Essex Safeguarding Adults Board

WILLIAM

SAFEGUARDING ADULT REVIEW

A REVIEW COMMISSIONED BY ESSEX SAFEGUARDING ADULTS BOARD INTO THE CASE OF WILLIAM, AN 83-YEAR-OLD MALE WHO DIED IN OCTOBER 2018

Sharon Rodie LL.B, MSW, MLTHE, DipSW

DECEMBER 2020

Contents

1. Introduction

1.1 William was an 83-year-old gentleman who had multiple long-term physical health problems, including Chronic Kidney Disease (Stage 4), prostate cancer, asthma, hyperparathyroidism, hypophosphatemia, renal calculi, chronic pancreatitis, rickets, poor vision and hearing loss. He also had a history of depression. William had lived alone in social housing since the death of his mother in 2001 and was supported by a number of close friends and neighbours. Records suggest that his health deteriorated significantly from summer 2018 onwards, leading to William contacting the emergency ambulance service and his GP surgery frequently between June and October 2018.

1.2 On 27 August 2018 William was taken to hospital after a fall, he was sent home the same day. He remained unwell and was admitted to hospital two days later; a scan showed he had subdural haematomas, which would not be operated upon due to William's other health problems. During his hospital stay William told staff he wished to die on two occasions. William was discharged from hospital on 9 September, but care did not commence until 11 September, as the care agency had not been informed that William had returned home. It quickly became apparent the care arranged was insufficient to meet William's needs, care was increased two days later. William's GP visited him on 21 September following concerns raised by a neighbour; William again said that he wanted to die, but also that he wanted to pay for respite care in a residential home. On 24 September William moved into a care home for a short stay, returning home on 1 October. During this period, he was transferred to another GP local to the care home. William's domiciliary care package resumed on his return home, Adult Social Care reviewed William's care on 8 October, but the GP service did not formally transfer back to his regular GP until 15 October 2018, by which time William was in hospital.

1.3 On 11 October 2018 William called 999 but abandoned the call. EEAST established that William had made the call, and established William had fallen but had been helped up by a neighbour and wanted to remain at home. At 1235 on 12 October the community nurse visited, and William disclosed he had taken some tablets the previous evening; the contemporaneous record states William said he wanted to die, but the nurse later stated that William had not disclosed thoughts of suicide. William informed the nurse and his home carer that he did not want to go to hospital. The nurse contacted William's temporary GP with whom he was still registered, and community mental health services; they were not able to help immediately. She also notified Adult Social Care, who visited William at 1650. By that point William appeared to have taken up to 24 co-dydramol tablets, and was pale and drowsy. The social workers called an ambulance and William was taken to hospital, where he unfortunately died four days later.

1.4 The causes of William's death were:
1a) Acute Myocardial Infarction
1b) Severe metabolic Acidosis with acute kidney injury
1c) Paracetamol and codeine overdose
ii) Chronic subdural haematoma

1.5 Following William's death a safeguarding investigation under s42 of the Care Act 2014 was opened in relation to the care provided to William. The outcome was referral for a Safeguarding Adults Review (SAR).

1.6 This report details the evidence, findings and conclusions of this review, and recommendations for future practices.

2. Aim of the review

2.1 Section 44 of the Care Act 2014 requires that the Essex Safeguarding Adults Board must arrange for there to be a review of cases involving an adult in its area with needs for care and support (whether or not the local authority has been meeting those needs) 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.

2.2 This review reflects the six safeguarding principles:

- Empowerment – personalisation and the presumption of person–led decisions and informed consent.
- Prevention – it is better to take action before harm occurs.
- Proportionality – proportionate and least intrusive response appropriate to the risk presented.
- Protection – support and representation for those in greatest need.
- Partnership – local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse.
- Accountability – accountability and transparency in delivering safeguarding.

2.3 The purpose of a Safeguarding Adults Review (SAR) is neither to investigate nor to apportion blame. It is only relevant when professionals can learn lessons and adjust practice in the light of lessons learnt. It therefore requires outcomes that:

- Establish what lessons are to be learned from a particular case in which professionals and organisations work together to safeguard and promote the welfare of adults at risk.
- Identify clearly what those lessons are, both within and between agencies, and how and within what timescale those lessons will be acted upon
- Identify what is expected to change as a result to improve practice
- Improve intra agency and inter agency working to better safeguard adults at risk.
- Review the effectiveness of procedures (both multi-agency and those of individual organisations).

3. Scope of the review and Terms of Reference

3.1 The Terms of Reference for this review are:

1. To develop an understanding of William's vulnerabilities, his health and care needs, capacity to care for himself and his level of independence and consider:
   - What practitioners knew of William's declining physical and mental health, including William's assertion that he wished to end his life.
   - How practitioners perceived and assessed risks to William and how these were responded to?
   - Any difficulties agencies encountered when supporting William that impacted on the case?
2. To explore how agencies respond when an adult with declining physical health develop thoughts of self-harm or suicide and whether responses are sufficient.
3. To consider what preventative actions could have been taken by agencies that may have made a difference to the outcome.
4. How effective was inter-agency communication and information sharing in providing support for William?
5. To explore the challenges faced by adults accessing GP services whilst in respite care.
6. To identify good practise that was in place.
7. To identify lessons to be learned to improve future professional practice

3.2 This review examined the information gathered, outcomes and learning from the events in the period between 1 June 2018 and William's overdose of medication on 12 October 2018, which led to his death. Some additional information from the period before this was provided by Basildon District Council's housing department, and this has provided some further information, which has been included in this report. Some information was also provided by the Grange Care home, where William stayed for a week in September 2018, and the care home's local GP.

4. Methodology

4.1 This review was carried out in three stages.

Stage 1 – Review of the safeguarding and processes following PC's death

Agencies' Individual Management Reports following William's death were reviewed:

- Basildon and Thurrock University Hospitals NHS Trust (from April 2020, Mid and South Essex NHS Foundation Trust)
- Basildon District Council (William's housing provider)
- East of England Ambulance Service NHS Trust
- Essex County Council Adult Social Care

- Laindon Medical Group (William's GP surgery when living in his own home)
- North East London Foundation NHS Trust (William's community nursing provider)
- Shalom Health Recruitment Ltd (William's domiciliary care provider)

Stage 2 – Review of learning

A meeting was held on 15 November 2019 to consider the learning from the events and the safeguarding investigations. This was attended by representatives of the Essex Safeguarding Adults Board team, Basildon and Thurrock University Hospitals NHS Trust, Essex County Council Adult Social Care, NHS Basildon and Brentwood Clinical Commissioning Group, North East London Foundation NHS Trust and Shalom Health Recruitment Ltd. The East of England Ambulance Service NHS Trust was unable to attend the event. Laindon Medical Group was also unable to attend; I was able to discuss the case by telephone with William's GP, who knew him well, to learn more about what happened and his views, and shared the agreed notes with those at the meeting.

Stage 3 – Meetings with additional organisations involved

In February 2020, I met with The Grange care home in which William stayed for a week in September 2018, and Robert Frew Medical Centre, the GP surgery with whom he was registered during that time, to gather further information to inform this review. Not all information was able to be obtained due to pressures of the crisis response to the Covid-19 pandemic; this is highlighted within the findings in this report.

5. Legal and policy context

Safeguarding adults

5.1 Safeguarding law is codified in the Care Act 2014 and associated statutory guidance. If the local authority reasonably suspects that an adult who has care and support needs is being abused or neglected and they are unable to protect themselves against the abuse or neglect because of those needs, under s42 of the Act it must initiate enquiries to decide whether or not the local authority, or another person or organisation, should act to safeguard the person from actual or potential abuse or neglect.

5.2 The Southend, Essex and Thurrock Safeguarding Adults Guidelines state that the Safeguarding Adult Board must undertake a review in any case where an adult with needs for care and support was (or it is suspected they were) experiencing abuse or neglect; and the adult dies or there is reasonable cause for concern about how the Safeguarding Adults Board, a member of it or some other person involved in the adult's case acted. The purpose of the Review is to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learnt and applied to future cases to prevent similar harm occurring in future. It is not to hold any individual or organisation to account.

Suicide prevention

Prevalence

5.3 The prevalence of suicides in Essex is higher than the national and regional averages; the table below shows the size of the problem in the male, and elderly male, populations.

	Essex	East of England	England
Suicide rate (male) per 100,000 population, 2016-18	17.2	15.3	14.9
Suicide crude rate 65+ years per 100 000 population, male, (5-year average) 2018	14.0	12.6	12.4

(Source: https://fingertips.phe.org.uk)

It is therefore particularly important that strategies and resources focus on reducing the risk of suicide in Essex.

Strategy

5.4 The Government's *Preventing Suicide in England* strategy sets out six priorities for action, including reducing the risk of suicide in key high-risk groups; tailoring approaches to improve mental health in specific groups; and reducing access to the means of suicide. In relation to populations at higher risk, it notes that rates of suicide in men aged over 75 are high, with risk factors such as loneliness and physical illness potentially being important in this age group. It also notes that higher rates of mental health problems are found in people living with long-term physical health conditions (for example in cancer, the risk of suicide increased by more than 10 times in the week after diagnosis), and people who are especially vulnerable due to social and economic circumstances. The strategy recommends that people with long term conditions be given a greater sense of choice and control over their lives, are routinely assessed for depression and have access to talking therapies.

5.5 The Southend, Essex and Thurrock Suicide Prevention Strategy (2017) highlights that its local suicide audit 'showed the expected national trends of the majority of suicides occurring in people not known to mental health services but experiencing everyday pressures of social, personal and financial vulnerability'. The strategy recommendations include:

- 'That organisations and forums undertake an impact assessment (similar to equality impact assessment) using the characteristics identified as high risk and apply to their current and intended interventions to ensure that each group has the best evidenced based targeted interventions'
- 'Explore feasibility of equipping people who are most likely to encounter people with mental health issues or suicidal thoughts with the skills and confidence to support them and to enable them to seek professional help (as per Zero Suicide initiative)'

Guidance on assessing risk and interventions

5.6 NICE guidance supports the assessment of risk in people who may be contemplating suicide. This includes:

- Factors to take into account when assessing risk include current and past suicidal intent; specific risk factors and protective factors (social, psychological, pharmacological and motivational) that may increase or decrease the risks associated with self-harm; mental illness and its relationship to self-harm; and significant relationships that may either be supportive or represent a threat … and may lead to changes in the level of risk immediate and longer-term risks. (NICE CG133)
- Be aware that all acts of self-harm in older people should be taken as evidence of suicidal intent until proven otherwise. (NICE CG133)
- Always ask people with depression and a chronic physical health problem directly about suicidal ideation and intent. (NICE CG90, NICE CG91 and NICE CG123)

Therefore, assessment of risk should consider the individual's behaviours and wider bio-socio-economic context as well as their mental wellbeing, including any recent changes.

5.7 However, the National Collaborating Centre for Mental Health's report *Self-harm and Suicide Prevention Competence Framework: Adults and Older Adults* (2018) highlights that 'while there are many factors associated with risk, evidence indicates that our ability to accurately predict risk is limited. This means that it is possible to both over-estimate and under-estimate the actual risk of suicide in a person at a given moment in time. Research suggests moving away from prediction to focusing on the needs of the person and seeing assessment as informing management rather than as a stand-alone activity.'

5.8 In terms of interventions, NICE guidance CG123 recommends that 'If a person with a common mental health disorder presents considerable and immediate risk to themselves or others, refer them urgently to the emergency services or specialist mental health services'. The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness report *Safer Services: A Toolkit For Specialist Mental Health Services And Primary Care* (2017) includes the quality/safety standard to have 'a mechanism in place to ensure that patients with certain markers of risk (i.e. frequent consultations, multiple psychotropic drugs and specific drug combinations) are further assessed and considered for referral to specialist mental health services'. However, it also notes that research indicates very few people who later die by suicide (8% in one study) are referred by primary care to specialist mental health services in the previous 12 months. Clinicians should therefore take self-harm in older people as a significant indicator of suicidal intent and ensure the person is referred to appropriate services, as a matter of urgency wherever appropriate.

