Essex Safeguarding Adults Board

WENDY

SAFEGUARDING ADULT REVIEW

A REVIEW COMMISSIONED BY ESSEX SAFEGUARDING ADULTS BOARD INTO THE CASE OF WENDY, A 74 YEAR OLD FEMALE WHO DIED IN SEPTEMBER 2018

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MAY 2020

Contents

1. THE REVIEW PROCESS

1.1. This summary outlines the process undertaken by the Essex Safeguarding Adults Board in reviewing the period of care prior to the death of Wendy.

1.2. Wendy died in September 2018, aged 74. She lived with her husband (aged 78) and her son (in his 40s). Her son was recorded as being her main carer. Wendy was recorded as being of White British ethnicity.

1.3. Wendy died of Faecal Peritonitis, Perforated Diverticular Disease, Pneumonia and Urinary Tract Infection.

1.4. The Review process began with the decision of the Essex Safeguarding Adults Board to hold a Safeguarding Adults Review (Review). The Southend, Essex and Thurrock Safeguarding Adult Guidelines state the Board must arrange a Review "when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult."

1.5. All agencies that potentially had contact with Wendy were asked to confirm whether they had been involved. Chronologies were requested from all relevant agencies and a composite chronology was created.

1.6. Partnership Learning Events were held with practitioners and managers from the agencies (see section six). The report was agreed at the Safeguarding Adults Review Sub-Committee and was then reviewed at the Essex Safeguarding Adults Board where amendments were requested. The final report was agreed at the SAR Sub-Committee in August 2019.

2. TERMS OF REFERENCE FOR THE REVIEW

2.1. The Review considered the period 1 September 2017 to 1 December 2018, to gain an understanding of the period from when safeguarding concerns were raised until the time Wendy died.

2.2. Based on the information gathered from agencies, the following terms of reference and key themes were identified:

- To develop an understanding of Wendy's vulnerabilities, her capacity to care for herself, her level of independence, her ability to manage her deteriorating health and consider in this context:
  - How agencies worked together to support her.
  - Whether different approaches could have been considered.

- What preventative actions could have been taken by agencies that may have reduced the possibility of Wendy's circumstances escalating.
- Whether agencies have policies and procedures in place in relation to working with people who have multiple health issues and are difficult to engage.

- To explore how Wendy was managed through existing adult safeguarding procedures and consider:
  - Whether systems and processes in place for assessments are sufficient in order to safeguard adults when assessment challenges are presented, such as accessing a property.
  - How this impacted on Wendy's care, and what alternative approach(es) could have been considered/taken.
- To identify whether agencies complied with any safeguarding protocols that have been agreed within and between agencies including those covering:
  - Information sharing.
  - Risk assessment and management.
  - Ensuring receipt and acknowledgement of referrals, concerns and emails, and ensuring reviews take place appropriately.
  - Ensuring accurate recordkeeping takes place.

3. PARTICIPANTS IN THE REVIEW

3.1. The following agencies participated in the Review:

- Local Hospital NHS Trust
- Domiciliary Care Provider 1
- Clinical Commissioning Group
- Ambulance Service
- Essex County Council Adult Social Care
- Essex Fire and Rescue Service
- Community Health Provider
- Wendy's General Practice

4. INVOLVEMENT OF FAMILY

4.1. The ESAB team wrote to Wendy's husband and son. The letter invited contact directly from the family, if they wished to be involved. Wendy's son informed the ESAB team that he wanted to be part of the Review. The report author made

contact and a meeting was arranged. Wendy's son did not arrive for the meeting. The report author made contact again to try to rearrange and had a telephone conversation with him to gather his feedback, which is within this report.

4.2. Wendy's other son was also notified of the Review, and the report author spoke with him on the telephone. His feedback has been incorporated into this report.

5. AUTHOR OF THE REPORT

5.1. The independent report author was Althea Cribb. Althea has been delivering Domestic Homicide Reviews for six years and has completed eighteen to date, including a number which have covered adult safeguarding concerns and issues, through which Althea has developed expertise in this area.

