Surrey Safeguarding Adults Board

'Mr D'

A Serious Case Review

Executive Summary

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Introduction

1. This Serious Case Review concerns the care given to Mr D by his daughter, Jill Watts, and by NHS and social care services over a four year period. He was 84 when he became known to statutory services in 2008. A crucial backdrop to this Review is (i) the adequacy of care he received as he physically deteriorated and became doubly incontinent, (ii) the quality of assessments and associated planning and (iii) responsiveness to concerns.
2. Mr D's wife died during 2009, *after which his daughter, Jill Watts, became his main carer*[1]. She lived with her father and also had caring responsibilities for her son. Mr D was diagnosed with Alzheimer's disease during 2011. He was funding his own support until he became eligible for continuing health care (CHC) during June 2012,[2] when the NHS assumed full responsibility for organising and managing his package of care. Jill Watts and her father had previously declined offers of care *from outside agencies*[3] even though Mr D had had several hospital admissions, typically resulting from falls, and Jill Watts had made intermittent requests for help.
3. During November 2012, the police attended Mr D's home following a call from home care staff to report that they had entered his house and found Jill Watts *with her hands round his neck*. The *Care worker was also alleged that she had been assaulted by* her. *Police officers found that* Mr D *had bruising to his jaw and had reddening at the top of his head*[4]. Mr D was admitted to Ashford and St Peter's Hospital (ASPH) by ambulance, where he disclosed that his daughter *punched him.* He was transferred to a nursing home in the same month where he died some eight months later. Jill Watts was convicted of three charges – Making a Threat to Kill, Assault Occasioning Actual Bodily Harm and Common Assault – and *received a 12 month community sentence and supervision requirement and £60 fine*.[5]

About this Serious Case Review (SCR)

4. The SCR was commissioned by Surrey County Council and is based on information from:
   - Surrey County Council, Adult Social Care *(ASC)*
   - *NHS Surrey*[6]*, Continuing* Health *Care* *(CHC)*
   - *Surrey Police*
   - *Surrey and Borders Partnership* Trust *(SBPFT)*
   - *Ark Health*
   - *Agi*ncare
   - *Ashford and St Peters Hospital NHS Foundation Trust* *(ASPH)*
   - *Virgin* Care
   - South East Coast Ambulance Service (SECAmb)
   - Sam Beare Hospice

Analysis of events concerning assessments, *decision-m*aking and planning

5. Following her father's hospital stay in 2009, Jill Watts was sent a Carers' assessment form to complete by post. This did not lead to any support for her.
6. In March 2010, Mr D spent four days at ASPH following *a fall and therapists led the assessment and discharge planning process. Mr D* was discharged home in the late evening despite being

[1] IMR Adult Social Care
[2] IMR Adult Social Care
[3] IMR Surrey and Borders Partnership NHS Foundation Trust
[4] Police: Individual Management Review (IMR) i.e. their own account of association with Mr D and Jill Watts.
[5] Notes of Safeguarding Adults Senior Strategy Case Conference 06.03.13
[6] Surrey Downs CCG is now the host NHS body for NHS Continuing Health Care

incontinent of urine, with unsteady mobility and having refused extra help at home. In September, the ambulance service attended Mr D after a fall and reported to the adult social care Emergency Duty Team (EDT) that he was surrounded by urine bottles and was wearing inappropriate clothing. He had no food, he had not taken his medication and his daughter was away for the weekend. EDT instituted an interim Safeguarding Adults Plan *to provide time for the safeguarding and vulnerability concerns to be explored parallel with medical treatment.*[7] The medical notes described Mr D as *a vulnerable adult unable to cope at home…* The Adult Social Care assessment noted that Jill Watts *struggled with caring for Mr D's incontinence*, that she was *finding caring for him stressful* and she requested a carer's assessment. Mr D was advised by a doctor of the need to accept his support plan, i.e. the assistance of two care workers each day, and he was discharged home. Overall, there appears to have been no collective agreement about how to respond to the alarming circumstances in which Mr D was admitted to hospital and to ensure a safe discharge home.