Guidance on safer prescribing

5.9 The National Confidential Inquiry into Suicide and Homicide 2017 explored the risk of overdose of medication and concluded that clinicians and pharmacists should be aware of the potential risks of opiate and opiate-containing analgesics. The report points out that 'Safer prescribing in primary and secondary care remains crucial, particularly for patients with long-term pain, a group at high suicide risk. This should include prescribing only short-term supplies and enquiring about opiate-containing painkillers kept at home.'

6. Findings

6.1 William's deteriorating physical health and mental wellbeing, 22 May 2018 to 29 August 2018

6.1.1 The following chronology describes in some detail William's increasing needs and his interactions with health and care services between late May and the late August 2018.

Chronology

22 May 2018 William called 999 as he was unwell with diarrhoea, nausea, inability to sleep and increased sweating. East of England Ambulance Service NHS Trust records show William was clinically assessed by phone and was referred to his GP for support. GP records show William spoke to the duty doctor the same day, who gave him advice.

11 June 2018 William attended his GP surgery, and was prescribed antibiotics by his GP for a urinary tract infection.

13 June 2018 William called 999 as he was unwell with weakness, lethargy, cough and reduced appetite. East of England Ambulance Service NHS Trust records show William was clinically assessed by phone; the assessor recorded that William was being treated for a chest infection. William was advised to contact his GP for support.

15 June 2018 William's GP called 999, and William was admitted to hospital with possible sepsis; he had been unwell for 2-3 weeks, with diarrhoea in recent days. The acute hospital treated him for infection, though William declined physiotherapy input. Hospital records show that William was given fluids intravenously and showed improvement; he declined physiotherapy input and was discharged home the following day with a plan to follow up in the renal clinic in 4 weeks; there is no evidence available to this review as to whether this clinic visit took place or the outcome.

18 June 2018 William reported to his GP that he was unwell with diarrhoea; a duty doctor home visit was planned.

21 June 2018 GP visited and referred William for a 2-week cancer appointment due to his continuing diarrhoea.

25 June 2018 GP changed William's anti-depressant medication as his mood had worsened.

28 June 2018 William's GP recorded that William declined any investigations for his diarrhoea.

1 July 2018 Ambulance service records show William fell off his bed while trying to apply cream to his back, and became stuck. He banged on the wall and his neighbour called 999. The police tried to obtain a key from another neighbour but were unsuccessful. The neighbour gained access and helped William up. The ambulance crew arrived 2 hours after the initial call, and dressed a skin tear to William's arm. William declined some observations tests, as he just wanted to go to bed, so the attending clinician advised William to arrange a nurse for his wound dressing.

2 July 2018 Care co-ordinator nurse from GP surgery visited William, the GP records show William was unsure about having investigations into his health, and worried about coping.

3 July 2018 William called 999 with abdominal pain, William said he felt like he was dying. East of England Ambulance Service NHS Trust records show William was clinically assessed by phone, and advice was given to him. The Trust arranged for the GP to visit the following day.

4 July 2018 The GP surgery's care co-ordinator nurse visited, and referred William to Adult Social Care due to his recent fall, living alone and feeling vulnerable, and increasing frailty – he had recently stopped driving because of this.

6 July 2018 The care co-ordinator nurse visited William, attended to a dressing, and referred him to the community nurses.

10 July 2018 William reported to his GP surgery, whilst ordering a repeat prescription, that his new anti-depressant was working well.

17 July 2018 Adult Social Care referred William to the local Community Agent service to discuss Careline, benefits, bathing and domestic support, and closed the referral.

3 August 2018 William attended his surgery for a knee injection.

16 August 2018 William's GP increased his anti-depressant dosage as he was increasingly depressed, and prescribed antibiotics for a toe infection.

22 August 2018 William called his GP due to continuing diarrhoea. GP records show a home visit was booked; the records available to this review do not show if this took place.

23 August 2018 William called 999 with diarrhoea. The ambulance service did not respond, the call was categorised C5, which is described by the ambulance Trust as: 'following the assessment of the patient's condition and with our current demand with serious emergency calls it has been determined that an ambulance response is not required.'

27 August 2018 William fell in his driveway and was found by a neighbour who dialled 999. William was taken to Basildon Hospital and investigated for the fall and head injury. He was found to have had a multifocal subcortical haematoma; medical advice was that there should be no intervention unless his condition deteriorated over the next 48 hours. However, William discharged himself against medical advice on the same day. The hospital records state William understood the consequences of his decision and his condition did not impair his mental capacity; he appeared to have full mental capacity to make this decision and his neighbour agreed with this view.

29 August 2018 William dialled 999, the cause was reported to be increased memory loss. A neighbour supported the discussions with the ambulance crew as William was also hard of hearing. It was noted that William had a canula in place, presumably from his visit to hospital two days earlier. The ambulance service made a referral to William's GP for a care package and an occupational therapy assessment as William had no access to the upstairs toilet; their records also noted William's neighbours were about to go on holiday for two weeks. William was taken to hospital where he was admitted for treatment, severe bruising to his left eye and left arm were noted. Expert medical advice from a partner hospital concluded that William had enlarged subdural haematomas, but surgical intervention would not be appropriate.

Discussion

6.1.2 The records available suggest that William's health deteriorated significantly and rapidly in the months prior to his death.

William's physical and mental health

6.1.3 Within this review William's GP confirmed William had a history of depression, and deteriorating physical health in the months before his death. The extent of his health problems was sometimes difficult to determine, however, for example he would normally have very limited mobility and require home visits by the GPs, but on one occasion arrived at the surgery for a knee injection. Within the GP practice's investigation for this review, the surgery confirmed that William had full support from the practice including telephone advice, surgery attendance, home visits, continuity of care when possible and help from its care-co-ordinator nurse.

William's support networks

6.1.4 Within this review, both William's GP and Shalom care agency, who later provided home care to William, confirmed William had no close family, but had friends and neighbours who were very supportive to him. However, the agency explained that William's immediate neighbour had his own health problems. William had a 'next of kin' who was another ex-neighbour, but he lived some distance away and did not want to

be involved in every aspect of William's care, including his care review. Therefore, whilst William had a supportive local network, it was limited, and William needed to be fairly self-reliant to cope with his deteriorating health and increasing frailty.

William's contacts with healthcare services

6.1.5 The records show William contacted his GP or the emergency ambulance service numerous times during this three-month period. Eight calls were made to 999, three of which were resolved by a telephone assessment and recommendation that William contact his GP, one was resolved by an ambulance visit and treatment on site, one led to no response due to pressures on the service (William did not call 999 or contact his GP in the following days but it is evident that his ill-health persisted), and three led to William being taken to hospital. William also had 13 contacts with his GP in this period, mostly involving home visits although he did attend the surgery on one occasion.

6.1.6 Records available to this review suggest the reasons William gave for his calls to his GP or 999 varied but had several common themes. During 7 of the calls, records show that William mentioned diarrhoea, abdominal pain, nausea, weakness, lethargy and/or low appetite, the first of these being on 22 May and the last on 23 August. William's GP responded appropriately to this chronic situation by referring him for investigations for cancer, but William declined to pursue these, although the evidence suggests he remained very worried by his symptoms. William also had two falls on 1 July and 27 August, and on 4 July his nurse co-ordinator referred to William worrying about frailty and not being able to drive any longer, all of which suggests William was becoming physically weaker. The ambulance Trust's investigation for this review identified that William should have been referred to a falls service after each time he had a fall (he had further falls in September and October 2018, so this remained a significant health issue). However, the learning review meeting noted that local falls services in William's local area now comprise strength and balance sessions for groups of patients. The East of England Ambulance Service NHS Trust is a regional service and so may not be aware of local variations in services, so it was important to keep local crews informed of the type of services available.

6.1.7 There are references in the records provided to this review to William having treatment for infections, though these are variously described as a urinary tract infection, chest infection, possible sepsis and a toe infection. It is unclear if these are different infections or whether the records are inaccurate – ambulance records appear to rely on William self-reporting his conditions so the information may be less reliable. Also, during this period, William's mental wellbeing appears to have deteriorated, leading to his GP increasing the dosage of his anti-depressants on 25 June, which William reported helped his mood.

6.1.8 Within this review William's GP said he was concerned that William was making high numbers of calls, both to the surgery and to the ambulance service. The surgery's investigation report states that each interaction with William provided the opportunity for assessment and decision making, and that William was assessed frequently, and every effort was made to sustain continuity. The surgery's investigation concluded that assessments and decisions seem to have been made in an informed and professional way. However, whilst William's feelings were recorded by the GP, it appears there was no clear risk assessment that considered the impact on him of his declining physical health and mental health in an integrated way.

William's initial contact with social care, July 2018

6.1.9 William first had contact with Adult Social Care in July 2018, following a referral from his GP surgery. William had a telephone assessment by Social Care Connect, which led to a referral to the Community Agent support service. It appears that William did not pursue this, but Social Care Connect was unaware of this. The evidence provided to this review states that the referral referenced William's recent fall, living alone and feeling vulnerable, ceasing driving and increasing frailty , but does not appear to have included his depression or the recent high intensity usage of emergency ambulance and primary care services, both of which are relevant to his wellbeing needs. Having all relevant information to a person's behaviours and risks would assist Adult Social Care to assess the level and urgency of their needs. The learning review meeting agreed that it was important that where a person does not follow up a referral to a community service, that risk is reviewed with the referrer to identify if the person should be contacted again.

William's fall and injury on 27 August 2018

6.1.10 Following a fall in his driveway on 27 August William was taken to hospital, where staff established he had suffered a subdural haematoma. The ambulance service appropriately referred William to occupational therapy services as he could not access his upstairs toilet. William discharged himself against medical advice, and it appears the hospital appropriately considered William's mental capacity to make this decision, concluding he had capacity on that occasion. However, it does not appear that any formal referral was made to follow up his welfare in the community at that time. William contacted the emergency ambulance service two days later as he felt more unwell and was later admitted to hospital. This point in time appears to signify a further and significant deterioration in William's health.

Summary

6.1.11 William contacted primary care or ambulance services 21 times in three months for a wide variety of health issues. In almost all cases these healthcare services responded to William's requests for help, and his GP recognised William's deteriorating mental health by increasing his anti-depressant medication. However, on one occasion the ambulance service did not respond at all, the ambulance service did not make a falls referral to community health services, and William declined the investigations into his bowel problems which his GP recommended. William was evidently experiencing worsening mental and physical health and frailty, and health services were aware of his frequent contacts asking for help, but no intervention took place to explore specifically the reasons for this, and whether mental health support could have helped him to manage his evident distress at his situation.

6.1.12 William also had one contact with Adult Social Care, who suggested he seek support from a community social care organisation. When William did not take up this offer, Adult Social Care should have considered whether this inaction posed any further significant risk. It is not possible to speculate on whether Adult Social Care would have attempted further interventions, but having full information on his high intensity usage of emergency and primary care, the limitations of his personal support network, and his mental health problems, would have helped in their decision-making.

6.2 William's discharge from hospital and community-based care, 30 August 2018 to 24 September 2018

6.2.1 The following chronology details William's continuing health and wellbeing difficulties, and the treatment, care and support provided to him during this period.

Chronology

30 August 2018 William was moved to a stroke ward. Although not on the formal stroke care pathway (as he had not had a stroke), he received physiotherapy, occupational therapy and speech and language therapy input. Hospital records state William asked to move into a care home and refused reablement at home.

3 September 2018 William disclosed to a member of staff on the ward overnight that he wanted to die, and asked the staff member if they could give him something for it. The staff member reassured William and informed the day staff. William declined a reablement package of care at home, he asked for a social work assessment to move into a care home so this was done; there is no record available as to whether this referral included William's wish to die. At this time, he mobilised with a stick and with help from one person, and a commode was planned for his discharge home.