6. PARTNERSHIP LEARNING EVENTS

6.1. Two events were held to establish and agree the learning: one for practitioners and one for managers. Participating agencies were represented as follows:

Agency	**Practitioner**	**Manager**
Local Hospital NHS Trust	N	Y
Domiciliary Care Provider 1	Y	N
Ambulance Service	N	N
Essex County Council Adult Social Care	Y	N
Essex Fire and Rescue Service	Y	Y
Community Health Provider	Y	Y
Wendy's General Practice	N	N/A
Clinical Commissioning Group	N/A	Y

6.2. For the practitioner event, the report author gathered the available information from agencies and family to develop a series of exercises with participants to: establish and agree the facts of the case and identify gaps that needed further investigation; attempt to understand Wendy's lived experience; identify the good practice and learning in relation to the case.

6.3. Following the practitioners' event, the report author wrote the report and a draft was shared with participants before sending to managers. The findings and recommendations were then discussed and agreed at the managers' event.

7. SUMMARY OF THE CASE

25 September 2017

7.1. Wendy attended her General Practitioner (GP). The appointment had been prompted by the GP, following a review in which it was noted Wendy was due a medication and blood pressure review. As Wendy had not attended, the GP had to stop the medication. Following this, Wendy attended for an appointment. She was accompanied by her husband and was recorded as being in a "neglected state". Her wheelchair was broken. Her son was her main carer and stated there was no hot water, the shower was on the ground floor and she was unable to go downstairs. A home visit from the community matron was offered and declined: the family said the dog had puppies and therefore it was not convenient. The GP made a referral for Wendy to Adult Social Care (with Wendy's consent), which was received. A medication review was scheduled for one year; Wendy's medication was reviewed when she was admitted to hospital in December 2017 and May 2018 as a result of which a GP review was not due until May 2019.

7.2. Adult Social Care contacted Wendy. She confirmed that her husband and son supported her with daily living activities; her son was her main carer and supported her with washing, dressing, meals and medication. She stated her husband had purchased another wheelchair. An appointment had been made to repair the boiler. Wendy did not wish the enquiry to go further and declined an assessment. She did not feel she was being mistreated in any way. She confirmed she knew she could contact Adult Social Care for an assessment or support if required.

5 – 19 December 2017

7.3. *5 December:* The Ambulance Trust responded to a 999 call for Wendy as she had not eaten for a week and could not move. The ambulance took Wendy to hospital and raised a concern to Adult Social Care. A notification was sent to the General Practice. Wendy was admitted to the local Hospital with general unwellness and infected grade one pressure sores on her buttocks for which she received treatment.

7.4. Adult Social Care received the concern from the Ambulance Service. It stated: "Patient was lying in bed when we arrived; she was saying that she was unable to get up. Patient is suffering with Polynueromyglia which means that she has pain constantly. Patient stated that she has not gone downstairs for 3 weeks; the patient stated that she had only got up to use the commode which is next to her bed. Patient's son is the main carer and he lives at the property along with 8 boxer dogs

which were in cages. Patient does not have any other carer. The living conditions, there were dog faeces on the floor, dog urine; the floor boards were sticky and dirty, there was no path to walk. There was no main central heating; the family stated that they are waiting for that to be fitted in. There were flies on the patient. There were no main lights apart from small lamps so it was difficult to see. The patient smelt strongly of urine and the whole property also smelt strongly of urine. The patient is complaining of bed sores on her bottom, she was uncomfortable and they are obviously not treated, we did not see the bed sores. As far as we are concerned the patient had capacity but she was unable to tell us what the date was today. We did ask the patient why she had not seen her GP but she had no reasons why she had not seen them."

7.5. *6 December:* Adult Social Care attempted to telephone Wendy; the number on file and on the referral was not in service. A Social Worker planned to visit the property as further information was required to establish Wendy's views on the safeguarding concern. If access was not allowed or it was not considered safe to enter, they would discuss attending with police present. A plan was also made to contact the GP if it was considered that there was a risk to Wendy and others.

