Safeguarding Adults Review

Jack

Overview Report

August 2022

Lead reviewer: Sarah Williams

Independent Safeguarding Consultant, Safeguarding Circle

Contents

1. Introduction

1.1 Bradford Safeguarding Adult Board (BSAB) have commissioned this Safeguarding Adult Review (SAR) after Jack, a 90 year old white British man, was found dead on 6 September 2019.

1.2 Jack had been an electrician and passionate cricketer, who loved going to matches with his late wife and daughter Kim, although his son was less keen. He was an avid Bradford City and Manchester United fan and music lover, who worshipped life and his family. Jack had a dry sense of humour and was a quiet man, but when he had something to say, it was worth listening to him. Jack's GP described him as '"*a really lovely chap who got quite frustrated at times*" due to his care and support needs; his district nurses said that he was determined and very well-liked. Kim had previously been his carer until his mobility deteriorated and she could no longer move him, but she remained very involved in supporting him. Jack's son was seriously injured in a motorcycle accident, but because Jack's home was accessible, he and his wife were able to visit regularly until his death. Jack's grandchildren also visited regularly, helping out their grandfather with chores around the house.

1.3 Jack had become confined to his bed in the year preceding his death due to increasing immobility, which resulted in him developing pressure ulcers, requiring hoist transfers, then his health began deteriorating, requiring several hospitalisations for catheter infections. He was also diabetic, requiring daily medication. Although frail, he was described as a man who had full capacity to discuss his needs. Jack was entirely dependent on four visits a day for all his needs including food/water, medication and mobility. He had a special drinking/ feeding cup to assist with eating and drinking but struggled to lift it on his own. Jack had a safe and sound alarm pendant that should have been placed around his neck or wrist, however due to his increasing frailty he would struggle to push the button or use his mobile.

1.4 Jack was admitted to hospital on 31 August 2019 after carers found him unresponsive. His daughter was on holiday abroad and wanted to fly home, but nurses told her that he would be well looked after. Jack was discharged home by ambulance on 2 September 2019. Although the ward sent notification to restart Jack's home care service that afternoon and this was confirmed by telephone, no visits took place. Jack was found deceased by the district nurse at his home on 6 September 2019. It did not appear that he had moved since being placed in bed by patient transfer services, his arms were 'swaddled' in hospital sheets and he was likely too frail to free them, his catheter bag was also tucked in the sheets. No food, water or phone was in the room. Jack's alarm pendant was later found hanging on the back of a headboard in a position Jack could not have reached. It is tragic that this generous, thoughtful man died in such circumstances.

1.5 Although the Crown Prosecution Service has taken a decision that criminal charges will not be pursued against the care agency in this matter because the cause of Jack's death could not be determined, the Care Quality Commission (CQC) are now resuming their investigation. The material from the police investigation will be shared with the CQC. The Coroner's Inquest remains open.

1.6 The author and SAR Panel wish to express their sincere condolences to all members of Jack's family for their loss and thank Jack's daughter Kim for contributing to the review. She shared valuable insight into Jack and her own experiences and her love for her father was abundantly clear. The author is also grateful to the professionals who worked with Jack for sharing their insight into his experiences so honestly. The efforts they made to support him were very clearly apparent throughout the review process and all expressed how devastated they were about the manner of his death.

2. Scope of Review

Purpose of a Safeguarding Adult Review

2.1. The purpose of having a SAR is not to re-investigate or to apportion blame, to undertake human resources duties or to establish how someone died; its purpose is:

- To establish whether there are lessons to be learned from the circumstances of the case about the way in which local professionals and agencies work together to safeguard adults;
- To review the effectiveness of procedures (both multi-agency and those of individual organisations);
- To inform and improve local interagency practice;
- To improve practice by acting on learning (developing best practice); and
- To prepare or commission a summary report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action.

2.2. There is a strong focus in this report on understanding the underlying issues that informed agency and professionals' actions and what, if anything, prevented them from being able to help and protect Jack from harm.

Themes

2.3. The BSAB prioritised the following themes for illumination through the SAR:

- Was the safeguarding process (s42 Care Act) used effectively to escalate concerns and secure multi-agency risk management in this case?
- What were the expectations of the commissioners who commissioned the care providers to remedy the alleged safeguarding concerns in respect of Jack and were these supported by the contractual arrangements? How did commissioners monitor performance?
- How well did the hospital discharge protocol work in this case, what does this tell us about barriers and enablers to safe discharge?