4 September 2018 Social worker reviewed William, who engaged positively in the assessment and said he wanted to go home with a care package. He agreed to 3-4 visits by carers per day to support and monitor him. Moving his bed downstairs, and a stairlift, were suggested. There is no record as to whether the social work assessment included his wish to die.

5 September 2018 William's ward round included discussion of his mood; nursing notes also recorded that William was in a very low mood, though the occupational therapy functional assessment recorded there were no mood issues. The hospital's investigation for this review found occupational therapists do not use any standard tool to assess mood. William's discharge was planned, which included falls care and fitting of a key safe. The hospital's investigation for this review identified that William said he wanted to die on two occasions, but no referral was made to the Rapid Assessment and Interface Discharge Team during his admission or on discharge.

8 September 2018 Social Care requested that Shalom care agency commence a care package that day of three daily visits to support William with personal care, nutrition, mobility, continence management and prompting for medication (William was noted to have capacity and to manage his own medication). The agency advised Adult Social Care that equipment was not in place and so it was agreed William would not be discharged yet. However, William was actually discharged home that day; the hospital discharge summary contained no reference to mental health or low moods.

9 September 2018 Adult Social Care asked the care agency to call them, so they could share William's new key safe number,

10 September 2018 In the evening, a neighbour reported to Adult Social Care that William's care package had not commenced and his situation was poor: he had soiled himself and trodden excrement around the house, and was sleeping on the sofa as he could not manage stairs. The following day the neighbour reported the same concerns to Adult Social Care, and added William had no food; the social worker recorded William had indicated at assessment that he managed shopping independently. Adult Social Care identified the agency had not been informed of William's discharge, and the care package was commenced the following day – the agency then reported concerns to Adult Social Care about the level of care William needed due to his limited mobility.

11 September 2018 out of hours GP visited William; his neighbour was also present and disclosed William had said he wanted to die, however William said he felt brighter. GP referred William to the community matron, occupational therapy and physiotherapy as William was not coping at home, and also needed an increase in his care.

13 September 2018 Adult Social Care increased William's care package following the agency's concerns that it was not sufficient; records show William needed more support in the mornings and also help with shopping, as his neighbours could not support with this. William's case was also transferred from the hospital social work team to the community social work team for urgent allocation. The social worker's case overview described William's physical health problems, assessed daily living and physical care needs, his lack of family support but good support from neighbours, that he could manage shopping and finances online, and his full mental capacity. The record does not include his mental health and wellbeing. Home care was increased from 10.5 hours to 15 hours per week.

17 September 2018 The community matron attempted to book a home visit with William, leaving a message on his answerphone.

18 September 2018 William's ex-neighbour contacted the GP with concerns that William's ankle was swelling and that he said he wanted to die. GP agreed with the neighbour that they would visit in 2 days, as William would be fine in the interim. The GP noted the need to identify what was going on and why there were so many phone calls. One hour later the ex-neighbour called again as William was actively saying he wanted to die but in the same breath stated he wanted to go into a home for a couple of weeks; and was unsteady on his feet. GP advised the ex-neighbour to take William to A&E for medical review (due to falls) and a mental health assessment, the ex-neighbour agreed to do this.

21 September 2018 GP visited William and identified that William's only medical issues were his swollen ankles and pressure sores; William was unwilling to go to hospital; therefore, the GP stated the problems were social. William said he was fed up and wanted to be looked after, and would pay for respite. GP called the ex-neighbour and asked her to liaise with Adult Social Care to arrange this. On the same day the community nursing service booked an appointment with William the following week.

24 September 2018 Community nurse visited for the first time. William had a bruised eye due to a recent fall, and reported some visual problems. The nurse recorded William had deformed lower limbs since childhood, oedema and sores on his legs, dry lips, a sore nose and low blood glucose; William informed he was tired but felt well, and had no continence problems. The nurse recorded William was cheerful and looking forward to respite care. Later that day William moved to a short stay at The Grange care home, in a neighbouring town to William's home.

Discussion

6.2.1 During his stay in hospital between late August to early September, William began to express to others a wish to die. A care package was arranged upon his discharge, and he briefly stayed in a residential

home, which involved changing GP and community nursing services. His physical health and mental wellbeing problems continued during this period.

William's disclosures in hospital that he wished to die

6.2.2 The hospital Trust's investigation for this review found that William told ward staff he wished to die on two occasions. Each time he was reassured, and there is evidence staff shared information about their concerns as doctors discussed the issue with William during the ward round on 5 September. It is of concern that despite ward staff being fully aware of the issue, the occupational therapy assessment stated William had no mood issues. The Trust's investigation found that no occupational therapy tools were used to assess William's risk of harming himself, and this may have contributed to their assessment, but therapists should be made aware of all concerns about a patient's wellbeing. At the learning review meeting the Trust explained that William stayed on a stroke rehabilitation ward, where stroke patients have dedicated psychological support. William was not on a stroke pathway but would not in theory have been disadvantaged by lack of access to this support, as he was eligible for Rapid Assessment and Interface Discharge Team (RAID) services. A referral to RAID was considered, which was appropriate, but did not happen, and the hospital has recognised it should have followed this issue up. NHS public advice (www.nhs.uk) states that the long term effects of subdural haematoma can include low moods, and this context, together with William's statements that he wished to die, should have led to an assessment of risk of suicide in line with the statutory guidance described in paras 5.6-5.8 above, however there is no evidence that this was done.

6.2.3 The hospital Trust's investigation for this review found that on William's discharge, the hospital did not share information with community health and care services on his low moods and expressed wish to die or refer him to community mental health services. The learning review meeting recognised that William's mental health issues should have been incorporated into the discharge summary; if this had been done the GP and care agency could have become aware of the concerns about his mental wellbeing. It was felt that enabling nurses to contribute to the discharge summary would improve the quality of these records, as they often hold a great deal of information about patients' wellbeing which should be shared with community-based services.

6.2.4 In addition, Adult Social Care did not record any information on William's mental health. It appears from information provided to this review that this issue was not identified in their needs assessment. Both in their own investigation and at the learning review meeting, Shalom agency expressed their main concern that the Individual Support Plan provided by Adult Social Care did not include mental health issues. This meant the agency was unaware of the extent of William's depression and his disclosures about wanting to die, and so they could not monitor his mental health effectively. Adult Social Care's investigation for this review found staff had not explored issues of loss with William, including living alone after his mother died, career and independence, and loss of physical capabilities as his health deteriorated. At the learning review meeting Adult Social Care recognised that the social work team's assessment had been of poor quality, and should have included consideration of mental health issues. It is evident that hospital staff were aware of William's mental health issues, and it is essential that social work teams in hospitals ensure their staff have access to such information for assessment and care planning, and to safeguard their service users when they return to the community.

William's health and care support following discharge from hospital

6.2.5 At the learning review meeting, Shalom care agency explained that they were commissioned to deliver William's care, but they were informed his discharge would be delayed as essential equipment for William's home had not yet been delivered. However, William was discharged as planned, and Shalom agency was not informed, causing a delay in the service starting for two days. The evidence available to this review, that William's neighbour found faeces on his floor, a lack of food in his home, and William unable to go upstairs to bed, suggests William was struggling to cope. The learning review meeting felt that this period without care could well have worsened William's low mood. Adult Social Care's investigation for this review also found that the delay in arranging care for William on his discharge may have been a missed opportunity for Adult Social Care to make a safeguarding referral and address the breakdown in communication.

6.2.6 Within days of the care package commencing the level of support was increased, as more time was needed to deliver care, and William's neighbours could not help him with shopping. The care agency's own investigation for this review found that care given to William was consistent with his care support plan and sensitive to his ethnic, social and linguistic background, though it does not clarify what his background was. William was hard of hearing and refused to have a hearing aid, so staff spoke loudly to him. The carers undertook extra tasks for William such as taking out bins, hoovering the carpet and cleaning the toilet and bathroom, for which William was very appreciative. William's bed was moved downstairs so he could live on one floor, he used a frame and could not manage stairs. The agency noted William's immediate neighbour's own health problems meant he was finding it increasingly difficult to support William. However, when social workers visited William on 12 October 2018, they discovered that William's care plan contained no medication administration sheet, care and support plan or risk assessment. The agency explained that they had difficulty in completing William's support plan with him; it is essential that when service users do not complete care plans that care agencies record the reasons, and how care will be delivered until agreement is reached.

6.2.7 At the learning review the care agency confirmed William had full mental capacity and was able to verbalise his wishes likes and dislikes. The agency confirmed William would often either want to get up late or would decline the offer of care support. Records show that on 5 October the community nurse asked the agency to record when William declined support; it is not known whether this was carried out. The agency pointed out that when they worked with William, he was articulate, knowledgeable and sociable, and would talk to the manager about current affairs when he visited; he might therefore not present as someone with underlying mental health issues or appear to be at risk. However, if the care agency had been aware of William's mental health, they would have been able to monitor and risk assess his mental health more fully.

<u>William's disclosures at home that he wished to die</u>

6.2.8 Records available to this review show that William expressed a wish to die on three recorded occasions whilst at home. The first of these was made to an out-of-hours GP on 11 September, when William would have been recently struggling to cope alone at home without formal care support. At this point the surgery would not have known of William's previous statements that he wished to die whilst in hospital. The GP referred William to physical health care services in the community, but not mental health support, and there is no evidence available to this review as to how the doctor risk assessed William's statement. It could be speculated that arranging care may have been seen as a way to also lift his mood, but consideration should have been given to reviewing William's mental health when his care had commenced to establish if this was the case.

6.2.9 On 18 September William's previous neighbour, his named next of kin, expressed concern to William's GP that William had said he wanted to die. The GP surgery wanted to provide continuity of care but the GP was unable to visit until the next day, however the next of kin confirmed the visit was not urgent. William's GP did recommend that William be taken to A&E for a psychiatric assessment, and the next of kin agreed to arrange this, but there is no evidence that this took place or that the GP reviewed the potential risks when William did not attend A&E. William's GP did visit William on 21 September, where he identified that the presenting issues included some physical health matters but in the GP's view were primarily related to social care needs. Within this review William's GP confirmed William said he wanted to die but then immediately afterwards that was going into respite care, which William would fund, and the GP agreed this was a good idea. This was the last occasion on which William saw a GP from his regular surgery.

6.2.10 Within this review William's GP confirmed he and his colleagues had tried to explore what was really going on for William, but William would make contradictory statements: he would say he wanted to die and then immediately say he wanted to be looked after, and so it was therefore difficult to understand the situation, and how best to respond. William's GP felt it had been difficult to determine if William was exhibiting clinical depression, feeling low, or loneliness. William's GP said that at no point during his conversations with William did it appear that William posed a risk of suicide. If he had indicated suicidal ideations, William's GP would have referred him to community mental health services, and considered whether admission to hospital under the Mental Health Act was appropriate. At this point the GP was not aware of William's wishes to die in hospital, and William's apparent minimising of the seriousness of his

statements made evaluating risk more complex. However, this was the second such statement that the GP was aware of within a week, and on balance greater urgency should have been given to William's potential risk of suicide, using assessment tools available to primary care practitioners.

6.2.11 The learning review meeting reflected on the issue of access to mental health services. Improved Access to Psychological Therapies (IAPT) is available for people with depression and is being extended for people with long term physical conditions. People who are on anti-depressant medication should have their needs for talking therapies considered at medication reviews (see para 5.4 above), which would have provided been opportunities to obtain counselling for William. Community Mental Health Teams support people with more severe mental health problems, but there is a challenge for referring professionals to understand when the threshold for more intensive involvement has been reached.