7. The resulting carer's assessment was vague, with no plan of action and no evidence that Jill Watts' concerns about her father's incontinence or her ability to care generally were considered. She went on to have one further assessment during 2011 and two more during 2012.
8. Between December 2010 and March 2011, Mr D had at least eight further falls, all resulting in 999 calls and attendance by paramedics and none of which resulted in a re-assessment of his needs.
9. Jill Watts called the Runnymede Locality Team in January to ask for respite care for her father for the weekend and, when her call was returned three weeks later, she expressed concerns about his falls. There is no information about any action resulting from this call.
10. The paramedics attended Mr D in March 2011 following his eighth fall and sent a second vulnerable adult referral form to social services, as they noted that Jill Watts appeared to have been drinking and was struggling to cope. Mr D was admitted to hospital. Although Mr D told doctors that his daughter had put his walking frame out of reach, often punched him in the chest and did not give him enough food, he told social services that he did not want to take the matter further and would like to go to a care home. The social care worker noted '*sounds like carer breakdown'*. Later, Jill Watts visited the ward, shouting that she wanted to take her father home. A social worker noted that she smelled *of alcohol*[8]*.* An unknown professional noted that Mr D had capacity and would sign the self-discharge form; there is no evidence of a mental capacity assessment or Best Interests Decision process. The ward doctor rang the GP to inform him of Jill Watts' behaviour on the ward, at which the GP expressed surprise. No-one appears to have made the link with the circumstances of his earlier admission to hospital six months previously.
11. Mr D was discharged home in April despite again refusing help. Mr D's file was *transferred back to Runnymede Locality Team for professional monitoring*[9] which did not occur. A week after Mr D's discharge, the GP referred Mr D to an old age psychiatrist for *an opinion on his dementia*.[10]
12. Two months later, Mr D was re-admitted to hospital with leg pain. The physiotherapist and occupational therapist assessed and treated Mr D and he was discharged home after 12 days. A failed attempt to contact Jill Watts was recorded. There was no reference to social care input.

[7] Emergency Duty Team chronology
[8] Hospital social care team (HSCT) information
[9] HSCT Information
[10] Referral letter from GP to Psychiatrist 18.04.11

13. During October, paramedics took Mr D to A&E following a 999 call by his daughter at 21.10. He was unable to mobilise without assistance. At A&E it was noted that he had a diagnosis of dementia and that his mobility had further reduced. He was diagnosed with a chest infection and prescribed antibiotics. At 00.50 the doctor rang his daughter and booked transport for his discharge.[11]
14. In March 2012, Mr D was admitted to ASPH, resulting in a period of rehabilitation at Woking Community Hospital before his transfer back to ASPH when he became very unwell. A second Supported Self-Assessment was completed in May and led to a support plan for care worker visits three times a day. By now, Mr D had a long term catheter, about the management of which Jill Watts had expressed concerns. Also Mr D had developed problems with swallowing and was at risk of aspiration. A carer's assessment[12] was carried out at the same time. This rated the impact on her of caring for her father and son as *substantial.* Jill Watts gave mixed messages about her willingness and ability to cope. There is no evidence that this triggered any additional concerns for Mr D's safety, despite the known history and the significant deterioration in his health.
15. The assessment for PEG feeding had concluded that this was not suitable. Although the completion of a mental capacity checklist was planned, there is no record of this being done.
16. In June, Mr D was deemed eligible for fully funded NHS continuing healthcare. The Continuing Health Care (CHC) Team assumed lead responsibility for planning his discharge and liaised appropriately. Mr D was discharged home later that month with visits four times daily to assist with hygiene, transfers using a hoist, and help to eat and drink. Ark Health, the care provider, was given no information concerning Jill Watts' erratic behaviour and the implications for the safety of Mr D or their staff.
17. There was no referral from ASPH to the community nursing service, even though the Fast Track care plan indicated *the need for District Nurse services alongside palliative care for symptom control* for him[13]. The community nursing service was therefore unaware of Mr D's nutritional and catheter care needs. It was not until four and a half weeks post discharge that a catheter care plan was completed, after the CHC Team had tried unsuccessfully to elicit further information from ASPH.
18. The Sam Beare Hospice team liaised with the district nursing service and with the CHC team. They provided advice to the health professionals looking after him and support to his daughter, who rang them twice for advice.
19. On 10 August, a Friday, Ark care workers reported concerns to the CHC team about Jill Watts' aggressive behaviour towards them and her threats not to give her father food and medication over the weekend. The CHC team contacted the GP surgery, the community nurses and social services to ensure that Mr D's needs were met over the weekend and to seek advice in relation to what they regarded as a safeguarding concern. However, having been informed that the GP had no concerns (despite only speaking to the daughter on the phone) the Runnymede Locality Team made the decision that this was not a safeguarding concern and that they would await a written report from the district nurses and the Ark care agency. The case was referred to the Carer's worker in the Locality Team, who set a date for a further carer's assessment during September following a failed contact with Jill Watts, i.e. three weeks after the concerns about her care of her