Methodology

2.4. The BSAB commissioned an independent reviewer to conduct a SAR using a hybrid of the Social Care Institute for Excellence Learning Together methodology and tools from the SAR In Rapid Time methodology. An initial SAR Panel took place on 28 February 2022 and the report was approved by the BSAB on 29 September 2022. The learning produced through a SAR concerns 'systems findings'. Systems findings identify social and organisational factors that make it harder or make it easier for practitioners to proactively safeguard, within and between agencies.

2.5. The following agencies provided documentation to support the SAR:

- Bradford Metropolitan District Council's Department of Health & Wellbeing, Home Support Reviewing Team (HRST), Safeguarding Adults Team and Contracts/Commissioning Department
- Bradford District and Craven Clinical Commissioning Group (on behalf of Jack's GP surgery)
- Bradford District Care Foundation Trust (BDCFT) (which incorporates the district nursing service and community mental health team, including the occupational therapy team)
- Bradford Teaching Hospitals NHS Foundation Trust (BTHFT) (including Bradford Royal Infirmary)

- West Yorkshire Police (WYP)
- Yorkshire Ambulance Service (YAS)

2.6. Multi-agency learning events took place, both with front-line practitioners who worked with Jack and the leaders who oversaw the services involved in supporting them. Due to the outstanding CQC investigation, the care agency was not involved in discussions, but the reviewer did have sight of their case records.

3. Narrative Chronology

3.1. From late 2018, Jack's health rapidly deteriorated. Pressure ulcers resulted in him becoming confined to his bed and he found use of the hoist provided by Occupational Therapy painful to use. His catheter site frequently became infected, which resulted in 4-5 hospitalisations over the course of the year. Records from different agencies indicate that there was no reason to believe that Jack lacked mental capacity to take decisions around his care and treatment – his views and concerns he raised are clearly captured.

3.2. Good care can be identified from the district nursing service, which provided regular home visits, treatment and advice around his pressure ulcer care. During June 2019 Jack received two planned District Nurse home visits which were for reviewing his skin areas for pressure area care and to review his general wellbeing and equipment and five unplanned urgent interventions related to issues with his catheter. Jack had a specialist mattress to relieve pressure ulcers and regular assessments were carried out to ensure the equipment was doing its job.

3.3. On 18 June 2019, the CQC made a safeguarding referral to Bradford Council's Multi-Agency Safeguarding Hub (MASH) after Jack and Kim raised concerns about the care he was receiving from his first care agency (Care Agency 1) because his medication was not being properly administered and improper use of his hoist was causing bruising. A multi-agency planning meeting took place to determine how to progress the investigation and the matter was referred to the Council's Commissioning team for oversight and to ensure that any wider concerns in respect of the agency could be identified, with feedback given to the CQC. Jack decided to change care providers. Adult Social Care arranged for a new care provider, Care Agency 2, who agreed to provide Jack's care package from 17 July 2019. This comprised four daily visits by two carers, to provide 'double-handed' care.

3.4. The GP's records indicate that they were not made aware of these safeguarding referrals, however, throughout the period of the review his GP surgery can be seen to have provided proactive care to Jack, supporting him with home visits, and being proactive in respect of prescriptions and referrals.

3.5. Concerns started to arise that Jack's dexterity and cognition were deteriorating. District nurses noted that in July 2019 Jack felt that he was losing function of his right arm, he was unable to pick things up, hold his cup or even use the telephone. On 22 July, Jack called his GP and was noted to be struggling to use the telephone, so a receptionist telephoned the community matrons on his behalf, who undertook a home visit the same day. He was referred to neurosurgery by his GP on 30 July in relation to the weakness in his arm, although this referral was declined as no surgical intervention would have improved Jack's functioning. District nurses had also noted that Jack was struggling with his mobile, but it does not appear that this was recognised as a risk, in that it would likely restrict his ability to seek help if he needed it urgently.

3.6. Four home visits were carried out by the occupational therapist, to explore ways to improve his quality of living. There was evidence of close working with the district nursing service, including regular joint visits. However, professionals noted that this was the occupational therapist linked to the community mental health team and that in light of Jack's increasing frailty, a referral should also have been made to the local authority's occupational therapy team to ensure his

physical needs were better met. Jack was not deemed to have complex needs and therefore did not have an allocated social worker, although workers would be allocated for specific tasks, for example when his care plan required review.

3.7. A community mental health nurse carried out a first home visit to carry out a baseline assessment of Jack's cognition, with a view to returning 9 months later to see if there had been any deterioration. Jack's memory of recent events was still very accurate and although there was some indication of cognitive decline, there was no indication that his mental capacity was impaired. He did report some paranoia in respect of wires in the wall. Kim subsequently advised that this period of paranoia occurred when his medication had been changed and only lasted a couple of weeks.

