significant. A prescribed semi solid diet is appropriate in the long term i.e. this condition requires long term management since there can even be difficulties with drinking fluids. Shrewsbury Court Independent Hospital states that they received no written recommendation concerning a long-term, semi-solid diet. Such a diet was not recommended in the discharge documentation and it was inappropriate of the hospital to rely on the presence of a member of Shrewsbury Court Independent Hospital to relay this information.[36] During October 2010, Mrs S's semi-solid diet was abandoned in favour of an ordinary diet because ***the clinical team agreed to Mrs S's request to go on a solid diet with the risk management plan of supervising her at mealtimes. As Mrs S was an informal patient she was able to access food and drinks without supervision and was also going out with her family when she would have food and drink***.[37] This is inconsistent with the decision to place Mrs S on a *semi solid diet as a precautionary measure* following discharge from East Surrey Hospital for choking during August 2010 and with her history of eating problems.[38] The doubts concerning Mrs S's understanding, her cognitive ability to appreciate her swallowing difficulties and her multiple pathology were not reflected in her care plan. It would appear that "diagnostic overshadowing" prevailed i.e. the process by which the symptoms of a physical illness are misattributed to a mental disorder (e.g. Disability Rights Commission 2006).
76. It appears that the staff working with Mrs S at Shrewsbury Court Independent Hospital were unaware of the nature of Mrs S's oesophageal dyskinesia with its swallowing risks or the implications of her drug regime (see Annex A: Questions to ask of Shrewsbury Court Independent Hospital's GP/ Medical Officer concerning the treatment of Mrs S); and critically, what constitutes a semi-solid or soft diet since she *just ate a piece of cake* nine days after having been hospitalised for choking and attended a BBQ six days after this. Neither cake nor BBQ food are associated with a soft or semi-solid diet. Shrewsbury Court Independent Hospital acknowledges that Mrs S should not have been offered cake and state that she did not eat at the BBQ. The statements that Mrs S "…claimed to have difficulty swallowing" (on 24 August 2010), "Mrs S was seen today and

[35] The substances used in medical imaging to highlight structures or fluids in the body
[36] Shrewsbury Court Independent Hospital – January 2014
[37] Shrewsbury Court Independent Hospital IMR
[38] During March-December 2007, Mrs S refused meals on 146 occasions and there were 55 days when she did not eat; during 2008, Mrs S refused meals on 116 occasions and there were 50 days when she did not eat; during 2009, Mrs S refused meals on 130 occasions and there were 24 days when she did not eat; during 2010, Mrs S refused meals on 136 occasions and there were 47 days when she did not eat; during 2011, Mrs S refused meals on 52 occasions and there were 8 days when she did not eat; and between January and May 2012, Mrs S refused meals on 20 occasions and there were 6 days when she did not eat

discussed her activity programme. She complained she was sick in the lounge but when we went there she said it wasn't in the lounge, it was in the bathroom. Mrs S has been telling everyone about this and it is my opinion this is attention seeking behaviour as there was no evidence of her being sick," (18 October 2010) anticipate the plan that Mrs S "will be gradually introduced to a more solid diet on supervision" (19 October 2010). During November and December 2011, Mrs S was eating sandwiches, biscuits and a mince pie. Although there is documented evidence that Mrs S was being supervised when she ate in the dining room during November and December 2010 and from January – November 2011, she was not supervised when she ate food which she purchased in the hospital's tuck shop for example. It is noteworthy that the Serious Untoward Incident Report (15 June 2012) arising from Mrs S's death stated that "she was not under any special observation or supervision during meal times."