[11] Discharging a frail old man with dementia, mobility problems and a chest infection in the middle of the night is poor practice and contrary to discharge planning guidance.

[12] HSCT information

[13] NHS Surrey IMR

father were raised by Ark. The Runnymede Locality Team did not appear to understand the sense of urgency expressed by professionals. Their response was unchanged even after Ark confirmed to them directly that Jill Watts had been under the influence of alcohol.

20. The CHC team arranged a review at Mr D's home. It concluded that the threat of withholding medications and meals had been 'misunderstood' by the care agency. It is unclear whether Jill Watts' aggressive behaviour towards the care workers was discussed. The review noted however that she 'barricaded' her father in his bed and chair with furniture. Although they did not regard this as a safeguarding matter they reported them to social services, resulting in an occupational therapy assessment the following day. The rationale for their conclusions was unclear.
21. Within a week, further concerns were raised when a community nurse visited Mr D to find him distressed and extremely thirsty. She gave him fluids and left another drink for him on leaving – an action contra-indicated in his nutritional care plan (he required supervision as he ate and drank), which was unknown to the community nurses. Identical concerns were expressed the following day by a hospice clinical nurse specialist and reported to the Runnymede Locality Team, which decided to hold a safeguarding meeting. Following further reports by Ark care workers that they felt vulnerable in the light of Jill Watts' behaviour whilst under the influence of alcohol, the Runnymede Locality Team sent an unqualified assistant practitioner to visit alone, to assess Mr D's wishes. The assistant practitioner observed that he was offered dry biscuits by his daughter and he said he wanted them despite his dietary guidelines.
22. The police were not invited to the Safeguarding Strategy Meeting. This was an unfortunate omission because they had attended several incidents from 2006 to 2009 at Jill Watts' former home, arising from her aggressive behaviour under the influence of alcohol, for which she had been cautioned. The main focus of the discussion at the Strategy Meeting was Mr D's mental capacity and the risks associated with his daughter's erratic care i.e. he was alone for long periods, his medication was irregularly administered, he was offered inappropriate food and drink and he was being 'barricaded' in his bed and chair. It was agreed that a mental capacity assessment would be completed within seven days and that risk assessments and a carer's assessment would be completed within two weeks.
23. There was no mental capacity assessment undertaken for Mr D until after Jill Watts' arrest. The task was allocated jointly to the district nurses and the CHC team at the Strategy Meeting. CHC sought to get (i) the GP (ii) the Runnymede Locality Team to do the assessment, without reference to the district nurses. ASC had no role in Mr D's care management because of his CHC funded package. Following legal advice on the council's responsibilities, ASC re-asserted that the assessment was the CHC Team's responsibility and wrote to the GP to request his co-operation.
24. This exchange illustrates the importance of explicitly agreeing actions arising from Safeguarding Meetings and ensuring their implementation.
25. The carer's assessment was undertaken during September without reference to the safeguarding context triggered by Jill Watts' behaviour. The conclusion that she was coping well lacks credibility. The assessment was signed off by a team manager who acknowledged that he did not read it before doing so[14]. The outcome of this assessment was not communicated to the chair of the Strategy Meeting until three weeks after its completion. Thus there was a lack of management direction and oversight within the Runnymede Locality Team and NHS Surrey to

[14] IMR ASC

ensure that assessments were carried out to the required standard and that information was fed back into the appropriate forum to ensure that decision making was based on clear evidence.