3.8. In late July, Jack's psychiatric consultant identified that he may have emerging dementia which needed to be kept under review. Although Jack's cognition was impaired, he had excellent recall of recent events. His poor vision and reduced manipulation skills hampered the assessment. The response to Jack's emerging cognitive needs was good practice by all agencies.

3.9. District nurses visited twice weekly for wound care visits for his category 2 pressure ulcers, skin inspections and catheter checks however, additional visits were also made on 9 occasions in July to assess specific concerns raised by Jack or the carers around his catheter and pressure ulcers. Two new category 2 pressures ulcers were identified in Jack's coccyx area.

3.10. Adult Safeguarding allocated the case to an officer on 1 August, who followed up on the previous safeguarding concerns, both with Jack and the new agency to establish whether use of the hoist continued to be problematic. Jack's daughter raised concern about short call times, which the officer addressed with Care Agency 2. It was noted that Jack was due to see the GP as he had been unwell for a couple of weeks.

3.11. On 8 August 2019, a further pressure ulcer was noted on Jack's buttock, he was advised to inform his carers to keep this clean and dry prior to applying barrier cream and a photograph taken to monitor its progress. A decision was taken to reduce district nursing wound care visits from twice to once a week, but five additional urgent visits took place in relation to discomfort from his pressure ulcers or catheter. On 13 August an ambulance was called because Jack was in pain all over his body but on arrival, he said he was not in pain and declined hospital attendance. He was deemed to have capacity to do so.

3.12. Adult Social Care followed up issues with respect to use of the hoist with Care Agency 2 and ordered an adaptation for Jack, to make use of his safe and sound alarm (which he had for a number of years) easier. Although this was installed, Kim reported that it did not make a significant difference in his ability to press the alarm. District nurses also visited with Care Agency 2 to establish a care routine and improve moving techniques, because Jack reported that use of the hoist hurt him and he felt unsafe. Referrals were made to occupational therapy and physiotherapy to update Jack's mobility assessment. Lengthy discussions took place around toileting and moisture care to improve his wound care. Kim subsequently advised Adult Social Care that he had decided to stay with this provider. On 23 August, Jack's moisture lesions were noted to be healing.

3.13. On 31 August 2019, carers called the agency's out of hours service because Jack was unresponsive in bed. Carers were advised to call 999, which they did, advising that Jack was 'not breathing'. The ambulance found him breathing but his consciousness fluctuating, so he was taken to A&E and admitted to Bradford Royal Infirmary (BRI).

3.14. Jack presented as drowsy and was diagnosed with hypoactive delirium, secondary to community acquired pneumonia. He was treated with antibiotics and required oxygen therapy on admission. A SKIN pressure care assessment was carried out, a category 2 pressure ulcer

was noted on his sacrum, so an incident form was completed in accordance with Trust policy, a referral made to district nursing and he was provided with an air mattress in hospital. A moving and handling assessment, fall assessment and triple screen (for dementia/delirium/depression) could not be completed due to his presentation although he was noted to be experiencing delirium on admission which was reported to his GP. Hospital notes record that DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) decision was registered on Jack's file, following an Advance Decision by Jack, after doctors discussed this with Jack and Kim on 22 March 2019. GMC guidance[1] is clear that decisions regarding DNACPR must be made in consultation with the patient and/or those close to them and clearly recorded on the patient's records, so this complied with best practice.

3.15. Care Agency 2 sent a message to all carers to cancel Jack's home care services until further notice, however, he remained on the carers' rotas pending an update from social care or the hospital, in accordance with their usual practice.

3.16. A decision was taken to discharge Jack home on 2 September 2019. He no longer required oxygen support and was alert and eating/drinking independently. Jack said he was eager to go home and the ward notified Jack's daughter who was also happy for him to return as she was told his care would restart that day. Although the district nurses were aware that Kim was abroad on holiday, it is not clear whether the discharge team were aware of this. There is no documented evidence of a capacity assessment in respect of discharge from hospital or managing risk at home in light of the fact he had been hospitalised for delirium, although all those involved with Jack's daily care prior to his admission were clear that they did not have concerns at any point in respect of his capacity to take decisions in respect of his care.