Summary

6.2.12 It is positive that William's expressions that he wished to die were discussed with him in hospital, and this led to a consideration of a referral to RAID psychiatric services. William did not have access to psychological support available within the ward, but RAID is a hospital-based service, which could have provided William with emergency support and referral to community services when he was discharged. However, a RAID referral was not made and no community mental health referral was made by the ward. These were missed opportunities to offer support to William when his mood was very low. As part of this review the hospital Trust's investigation made a number of recommendations, including reviewing mental capacity tools and training, and reviewing the RAID referral process to see how this could be improved. Within this review the Trust has confirmed all recommendations from their investigation have been implemented, and the mental capacity tool remains under review. A further key point of learning is promoting professional curiosity in clinical areas, and this is discussed further below in section 6.6.

6.2.13 The hospital's failure to share information about William's mental health in their discharge letter, and the failure of Adult Social Care to identify and assess his mental health difficulties and to include them in William's Support Plan, meant that community health and care services were unable to monitor William's welfare or risk assess his needs. The two-day delay in commencing William's domiciliary care package was due to failures in communication between the hospital, Adult Social Care and the care agency. The source of communication breakdown is unclear from the evidence available to this review, but it is clear that this period was very challenging for William. He was clearly not coping, as evidenced by faeces on the floor, lack of food supplies and inability to access his bed. As Adult Social Care has recognised, a safeguarding referral at this point could have provided a further opportunity to share information about William's low moods in hospital. Effective systems are essential for seamless communication between Adult Social Care, the discharging hospital ward, and the care provider, to prevent people being discharged without the care they need.

6.2.14 William's care appears to have met his needs according to his wishes. He often did not want help with his personal care, but did accept support with other daily tasks. However, William's mental health was not monitored at this time. If the agency had known about his low mood his carers could have explored if his refusals of help were because he did not need support and was managing well, or whether he did not wish them to know the extent of his mental health problems.

6.2.15 William expressed a wish to die on three recorded occasions whilst at home during the five-week period after his discharge from hospital: to an out-of-hours GP, a neighbour and to his long-term GP. None of these statements was treated as potentially urgent at the time. William's GP should have explicitly risk assessed the potential risk of suicide, in line with the guidance described in section 5 of this report, taking into account William's stated wish to die twice in the last week, his deteriorating mental and physical health, his resistance to investigations into possible cancer, his recent loss of independence, and the limitations of his support networks. This could have led to mental health input and action to reduce the means of suicide from his home. GPs need clear guidance to ensure they take all bio-psycho-social factors into account when assessing risk of suicide, and are aware of the thresholds for access to appropriate mental health services.

6.3 William's short stay in a residential care home, 24 September 2018 to 1 October 2018

6.3.1 The following chronology details the treatment, care and support provided to William during his temporary stay in a residential care home. It should be noted that information on this period was in the process of being gathered and evaluated for this review when the Covid-19 pandemic ensued, and neither the care home nor the temporary GP surgery was able to complete this process. All findings in this section are therefore partial, but have been included as they are valuable contributions to learning from these events.

Chronology

24 September 2018 William moved for a short stay to The Grange care home. The home states that William visited with a friend prior to his admission to the home, where staff gathered information on his health and care needs. The community nurse liaised with the care home regarding his pressure sore care and need for a pressure relieving cushion, and referred William on to the local community nursing team.

25 September 2018 Local community nurse visited William in the care home and assessed his physical needs, no mental health issues are recorded. The home has reported within this review that William appeared content, and although he stayed in his room for the duration of his stay, he appeared initially happy.

27 September 2018 The community nurse contacted William's long-term GP to request a specific medication, a limited supply of which William had brought with him. The GP noted that William was now living outside the practice's area, and recommended that William register with a new GP.

28 September 2018 William's registration with the home's local GP was completed, and the nurse requested the medication from the new practice. However, the GP could not see from the records that William had been prescribed the medicine and so declined to prescribe it.

28-29 September 2018 Social Care tried to contact William six times to arrange a review of his care, without success.

1 October 2018 The care home has confirmed that William became unhappy at the home and contacted his friend to ask him to take him home. The neighbour came to the care home, and William returned home the same day. The community nurse team transferred the case to the team local to William's home and asked that the nurses liaise with his neighbour to arrange visits. Adult Social Care contacted the care agency and were advised William had been in respite care but had returned that day. Adult Social Care wrote to William arranging a review for 8 October 2018.

Discussion

6.3.2 Within this review, The Grange care home has confirmed that one of William's neighbours originally contacted the home about William staying in residential care for a short stay as respite for the friends that supported him. William visited the home with another friend, who also brought him to the home on 24 September 2018, the day that his stay commenced. William's stay was not funded by Adult Social Care or the NHS, it is therefore presumed he funded it privately.

6.3.3 Within this review Shalom care agency has confirmed they only learned William was going to stay in a care home on the day he left, and the agency informed Adult Social Care's Service Placement Team (SPT) at that time. Adult Social Care's social work team was not aware of William's move, hence their failed attempts to arrange a visit to him. Adult Social care has since confirmed that SPT would not have routinely informed a social worker of such a move. The Grange has confirmed they were not aware of William's social services involvement or the domiciliary care package; if they had been aware they would, with William's agreement, have spoken to his social worker and care agency for more information. The home was under the impression that William's friends were his main carers, and the placement was respite for them. William was very independent and managed his own needs well during his stay, so the care home would not have been unduly concerned therefore when he returned home, as they would have assumed William would have resumed the level of care he was being given by his friends.

6.3.4 Within this review The Grange explained that care homes rely on prospective residents sharing full and accurate information about the nature and extent of their needs. If Adult Social Care has assessed the

person for residential care, their care plan will include detailed health and social needs information which will enable the home to provide the right care. If a resident is privately funded and does not want, or have, any support from Adult Social Care, the home relies on the resident, family and friends for information. Families and friends may not however have the information, or if they do, permission to share it. This can impact on the delivery of care in the care home, until staff get to know the person and their needs. In addition, Adult Social Care's lack of awareness of William's stay, meant that they did not have the opportunity to explore whether his move had been caused by a crisis in his health or support systems, to assess whether his needs might have changed. The care agency and/or SPT should therefore have informed William's social worker so they could have made enquiries and shared any relevant information, with William's consent as appropriate.

6.3.5 The learning review meeting recognised that it was not known how William's placement was funded and expressed some concerns about how William might have been able to afford to privately fund his care, as he was in receipt of welfare benefits. Adult Social Care explained that if a social worker understood that the move had been made by choice using private funds, they would not normally have made further enquiries. Within this review The Grange has confirmed that William paid for two-week stay in advance, though he was refunded the second week as he returned home on 1 October. The care home confirmed that if William had decided to remain as a permanent resident, their normal procedure is to check whether this option would be affordable for the person, and to contact Adult Social care if there was a possible need for financial support. Therefore, if William had difficulty paying for his stay, mechanisms existed to explore his finances and provide means tested support. If William's social worker was aware of his move however, this could have provided a further opportunity to give him early advice and support.

Temporary change of GP

6.3.6 Within this review, the care home's local GP surgery has confirmed that William was registered with them on 28 September 2018, three days after William moved into The Grange. The surgery explained that if the previous GP practice uses the same database as their practice, SystmOne, a transfer can be completed very quickly, but if the transfer is between two different systems, it can take some time. Until the registration is complete their practice cannot view the patient's records and, in an emergency, staff would have to ask the previous GP to fax a summary care record to them. The surgery explained that residents staying temporarily in a care home should complete a temporary registration form, whereby their practice and the previous GP practice could both access the patient's full care records to provide treatment or advice if needed. The care home can request temporary registration for between either 0-15 days or 16-30 days. In this case, the care home has stated that it completed a temporary form, but the surgery states the home requested a permanent registration. No records are available to verify the home's initial request and so no conclusions can be drawn on this issue. However, William was registered as a permanent patient at the care home's local GP surgery, and registration with his long-term GP closed on the same day.

6.3.7 Both the Grange and the agencies involved in the learning review meeting expressed concerns that when service users change GP it can lead to delays in prescriptions, and the new GP would inevitably not be familiar with the person's needs. It was also recognised that some people who move GP temporarily may risk not being able to return to their normal GP if the surgery is closed to new patients. However, it was also recognised that GPs cannot provide services to people outside their geographical area, and people have the right to choose their GP practice where possible. It is important therefore to register people temporarily wherever appropriate, and to facilitate prompt moves between practices so that the right clinicians have access to records they need at the right time.

Medication support during William's temporary stay in a care home

6.3.8 Within this review The Grange confirmed their pre-assessment form detailed a number of William's physical health problems but did not mention his depression, or any anti-depressant medication. It therefore appears that William did not disclose his mental health problems to the home at that stage. The care home has explained that when William was admitted, the Medication Administration Record (MAR) would have been created based on the medications he arrived with. If Adult Social Care or a hospital is involved with admission to a care home, their documentation can provide details of the person's medicines, but William moved into this care home with no involvement of external agencies, so the care

home relied entirely on the information he provided. Within this review attempts were made to obtain details of the MAR, but due to severe pressures on the health and care sector during the Covid-19 pandemic crisis, it has not been possible to secure the record. It cannot be verified whether William brought his anti-depressants into the care home or whether he took them during this period, but this issue highlights that a care home may not be aware of all the medicines that a new resident may be taking on the first day of admission.

6.3.9 On 28 September 2018 the community nurse queried one of William's medications with William's new GP, using the SystmOne database. However, the new GP, who had only become responsible for William's care that day, could not see any records of medicines prescribed historically and so decided not to issue a new prescription. There is no evidence available to this review that the failure to issue this prescription had any adverse on William's health, but neither is there evidence that the need for and urgency of the prescription was reviewed by any healthcare professional. Within this review William's new GP surgery has suggested it would be helpful if people who are planning to move from their own home into a care home request from their GP to provide a month's medication in advance, so they have sufficient supply during the transition period to the new practice. This would give time for the new practice to liaise with the previous practice if necessary, avoiding any need for an emergency prescription. This is a valuable suggestion.

6.3.10 Within this review The Grange has highlighted that better communication between care homes and GPs would enable care homes to obtain healthcare support when the resident needs it. The home suggested that consent from the resident to share information between the home and the previous GP would enable the care home to have an accurate basic set of information including diagnoses, medication, and any flagged issues. A sharing information agreement could also enable the care home to obtain continued support from the previous GP, even if they are located too far away to visit the resident.

William's return to his own home

6.3.11 The Grange has confirmed that while William was in the home he stayed in his own room and used the call bell to ask for any help; he also took meals in his room. The home confirms William managed his own personal care, only asking for help if he was struggling. He was smartly dressed each day, and his manner was pleasant, there was no indication that he was depressed or had any suicidal ideations. However, he decided he did not like being in a residential care environment and on 1 October phoned his neighbour to ask that they take him home that day. William's domiciliary care commenced on his return home, and the evidence available shows William's social worker became aware at that point that William had been in respite care; a review was arranged with him for the following week, which would have provided an opportunity to discuss his stay. There is evidence that the community nursing team learned of William's return home and informed the appropriate team promptly; within this review the community health service has confirmed that in this case William's nursing service transferred within the same Trust, but if he had moved out of their area, effective systems are in place to inform the new health provider. The date on which William applied to re-register with this GP has not been provided to this review, but evidence shows re-registration was not completed until 15 October 2018, by which time William was in hospital, after taking an overdose. William did not therefore benefit from continuity of GP primary care after he returned to his home on 1 October 2018.

