Walsall Safeguarding Partnership

Safeguarding Adult Review – SAR14

Review in Rapid Time Report

'Frederick' (pseudonym)

1. Details of initial referral

Frederick was a 90-year-old White British male with care and support needs who lived at home in Walsall where he received care provided by a care provider. On 14th October 2023 Frederick was allegedly fed otherwise than in accordance with his care plan, resulting in him aspirating and being transferred by ambulance to Walsall Manor Hospital where he was pronounced deceased. A police investigation has been commenced.

2. Review in Rapid Time

Reporting agency: West Midlands Police
Date submitted to Walsall Safeguarding Partnership: 16 October 2023

Short summary of rationale for referral:

Frederick lived with his wife at his home address in Walsall where he received nursing and domiciliary care. Prior to 26th September 2023 care was provided by a care provider until they ceased trading. The relevant commissioning department at Walsall Council were notified and on 28th September 2023 responsibility for Frederick's care was transferred to another care provider.

On 14th October 2023 it is believed that Frederick was fed 'on his back', a method otherwise than in accordance with his care plan.

Further concerns were raised by Frederick's granddaughter with West Midlands Police that the carers had not informed the attending paramedics what had happened, and that this may have caused a delay in Frederick receiving appropriate care. It was further alleged by Frederick's granddaughter that he had skin tears and bruising that may have been as result of neglect by the carers.

West Midlands Ambulance Service had been called twice relating to Frederick on the 14th October 2023, at 17:33 and at 18:17 hours.

It was also noted in the initial referral that that approximately two weeks prior to his death, concerns had been raised by District Nurses regarding bruising to Frederick, and that the family had been assured these concerns had been addressed.

An investigation by West Midlands Police found that there was a 'Respect/Do Not Resuscitate' form in place for Frederick, and no criminal offences had occurred.

3. Family context

At the time of his death Frederick lived at home with his wife.

4. Initial scoping discussion

An initial scoping meeting was held on 19th October 2023. When considering the criteria for a Safeguarding Adult Review, it was noted that there was uncertainty as to whether the criteria had been met; a person had died, there was suspicion of neglect, but it was unclear whether there were concerns as to whether agencies had not worked together effectively.

It was noted that a safeguarding concern had been raised on 4th October 2023 with regards to the bruising and skin tears seen by staff from the district nursing service. The representative from Adult Social Care was able to confirm that a Section 42 Care Act 2014 enquiry had been started following the referral.

There was also confirmation that these concerns related to care provided by the care agency and that between the 28th September 2023 when they assumed responsibility for Frederick's care and his death on 14th October 2023, there was no suggestion of any concerns regarding how he was fed.

West Midlands Police confirmed that their investigation was being conducted by their Adult Safeguarding Team as a 'fact finding' exercise, and that it was not a murder investigation.

It was agreed that further information was required from Adult Social Care, and that a further meeting would be convened.

A further meeting was held on 22nd November 2023 at which time more background information was made available.

Frederick had been discharged from hospital on 8th February 2023 but was not deemed as in need of additional support at that time. Long term care was commenced on 15th July 2023 after it was noted that Frederick required 'encouragement and assistance' to eat.

Care was provided by a local care agency until 26th September 2023 when they ceased trading, and a new care agency was assigned to be the provider of care on 28th September 2023.

Information available at the meeting indicated that a Section 42 enquiry had commenced around 5th October 2023 in relation to bruising on Frederick's upper arms, and that it was believed this was due to him needing to be fed whilst positioned at a "45 degree" angle. The feeding position had apparently been requested by a district nurse.

After Frederick's death on 14th October 2023, the Emergency Duty Team at Walsall Council Adult Social Care were notified by West Midlands Ambulance Service of concerns that he had been fed on his back and that he had aspirated.

It was confirmed that the Adult Social Care Assessment and Care Plan did not include any reference to a need to be sat at an angle for feeding.

It was agreed that further assurance was required regarding the care provider, whether a care plan had been followed and whether there were any concerns in terms of CQC ratings.

It was also agreed that the criteria for a Safeguarding Adult Review had been met as there were outstanding issues in relation to how agencies had worked together in terms of transfer of, and adherence to a care plan.