3.17. The ward faxed the district nursing service to restart his district nursing service for wound and catheter care. The section of the restart form that indicated whether district nurses needed to contact the patient on the date of discharge or required an urgent visit was ticked 'no'. The letter advised Jack's district nursing service should recommence on 3 September for a review of his category 2 pressure ulcer and that his catheter had not been changed while in hospital. This was triaged by the district nurses involved in Jack's care who noted that there were no new needs identified that would indicate that a more urgent visit was required. The team therefore decided that Jack's visits would recommence at his next scheduled visit on 6 September. The GP also received a discharge notice, with a request to review Jack's medication.

3.18. The ward faxed a home care restart and documented that home care would restart at teatime on 2 September and that the home care provider had telephoned the ward to request a copy of Jack's MAR (medicine administration record) chart. Adult Social Care's records confirm that the restart was received from the ward. Recordings were made of two telephone calls between BRI administrative staff and Care Agency 2. Both confirmed that Care Agency 2 knew Jack would be discharged at teatime, the first occasion the call taker said that they would send a message to the carers and on the second occasion, they said the message had been sent out and enquired about his medication and treatment. No request for confirmation of the discharge was requested or offered during these calls. The identity of the staff member from Care Agency 2 is not recorded. The administrative officer relayed this information to the ward. Kim has subsequently advised that Jack's 'teatime' care visit usually occurred around 3pm, but there is no evidence that the specific time was discussed during the conversation with the care agency.

3.19. Care Agency 2 acknowledged that they were contacted by BRI to inform them of a possible restart in Jack's services, but stated that their practice is to wait for a second call from BRI to confirm discharge and arrange any support for emergency services or additional requirements such as medication or increased services. Care Agency 2 stated that as second call was not

[1] https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/treatment-and-care-towards-the-end-of-life/cardiopulmonary-resuscitation-cpr

received, they did not restart the service. However, this is not borne out by the content of the telephone calls with the ward, where medication needs had been discussed and confirmation given by Care Agency 2 that a message had been sent to carers to restart the service.

3.20. An ambulance transfer was booked by the ward and details for Jack's key safe, medication and MAR and the DNACPR document provided. The Ambulance primary care attendant stated that they were instructed to transfer Jack home before 2pm as the ward was short on beds and that his carers would be arriving between 2-2.30pm.

3.21. Jack was returned home by an ambulance primary care attendant. When interviewed by police as part of their investigation, the attendant recalled using a sheet and carry chair to transfer Jack into his house and left him loosely covered with his duvet. The attendant could not recall if there was an emergency cord or phone in Jack's room and was not told about a safe and sound alarm. He stated they have no responsibility as to food or drink for the patient. He turned on the television, as requested, left him comfortable, and was given permission to leave by the patient. Jack was asked if he needed anything, which he did not. The ambulance staff believed a carer would be there within the hour and left, locking the door behind him.

3.22. On 3 September a prescription was delivered to Jack's home by a pharmacy. The member of staff called out to Jack, but when he did not respond, the staff member assumed he had gone to a cataract appointment and left the medicine on the kitchen counter without checking his room. The appropriateness of this was discussed with frontline practitioners, who explained that in circumstances where agencies had to access someone's home using a key safe because they had limited mobility, it was very important to be respectful of their privacy and personal space. It would not be professional or respectful to intrude further into the home than was necessary for the task being undertaken (here, dropping off medication to someone with carers visiting 4 times daily), or to disturb someone who may not answer because they are sleeping.

3.23. At 8am on 6 September 2019, district nurses attended Jack's home for a scheduled wound care visit and found him obviously dead and surrounded by flies. His table and drink were not nearby, tablets from the hospital were unopened and the TV on. Jack remained in his hospital gown and 'cocooned' by hospital sheets under his duvet, his arms were pinned to his side. Due to his frailty, he may have been unable to free himself. Jack's catheter bag was contained within the sheet, against his leg, instead of hanging to allow proper drainage. His catheter bag was full, his bedding wet and faeces were in his incontinent pads. Jack's safe and sound chord was subsequently found hung over the back of his bed, in a position he could not have reached.

3.24. The district nurse called Care Agency 2's out-of-hours staff at 8.30am, who said that they thought Jack was still in hospital. When the nurse advised he had been discharged, the care agency worker said carers would have seen him last night or this morning. The nurse advised that he had died and was told to expect a call back, but did not receive one.

3.25. Care Agency 2 then called the Adult Social Care's Access team to find out which ward Jack was admitted to. The Access team provided the BRI administration number to the agency to check.

3.26. Care Agency 2 subsequently claimed during the S42 investigation that their procedure is to wait for a second call confirming that the patient is definitely being discharged before restarting a care package. Police commented that Care Agency 2 have no written restart policy and organisation of workers happened via text or WhatsApp, relying on carers to alert manager to issues or missed care appointments.