7.6. *7 December*: The Social Worker spoke with the hospital ward and was advised that Wendy was medically fit for discharge, but they could not state what the discharge plan was. The Social Worker informed the nurse of the safeguarding concern. The Social Worker noted that the nurse had not been aware of this although the community manager had informed the ward the previous day. There is evidence throughout the nursing notes of awareness of the safeguarding concern. The Adult Social Care record stated that the case was allocated to a Social Worker to ascertain Wendy's views and identify whether a full safeguarding enquiry under s.42 of the Care Act 2014 was required, or case management to address Wendy's needs.

7.7. *8 December*: The GP contacted Adult Social Care for an update. They referred to the concern raised in September that they had not had an update on. The GP informed Adult Social Care that they had tried to visit the home, but Wendy's son did not allow them in and had said they had eight dogs and therefore avoided contact. Adult Social Care asked about Wendy's capacity and the GP stated there was "no doubt" about Wendy's capacity.

7.8. *11 December*: a risk assessment was completed in hospital with Wendy. She was recorded as having capacity and did not want the safeguarding to go further. She

agreed to risk management through a case management plan. Wendy was asked her views on what she needed and was recorded as being happy to have support with her personal care and her family could provide all her other care needs.

7.9. *15 December*: an assessment was completed with Wendy by the hospital team. It recorded the information outlined above about the situation. Wendy was recorded as being able to express herself with no problem, and that she felt she needed help with her personal care tasks in the morning due to her polyneuropathy. A plan was made for carers to be sourced for 3.5 hours a week. A Carecall pendant alarm system was provided. The Fire Service were contacted for a home safety check to be completed. A local older people support service[1] was contacted to help signpost the family for support with boiler repairs. The record stated that a referral would be made to the Carers Hospital Liaison and Support Service to support Wendy's carers (son and husband). This Review has not been able to establish whether this took place (Wendy's son informed the Review that he had not had contact from this service). The hospital confirmed that the service continues to be offered and is advertised throughout the hospital.

7.10. *19 December*: Wendy was discharged from hospital with a care package, which also included assessment by Occupational Therapy and Physiotherapy. The General Practice were notified.

20 December 2017 – 3 February 2018

7.11. *20 December*: Domiciliary Care Provider 1 commenced providing personal care to Wendy with one carer attending for 30 minutes a day in the mornings.

7.12. *21 December*: The Community Health Provider recorded receipt of the referral for Occupational Therapy for Wendy "*to assess patient's safety and ability to use new armchair son is ordering. Risk of falls*". The referral was triaged and added to the waiting list for an assessment.

7.13. *28 December*: A Senior Rehabilitation Assessment was completed. Wendy was recorded as having the following issues/problems: poor mobility and unable to access the bathroom safely to use the bath lift and toilet; had a worn foam mattress that was ineffective in providing adequate pressure relief; was struggling to manage her continence needs; was housebound as she was unable to use the stairs due to poor mobility. The conclusions and actions were: that Wendy required aids / appliances; she had a Mowbray frame, rollator frame, bath lift, static

[1] A countywide network of agents and volunteers who support older people and informal carers to find and develop independent living solutions

commode and self-purchased adjustable bed in situ; Wendy's poor balance was observed; three falls in the past three weeks were reported by Wendy; a referral to the continence nurse would be made; a referral to equipment for replacement foam mattress would be made. Wendy was provided with information and contact details for Adult Social Care for her son to contact regarding a possible stairlift installation. The referrals to the Continence Service and Equipment Service were recorded as having been made and acknowledged. A notification of the assessment was sent to the General Practice.

7.14. *5 January 2018*: Essex Fire and Rescue Service made a Home Fire Safety visit. They recorded that three smoke alarms were installed and safety information given. It was noted that there were eight fully grown dogs in the property and the condition of the property was not good. The son was in attendance as the main care giver for his mother and father. He was asked by the Technician if he needed any help or assistance and he said he does have assistance with cleaning his mother and respite has been offered. The Technician recorded that therefore other agencies are aware. The son stated that the gas supply is being removed from the property and he is saving to redecorate.

7.15. *8 January*: The Community Health Provider contacted Wendy to arrange an equipment check; no answer and no message facility on home or mobile numbers.