26. Following further incidents of aggressive behaviour by Jill Watts, Ark gave notice of withdrawing from providing the care package in early September. The new home care agency, Agincare, started and there were no reported problems until early November when the care workers arrived at the house to find Jill Watts with her hands around Mr D's neck.
27. Mr D was admitted to hospital and the care planning and decision making processes from then on appear to have been effective. A further strategy meeting was held when it was established that only three of the ten agreed actions at the first strategy meeting had been completed. Mr D was transferred to a nursing home in November. The medical notes state *Social Services, PCT and IMCA all agree best interest*[15]*,* the first time that a formal record is made of such a process.

How were Mr D's (i) medical diagnosis, (ii) mental health and (iii) care needs addressed by the various agencies?

28. The clinical care that Mr D received during his various hospital stays appears to have been good. There is evidence of regular medical and therapy reviews, including a thorough assessment of his swallowing problems and nutritional needs by a Speech and Language Therapist and a dietician respectively and consideration of his suitability for PEG feeding (all in 2012).
29. Mr D had many falls at home that resulted in 999 calls and attendance by paramedics, far more than resulted in conveyance to hospital and subsequent admission. Yet these did not result in re-assessment or referral to a falls clinic.
30. Although Mr D was diagnosed with dementia during October 2011, there is no evidence of any attempt to undertake a comprehensive assessment of his cognition or his mental capacity until after the safeguarding strategy meeting in September 2012 (see Lepping 2011).[16] No-one instituted a Best Interests Decision process, irrespective of escalating concerns and an unqualified assistant practitioner was sent to assess his wishes regarding support from the care workers. Her view that Mr D had capacity was later influential in the police's decision that they did not need to become involved following the safeguarding meeting.
31. ASPH failed to refer Mr D to the community nursing service on discharge from hospital in June 2012. This meant that Mr D's catheter was not changed for almost 20 weeks.[17] Once the nurses became aware of the catheter problem they obtained the relevant information from the ASPH and completed a catheter care plan.
32. Mr D was referred to the palliative care team whilst in ASPH and they referred him to the Sam Beare Hospice team for support when he was discharged. The team were in regular contact with him, liaised with the community nurses and the CHC team and reviewed his needs during the three months of their contact.
33. Both care agencies appear to have provided a good quality of care. Jill Watts' aggressive behaviour towards some care workers eventually led to their giving notice of withdrawal. When the care provider changed to AginCare, the package seemed to work well and there were no reported problems by any agency for seven weeks. However, there was no proper hand-over between care providers, so the care workers were unaware of the concerns about Jill Watts' care of her father.

[15] IMR ASPH

[16] Lepping, P (2011) Overestimating patients' capacity. *The British Journal of Psychiatry (2011) 199:355-356*

[17] Good practice guidelines that recommend at least every 12 weeks, depending on individual needs

How were Mr D's daughter's mental health and carer's needs addressed?

34. Jill Watts underwent carer's assessments in 2008, 2010, 2011 and 2012 (twice) – five in total. Despite these, little is known about her life - although it appears to have centred on caring for members of her family for a considerable length of time. Broadly, the assessments were ineffective in identifying her needs and agreeing appropriate support for her and none had clear action plans. An assessment undertaken by the Community Mental Health Recovery Service (CMHRS) advised her to ring ASC herself, rather than advocating on her behalf. Another noted that she provided *some* support for Mr D, suggesting inaccurately a minor role. The assessment of 2012 arose from safeguarding concerns and yet it was planned by ASC three weeks after the alarm was raised. It lacked credibility because it did not address the safeguarding concerns.
35. Jill Watts gave contradictory information about her ability and willingness to look after her father. There was clear evidence both at home via the paramedics and in hospital that she misused alcohol and the GP referred to her in his psychiatric referral letter of April 2011 as *a heavy drinker*. Yet there is no evidence that professional attention was paid to her father's reports of neglectful care, her aggressive behaviour or the implications for how she was caring for her son, also a vulnerable adult who was reliant on her support.
36. In her telephone interview with the author, Jill Watts described the befriending nature of the support she provides to her son. He used to help her look after her father, but he ceased to help when carers began to visit his grandfather. This placed additional pressure on her to visit her son. Jill Watts stated that her father *'hated being in hospital'* and it is possible that she allowed her desire to meet her father's wishes to be at home to override her own needs. She also believed that the house in which she lived would have been taken into account in her father's financial assessment and she was worried about losing her home.