4. Analysis of Agencies' Actions

Multi-agency risk management and the impact of quality of care on safeguarding

4.1. Overall, good multi-agency working could be seen across Jack's case, with professionals working together to address issues collegiately, concerns followed up consistently to ensure these had been actioned and the appropriate legal frameworks applied. Referrals were appropriately made by district nurses and the GP to specialist services such as tissue viability, continence, occupational therapy and physiotherapy, with services proactively provided and effective communication between professionals involved in his care. There is also evidence of good practice consistent with NICE guidelines in respect of pressure ulcer management,[2] as pressure ulcer assessments were regularly updated and any necessary equipment provided to manage these. District nurses took a photograph of Jack's category 2 pressure ulcer and uploaded it to Jack's health record to enable staff to observe if his skin was improving or deteriorating. Although an issue which required good care, medical practitioners noted that because of Jack's age and immobility, pressure ulcers were not uncommon and as long as these were well managed, not necessarily a matter which required a safeguarding referral. Jack's consent was obtained to any re-catheterisations and ambulance staff appropriately considered capacity when Jack refused to attend hospital on 13 August.

4.2. Jack received four daily visits by two carers, to provide 'double-handed' care as he could not be safely moved by a single person, with most visits lasting no more than 15 minutes. Practitioners reported that this was the highest frequency of home visits that would be offered to someone living independently as part of their package of care. It is widely reported that, nationally, there is intense pressure on social care budgets for local authorities as a consequence of a decade of the Government's national austerity measures, together with reduced workforce capacity arising from a crisis in recruitment and retention of care staff (an issue which has worsened since the pandemic).

4.3. These pressures on the care staff had a necessary impact on the care that Jack received, as care had to be provided in the most efficient way possible, with staff undertaking a high number of short home visits each day. Kim reported that several of the care staff from Care Agency 1 were kind, interested and took the time to support his emotional as well as physical care needs. Likewise, she said that many of the district nurses were proficient, supportive and engaged. However, she said that overall, examples of such compassion were relatively few, describing his last months as a 'horrendous' time for her father. Jack was a proud man and felt the loss of his independence and dignity acutely as his mobility deteriorated and he became increasingly dependent on others. It seems likely that as his perception grew that carers viewed provision of his care as highly transactional, Jack withdrew from interacting with carers, who may in turn have thought that he wanted them to leave him to his privacy as soon as possible.

4.4. This may have led to some of the safeguarding concerns identified in the last year of Jack's life, in particular being moved around his house in his hoist, which may have been quicker than using the hoist to move him into his wheelchair, then transferring him again to his chair in the living room, but was unsafe and contrary to safe handling training. On one such occasion, this resulted in Jack's shin being badly injured, which took months to heal. Likewise, concerns raised that carers had refused to put Jack on the commode when he requested this are likely to relate to these time pressures, but caused Jack enormous distress and may have contributed to worsening of his pressure ulcers. Carers also told Kim that different district nurses had given

[2] 1 Recommendations | Pressure ulcers: prevention and management | Guidance | NICE

inconsistent advice about care for the pressure ulcers, but the nurses reported that proper advice had been given.

4.5. The response to these safeguarding concerns by Bradford Adult Safeguarding was prompt and appropriate, convening a multi-agency meeting with respect to use of the hoist and wound care. After investigating the allegations, the Safeguarding team notified Bradford's Local Authority Adult Commissioning team, which oversees performance management of social care contracts, in particular monitoring whether any patterns arise in the type of frequency of safeguarding concerns raised in respect of different agencies. They reported that there had been some performance issues in respect of Care Agency 1 which were being monitored and had been reported to the CQC, but that there had not been a similar pattern of concern in respect of Care Agency 2.

4.6. Senior managers involved in the review noted that from a community nursing perspective, the key was to consistently work in partnership with carers, the GP and other professionals. Nurses would start with a conversation or an offer of a joint visit and there was a mechanism for senior nurses to attend a serious concerns meeting with the local authority and in managers' experience, such concerns were always appropriately acted upon.