Summary

6.3.12 It appears William moved into The Grange care home both to be cared for, and to give his friends some respite from their responsibilities. He did not inform the care agency or community nursing service until the day of his move, and although the care agency rightly informed Adult Social Care Service Placement Team promptly, William's social worker was not made aware of this. It is important that people have the freedom to arrange their own care, but the lack of sharing of information between the care agency, social worker and care home could have led to several potential consequences. Firstly, the care home may not have been aware of all William's needs which could have compromised their ability to deliver the right care. NICE Guideline SC1 states that on the day a resident moves into a care home the home should have details of the resident's GP and other involved professionals, their medicines (including purpose and dosage) and any support needed with medicine administration. In this case, William did not disclose his depression to the home prior to his admission, and in theory may not have informed the home after admission. Secondly, William's social worker did not have the opportunity to explore the reason for

his move, for example, if it had been caused by an urgent issue, he may have needed additional support and a reassessment of his needs and risks. Most importantly, exploring the decision with William would have enabled his voice to be heard fully. Thirdly, if William's social worker had been aware of the move, William could have benefitted from advice and guidance on the right type of care home for his needs or the potential availability of financial support. In this case there is no evidence available to this review, that the care home provided care that was below required standards; however effective liaison between the agencies involved helps to ensure that high quality care is delivered safely, and that the person can make informed decisions about their care.

6.3.13 When William moved into the care home, the staff arranged the transfer of GP services to their local practice. If such a transfer is requested on a temporary basis, both the previous GP practice and the new GP practice can view the patient's records and provide support, which enables the patient to have some continuity of care. If the transfer is permanent the previous GP can no longer view the patient's records, whilst the new GP will be able to treat the patient but will not have the benefit of guidance from the previous GP in the early days when they are less familiar with the patient's needs. In this case there was no consensus between the home and their local GP as to whether the transfer was short term or permanent, but it is evident that the right registration should be completed for the person's individual circumstances. The gap in GP support during transition between surgeries, led to the community nurse not being able to secure a decision on whether one of William's medications was still needed. The potential for patients to fall between the gaps in services must be avoided, therefore in the case of permanent transfers of GP care, both surgeries should hold responsibility for the patient's care until the transfer is complete.

6.4 William's health and care following his return to his own home 2 October 2018 to 16 October 2018

6.4.1 On 12 October William disclosed he had taken some tablets the previous evening, and later that day took a further overdose, which contributed to his death four days later. This section explores case management by the agencies involved.

Chronology

2 October 2018 Community nurse tried to visit William without success; William's friend gave the nurse William's door key code and advised his dressings needed changing. A nurse visited the following day and changed his dressings.

5 October 2018 Community nurse liaised with Shalom care agency regarding William's pressure area care; the agency said that William sometimes declined help with washing; the nurse suggested this should be documented whenever it happens.

8 October 2018 Adult Social Care reviewed William's care, and referred him to hearing and eye health services. No detailed record of the care review is available to this review.

10 October 2018 Community nurse visited William, and recorded that he was not using his pressure cushion as he found it uncomfortable and too high.

11 October 2018 Adult Social Care was informed by the NHS that NHS hearing tests are not available in his area, and recommended contacting his GP. Adult Social Care noted there was no covering GP at that time as William had returned from his respite stay. The community nurse also visited William.

11 October 2018 At 1605 William called 999 but abandoned the call. The ambulance service established with the help of the police and phone provider that it was William who had called, and attempted to call him back, without success. An ambulance crew attended his home where they found William had fallen and been helped up by his neighbour, with no injury. The crew attended to William at the scene, and recorded that he wanted to be left alone. The crew queried with the community nursing service that the care agency had only arrived at 11am that morning, and not arrived that lunchtime, and that William was paying for care three times a day but only received two visits.

12 October 2018 The following chronology details the events on this day; timings are included where known.

0920 Carer visited William, who declined help with his personal care, so the carer provided help with breakfast and reminded him to take his medication (William took his medication independently). The agency has noted William did not say he was unwell or disclose he wanted to end his life during the visit.

1235 approx. Community nurse visited William, who informed her that he had taken some tablets the previous evening as he wanted to die; he did not want any fuss or for the nurse to contact anyone. During the Trust's investigation for this review the nurse said she was concerned for William's welfare but disputed that William disclosed he had taken an overdose, saying he was alert and orientated and appeared to have full mental capacity.

William's carer arrived and he repeated his wish to die. The nurse recorded that William was orientated to time and place and although hard of hearing, was able to converse. She also recorded that the carer reported William often did not want the carers to do anything, they would often find him in the kitchen on arrival. The nurse attended to William's pressure area care, and noted some possible faecal incontinence.

1330 approx. Adult Social Care records indicate the community nurse left William's home around this time. The community nurse then sought advice from her line manager, and as a result called the GP surgery local to The Grange. The practice manager informed that they would ask William's next of kin to support him in re-registering with his previous GP urgently.

1340 William's carer called her manager, who advised the carer to hide William's medication.

1410 approx. The community nurse called William's social worker but was unable to contact her as she was 'offline', and so left a message with a duty social worker; the duty worker advised the nurse to call the Community Mental Health Team.

The nurse then called the Community Mental Health Team, who said they could not see William unless he was declared medically fit by A&E. The nurse explained that William would be unlikely to attend A&E as he did not want to cause any fuss. The alternative would be a GP referral to First Response Team, so the nurse recorded she would task the GP surgery to do this before William re-registered with them; she also noted William had visits by carers three times a day so would be seen regularly.

1420 Care agency manager attempted to call William's neighbour of over 20 years, eventually reaching him at 1620 approx. The neighbour confirmed William had not attempted an overdose before; strategy meeting minutes on 6 February 2019 state that the neighbour told the agency manager that William was 'attention seeking' and 'messing about'. The manager arranged to meet the neighbour at William's home and left the office. The manager later gave the key safe details to the social workers and asked a carer to attend William's home.

1650 approx. Social workers from Adult Social Care visited William due to the nurse's concerns and William's lack of response when they tried to telephone him; their visit had been delayed by some time due to the need to obtain information on the care agency. Adult Social Care records show William appeared lethargic, pale in colour and disorientated at first, and disclosed he did not want to live any more. Several packets of co-dydramol were at his feet, with most tablets missing, suggesting he had ingested up to 24 tablets; William also disclosed he had taken an overdose and wanted to be left to die in peace.

1740 Ambulance service records confirm they received a 999 call regarding William. The social workers recorded they called 999 with William's 'reluctant consent'.

William told the social workers his health had changed significantly a few months ago, leaving him with poor vision, hearing loss, reduced mobility, difficulty swallowing, chronic pain, inability to continue driving, and a cancer 'of an unknown origin'. William said he was extremely depressed and had made attempts to end his life over recent months but was unable to recall the timeline. He reported that it was his birthday tomorrow and he took the tablets with the understanding he would be dead in a few hours. The social workers also recorded that throughout their visit there were no concerns that William lacked mental capacity.

Adult Social Care records state the carer then arrived and confirmed there had been no empty packets on the floor at her earlier visit. The carer reported William's earlier disclosure to the carer and nurse of his intention to end his life. The carer stated she informed her manager of the disclosure, and that her manager said he would contact Adult Social Care; however, no contact had been made. The carer also explained that the agency had had concerns regarding William inappropriately taking his prescribed medication in blister packs and had taken the informal action to hide them. The social workers recorded

concerns that William's care plan was incomplete, with no medication administration sheet, care and support plan or risk assessment; and William had uneaten food and drink beside him, but no nutrition or fluid charts had been completed (discussed above, para. 6.2.6).

The social workers contacted William's friend, next of kin, to inform him of the situation. They also spoke to a neighbour who confirmed William had not allowed him to call 999 when he fell the previous evening and felt William could be trying to seek attention.

1755 Ambulance crew arrived. The social workers recorded they emphasised to the crew the importance of ensuring William had a psychiatric assessment at the hospital.

1830 approx. William was transported by ambulance to Basildon Hospital, the crew made a pre-alert call to inform the hospital that they were on their way.

12 October 2018 Safeguarding referrals were made by the ambulance service, care agency and Adult Social Care.

13 October 2018 Adult Social Care requested a Rapid Assessment and Interface Discharge Team assessment. This was carried out the following day, with a plan for possible review.

15 October 2018 William was formally re-registered with his long-term GP.

16 October 2018 William passed away in hospital.

Discussion

6.4.2 As explained above in para 6.3.11, William left respite care on 1 October 2018 but did not change back to his previous surgery immediately. This meant he did not have the access to his usual GP, and the continuity of care with which he had normally been provided, in the days leading up to his death. Records available to this review show that the community nurse service resumed after William returned home, albeit with a slight delay due to difficulties accessing William's home. The community nurses visited William on four occasions between 1 October and 11 October, primarily to manage his pressure area care. William's home care was also reviewed by Adult Social Care on 8 October, and as a result the care package continued; it is positive that the social worker referred William to hearing and eye health services, although it appears the hearing service referral was not successful as there was no availability locally.

6.4.3 The Adult Social Care review explains that William continued to need support with his personal care, meal preparation and keeping his home clean due to his lack of confidence and inability to stand for long periods following a fall. It added that his neighbours were supportive but could not always be there to help. It also states that William had mental capacity in all his decision-making. William was noted to feel lonely and isolated, so details of befriending services were given to him. It also noted that William had 'let himself go' and needed encouragement to look after himself. The review notes there were no indications that he wished to end his life, although there is no evidence that at this point the social worker was aware of William's suicidal ideations. The care plan focused on William's physical health needs, but did not mention his wellbeing needs. It does not appear, that William's stay in the care home was discussed with him, even though records demonstrate Adult Social Care's Service Placement Team had been informed of the stay by the care agency on 1 October. An opportunity was therefore missed to pass this information to the social worker who could then talk to William about the reasons for his stay in the care home and why he returned home earlier than planned. The social worker could have also consulted with partner professionals such as the care agency, community nurses and GP and potentially uncover his history of suicidal thoughts.

6.4.4 There is some evidence that William continued to experience health problems: on 5 October the community nurse liaised with the care agency regarding William's pressure area care; on 10 October the nurse noted William was not using his pressure cushion as it was uncomfortable, and on 11 October William sustained a fall. The ambulance service attended, but William wanted to be left alone. The ambulance service subsequently highlighted to the community nursing service that William's carers were arriving late and so might not be meeting his needs; such sharing of information and concerns with partners is good practice. However, the subsequent ambulance trust investigation for this review, found that the crew should have also referred William to a falls service (this is discussed above in para 6.1.11).

6.4.5 Contemporaneous evidence shows that at lunchtime on 12 October William disclosed to a community nurse that he had taken some tablets and wanted to die, and that he repeated this to the carer who arrived during the nurse's visit. The nurse noted that William appeared alert and orientated, but the Trust's investigation for this review notes that there is no evidence that the nurse took baseline observations or completed a mental capacity assessment, nor is there any evidence of any discussion regarding medication taken or potential risks and side effects. Their investigation also found that the nurse recognised her records suggested William had taken an overdose the previous evening, but that the nurse refuted that William said that was what had happened, and if she had believed this was the case she would have called 999 despite William's refusals of help. At the learning review meeting, the care agency confirmed that William could avoid telling people how he felt to avoid making a fuss, and if this happened on the day, this may have played a part in the nurse believing William was not a risk of suicide. Establishing William's state of mind would therefore have been challenging, but seeking information on the number and type of tablets taken, gathering evidence through taking baseline observations, and exploring mental capacity, would have enabled the nurse to make an informed assessment of William's health and wellbeing.

6.4.6 The evidence available shows that the community nurse was concerned that William was depressed and after she left William's home, she sought advice from her manager. This led to her making a number of calls to partner agencies. William's registered GP, at that time still the practice close to the care home, advised that now William was back home he needed to re-register with his previous GP, and offered to ask William's next of kin to support this. Within this review, William's long-term GP has commented that if a person is living in a practice's area and is in need of urgent help, the practice should respond regardless of whether the person is registered with them or not. The GP felt some community healthcare staff are confused about this principle and the correct practice approach, but in this case the practice manager should have advised the nurse to contact the long-term GP practice for an urgent response.

6.4.7 The community nurse also attempted to call William's social worker, without success, and left a message with a duty worker at Social Care Connect, Adult Social Care's single point of access. Adult Social Care has recognised that this message should have been treated with greater urgency, with Social Care Connect calling or emailing the social work team, rather than a case note alert on William's records for his social worker to respond to. Adult Social Care's report for this review has recommended that its systems should be altered to allow alerts such as this to be given greater prominence and urgency.