How effective was information sharing (i) within organisations and (ii) with other agencies, (iii) with Mr D and (iv) with his family?

37. Within ASPH, there is evidence of involving Mr D in decision-making. However, there was an optimistic over-reliance on his cognitive abilities. The GP was informed of concerns about Jill Watts' behaviour and she was involved in discussions about her father's treatment but her involvement in discharge planning was patchy. Crucially, the hospital failed to refer Mr D to community nursing regarding his catheter care and nutritional needs.
38. The GP did not respond directly to messages expressing concern about Mr D's situation or when he was asked to visit Mr D. The GP neither shared information concerning the mental capacity assessment nor accepted information about Jill Watt's behaviour as a reason to work more collaboratively.
39. The Carer's assessment from the CMHRS was not shared with the locality team. Similarly, the other four assessments were not shared with the CMHRS or used as a means to assess whether there were any risks to Jill Watts' son, for example.
40. Neither Ark Health nor AginCare were fully briefed about Mr D's needs and his daughter's difficulties prior to commencing the care package.
41. The police and the Sam Beare Hospice team were not invited to the initial strategy meeting.
42. There is little evidence of information exchanges between the hospital social work team and the locality team, in either direction, other than the transfer of the case for *professional monitoring*.

Identify any organisational factors which may have impacted on practice in working with Mr D

43. The community nursing service was in transition in late 2012 following the change of provider as a result of a tendering process. This included the merger of two teams and nurses reported large caseloads and absent leadership. Handovers were sketchy, which may account for the lack of documented input from the community nursing service during 2012 and the failure to contribute to Mr D's mental capacity assessment.
44. The pressures on A&E and acute medical services meant that Mr D was seen by many different doctors, so that no one person or medical team had a clear overarching view of the unfolding events during 2008-2012. Better recording, more accessible summaries on discharge, and systematic review of medical notes when clerking in patients may have resulted in a better understanding of Mr D's circumstances.
45. Staffing levels in the Runnymede Locality Team were low during 2011 when the Personal Care and Support service was being restructured. The changes were intended to support the introduction of personalisation, with strengthened supervisory capacity. Since the assistant practitioner role for carer's support was new in September 2012, this may have accounted for the poor assessment of Jill Watts' needs.
46. As a self-funder Mr D would not have had an annual review by the Runnymede Locality Team. It is possible that his status as a self-funder may have influenced hospital staff, who did not refer him to the hospital social care team during his later admissions in 2011.

How effective were agency responses as measured against the expectations set down in the multi-agency policies and procedures for safeguarding adults?

47. In terms of a collective safeguarding response, there was a failure to connect up the various pieces of information concerning Mr D's vulnerability and resistance to accepting help, even when there was clear, documented evidence of his daughter's aggressive behaviour and neglectful care. All agencies must take responsibility for agreed actions and ensure that their internal procedures support this.

48. ASPH followed internal procedures for reporting safeguarding concerns in terms of completing incident forms but there were no responses from senior personnel, for example concerning Mr D's neglected state, his allegations that she hit him or Jill Watts' behaviour. Neither the concerns nor the allegations were reported externally as safeguarding alerts to the local authority.

49. There are two key events prior to the safeguarding alert in August 2012, when ASC could have responded more effectively. The first occurred in September 2010 when Mr D was admitted to hospital after being found surrounded by urine bottles and left unattended. Six months later he was re-admitted to hospital, when the ambulance service reported that Jill Watts was not coping and Mr D said that she often hit him and did not give him enough food or drink. On neither occasion did these prompt safeguarding responses or concern about Jill Watts' care-giving.
50. Following the safeguarding alert by the CHC Team in August 2012, the Runnymede Locality Team waited for feedback from the district nursing service, a written report from the care agency and the results of a carer's assessment which was arranged for three weeks later.
51. Further concerns resulted in a strategy meeting on 3 September 2012. Because the chair did not brief the carer's lead on the escalating safeguarding matters, the carer's assessment of the following day was inadequate. Critically, identified actions from the strategy meeting were not undertaken.