4.7. Jack and Kim took a decision to change care agencies, and the Adult Social Care area team provided them with details of Care Agency 2, for the reasons above. However, Kim reported that after changing care agencies, similar concerns continued to arise. She felt that staff from Care Agency 2 would be 'in and out' even more quickly, regularly completing visits within 5-7minutes, infrequently bathing Jack and often would not change his catheter bag. She bought her father's groceries, so worried that staff were feeding him the bare minimum which she felt contributed to his increasing frailty and had concerns about unhygienic practices such as leaving open food out of the fridge and throwing used disposable gloves in the garden. Despite the Safeguarding Team being proactive in following up to ensure that there were no ongoing safeguarding concerns, neither Kim nor Jack thought that there was a purpose in formally complaining again – "*that's just the way it was*". However, careful consideration was given to the concerns Jack raised that the new care provider was 'no different' to the previous provider in terms of the quality of care he received.

4.8. By contrast, the district nurses reported that they felt their professional relationship with Care Agency 2 was relatively good, that carers had escalated any health concerns for Jack appropriately and promptly and that they tried to follow advice from nurses in respect of his care needs. They were sympathetic the pressures that care staff were under to meet the needs of all of the people they were caring for every day under enormous time pressure, which, for some staff, may present as brusque or rushed. All professionals were sympathetic to Jack's experience of the care he received, but commented on the strain that individual carers and the care system overall were experiencing.

4.9. Managers at the learning event felt there may have been a missed opportunity to improve Jack's experience of care as carers perceived that he had an aversion to use of his hoist, which, in the context of the serious injury he had sustained and experience of being moved inappropriately around the house in the hoist, was very understandable. Although this issue was addressed with both Care Agency 1 and Care Agency 2, a more proactive response, perhaps drawing on the occupational therapy service to deliver bespoke training could have ensured that Jack had confidence in his new carers to move him safely, which may have improved his care overall, for example, making it easier to bathe him.

4.10. Jack would also have benefitted from a comprehensive geriatric assessment (CGA), a multidisciplinary diagnostic and treatment process that identifies the medical, psychosocial, and functional limitations of a frail older person, with a view to developing a coordinated plan to

maximise overall health with aging.[3] This would have enabled practitioners to identify what Jack's support needs were in respect of his environment as opposed to just his physical care needs, taking a personalised approach to his wishes and priorities.

4.11. A workstream is currently underway in Bradford as part of the NHS Ageing Well programme using an adapted hybrid approach for the CGA. Since the start of the Covid-19 pandemic, Bradford Teaching Hospitals NHS Foundation Trust (BTHFT) has introduced a 'Virtual Ward', which is a multi-disciplinary enabling team that provides a 'discharge to assess' approach to support older people returning home from hospital. The Virtual Ward aims to introduce a CGA to all older patients, with a view to preventing admissions from primary care. However, managers commented that use of the CGA was not yet standardised across Bradford District Care Foundation Trust (BCDFT) and BTHFT which led to an inconsistency of approach.

4.12. A more standardised approach would be consistent with Bradford District and Craven's Health and Care Partnership's 'Act as One' ambition to help people to live '*happy and healthy at home*'. This aims to support people to stay healthy, well and independent through their whole life and through prevention and early intervention with greater focus on healthy lifestyle choices and self-care and providing care and support through a proactive and joined up health, social care and wellbeing service designed around their needs.

4.13. High quality, personalised care services rely on a valued workforce, who are well-trained and appropriately rewarded. Although outside the scope of a Safeguarding Adults Review, partners and commissioners may wish to consider how the positive work by outstanding carers, such as those identified and praised by Kim, can be recognised and used to model best practice for the wider workforce.

Systems finding

4.14. There was good evidence of multi-agency working in response to safeguarding concerns and referrals were made promptly to ensure emerging needs were assessed as they were identified. A comprehensive geriatric assessment of Jack's needs may have facilitated a development of a holistic assessment of his functional and psychosocial needs that may have slowed the deterioration of his health needs and helped carers to better recognise and meet his personalised needs. A standardised multidisciplinary approach to comprehensive geriatric assessment is required across all health and social care partners, to ensure a consistent approach across Bradford, promote an early response to emerging needs, better support frontline carers to meet the needs of individuals including their safety and safeguarding needs.

Recommendation 1: *Bradford Teaching Hospital NHS Trust should share good practice in respect of comprehensive geriatric assessments with other health and social care partners including GPs, with a view to developing a standardised approach to assessments of the holistic needs of older patients.*

Hospital discharge procedure

4.15. Effective communication and a shared understanding of proper procedures between agencies was essential to keep Jack safe. No internal or intra-agency procedures in respect of discharge were identified during the police investigation or course of this review and these should have been in place, and clear in respect of what notification was required to trigger a restart of a care package and the requirements around a response. This should be followed by all agencies. However, it is very clear from the records of the faxed hospital discharge notifications sent to Adult Social Care, the District Nursing service and Care Agency 2 that Ward staff took reasonable steps to ensure that that Jack's discharge home was safe. Further, the transcripts

[3] Comprehensive geriatric assessment: a meta-analysis of controlled trials; Stuck et. al; Lancet; 1993; 342(8878):1032

of telephone conversations between BTHFT's Ward Discharge team and Care Agency 2 evidence that the agency had confirmed that they had actioned the restart request by notifying the carers to resume visits to Jack.