7.16. *10 January*: The Community Health Provider Continence Service (Senior Healthcare Assistant with additional training in continence assessment) attended the home. They recorded "*When I arrived I could see that the house was very dirty. Wendy was upstairs and her family had to put 8 fully grown boxer dogs away in cages. I had to walk close to the cages to get past them. All the dogs were barking and trying to get out. I went upstairs and as I went up I got faeces all over my hands. I was given a bowl of water to wash my hands. I could see that Wendy has 2 commodes she said that she needs pads for the night as she cannot get up during the night*". A plan was agreed for Wendy to use pads at night. An information leaflet was provided on pressure risk and prevention.

7.17. *16 January*: The Community Health Provider Occupational Therapy Service carried out a review. The foam mattress was in place; Wendy was noted to spend all day and night in bed; Wendy declined a pressure area check and stated carers treat the area daily; she reported eating and drinking well (an improvement from the initial assessment) and that her mobility was good, she could get to the commode

and be wheeled to the bathroom for a wash. Wendy was discharged from care. Her General Practice was informed.

7.18. *18 January*: A home visit was arranged for Adult Social Care to carry out a review "with the son to review Wendy's care needs". Wendy's son had been requested to put the dogs away before the visit. It was noted a joint visit with Domiciliary Care Provider 1 "may be required."

7.19. *30 January*: Adult Social Care conducted a face to face review at Wendy's home. Nothing was recorded about the condition of the house. The initial six-week contract for home care was due to end the next day. Continued support was identified as being required, at the same level, until further notice. Wendy stated she needed support with her personal care but was happy for her family to continue to provide the rest of her care and support and her son was noted to be happy to do this. He declined a carer's assessment and confirmed he knew he could contact Adult Social Care if that need changed. A financial assessment was made and there was no cost to Wendy. A request was sent to and received by Domiciliary Care Provider 1 for this. A three-month review was recommended (due at the end of April 2018; there was no record of this taking place).

7.20. *3 February*: Wendy's son called Domiciliary Care Provider 1 and stated they no longer needed the care being provided and cancelled the care. Domiciliary Care Provider 1 emailed the Adult Social Care Duty team to inform them of the cancellation of care.

11 – 25 May 2018

7.21. *11 May*: The Ambulance Service responded to a 999 call for Wendy due to hip pain following a fall. Wendy was recorded as being confused and agitated, with no pain; her son informed staff of Wendy's "*worsening mental health*". Bruising to Wendy's chest was noted. Observations and treatment were not able to be completed due to the patient grabbing or pinching staff. The Ambulance Service took Wendy to hospital and sent a concern to Adult Social Care. A notification was sent to the General Practice. Wendy was admitted to hospital and treated, including for a suspected urinary tract infection.

7.22. Adult Social Care received the concern from the Ambulance Service. They recorded: "*The crew have concerns about the living conditions, Wendy lives in a small house with ten large adult dogs and two litters of puppies (ten puppies). There is dog faeces and urine throughout the house. Wendy is also in a poor hygiene state, her hair is matted, her skin is dirty to touch and wipe, she has poor*

oral and hand hygiene. Wendy has bed sores on her bottom from poor hygiene maintenance. The crew witnessed some bruises on Wendy's chest from an unknown origin. Wendy has had a rapid deterioration in her mental health and she requires a dementia assessment. Wendy's son is her main carer although the crew do not feel this is sufficient for Wendy due to the above concerns. Admitted to hospital."

7.23. *14-17 May*: Adult Social Care contacted Domiciliary Care Provider 1 to ask that care be suspended due to Wendy's admission to hospital. Domiciliary Care Provider 1 responded that care had not been provided since February; this was queried by Adult Social Care. Domiciliary Care Provider 1 responded advising that the family had cancelled the care and that they had notified Adult Social Care.

7.24. *18 May*: The hospital Adult Social Care team met with Wendy on the ward and discussed her situation and care needs. She was recorded as having capacity. Wendy stated that she was able to wash herself and apply treatment to the pressure sore with the help of her son. She was able to use a commode in her room and if she had issues with continence her son would change the sheets. She stated the carers had previously been cancelled because they could not afford them. Wendy was adamant that she wanted to go home. She was asked and talked about her family. A joint home visit was made by the hospital Adult Social Care team and the Occupational Therapy Service in which there were no concerns over the home environment prior to Wendy's discharge. This was recorded in the Adult Social Care system through an uploaded Occupational Therapy report; it was not recorded in the case notes. It was not recorded in the Occupational Therapy case notes.