5. Review in Rapid Time

Attendees:

- West Midlands Police
- Black Country Integrated Care Board
- Walsall Council – Adults Social Care
- Walsall Healthcare Trust
- West Midlands Ambulance Service
- Walsall Safeguarding Partnership Case Review Coordinator
- Walsall Safeguarding Partnership (Adults) Chair

The Chair of the Walsall Safeguarding Adult Board chaired the meeting and began by explaining the 'Review in Rapid Time' process.

It was confirmed that Frederick:

- had care and support needs,
- there was reasonable concern how partnership agencies had worked together to safeguard him,
- condition 1 was met as Frederick had died,
- there were unresolved concerns as to whether his death resulted from neglect.

It was further noted that there are a range of Safeguarding Adult Review methodologies available, and that a Review in Rapid Time was one option. At the conclusion of the meeting, it would be determined whether all relevant learning had been identified via the Review in Rapid Time process or an alternative form of review was required, and this could include a traditional Safeguarding Adult Review methodology.

As the initial referring agency, the West Midlands Police representative provided a short synopsis of the rationale for a referral.

A discussion took place as the process that occurs when a provider is no longer able to provide care and a transfer of care takes place.

The Adult Social Care representative confirmed that no information was sent from the outgoing provider to the new provider as this would not be appropriate. A Care Plan completed by the Local Authority (Adult Social Care) was sent to the new provider.

This did not include any reference to a feeding regime as this was not known to the Local Authority at the time of the transfer and had been conveyed to Complete Care by a district nurse.

It was noted that ordinarily a clinical assessment and plan would be done by a Speech and Language Therapist rather than a District Nurse. No evidence was provided as to why this was not the case regarding Frederick.

The Adult Social Care representative informed the meeting that there had been a discussion on 6th October 2023 between themselves and the NHS Community Health Complex Care Team from Black Country Healthcare Trust regarding the reported bruising. During the meeting mention was made of Frederick needing to be fed at a forty-five degree angle. This information was noted on his case notes, but not on the care plan.

For information: Case notes are records of telephone conversations, discussions, contacts including management decisions /supervision discussions/decisions relating to the individual. The Care Plan is legal document that details how a person's assessed needs are met, including provision and outcomes to be achieved, some care plans may also include financial information, i.e. the cost of care services based upon a person's personal budget.

Other issues:

Following the referral regarding skin tears and bruising, it was determined that the criteria for a Section 42 Care Act enquiry were met.

This was progressed by way of a 'Caused Enquiry' with the care agency, which was noted as the appropriate course of action and that this process had concluded that there was no further action required as marks on Frederick's arms were in keeping with him needing to be lifted by carers and due to injections given and blood samples taken.

There were discussions as to what medication Frederick was prescribed to determine whether this had been a contributory factor in his skin condition. Information was provided that Frederick was receiving medication for stomach acid and heartburn, and that he was taking folic acid, paracetamol and using inhalers. No concerns were highlighted.

It was further noted that Frederick's GP had informed his family that he was receiving end of life care.

The initial referral and subsequent scoping conversations had suggested concern around two '999' calls having to be made on 14th October 2023.

This had been reviewed and both calls listened to. The first call at 17:33 hours referred to 'rattling breathing' and was classified as category two. Advice was given to call '999' again should his condition change. The categorisation and advice were agreed by the Panel as being appropriate.

The second call at 18:17 hours gave details of Chronic Obstructive Pulmonary Disease and chest problems. The carer from the care agency was described as distressed and it was noted they had said they would remain with Frederick.

No safeguarding concerns were noted with regard to the actions of West Midlands Ambulance Service.

Learning identified:

- Where there are significant changes to the care required, such as a feeding regime in the case of Frederick, and these changes are incorporated in case notes, it is essential that care plans are also updated and the commissioning department are made aware.
- The commissioning department must ensure the care provider is also made aware.

Recommendations:

- Adult Social Care to provide assurance to the SAB following work that is underway to review the Local Authority's 'provider failure' process. This will include regulated care provision (care homes) and domiciliary care (at home).

- The SAB should seek assurance from relevant agencies that information is updated and support/care plans are routinely transferred when there is a change of care provider.

Conclusion

In summarising the discussions, it was the consensus view that the criteria for a Safeguarding Adult Review had been met and that the Review in Rapid Time process had identified all the likely relevant learning and that it was not necessary to commission a 'traditional' Safeguarding Adult Review.

An Action Plan to address the learning points will be produced in line with the recommendations above.