4.16. There were some procedural errors on the part of the hospital. Records of telephone contacts between agencies should have included details of the identity of callers. A more specific time than 'teatime' should have been clarified for the restart time, in particular as Jack had diabetes and needed to eat at regular intervals. Confirmation from the care agency and district nursing that visits would restart should have been obtained in writing. However, there is little indication that these steps would have changed the outcome in Jack's case.

4.17. It also appears that the fact that the hospital discharge notice had been received was not properly recorded on Jack's Adult Social Care file. Consequently, when Care Agency 2 contacted the Council's Out of Hours team on the morning on 6 September to see whether he had been discharged, Adult Social Care was unable to clarify this and gave them the number for the ward. Although it had no bearing on the case as Jack had already died, this could have led to confusion or created a risky situation in other circumstances. Bradford Adult Social Care should therefore take steps to ensure that hospital discharges are accurately and promptly recorded on people's files.

4.18. When interviewed by police, Care Agency 2 stated that their procedure was to text carers or send a message to the carers' WhatsApp group to resume a care service when clients were discharged from hospital. Care Agency 2's practice of keeping clients who have been admitted to hospital on the carers' rotas pending an update from social care or the hospital, is designed to ensure that care can resume immediately if the client's stay in hospital is brief, and is good practice. However, Care Agency 2 was unable to provide any evidence to police that carers had been sent a message to notify them that care should resume. It may well be that this was a simple human error, but one which had the most tragic consequences.

4.19. Given the potentially dire consequences of a failure to restart care packages following hospital discharge, it is essential that care providers have robust systems in place to ensure that care packages always resume when they receive notification that a patient has been discharged from hospital. These requirements need to be incorporated into contractual arrangements between care agencies and health and social care commissioners, with clear assurance procedures in place to monitor compliance.

4.20. Discharge processes in respect of resumption of District Nursing Services were also explored during the review. District nurses explained Ward staff will automatically make a referral to District Nursing if they identify particular issues, for example, pressure ulcers and catheter care, as these will always require oversight from nurses. A visit the following day was therefore requested, however, in Jack's case, these health needs were well known and already being managed by the District Nursing Service. There was no indication that his condition had worsened and the discharge notification stated that an urgent visit was not required. The nurses considered that their relationship with Jack's carers was good and that they would notify them if he needed an earlier contact. Consequently, a decision was taken that Jack's district nursing care would continue in accordance with the usual schedule, with the planned visit on 6 September. This triaging process is usual practice for District Nursing, necessary to manage demand on the service and no concerns arise from this triaging process. However, irrespective of the timing of their visit, it would have been good practice for the District Nursing Service to have contacted both BRI and Care Agency 2 to advise of their decision and to coordinate his care together.

4.21. Since 2020, the procedure for restart of care packages arranged through Adult Social Care has changed so that the wards contact the Home Care duty manager to notify them that a patient is ready for discharge, rather than contacting the agencies directly. BTHFT has also introduced a

Multi-Agency Integrated Discharge (MAID) team, which is a hospital-based multiagency service that facilitates safe discharge home in circumstances where the patient is assessed by the acute ward to have complex care needs as a consequence of two or more co-morbidities. The MAID services is nationally recognised for the success of its work in supporting a timely and safe discharge process, including by ensuring that a patient is assessed by the Virtual Ward. However, managers debated whether, even now, Jack would have been identified as having complex needs, as although severely frail, he did not have co-morbidities such as dementia or mental health needs and his care needs were managed through an existing care package in the community. The phrase 'complex needs' is used inconsistently across departments, safeguarding partners and nationally, meaning different things to different disciplines. Most managers, on balance, felt that Jack required more than a standard discharge process when looking at his health and care needs holistically.

4.22. Since the period under review in this case, there have also been significant changes to hospital discharge processes introduced through the Department for Health and Social Care's Hospital Discharge and Community Support Guidance, which came into effect as of 1 April 2022. Discharge to Assess and Home First are underpinning principles in this latest guidance and it is likely that, were Jack subject to this process he would have been allocated to Pathway 0 because there was no substantial change to his care plan. This pathway would not, under the current guidance, require BTHFT's MAID team to have oversight of the discharge as this would continue to be led by ward staff.