52. Within Virgin Care, neither the Community Nursing Manager nor the Lead for Safeguarding Adults was informed of impending strategy meetings as required by their Internal Surrey Community Health Safeguarding Adults Operational Guidelines (2012, v4). They were therefore unable to ensure that the mental capacity assessment was undertaken.
53. Although written records are kept in the patient's home, which inhibits staff from recording all known information, there is also an electronic system which included a "vulnerable adult" alert. If set, this would have alerted visiting health professionals to be vigilant in their approach. There was no such alert. It does not appear that the District Nurses recorded their weekly visits or reported on their findings. Virgin Care noted that community nurses were recording in several places – e.g. patient held records, electronic system and often on GP records – which does not ensure safe and co-ordinated care.

54. The Continuing Health Care Team, NHS Surrey CHC responded promptly to the concerns raised on in August 2012 and communicated with the Trust's safeguarding lead and the Runnymede Locality Team. However, their conclusion that Jill Watts' threats to withhold her father's medication and meals had been 'misunderstood' by the care workers and their rationale that 'barricading' her father into his bed and chair was not a safeguarding matter are puzzling.
55. The duty nurse did not record the name and details of the CNS who gave the alert later in August.
56. Following the safeguarding strategy meeting there was a confused response from the CHC Team. Even when it was finally decided after three weeks that the Team would carry out the mental capacity assessment, the team was pursuing the GP for a written opinion.

57. Ark Health responded quickly and appropriately to the concerns raised by the care workers. They informed the CHC team, on advice from the palliative care team which they contacted initially, and kept them informed of further events.

58. It is accepted by Agincare that the care workers should have called the police as the first response when they found Jill Watts with her hands around Mr D's neck.

59. On being told that Mr D had capacity and would not co-operate with an investigation, Surrey Police decided that it would not be appropriate to pursue the safeguarding concerns. Under the circumstances this was a reasonable conclusion to come to.
60. Following the alert on 10 November the police responded promptly and Jill Watts was arrested and charged.

The Lessons

61. Hospital social workers can only respond if patients are referred to them, so clear understanding of their role by other members of the multi-disciplinary team is essential. Staff need the skills and competences to be able to work with the complexities of Mr D's circumstances, including safeguarding concerns raised by other professionals. Their input to multi-disciplinary decision making must be clear and accountable. They must share information appropriately and in a timely way, including with their locality colleagues. From the information available to this SCR, this did not happen.

62. Not only were no mental capacity assessments or Best Interests Decisions undertaken by any professional prior to the safeguarding alert in August 2012, confusion followed once it was decided at the strategy meeting that these were required and there was a lack of clear leadership to ensure that they were done. The Mental Health Foundation (2012)[18] highlights various methods for gathering evidence to support capacity assessments and the importance of clear recording systems. It also emphasises the value of providing good information, and being open and timely in sharing information and planned actions. An assumption of capacity on Mr D's part did not remove the responsibility to manage risk and put protective measures in place for him. People may make unwise decisions, but the risks remain. There was only one risk assessment prior to the strategy meeting.
63. Discharge planning for people with complex needs is a multi-disciplinary responsibility. Mr D was discharged from hospital twice at inappropriate times, once in the late evening and once in the early hours. On the latter occasion, his diagnosis of dementia was not taken into account. Mandelstam (2011)[19] has highlighted the unacceptably high numbers of frail people who are discharged from hospital at inappropriate times of the day and night. No-one was clearly designated as being in charge of planning his discharge in the two earlier admissions where there were safeguarding concerns. On his penultimate admission in 2012, the CHC team took the lead, but the acute hospital failed to make a vital referral to the community nursing service concerning catheter care and nutritional needs.
64. Carers' assessments should provide a genuine opportunity for family carers to state their needs and discuss how they can be supported in their caring role. Jill Watts had five assessments, none of which led to any action to support her in her role, despite evidence of stress and erratic behaviour. None of them made an explicit connection between her care for her father and her care for her son, nor identified that she had previously cared for her mother with dementia.
65. Mr D was in a supposed place of safety – an acute hospital – on two occasions when he was referred as a vulnerable adult, with clear indications of neglectful care and physical abuse, yet there is no evidence that the concerns were investigated thoroughly or that steps were taken to protect him. Mr D's assertion that he wanted to go home without support other than from his daughter was not challenged or explored in any depth. Professionals relied on what he told them and took what his daughter said at face value, even though they both gave contradictory information about what they wanted and her ability to look after him
66. Safeguarding and protecting vulnerable adults require strong leadership at every level and in all agencies. The local authority is the lead agency and must establish a culture that ensures that procedures are followed and action taken by partner agencies, providing guidance and direction when difficulties arise. Individual agencies must ensure that clinicians and practitioners are supported to respond to safeguarding concerns that go beyond attending a training course and filling in incident forms. Staff must be prepared and supported to have difficult conversations with individuals to address concerns about the safety of a vulnerable person.