7.25. *22 May*: Adult Social Care requested Domiciliary Care Provider 1 to provide care to Wendy following discharge from hospital. Domiciliary Care Provider 1 declined the care package due to insufficient resources to deliver the higher level of care now required.

7.26. *25 May:* Wendy was discharged from hospital; a notification was sent to the General Practice. The discharge summary referred to Adult Social Care having sourced six weeks of reablement care from Domiciliary Care Provider 2. The hospital Adult Social Care team recorded that a referral would be made to District Nursing Service. This would have been done by the hospital ward staff; there are no ward records that the referral was needed, and it was not recorded in the

discharge summary. The Partnership Learning Event for managers could not find clear evidence for what the nursing need was.

7.27. The discharge summary stated that Wendy had dementia, and this was also referred to many times within records about Wendy's care. None of the records stated where this diagnosis came from. Episodes of Wendy being confused, vacant and drowsy were also recorded, and that her capacity fluctuated during admission. A record was made that Adult Social Care planned to carry out a Mental Capacity Act assessment shortly before Wendy was discharged.

7.28. There was no evidence of the assessment having been done. There are no records with any other agency that Wendy had a diagnosis of dementia.

7.29. The Adult Social Care hospital team process was to action a review work flow to the Adult Social Care system (Discharge to Assess Team Allocation Ladder) and send an email with the discharge details. This should have taken place in May 2018 but it appears now that this did not happen until much later.

August and September 2018

7.30. *8 August:* Wendy was listed on the Discharge to Assess Ladder; a Social Worker recorded that they had contacted the Reablement Service to find out whether they were providing care for Wendy. They stated that they were not (and had never been requested to do so). The Social Worker recorded an action to contact Wendy.

7.31. *7 September*: A Social Worker contacted Domiciliary Care Provider 2 to find out if they were still supporting Wendy. Domiciliary Care Provider 2 informed Adult Social Care that there was nothing on their database to show that Wendy had ever been supported by them (this was investigated and it could not be established why Adult Social Care records showed them to be providing care when they were not). There were several attempts to contact Wendy and her son: the number on the system was not in service and the son's mobile rang out with no message facility. The Social Worker recorded an action to discuss the case with the team manager. This does not appear to have been done. It appears now that the review was cancelled because the Social Worker at the time (who has since left the service) believed incorrectly that Wendy was self-caring.

7.32. *24 September:* Wendy died.

8. INFORMATION FROM THE FAMILY

8.1. Wendy's son and carer contributed to the Review through a telephone conversation with the report author. He felt frustrated with the absence of care, that

had been promised, following his mother's stay in hospital in May 2018. He reported having called a Social Worker on their mobile repeatedly about it, and leaving messages as there was no answer. He stated that he did not have another number to call and felt left alone with caring for his mother and his father.

8.2. Wendy's other son who lives abroad, fed back to the report author that he had concerns over his mother's care but was unable to act on this due to being so far away. He tried to support the family but felt that his brother, Wendy's other son, controlled the situation. He understood that the carers had stopped attending the home due to the presence of the dogs; he was not aware that the care had been cancelled by Wendy's other son and felt strongly that his mother should have been spoken to at that time. He also fed back that, despite not being nearby, agencies could have considered contacting him at this and other times for his input and perspective; because they did not, the situation was dominated by his brother's perspective and choices.

9. FINDINGS

9.1. The Partnership Learning Event for practitioners reviewed and discussed the summary of the case (section seven) and the key themes (section two) to produce the learning from this case. Individual agency and multi-agency findings have been collated and are presented in this section under the headings of the six guiding principles underpinning Southend Essex and Thurrock's Vision for Adult Safeguarding (*The Southend Essex and Thurrock Safeguarding Adult Guidelines Version 4.2, March 2017*). Section Ten gathers together these findings under the key themes to identify learning and make recommendations where required.

Empowerment: people are supported and encouraged to make their own decisions and give informed consent.