6.4.8 During their call, Social Care Connect recommended the community nurse contact the local Community Mental Health Team (CMHT) to support William. However, CMHT advised the nurse they could not see William unless he was declared medically fit at A&E, which was not possible as William refused to go there. The nurse agreed with CMHT that she would ask the GP to refer William to a First Response Team instead to request an assessment. William's long-term GP confirmed he believed CMHT's advice was appropriate, as it is important to ensure physical illness does not affect the patient's assessment. However, this was potentially impossible to achieve as William refused to go to hospital; therefore, on reflection, the nurse should have contacted the First Response Team directly. However, Essex Partnership University NHS Foundation Trust, local provider of mental health services, states on its website[1] that the First Response Team provides assessment and short-term treatment within 14 days of referral by a GP, or one day for urgent referrals. The nurse may not therefore have been able to access this service directly herself. The learning review meeting also highlighted that the community mental health crisis service only accepts referrals from doctors, not from nurses or other clinicians, so again the nurse would have needed to ask William's GP to refer him. At that point William was still registered with the GP practice close to the care home, who did not know him well. The meeting agreed the requirement for referral by a doctor was an unnecessary barrier to securing urgent mental health treatment for people in the community and should be addressed.

6.4.9 It is important to note that at this point, neither the carers nor William's social worker would have been aware of William's previous expressed wishes to die, due to failures in communication within the hospital discharge documentation and social work assessment (see above paras 6.2.2 – 6.2.4). However, three

[1] (https://eput.nhs.uk/our-services/essex/essex-mental-health-services/adults/community-teams/adultcommunity-mental-health-teams/

statements by William that he wished to die between 11-21 September 2018 were recorded by his GP surgery at that time, and this information could have been accessed by both his new GP and the community nursing service. When the community nurse made contact with the surgery and her manager, these records could have been consulted to support the nurse and inform the assessment of risk on that afternoon.

6.4.10 After William's disclosure that he had taken tablets and wished to die; William's carer consulted her manager. Adult Social Care recorded that the carer believed her manager would report the issue to the social worker, but no contact had been made. The agency manager did however seek further information from William's neighbour, who minimised the potential risk. It is appropriate to seek further information from those closest to the person at potential risk, within the principles of confidentiality, and this should form part of the risk assessment, but it should not be relied on solely to judge the level of risk. The agency should have fulfilled its duty of care to William by seeking the support of William's social worker, his local GP, and called 999 if necessary; all of these agencies could have conducted their own risk assessment of the situation based on the presenting problem and any information they already held on William, and organise a response accordingly.

6.4.11 It is essential in urgent situations such as this, that agencies do not delay reporting of concerns, to ensure their service users are being safeguarded. The care agency's investigation for this review confirmed that since these events, the agency has put measures in place to train staff in mental health awareness to enable them to recognise basic signs and symptoms of mental health breakdown, including extreme mood swings, thoughts of suicide and self-harm, avoiding social functions and engagements, inability to cope with life's challenges and maintaining poor hygiene; these measures should help to promote early detection, to seek appropriate interventions and achieve good holistic practice.

6.4.12 The agency's own investigation for this review confirms that action was taken to attempt to remove the means of suicide, when the agency manager advised his carer to lock William's tablets away. However, it is evident that William did access his tablets and take an overdose. At the learning review meeting the agency confirmed that William had a large amount of co-dydramol in his home; most of his medication was in blister packs but his pain relief was be taken when needed and so was not in the blister packs. The review meeting noted that if a GP is concerned a patient might overdose, they would be mindful of how much to prescribe at a time, and this should be considered at regular medication reviews. This would be in line with the Safer Prescribing guidelines discussed above at para 5.9.

6.4.13 The learning review meeting highlighted that it was unclear why the community nurse's manager did not check later with the nurse that support was in place; it was noted that the manager was not interviewed within the Trust's investigation as she was no longer employed in the organisation. NHS Basildon and Brentwood Clinical Commissioning Group however confirmed that during a recent visit to the Trust staff in the community and their managers were observed to liaise frequently, and when issues arose, they were followed up to ensure they were resolved.

6.4.14 When two social workers arrived at William's home at approximately 1650, William had apparently taken more tablets. They saw medication packets which suggested he had taken up to 24 co-dydramol, which contains paracetamol and codeine, later found to be consistent with one of the causes of his subsequent death. Social workers reacted promptly when his condition deteriorated and an ambulance was called, which arrived soon after. William was taken to hospital, and Adult Social Care appropriately monitored his condition and began considering support on discharge, but William died four days later.

<u>Summary</u>

6.4.15 Following his return home, William had a range of input from health and care services, including community nurses and home carers, but he had no GP service, as he was not registered with his local practice. His social worker reviewed the care package, where his mental health was discussed but no evidence of suicidal thoughts emerged, and his mental wellbeing did not form part of his care plan. It does not appear that the social worker explored the causes, or his views on his stay in the care home, or that information on his health and wellbeing was obtained from partner agencies. William's health problems

continued, for example his fall on 11 October, and bowel problems reported by the community nurse on 12 October.

6.4.16 On 12 October William disclosed he had taken some tablets the evening before and wanted to die, and although contemporaneous recordings suggested this was an overdose, the community nurse later explained she had not interpreted William's disclosure in this way. It is of concern that she did not carry out any baseline observations or ask William about his disclosure in order to assess risk. It is also of concern that neither the community nurse nor the GP practice consulted existing records which noted William's previous recorded wishes to die, to inform their responses.

6.4.17 The community nurse acted appropriately in contacting William's GP surgery, social worker and community mental health services. However, all of these attempts failed for different reasons. The surgery should have sought advice from one of its GPs during the call and advised the nurse to seek urgent support from William's long-term GP, in whose catchment area he was residing again. Adult Social Care should have escalated the issue internally to the relevant social work team, which would have enabled them to liaise with the nurse and care agency, and carry out its own assessment of risk earlier. The mental health team was unable to help resolve the nurse's dilemma that crisis support could not be obtained for William as he refused to attend A&E, and suggested the nurse arrange a referral to their service through the GP; however it appears a community nurse cannot refer to the mental health service directly, and the need for GP referral will inevitably create a delay in any response. It is recognised that the community nurse did not think William was at immediate risk of suicide, but she was significantly concerned about risk to contact her own and three other agencies. The community nursing service should have explored William's physical and mental health further, obtained background information, and secured urgent support for William that day.

6.4.18 The care agency was clearly concerned at William's disclosure and took action to partially remove the potential means of suicide. However, the agency also based its view of risk on the community nurse's decision that there was no need to request an emergency ambulance, and on the reassurances of William's neighbour. The agency should have pursued efforts to seek support for William independently, to fulfil its own duty of care and to reflect the urgency it obviously felt.

6.4.19 There was a delay in William's social work team becoming aware of William's actions in taking tablets the previous evening, and the team's action in carrying out a welfare visit that afternoon was good practice, and enabled them to obtain an emergency ambulance for William after he had overdosed on prescribed medicine. It must have been extremely disheartening that despite their efforts William was not able to recover, dying in hospital four days later.

6.5 Safeguarding enquiries

6.5.1 Following William's admission to hospital, several safeguarding referrals were made:

- By Adult Social Care social workers regarding possible neglect and omission by the care agency due to the shortcomings in their care planning and recordings.
- By the ambulance service relating to William's possible self-neglect.
- By the community nursing team regarding potential quality of healthcare support.

Essex County Council commenced safeguarding enquiries under s42 of the Care Act 2014, and requested investigation reports from each of the agencies involved in William's care.

6.5.2 Safeguarding meetings were held on 22 November 2018, 19 December 2018, 13 January 2019 and 6 February 2019. Detailed minutes are available for the first and last of these meetings, the records of the meetings simply restate the events surrounding William's admission to hospital and record that enquiries were continuing.

6.5.3 The first strategy meeting, on 22 November 2018, was attended by representatives of Adult Social Care, the community nursing service, and the care agency. At that point agency investigations were continuing, but the meeting noted a lack of clarity over whether the community nurse, William or his carer first stated that William wanted to end his life. The meeting queried whether the agency or community nurse should have contacted emergency services and notified Adult Social Care. It also identified that the

response by Social Care Connect when notified that William had taken some tablets the night before, should have been more urgent; and explored whether the care agency relied excessively on views of William's neighbour on whether William had suicidal intent. The meeting agreed further information was required.

6.5.4 The final strategy meeting, on 6 February 2019, updated that the community nurse had not believed that William had intended suicide, and hospital records suggested the tablets taken on the evening of 11 October had not constituted an overdose; the symptoms William showed when the social workers visited late afternoon on 12 October suggested the overdose was taken after the carer and community nurse left William's home at lunchtime. Development opportunities had been agreed with the nurse involved to improve her recording, and knowledge of mental health and safeguarding. With regard to mental capacity, the meeting noted the community nurse needed to assess William's capacity, but that people have the right to make unwise decisions. The Trust recognised training on mental capacity and mental health, needed to be strengthened for community nurses. The care agency stated that the carer had not called an ambulance as the community nurse, a qualified professional, had decided this was not necessary, but if a service user is unwell, a carer must call 999 and the agency. The agency manager also clarified that he had sought the opinion of William's long-time neighbour, who felt William was 'attention seeking' and 'messing about'. The agency also recognised that it had experienced difficulties persuading William to sign his care plan, and recognised carers should have been using the unsigned plan. The meeting agreed that information gathered for the safeguarding enquiry would be passed to the Essex Safeguarding Adults Board for their decision on further action.

6.6. Further learning from this review

6.6.1 The discussions and reflections at the learning review meeting in November 2019 have been discussed throughout this report, however three further issues were discussed at the learning review: the challenges of assessing risk, the importance of professional curiosity, and the need for effective inter-professional collaboration.

Assessing risk

6.6.2 The learning review meeting identified several possible factors that may make assessing risk more challenging:

- There may be assumptions among professionals about older people's views about the end of life, which may mean they do not explore or challenge sufficiently.
- The impact of deteriorating physical health on people's mental health may not be sufficiently recognised or understood by all professionals.
- When a person has had a head injury following a fall, it can be difficult to distinguish whether things they say are a sign of an underlying mental health problem or an impact of their injury.

6.6.3 As highlighted in paras 5.3 – 5.4 above, older men are a high-risk group, and the rate of such suicides in Essex is higher than the national average. Assessing risk of suicide is a complex issue, and a broad range of factors should be incorporated to inform assessment of both risk and needs. We know (paras 5.4 – 5.8 above) that risk factors include a range of bio-psycho-social factors including old age, both long term and recently diagnosed physical health conditions, mental illness, poverty and the quality of close relationships. Frequent consultations with health services is a marker of risk that may need specialist mental health services, and self-harm in older people is a significant indicator of risk of suicide. National strategy and NICE guidance recommend people with long term conditions being routinely assessed for depression, and can access talking therapies. In William's case, his depression was diagnosed and treated with medication, but there is no evidence he was offered talking therapies, or that his risk of deteriorating mental health, or suicide, was risk assessed in the light of deterioration in his physical health and his loss of independence.

6.6.4 Assessing risk also involves addressing the means of suicide, which includes safer prescribing. In William's case he had a large amount of opiate painkillers, and his dosage was not restricted through the use of blister packs, as he was prescribed them as and when needed only. Safer prescribing guidance states only short-term supplies should be in a person's home, and it is important that stocks are

monitored. Responsibility for monitoring this should lie with the GP practice, but it is important that all agencies involved in a person's care, including care agencies and community nurses, highlight any concerns about excessive stocks of opiates in a person's home.