Conclusions

67. The experience of Mr D and his daughter were compromised by the poor recording of crucial facts and lack of detail in assessments. His hospital discharge planning was poorly co-ordinated

[18] Williams V, Boyle G, Jepson M, Swift P, Williamson T and Heslop (2012), *Making best Interests Decisions: People and Processes* London: Mental Health Foundation Norah Fry Research Centre and University of Bradford. Available at www.mentalhealth.org.uk/publications/bids-report

[19] Mandelstam, M (2011) *How we treat the sick: neglect and abuse in our Health Services* London: Jessica Kingsley Publishers

and information about Mr D's cognitive impairment, his mental capacity, allegations about his daughter's neglectful care and the protective measures which needed to be in place if he were discharged to her care were not known across agencies. These are suggestive of systems failures both in relation to assessment and care planning for father and daughter and in response to safeguarding concerns. Crucial facts were not checked out, including Mr D's assertion that he had a walk-in shower and a stair-lift, and Jill Watts' claim that she had Lasting Powers of Attorney for health, wellbeing and finance.

68. There was a significant lack of understanding about the provisions of the Mental Capacity Act 2005. Further, there are many examples of inattention to timely information sharing.

69. There was no urgency in addressing the safeguarding concerns. The circumstances which led to Mr D's hospital admission in September 2010 became '*self-neglect*' and this, combined with his status as a self-funder and the assumption that he had capacity to make his own decisions, may have influenced professional decision making. When further safeguarding concerns were noted six months later, there was no evidence of explicit discussions about the risks within the multi-disciplinary team and the potential protective measures required if he did have capacity – in which case his decisions were unwise (see Brown 2011[20]). The view that Mr D had capacity is dubious since there are no documented capacity assessments and his GP had referred him to the old age psychiatry service for an assessment soon after a discharge from an extended hospital stay. When the safeguarding concerns of the home care staff were reported during August 2012, the Runnymede Locality Team's response was to await information from the district nurses and a written report from the home care agency and to refer for a carer's assessment - which did not take place for a further three weeks.

Recommendations

70. **Surrey Safeguarding Adults Board**:
    - The Board should review how it audits and monitors the application of multi-agency safeguarding procedures and how it can inform training plans and competency frameworks. This is because the case illustrates failings in a number of agencies in their application
    - The Board should use this SCR as a case study to examine the effectiveness of its multi-agency procedures for protecting vulnerable adults, in particular the threshold for convening a strategy meeting; the recording of strategy meetings and the quality assurance of the resulting documentation; who should attend; and the follow up of agreed actions
    - The Board should review its multi-agency training strategy to ensure that it addresses i) the need to have difficult conversations with individuals, especially family carers, about matters such as substance or alcohol abuse; ii) ways of helping staff identify when they may need additional support; and iii) the fact that an unwise decision does not remove risks and that individual protection plans may still be required

71. **All agencies** (Surrey County Council Adult Social Care, all Surrey CCGs, Surrey Police, Surrey and Borders Partnership NHS Foundation Trust, Ashford and St Peters Hospital NHS Foundation Trust, Virgin Care) should:

[20] Brown, H. (2011) The role of emotion in decision-making. *The Journal of Adult Protection* 13, 4, 194-202

- Ensure that their internal procedures and training arrangements for the Mental Capacity Act include: undertaking mental capacity assessments; how to make Best Interests Decisions; and the implications for professional practice when unwise decisions are made by people assessed as having mental capacity. Confusion and a lack of understanding about the Mental Capacity Act are highlighted by this case. In addition, commissioning organisations should consider the adequacy of their contracting arrangements with providers to ensure compliance with the Mental Capacity Act
- Assure themselves that their internal procedures and training arrangements for assessing and managing risk are adequate
- Ensure staff are trained in safeguarding procedures
- Remind staff of the need for accurate, factual and timely recording and the sharing of key information, revising their training and auditing arrangements where necessary