9.2. As an adult with capacity, Wendy was able to decline the assessments, care and support offered. She declined an assessment in September 2017 and this was respected. She declined a safeguarding assessment but agreed to case management in December 2017 and this was proceeded with. When Domiciliary Care Provider 1 first attended they talked to Wendy about her likes and dislikes, and what was important to her, and this was recorded. During the assessments in December 2017 and May 2018 there was evidence of Wendy's views being sought and recorded.

9.3. Contact with Wendy was often through her son who was her main carer. Wendy did not have access to a phone and was bed-bound. When practitioners made contact it was through the son's mobile phone, or through him letting them into the house (or not, in some cases). While there were no indications that she was unhappy with the care and support she received, and there was evidence that her views were sought when practitioners spoke with her, there was no recognition that if she did have concerns it may have been hard for her to communicate these to services once she was at home.

9.4. Wendy's son contacted Domiciliary Care Provider 1 to cancel the care package in February 2018 (see 7.20). The practitioner Partnership Learning Event highlighted that the care should not have been cancelled without a conversation with Wendy to ensure this was also what she wanted. A new package of care had just been agreed, to continue until further notice, and therefore no Adult Social Care review would have been scheduled for a year. The Review could not establish whether the email had been sent, and if so where to and whether it had been received. As a result, no review was conducted following the cancellation. Email alone should not have been used to communicate such a significant change in the care for Wendy.

9.5. Some practitioners (Domiciliary Care Provider 1, Community Health Provider, Occupational Therapy and Continence Services, Ambulance Service) were able to enter the property to see, assess and provide care and support to Wendy; others (Adult Social Care and the GP), were unable to access the property due to Wendy's son stating it was not convenient (for example due to the dogs/puppies). These services did not speak with each other to establish who had access and who did not; nor to arrange joint visits if required.

Prevention: it is better to take action before harm occurs

9.6. In May 2018, a joint home visit was made by the hospital Social Worker and the Occupational Therapy Service, in which there were no concerns noted about the condition of the home. This was an example of good practice prior to Wendy's discharge from hospital. A similar visit should have taken place in December 2017. This would have highlighted the worn state of Wendy's mattress, and it could potentially have been replaced more quickly: instead, Wendy returned home with pressure sores and a new mattress was not in place for some weeks.

9.7. Information about the condition of the home, as highlighted in the Ambulance Service's safeguarding concern in December 2017, was not communicated to

Domiciliary Care Provider 1, Community Health Provider or the Fire Service prior to their contact with Wendy in January 2018. This would have helped services to be better informed and prepared prior to practitioners entering the home.

9.8. Reviews by Adult Social Care did not take place when they were due, most pertinently in August and September 2018. This Review could not establish why this was the case from a review of the records. If reviews had taken place, they would have enabled Adult Social Care to be aware that the care package was not being delivered as they believed. A recommendation is made.

9.9. The process in place for handovers between hospital and community has now changed. A weekly list of reablement discharges are sent by the hospital teams to a named worker in the Discharge to Assess Team who then contacts the adult and the provider to ensure care has commenced. The worker also ensures the case management system review workflow has been received to the Allocation Ladder. If a case is deemed complex or to require urgent community support the hospital teams will also alert the Discharge to Assess Team by email to a dedicated inbox which is checked daily. Those who are discharged to the Reablement Service or block providers are discussed at a weekly Multi-Disciplinary Team meeting.

Proportionality: the least intrusive response appropriate to the risk presented

9.10. Wendy was consistently recorded as having capacity; when she declined safeguarding assessments, this was respected. Wendy was offered support proportionate to her presenting needs at those times.

9.11. In December 2017 a home visit was not conducted prior to Wendy's discharge. A home visit will not always be required but given the information provided by the Ambulance Service in the safeguarding concern, would have been appropriate. It may be that an increased level of care, or a more urgent Occupational Therapy visit, would have been requested had this been done.