77. The general law is that an adult with full mental capacity has the right to choose whether or not to eat and what to eat. It is possible that Mrs S was *unable* to make a decision for herself about her diet, i.e. she was unable (a) to understand the information relevant to what should have been a medical decision, (b) to retain that information, (c) to use or weigh that information as part of the process of making the decision, or (d) to communicate her decision. It is not clear that Mrs S was making a true choice as to whether or not she could eat safely because the daily records track her precarious cooperation with the opportunistic "education" of reminding Mrs S to eat more slowly for example. Mrs S's behaviour concerning food was troubling and was known to be so. Typically she put too much food in her mouth. This was borne out by her family and staff at Shrewsbury Court Independent Hospital. Between 2007 and 2012 there were almost 200 days when Mrs S ate nothing at all and around 600 occasions when she missed at least one meal during a single day. It follows that it is not surprising that Mrs S's weight fluctuated during the time she was a patient at Shrewsbury Court Independent Hospital (she had lost around four stones by July 2008). Also, Mrs S was known to have deliberately ingested foreign objects and toxic fluids. Thus the failure to consult the GP/ Medical Officer and Mrs S's daughters concerning her diet when she had been discharged from S.3 MHA 1983 is significant.
78. Given that the role of the GP hinged solely on the physical health care of Shrewsbury Court Independent Hospital patients, it would appear that Did Not Attend notifications did not result in any action. Shrewsbury Court Independent Hospital's treatment of Mrs S's mental health involved psychological counseling and polypharmacy with behavioural approaches; e.g. during July 2007, it was noted that Mrs S "doesn't seem to understand that her activities depend on her eating and drinking…can go out if she eats and drinks normally for three days." It would appear that symptom reduction was the overarching goal of Mrs S's mental health treatment.
79. Every month during Mrs S's stay at Shrewsbury Court Independent Hospital she refused food. These refusals were consistently associated with her mental status i.e.
    - "Was in low mood. Was not eating, drinking or taking medication" (MDCTM September 2008)
    - "Her mood and behavior fluctuate from one moment to the next. She can become very agitated and depressed, refusing to eat or take medication" (Nursing Report for MHRT July 2007)
    - "The intermittent stopping of eating was attributed to the presenting mental health difficulties at the time" (May 2008)
    - "Taking in meals has often depended upon her mood" (MDCTM November 2008)

80. Shrewsbury Court Independent Hospital ceased to regard this persistent pattern of behavior as a manifestation of Mrs S's mental health when she was discharged from S.3 MHA 1983. What displaced this position in favour of the assumption that Mrs S would make a capacitated decision concerning her diet is not clear. At the Inquest a member of the clinical team at Shrewsbury Court Independent Hospital's explained that they did not recall a discussion concerning Mrs S's transfer to a solid diet. Mrs S's diet as described in Shrewsbury Court Independent Hospital's records cites "soup" occasionally. It does not document Mrs S being offered pureed or mashed foods, or foods softened with sauces, for example. It is arguable that the hospital itself failed to understand the importance of Mrs S avoiding fibrous, dry and crumbly foods, including toast.