72. **Surrey County Council should:**
    - Assure itself that Chairs of Safeguarding meetings are assessed as competent and that they understand their role and responsibilities in terms of ensuring that the appropriate agency's are invited to safeguarding meetings; co-ordinating the actions of other agencies; following up agreed actions; and ensuring that these occur within the required timescales. They should inform the Board of how they will do this
    - Be unequivocal about what work should be allocated to qualified social workers and unqualified practitioners in relation to safeguarding and how they should be supervised and supported, to ensure that unqualified practitioners are not asked to (a) undertake inappropriate tasks or (b) work without appropriate support. ADASS has produced an advice note in partnership with Skills for Care on social work in adult social services[21]
    - Assure itself of the quality of Carers' assessments at team level, so that they are signed off appropriately and take account of adult safeguarding; and ensure staff are trained in how to undertake Carers' assessments so that they are holistic, take account of safeguarding concerns and support the intelligent use of information both to support carers better in their role and to protect vulnerable individuals
    - Take steps to improve information sharing and communication between hospital based and locality social care teams to ensure that each is aware of concerns and is clear about their respective responsibilities
    - Consider how it might improve responses to referrals for people funding their own care to ensure that they are not disadvantaged in terms of access to advice and support.

73. **Virgin Care should**:
    - Ensure that its recording systems and application of its own procedures enable key information to be recorded for each patient, shared as necessary with colleagues and easily retrievable
    - Confirm to the Safeguarding Adults Board that it has implemented the Choking Prevention guidelines (2014) which have been adopted by the Board
    - Ensure that patients receive holistic assessments with individualised care plans

[21] Association of Directors of Social Services (2010, updated 2012) *Social work in Adult Social Services* available at www.adass.org.uk/images/stories/Workforce_Development/advicenote1.pdf

74. **All Surrey acute NHS hospital Trusts should:**

- Ensure that their procedures for referring patients to adult social care are inclusive of people who pay for their own care so that they are neither administratively invisible nor disadvantaged (see Carr-West and Thraves 2013[22])
- With adult social care, ensure that arrangements for hospital discharge comply with best practice; take account of safeguarding concerns; are timely; and are explicit about multi-disciplinary assessments and decision-making
- If they have not already done so, sign up to the *Call 2 Action* for acute care as part of the Prime Minister's Challenge and ensure they have plans in place to improve the patient experience of people with dementia and family carers. This should include: raising awareness and understanding of the workforce about dementia; identifying a senior clinician to take the lead for quality improvement in dementia in the hospital; and developing an explicit care pathway for the management and care of people with dementia in hospital, led by that clinician. There are high numbers of people with cognitive impairment in the in-patient population and some aspects of this case, for example discharge from A and E and discharge planning from the wards, confirm the evidence that the patient experience of acute hospital care is often poor

75. **All Surrey CCGs should:**

- Ensure that their arrangements for assessing and reviewing patients receiving NHS continuing healthcare and funded nursing care include safeguarding concerns and the involvement of other agencies, such as adult social care and hospice teams, as necessary
- Confirm that each CCG has Mental Capacity Act and adult safeguarding leads and that they receive appropriate training
- Work with the ambulance service, acute NHS Trusts, primary and community health care services to ensure that people who are frequent fallers, and their family carers, are referred for appropriate assessment, advice, treatment and support

76. **NHS England should:**

- Consider ways of influencing and supporting GPs to develop and participate in networks within their local health and social care economies
- Consider ways of securing the engagement and active participation of GPs in safeguarding and in the Serious Case review process in anticipation of the new statutory function of Adult Safeguarding Boards

77. **Surrey and Borders Partnership Trust should:**

Take steps to improve its arrangements for information sharing, particularly in relation to Carers' assessments, between their community teams and Adult Social Care.

[22] Carr-West, J. and Thraves, L (2013) *Independent ageing: Council Support for Care Self Funders* London: Local Government Information Unit and Partnership Assurance Group plc