Professional curiosity

6.6.5 The hospital Trust involved in this case identified professional curiosity as a key issue, and within the learning review meeting highlighted that the main challenge in this case, in common with many others, is how to encourage professional curiosity and to embed it within practice. The learning review meeting agreed that clinicians need to exhibit professional curiosity and the confidence to discuss feelings of suicide. Busy clinicians can feel deterred from raising issues with the people they support, if they feel they lack the time or skills to support them effectively. However, the meeting felt clinicians should always seek to 'treat' causes and not just symptoms, and their organisations should support them to take time to do this where appropriate.

6.6.6 NICE guidance (para 5.6 above) states that people with depression and a chronic physical health problem should be asked directly about suicidal ideation and intent; and the Southend, Essex and Thurrock Suicide Prevention Strategy (2017) recommends that people who are most likely to encounter people with mental health issues or suicidal thoughts should have the skills and confidence to support them and to enable them to seek professional help. The learning review meeting agreed that clinicians need training on the difficult conversations that may be needed on loneliness, end of life, physical ill-health and changing self-image, as factors that can lead people to think of suicide. The meeting also identified that adult nurses such as those in the community nursing service may not have sufficient pre-qualifying training in mental health; for example, a lack of student placements in mental health could lead to a lack of experience in this area.

6.6.7 Research by Thacker et al (2019) defines professional curiosity as 'the capacity and communication skills needed to explore and understand what is happening with an individual or family. It is about enquiring deeper and using proactive questioning and respectful challenge, understanding one's own responsibility and knowing when to act, rather than making assumptions or taking things at face value.' They identify a number of themes, taken from lessons learned in Safeguarding Children Reviews and Safeguarding Adults Reviews, which can impact on professional curiosity, that are relevant here.

6.6.8 Firstly, case dynamics can impact on practitioners' engagement with the individual(s) experiencing or at risk of harm, their family, carers or other interested parties. Factors include knowing something is wrong but not exploring what it is, failing to identify and evaluate accumulation of risks and over-optimism. In William's case, health and care agencies did not show professional curiosity to explore the impact of William's losses of health and independence on him, and showed optimism when he followed statements that he wanted to die with statements that he wanted to be looked after.

6.6.9 Secondly, professional perceptions and attitudes can inhibit curiosity. This can normalise people's risky behaviours which can prevent risk being recognised and evaluated, such as William's frequent contacts with health services when his health deteriorated; deferring to the opinions of people with higher professional status; and a lack of confidence in managing tension or uncertainty. In this case William's carer deferred to the community nurse on 12 October 2018 when the community nurse decided emergency services were not needed, and it could be speculated that the community nurse may have lacked professional confidence when her efforts to obtain support on 12 October were unsuccessful.

6.6.10 Thirdly, organisational issues such as inadequate supervision' lack of management or regulatory oversight and work pressures can all inhibit critical reflection and professional curiosity. In this case, the poor quality of William's social work assessment and the lack of completion of a care plan by his care agency were not identified through supervision or manager/commissioner oversight, and so the shortcomings were not addressed. On 12 October the community nurse sought support from her manager to manage William's depressive state, but it appears did not receive management support to ensure she had gathered all relevant information on William's health and wellbeing, or to establish whether her efforts were successful and to agree a way forward.

6.6.11 Thacker et al suggest a range of skills needed to develop professional curiosity:

- Communication skills to support a deeper process of enquiry
- Risk assessment to identify and quantify risks
- Accurate recording and checking of records to identify cumulative risk
- Exploring networks and consulting widely with family members and professionals to gather a range of views
- The ongoing development and use of reflective/analytical skills to help us to understand complex situations or seek further information.

These skills could be incorporated into local training and development of professional curiosity.

Effective inter-professional collaboration

6.6.12 The learning review meeting reflected that a number of agencies held information that was of concern about William's mental wellbeing, and it was essential that all pieces of the jigsaw are not only available, but are also joined up.

6.6.13 There are several examples of developments in inter-professional collaboration since the events leading up to William's death which are good practice. During this review Adult Social Care confirmed that since this time, the social work team has been represented in daily multi-disciplinary board meetings on wards; although new Discharge to Assess arrangements will mean that all social work assessments of patients' needs will now take place when they have returned home.
Within this review Adult Social Care confirmed that today, since this time, the social work team has been represented in daily multi-disciplinary board meetings on wards; although new Discharge to Assess arrangements will mean that all social work assessments of patients' needs will now take place when they have returned home. William's long-term GP has also explained that his practice now has a list of patients that the GPs are concerned about, and a monthly multi-disciplinary meeting is held to discuss these patients, with representation from community health and social workers. The meetings are a means of communication and sharing concerns, which is far more effective than simply recording information for others to read. William's GP felt that if this had been in place when William was alive, he would certainly have been on this list and would have been discussed. The learning review meeting agreed this is a good forum to share information and consider risk and appropriate support; these meetings currently include statutory and voluntary agencies, and care agencies are invited where appropriate for discussions about specific services users. Meetings are in place across Basildon and Brentwood but may not happen across Essex; if this is the case, this good practice should be promoted. Integrated neighbourhood hubs should also provide a forum for multi-agency sharing of information and reviewing risk.

6.6.14 However, there is still opportunity for further development of joint working. Following the learning review meeting the Essex Safeguarding Adults Board provided anonymised information on another recent Serious Adults Review which has similar themes regarding inter-agency collaboration. Two community-based health services were involved in the care of the person in that case, one of whom could view the records of the other service, but the same did not apply in the other direction. The management of the case could have benefitted from a multi-disciplinary meeting to discuss the person's care and support needs and family issues, but none of the agencies involved requested one. The Review of this case has recommended that Adult Social Care alerts the providers that it commissions of any potential risks and their impact on delivery of care, and that any confidential information is shared by the social worker appropriately. This case highlights the importance of information sharing from the outset of care delivery.

6.6.15 Thacker et al (2019) describe a number of positive features of partnership working:

- a shared overarching purpose (which adds value), objectives and aims
- shared values, principles (including clarity, openness and trust) and goals
- trusting relationships
- regular communication (vertical and horizontal)
- understanding issues from different perspectives to develop "joined-up thinking"
- understanding each other, diversity and dynamism
- mutual understanding of the value of each partner's contribution
- acknowledgement of imbalances of power, access to resources, knowledge and understanding of issues

- participation and engagement by all members
- coordination, leadership and facilitation
- reflection – monitoring and evaluating to show what works
- positivity

It is important therefore that inter-professional collaboration includes not simply arranging opportunities to collaborate, but ensuring the purpose of the collaboration is clear, that each agency involved recognises and values the different perspectives each professional brings, and that collaboration leads to improved services that benefit the people who use their services.

7. Conclusions

7.1 There is no single identifiable factor that could have prevented William's death, but there are a series of missed opportunities where the professionals involved in his care could have established his mental health needs, shared information on risk, and arranged interventions that could have supported him to improve his wellbeing and, ideally, to prevent him taking a significant overdose of medication on 12 October 2018.

Practitioners' knowledge of William's declining physical and mental health, including William's assertion that he wished to end his life

7.2 Between May and October 2018 William's physical health deteriorated significantly, and his mental health also deteriorated necessitating an increase in anti-depressant medication which William reported was helpful. William contacted his GP and ambulance services on numerous occasions, which would indicate both deteriorating health and increasing anxiety. William's GP was aware of, and concerned at, his high usage of these services, and William's statements in September 2018 that he wished to die, and he did attempt to explore the cause. It is recognised that evaluating the situation was made more complex by William minimising any concerns and making apparently contradictory statements about what he wanted; however, no explicit risk assessment of risk of self-harm or suicide was carried out, and no referral was made to mental health services.

How practitioners perceived and assessed risks to William and their responses

7.3 As discussed above, William's GP found it challenging to assess risks to William and although he continued to visit and discuss William s health and wellbeing with him, he did not evaluate risk holistically taking all William's practical, social, emotional and physical needs into account, or seek any mental health support services for him. It is positive that when, on 18 September, the GP was informed by William's next of kin that William had expressed a wish to die, he recommended that William be taken to A&E for psychiatric assessment, however there was no follow up that day to ensure this had been done, or to assess the impact of William declining to go to A&E.

7.4 In July 2018 the GP practice referred William to Adult Social Care for support due to his deteriorating physical health and isolation, and as a result William agreed with Adult Social Care a referral to a community support organisation. William did not follow this up, and there is no evidence that the potential risks of being without such community support were not evaluated. However, it appears Adult Social Care were not aware of all of William's risk factors, including his recent high intensity use of health services and his history of depression, which would have compromised a risk assessment. The full sharing of information at the referral and needs assessment stage is therefore vital, and this was a missed opportunity for early intervention to support William's practical and social needs.

7.5 Whilst in hospital in September 2018, ward staff appropriately responded to William s statements that he wished to die by raising the issue with him at a ward round. It is of concern that whilst William's statements were recorded and discussed, neither the occupational therapist nor the hospital social worker appear to have been aware of the issue. The ward agreed a response to their concerns, in this case a referral to the Rapid Assessment and Interface Discharge team, but there was no follow up to ensure the referral was completed. This shortcoming was a further missed opportunity to support William's mental health needs.

7.6 With the exception of his GP and the hospital ward staff, the providers of William's health and care services did not assess William's mental health and wellbeing. This was partly due to William's presentation as someone who was positive and managing well, but also due to the lack of active sharing of information by those who were aware of his low moods. It is positive that multi-agency forums are in place in primary care in William's area, and this opportunity to identify and manage risks should be available throughout Essex.

Difficulties agencies encountered when supporting William

7.7 Neither William's home care provider, his care home, his community nursing service nor his social workers appear to have been aware of William stating that he wished to die prior to 12 October 2018. Information on risk available within the hospital was not gathered and shared with community health and care services, and concerns recorded on the GP's database were not actively discussed with community nursing services or his care provider. This meant that William's mental health and wellbeing did not form part of assessments, care plans or delivery of care. The care agency and community nurses were not able to monitor William's mental state, or evaluate issues such as declining help from his carers in the context of his wellbeing. The cause of these failures to gather, share and evaluate this information is not known, but it is a significant missed opportunity to monitor William's wellbeing and to actively provide support to him.

7.8 The initial delay in the commencement of William s domiciliary care package would have also been a distressing time for him, and he clearly struggled to cope, saying around that time that he wanted to die. Had a safeguarding referral been made at this point, information held by partner agencies on William s mood and resulting risks could have been gathered and reviewed. This is a potential missed opportunity to ensure William's voice was heard and his mental health needs met.

Agencies' responses when adults with declining physical health develop thoughts of self-harm or suicide and whether responses are sufficient

7.9 As discussed above, William made five disclosures both in hospital and when living in his own home that he wanted to die; all of these were discussed with him, but none led to a referral to mental health services.

7.10 On 12 October William again disclosed that he wanted to die, and that he had taken tablets the evening before. His community nurse did not interpret these two statements as an indication of suicidal ideation, however there was no consultation of the existing records on William's mental health, exploration of the amount of tablets taken, assessment of any impact on William physically or discussion of whether William had plans for self-harm or suicide. These shortcomings meant that the community nursing service and partner agencies did not have the information they needed to assess risk or determine the urgency and type of response needed.

7.11 Despite this lack of information, the community nurse did appropriately attempt to contact partner agencies to obtain support for William but was unsuccessful due either to lack of access either to the right professional or to the right service for William's needs. The nurse did set in motion requests to the GP for referral to the community mental health service, but there was no clear understanding by any of the agencies involved of the level of risk and urgency. Advice and support must be available where people do not want to follow the normal pathway to services, as in this case where William did not want to attend A&E, which is flexible and person-centred. In this case William fell between gaps in services in both primary care and mental health, which prevented the community nurse obtaining vital support for William during a period of crisis.