Protection: support and representation to those in greatest need

9.12. Safeguarding concerns were raised appropriately by the GP in September 2017, and the Ambulance Service in December 2017 and May 2018. A concern should have been raised by the Community Health Provider Occupational Therapy Service when they attended the property in January 2018 due to the condition of the house at that time. The practitioner Partnership Learning Event felt that each concern was viewed in isolation; a collective view of the situation over time, and

how it had deteriorated by May 2018, was not formed. Any professional could have called a strategy / professionals or multi-disciplinary meeting in response to Wendy's case.

9.13. Due to her multiple health needs, Wendy did not have the ability to take care of herself; she required care and support for daily activities. Most of this was provided by her son but she recognised and informed services that she required help with washing and personal care as she did not want her son to do this. This was provided in January 2018. Her wishes in this respect, and her inability to care for and protect herself, were not considered when her son cancelled her care.

Partnership: local solutions through services working with their communities

9.14. Services did not work together to provide care and support for Wendy. They worked in isolation to deliver care for Wendy. Practitioners did not speak to one another about the care provided to Wendy, or any new issues, concerns or information that came to light. An example of the outcome of this was when the GP stated to Adult Social Care in December 2017 that they had not had an update following the concern they raised in September 2017, and therefore did not know the current situation.

9.15. As outlined above, information about Wendy, her home and her family and the concerns that had been raised were not communicated in referrals or requests for care to be provided. Not all information can be shared in these circumstances due to the confidentiality of the adult receiving care. Nevertheless, the fact that there had been concerns should have been noted so that those receiving the referrals / requests could have contacted Adult Social Care for proportionate information to be shared to enable the correct level of care and support to be provided and to ensure that services were working together to safeguard Wendy.

9.16. There was a lack of communication between the hospital-based Adult Social Care team and the community-based teams (see accountability section below).

Accountability: accountability and transparency in delivering safeguarding

9.17. No agency or practitioner had ownership of the case. Due to her admissions to hospital, Wendy's care moved between the hospital social work team and the community social work team, and there were no handovers to highlight key issues in Wendy's situation or care that could have led to faster and more appropriate responses. If the hospital-based teams have concerns they will now refer to the

community-based teams for a Multi-Disciplinary Team meeting to be held to discuss the case, which is an improvement since the time Wendy was receiving care. There could still be improvements to the handover of adults between the two teams, through increased communication when there are concerns or risks.

9.18. The last record for Adult Social Care was for the practitioner to discuss Wendy's case with their manager; we do not know whether this discussion took place, or what the outcome may have been, such as a new assessment being offered which may have provided Wendy with care in the last weeks of her life (we also cannot state whether this would have been accepted by Wendy or her family).

10. LESSONS TO BE LEARNED

10.1. Drawing on the findings above, the lessons to be learnt from this case are set out below, under the headings of the key themes of the case.

How agencies worked together to support Wendy

10.2. Wendy was vulnerable due to her lack of independence and mobility, multiple health conditions and inability to self-care, and in 2018 the fact that her physical health, and possibly mental health, were deteriorating. She had the support of her family but there were limits to the care they could provide, for example her expressed wish that her son not be responsible for her personal care (e.g. washing).

10.3. Agencies did not work together to support Wendy. Referrals were made for care and support to be provided to Wendy, but this was not accompanied by a joint meeting such as a Multi-Disciplinary Team meeting, which any practitioner could have requested. This meant there was a lack of information sharing about the family and Wendy's situation and needs. This included between the two services provided by the Community Health Provider Continence and Occupational Therapy Services: each service can view the notes of the other provided the adult has consented to this, but in this case, this only worked in one direction (the Continence Service could see the Occupational Therapy notes but not the other way around). While this would not have impacted on the care given to Wendy during the second visit of the Occupational Therapy Service, it is an example of the importance of practitioners seeking information and sharing it between each other. There was a lack of handover and information sharing between the hospital and community Adult Social Care teams; this has since improved (see 9.17).

10.4. Processes are now in place to ensure that joint meetings take place more consistently, and practitioners agreed that in situations such as Wendy's a meeting would now take place. There were concerns that such silo working could still be possible, as the information about the concerns for Wendy, particularly her living conditions, and the inability of some agencies to enter the property, were not consistently shared between agencies. A recommendation is made.