Recommendations

1. **That the Serious Case Review is shared with the Care Quality Commission, East Surrey Clinical Commissioning Group, Shrewsbury Court Independent Hospital, Surrey Borders and Partnership NHS Foundation Trust; Surrey and Sussex Healthcare NHS Trust, Surrey County Council, Surrey Police, Surrey Primary Care Trust and Surrey Healthwatch; and is promoted by local authority members with a view to highlighting the circumstances of older people using mental health services**. Mrs S's admission into Shrewsbury Court Independent Hospital offered little that was substantive in terms of effective physical health care and treatment.
2. **That Shrewsbury Court Independent Hospital informs and provides evidence to the Safeguarding Adults Board and the Care Quality Commission as to how it is giving priority to regular physical health checks for patients and regular medication reviews which are based on evidence about patients' physical health needs**.
3. **That Shrewsbury Court Independent Hospital informs and provides evidence to the Safeguarding Adults Board and the Care Quality Commission as to how pharmacists are involved in medication reviews and advises of the actions that would be taken where concerns are identified where prescribing may exacerbate underlying medical conditions or adversely interact with other medication.** There were concerns about Mrs S salivating during November 2008 and February 2009 and Mrs S's daughter reported that her mother appeared "over sedated" during April 2010. Also, it was known that Mrs S's adherence to her medication was poor. Significantly, the side effects of some of the drugs Mrs S was prescribed e.g. Olanzapine, had implications for her swallowing .
4. **That Shrewsbury Court Independent Hospital provides evidence to identify how patients' nutritional needs are met and risks of possible malnourishment mitigated and managed. It should inform the Safeguarding Adults Board and the Care Quality Commission of actions it has taken since Mrs S's death.**
5. **That Shrewsbury Court Independent Hospital identifies and provides evidence as to how it proposes to act on information concerning patient falls to the Safeguarding Adults Board and the Care Quality Commission. That Shrewsbury Court Independent Hospital provides a copy of its falls prevention strategy.** Urgent and positive action is required since Mrs S is likely to have been referred to a Falls Clinic had she not been in an independent psychiatric hospital.
6. **That Shrewsbury Court Independent Hospital informs and provides evidence to the Safeguarding Adults Board and the Care Quality Commission how it is giving priority to adult safeguarding. This is in relation to Safeguarding Policy and Procedures, Internal**

safeguarding reporting, Safeguarding training framework, a Safeguarding competency framework and engagement with the Surrey Safeguarding Adults Board. It should inform the Safeguarding Adults Board and the Care Quality Commission of actions it has taken since Mrs S's death.

7. **That Shrewsbury Court Independent Hospital outlines and provides evidence of how it proposes to ensure that the assessment of patients' mental capacity and decision-making, which has implications for patients' medical conditions, is shaped by multi-disciplinary team working, and which proactively involves GPs and family members. The outcome should be shared with the Safeguarding Adults Board and the Care Quality Commission.**
8. **That Surrey Downs CCG clarifies to the Surrey Safeguarding Adults Board that there is a clear ownership, accountability and clarity for the Continuing Health Care process.**
9. **That Surrey and Borders Partnership investigates the conduct of their employee who had a key role in this case, plus the line management and supervision of this person during the period of his involvement with Mrs S.** This employee was believed by Mrs S's family to have been identifying a post-Shrewsbury Court Independent Hospital placement for Mrs S during 2008 and thereafter. No action resulted.
10. **That Surrey and Sussex Healthcare NHS Trust should assure the Safeguarding Adults Board that the confirmation of out-patient appointments for older patients in mental health services is negotiated with (i) employed carers accompanying the patients (ii) the mental health services (iii) GPs.**
11. **That all Surrey CCGs should assure the Safeguarding Adults Board that they are commissioning Speech and Language Therapy services for older people with mental health illnesses and (ii) that Surrey Borders and Partnership NHS Trust should advise the Safeguarding Adults Board of the steps they have taken to ensure that their staff provide referrers with information about where older people with mental health illnesses may access Speech and Language Therapy services.**
12. **That the Surrey Safeguarding Adults Board raises with NHS England and the Clinical Commissioning Group concerns about the accountability of GPs offering "physical health care" to the patients of independent psychiatric hospitals**. GP/ Medical Officers should take overall responsibility for the oversight of the physical and mental health of patients, involving for example discussion concerning the results from hospital visits, the results from out-patients appointments, the implications of non-attendance and monitoring of polypharmacy.
13. **That the Surrey Safeguarding Adults Board raises with NHS England and Surrey CCGs its concerns regarding the engagement of the GP in the Serious Case Review**. **The GP was unclear in his role and responsibility regarding safeguarding and the requirement to complete an Individual Management Review that could help inform the Serious Case Review.**
14. **That the Safeguarding Adults Board may wish to consider the promotion of training in assessing mental capacity and decision-making, risk assessment and risk management, drawing from Mrs S's circumstances. Learning from the events which resulted in Mrs S's death is a fitting way of remembering her.**

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