Preventative actions that could have been taken by agencies that may have made a difference to the outcome

7.12 As already highlighted, there is no single action that could have prevented William's death, but a series of missed opportunities to identify risk factors and arrange support early to prevent deterioration in his mental health and remove the potential means to attempt suicide. These include:

- Failing to investigate William's high intensity use of primary care and emergency ambulance services, particularly between May and August 2018. This could have led to combined mental health and physical health input to support William to reduce the need for these services.
- The lack of full information on William s needs and risks within the referral to Adult Social Care in July 2018, which it appears contributed to failure to risk assess when William did not take up Adult Social Care's offer of services.
- Failure to complete a planned RAID referral when William was in hospital in September 2018, or to refer William to community mental health services on discharge. This would have been an opportunity for early intervention.
- Lack of information on William's low mood within the hospital discharge letter in September 2018, which would be have been shared with the GP and community nurses and would be available to the social worker and care agency with William's permission. This would have enabled professionals to monitor William's mental health and potentially remove potential means of self-harm or suicide.
- Failure to include William's mental health and wellbeing within the hospital social work assessment and individual support plan. This meant the care agency and reviewing social worker could not monitor William's mental health and help prevent self-harm or suicide.
- Lack of safeguarding referral when William's care package was delayed due to failures in communication regarding his hospital discharge date. This would have enabled further sharing of information on risk, consultation with William to ensure his voice was heard, and potentially measures to safeguard him from self-harm.
- Lack of liaison between the care agency, social worker and care home when William entered short stay care in September 2018. This could have compromised the care home's ability to provide safe care, monitor William's welfare and inform his social worker when he left early in case this necessitated reassessment of needs. It also meant that William could not access social work advice on the right type of support for his needs, sources of financial advice, and was a missed opportunity to explore the feelings that led to his decisions regarding institutional care.
- Lack of consultation with partner agencies within the social work review. The review process could have enabled sharing of information held within primary care records about William's expressed wishes to die, and facilitated a discussion with William to enable support for his wellbeing William's mental wellbeing needs should also have been explicit within his care plan.
- Barriers to direct access to urgent primary care and community mental health services for advice and/or assessment, where people may have self-harmed and are at high risk of further harm, but decline to attend A&E.

The effectiveness of inter-agency communication and information sharing in providing support for William

7.13 As discussed above in Section 6, inter-professional collaboration needs to have a clear purpose, provide the opportunity to share information and judgement valuing each professional's perspectives, and lead to positive benefits for people's health and wellbeing. The shortcomings described in para 7.12 above highlight how effective information sharing could have led to better quality support for William's mental health and wellbeing, preventing deterioration and safeguarding him from harm. In practice, information on William's mental health was not shared, available information was not sought out, and in relation to William's short stay in a care home a lack of knowledge of the involvement of community services meant sources of potential information were not available to the care provider.

The challenges faced by adults accessing GP services whilst in respite care.

7.14 William moved into respite care initially for two weeks, though he stayed for one before returning home. The home was in a different town to his normal residence, and necessitated a change of GP. Three days elapsed before the registration process was complete, and in that time despite contacting both GPs, the community nurse was unable to resolve a medication query, the previous GP declined to provide advice and the new GP could see no record of the medication being prescribed. There is no record that this issue was ever resolved fully, and reflects similar experiences by the care agency involved with their service users. William's registration should have been temporary, enabling both previous and new GP to see his records, but the change was permanent. Thus, when he returned home a return to the previous GP was needed, but was not completed before his overdose of medication. This meant that for 15 days

William was without access to a GP. It is evident that patients fall between gaps in services during periods of transition between practices, with no surgery holding responsibility for their care. Patients should always have full access to GP services throughout transition between services, particularly if they have physical and mental health vulnerabilities, as in this case.

Good practice identified within this review

7.15 A number of examples of good practice were identified in this review, although in most cases the outcomes were not successful in practice:

- When William disclosed his wish to die in hospital, ward staff ensured they explicitly discussed his feelings with him.
- When William disclosed his wish to die at home, his GP visited him to discuss the issue.
- William's social worker discussed William's mental wellbeing during the review on 8 October, but the information obtained was not incorporated into the care plan.
- When the community nurse recognised William's level of depression on 12 October, she attempted to seek support from a range of health and care services.
- When William's social work team became aware, on 12 October, that William had taken tablets the previous evening, they urgently carried out a welfare visit and called an emergency ambulance for William after he had taken a further overdose of medication.

7.16 Since the events surrounding William death, the agencies involved have changed practices:

- The care agency has developed its mental health training for carers to better recognise mental health and the risk of self-harm.
- Multi-agency meetings are now held regularly at the GP surgery to discuss patients where there are concerns.
- Social work assessment procedures for patients being discharged from hospital have been reviewed, and changes made in the light of Discharge to Assess requirements and the Covid-19 pandemic.
- The hospital trust has reviewed its Rapid Assessment and Interface Discharge referral process

Lessons to be learned to improve future professional practice

7.17 A number of recommendations are made below in Section 8, with the aim of embedding the lessons learned from these events. The common themes of this learning are:

- Having effective systems and high-quality professional practice in recording and sharing information on people's needs and risks.
- Developing professional skills, confidence and professional curiosity in assessing and reviewing risk
- Greater professional understanding of the impact of loss and ageing on individuals.
- Improving access to mental health and wellbeing services and physical health support services.
- Ensuring that the means of self-harm or suicide are removed when risk is identified, including safer prescribing.
- Improving the sharing of information between hospital and community services, and between domiciliary and home care services.

8. Recommendations

1. Adult Social Care should:

- Incorporate into the current review of Social Care Connect the strengthening of links between the service and Adult Social Care local teams, and social work practitioner support including risk assessment. This should take into account learning from this review.
- Ensure that when the Service Placement Team is informed that whenever a current service user has moved to a care home, they inform the person's social worker.
- Ensure that a person's mental health and wellbeing forms part of any assessment and consequent care planning. Full and accurate information must be shared with care providers wherever possible, with

appropriate consent from the person or their representative, recognising there may be impacts arising from time constraints when care is arranged in urgent circumstances.

- Consider a safeguarding referral where commencement of care is delayed, and record the decision and outcome.

2. Mid and South Essex NHS Foundation Trust should:

Remind all relevant staff of criteria for referrals to the Rapid Assessment and Interface Discharge Team and ensure referrals are made promptly.

Ensure that on discharge, patients who have mental illness or exhibit mental health concerns have their needs considered, with multi-disciplinary input where required, and are referred to community mental health services. Information on the patient's mental health issues, support provided and any referrals made should be included in the hospital's discharge summary.

3. Adult Social Care, hospital trusts, and providers of reablement and domiciliary care should:

- Collaborate to ensure hospital staff share all relevant information on a person's physical and mental health needs at the time of discharge, so that assessment, care planning and review can take place promptly, with all decisions based on informed consideration of the person's needs and risks.

4. Domiciliary care providers should:

Inform a service user's social worker if a delay occurs in completing their care plan or any other documentation deemed essential to the delivery of safe care, and this should trigger an unscheduled social work review.

Where a service user has changed provider and where Adult Social Care has not been involved in decision making, share relevant information about the service user's care and support needs and risks with the new care provider, with consent of the service user.

5. Care providers and GP practices should:

Be reminded of the importance of the need to promptly register short stay residents with GPs on a temporary basis wherever appropriate, and to inform the GP practice when the resident leaves the home. These procedures must ensure continuity of primary care services during a transition period, including ensuring that an adequate stock of the person's medication is in place, and supporting re-registration with the resident's previous GP where required.

6. Clinical Commissioning Groups should:

Collaborate with Primary Care Networks, NHS England and NHS Improvement to ensure processes are in place so that patients moving permanently between GP practices have continuity of care during the transition and can access advice and support from their original GP.

Ensure that East of England Ambulance Services Trust ambulance clinicians are kept informed of the type of falls prevention support available in their locality.

Work with medicines management services to remind pharmacies to monitor any excessive amounts of medication that a patient may have at home, which could lead to risk of over-medication or substance abuse.

Ensure that GPs are reminded to discuss patients' needs for talking therapies at mental health medication reviews.

7. Community nursing services should:

Remind all clinicians who visit patients in the community about the importance of investigating potential self-harm, including taking baseline observations, establishing the extent of the self-harm, actively exploring with the patient their risk of further harm and removing the means of self-harm wherever possible.

Ensure all clinicians are sufficiently aware of primary and community care services systems and practices to be able to make the right requests for care and support, and to advocate for patients where necessary.

8. Mental health providers and community-based mental health services should:

Review referral pathways to urgent community mental health care support, where a person has self-harmed and is at high risk of further harm but declines to attend A&E. The review should include rationale for receiving/accepting referrals from specific professionals, and consider increasing the range of professionals able to refer, to prevent barriers to access for urgent mental health care.

9. Clinical Commissioning Groups, Adult Social Care and health and social care providers should:

Aim to be consistent when multi-disciplinary meetings are held, sharing a common terms of reference to include purpose of meeting; observation of equalities and confidentiality; confirmation of consent and criteria where consent may have to be over ridden; management of information sharing; how risk will be assessed and managed; identification of appropriate support; how differing perspectives and views will be managed; how mental capacity issues will be managed; the importance of involving relevant organisations, the importance of decision making and the critical need to hear and listen to the voice of the person themselves and or their carer or representative.

Ensure health and social care planning enables individuals to make informed decisions about their care and that information is shared effectively to enable delivery of high quality, safe care.

Incorporate into clinical training and professional development skills in professional curiosity.

10. Essex Safeguarding Adults Board should:

Remind community-based health and care providers of the importance of actively listening to adults who may be at risk of suicide or self-harm, and try to establish the means that may be intended for use, to enable risk to be removed or reduced.

Remind all care agencies of the need to advise the person's GP about excessive stocks of opiates stored in a person's home.

Develop training on holding difficult conversations with service users who have expressed a wish to die, which considers biological, psychological and social factors such as loneliness; isolation; loss; ageing; end of life; physical and mental ill-health; economic factors and pathways to access appropriate mental health services.

Develop training on the value of professional curiosity, to include communication skills, risk assessment, recording of risk, consulting networks, evaluating information and using reflective practice with analytical skills.

Advise the local group who manage the development of the Essex Suicide Prevention Strategy of the outcomes of this review.

Compliance of these recommendations should be monitored through each organisation's regular quality audit systems, and collaboratively between organisations.

References

HM Government (2012) *Preventing Suicide in England: A cross-government outcomes strategy to save lives* available at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/430720/Preventing-Suicide-.pdf

Southend, Essex and Thurrock Public Health Teams 2017-21 (2017) *Suicide Prevention Strategy* available at https://www.livingwellessex.org/media/470330/MH_Strategy_Lets_Talk.pdf

National Collaborating Centre for Mental Health (2018) *Self-harm and Suicide Prevention Competence Framework: Adults and Older Adults* available at https://www.rcpsych.ac.uk/docs/default-source/improving-care/nccmh/self-harm-and-suicide-prevention-competence-framework/nccmh-self-harm-and-suicide-prevention-competence-framework-adults-and-older-adults.pdf?sfvrsn=5c12349f_2

National Confidential Inquiry into Suicide and Homicide (2017) *Annual Report* available at https://www.hqip.org.uk/resource/national-confidential-inquiry-into-suicide-and-homicide-annual-report-2017/#.XosvqS3MyL8

National Confidential Inquiry into Suicide and Homicide by People with Mental Illness *Safer Services: A Toolkit For Specialist Mental Health Services And Primary Care* (2017) available at http://www.champspublichealth.com/sites/default/files/media_library/Safer%20services%20A%20Toolkit.pdf

NICE (2019) *Quality standards and indicators Briefing paper: Suicide prevention* available at https://www.nice.org.uk/guidance/qs189/documents/briefing-paper

Thacker, H, Anka, A and Penhale, B 'Could curiosity save lives? An exploration into the value of employing professional curiosity and partnership work in safeguarding adults under the Care Act 2014' in **The Journal of Adult Protection** vol. 21 no. 5, pp. 252-267).

All NICE Guidelines and Quality Standards are available at www.nice.org.uk