10.5. Emails are not sufficient when making requests for information, or action, or when communicating critical information such as the cancellation of care by a family. There appears to be a culture in which emails are sent but not acknowledged, and practitioners have become accustomed to the lack of response and therefore when no response is received this does not cause concern. Agencies were not clear on the best way to share information with Adult Social Care, which is through Social Care Connect. Two recommendations are made.

Systems and processes for identifying and safeguarding adults when there are difficulties gaining access

10.6. Some services could not gain access to the property, while others had no difficulties; this was not communicated between them. A collective picture of the situation was not gathered, both through reviewing the three safeguarding concerns that had been raised between September 2017 and May 2018, and through gathering all the services together.

10.7. This issue should be addressed through new processes for more proactive Multi-Disciplinary meetings; and through the recommendation to support increased sharing of information about concerns that have been raised.

10.8. A further recommendation is made for Adult Social Care to ensure that they are satisfied all Social Care staff know where to look for, and to review, previous safeguarding concerns when a new one is received.

10.9. Both Partnership Learning Events identified that some practitioners, through the course of their experience, may not have been concerned over the condition of Wendy's home. While they might see many homes in poor condition, and some in worse condition than Wendy's, they had a duty to respond to the situation as a whole: the condition of the home, combined with Wendy's physical health and vulnerability, and the potential risk to her caused by the home environment. A recommendation is made for relevant agencies to act on this learning.

Compliance with safeguarding protocols

10.10. Wendy should have been spoken with when her son called Domiciliary Care Provider 1 to cancel the care package, to gain her views prior to the care ending. If there were any concerns for the family that led to them wishing to cancel the care, such as finances, then these should have been discussed at the time to ensure that any other support in this area could be offered. A recommendation is made. Wendy's son, who lived abroad and was not her carer, also fed back that he and other family members could have been approached to support the situation and give their views.

10.11. In December 2017 a note was made to refer Wendy's son, as her main carer, to the Carer Support Service, provided within the hospital. It does not appear that this was done. As part of any assessment and decisions with regard to an adult's care, those caring for them, whether formally or informally, should be considered. While this was done, the subsequent referral was not made which was a missed opportunity to offer support. In January 2018 Wendy's son was offered a carers assessment which he declined.

10.12. All agencies involved in Wendy's care and support should have been aware of the whole picture that had been formed through the safeguarding concerns, conversations with the family and assessments completed. This is addressed through the recommendations already made.

10.13. The hospital discharge summary, hospital records and a report from the Occupational Therapy and Hospital Adult Social Care home visit (May 2018) recorded Wendy had a diagnosis of dementia, which was not the case. Practitioners may have been influenced by Wendy's presentation, or something said by family or professionals. It is essential practitioners make accurate records based only on what is known.

10.14. All agencies involved with this case now have case file audit processes in place to ensure that all practitioners carry out the highest level of case recording.

11. RECOMMENDATIONS

11.1. Adult Social Care to ensure that when commissioning care, agencies are alerted about potential risks that may impact on its delivery. Where confidentiality prevents the information being provided, in the service request it should include a request to discuss the care with the referring social worker before accepting the package.

11.2. Essex Safeguarding Adults Board to share the learning from this review; that agencies and practitioners retain responsibility for the concerns raised until the receiving agency acknowledges receipt of that information.

11.3. Adult Social Care to be clear with providers about the correct communication pathways for issues relating to commissioned packages.

11.4. Adult Social Care to review its internal communication pathways for adults going in and out of hospital so that vital information isn't lost in transition.

11.5. Essex Safeguarding Adults Board to review how practitioners consider environmental factors when assessing risks for vulnerable adults, learning from environmental assessment tools that other agencies currently use.

11.6. When Adult Social Care or other agencies receive a safeguarding concern, practitioners should consider historic information in a holistic way and must be professionally curious about what the information is telling them.

11.7. All agencies must reinforce the need for all work with adults to be person centred and to ensure that the voice of the adult is always heard when making any decisions relating to their care needs. It is particularly important that the principles of Making Safeguarding Personal are implicitly followed.

11.8. Essex Safeguarding Adults Board to work with the Essex Social Care Academy to develop training for practitioners in relation to coercive control which is a developing area of work in adult safeguarding and could have been a factor in this case.