4.23. Had Jack been referred directly to the Virtual Ward, staff would have assessed his progress on discharge from hospital, which may have triggered an early conversation with care staff that would have facilitated identification that the care package had not restarted. Managers also discussed whether the current practice of district nurses being expected to have a conversation with ward staff (as opposed to just written communication) prior to discharge would have resulted in a smooth transfer of care. Although good practice generally, unless this resulted in one of those services contacting the care agency directly post-discharge, this seems unlikely to have changed the outcome for Jack.

4.24. There are a number of SARs published nationally where people in need of care and support have died after their care packages were not restarted when they were discharged from hospital.[4] During the course of this review, practitioners also referred to two other incidents where care packages were not restarted within the Bradford area, albeit where the individual did not suffer harm as a consequence. Bradford Teaching Hospitals NHS Trust will need therefore to carefully weigh how to proportionately introduce failsafe measures to prevent to what might be a very small chance of very, very serious harm during hospital discharge. This will be particularly pertinent for patients discharged via Pathway 0.

4.25. Changes introduced in the Discharge to Assess process in 2019 means that the Ward Discharge Service at BCFT will now follow up when people who lack capacity are discharged, to check that they are safely home and that their care package is in place. If there is no response, a home visit will be promptly undertaken. It may be considered proportionate to expand use of these 'safe discharge' calls to situations where a frail, elderly or otherwise vulnerable patient has daily care visits and/or required an ambulance transfer, perhaps using a 'RAG' rating system. Consideration would need to be given to how this would be put into effect for self-funders, where contact details for carers may not be available to staff. Ambulance or hospital staff involved in transporting patients home should be aware of any protocol and know how to report any concerns they may have in respect of a person's ability to safeguard themselves.

[4] For example, SAR Sheila.pdf (nationalnetwork.org.uk); 7 Step Briefing regarding LB.pdf (nationalnetwork.org.uk); SAR_Report_Mrs_A.pdf (towerhamlets.gov.uk)

Systems findings

4.26. Administrative staff at Bradford Teaching Hospitals NHS Trust demonstrated good practice in ensuring that the existing hospital discharge processes were properly followed, contacting family, district nursing and the care agency to ensure services were restarted, and reasonably relying on telephone confirmation from the care agency that arrangements were in place for care to resume. However, the care agency's system for notifying carers that they should restart care arrangements was inadequate and there was no evidence of management oversight of this process. Although there is no evidence of any miscommunication between the hospital and care agency, a clear and consistent health and care restart procedure across all partner agencies could mitigate this risk in the future. Additionally, in cases where patients are extremely vulnerable, either due to their frailty or mental capacity and live alone, BTHFT should consider how to introduce proportionate failsafe measures to ensure that discharge has been safe, within existing workstreams to improve hospital discharge processes.

Recommendation 2: *Health and social care partners should develop a consistent care restart procedure across Bradford, and health and social care commissioners should embed this procedure in contractual safeguarding requirements for all commissioned care services going forward.*

Recommendation 3: *Health and social care commissioners should require evidence from commissioned care services that their internal care restart processes are robust, with adequate management oversight.*

Recommendation 4: *The Bradford Integrated Care System (ICS) and/or BSAB to seek assurance from Bradford Teaching Hospitals NHS Trust that proportionate failsafe measures have been introduced to support safe hospital discharge and that this includes guidance for staff involved in patient transport.*

Safety planning

4.27. Jack was wholly dependent on others to meet all of his care needs. He was unable to get out of bed without support and because of limited mobility in his hands and arms, increasingly struggled to use a cup, his mobile and most importantly, his safe and sound alarm, a vital safety line in case of emergency. Jack was very aware of this, and district nurses commented that he was always very careful to check before they or carers left the home at every visit, to ensure his alarm was around his neck and his table with his drink, mobile and remote was in reach.

4.28. Following a referral from the community mental health occupational therapist, Bradford Adult Social Care was aware that due to his increasing frailty, Jack was having difficulty pressing the button on his safe and sound alarm and had ordered an adaptation for the alarm to make it easier for him to use, which was good practice. However, Kim reported that even with the adaptation, Jack was still unable to press the alarm. Jack's ability to use the adaptation should have been assessed at the time this was installed, and an alternative option identified to ensure that he could seek help in an emergency. The receptionist at Jack's GP surgery and nurses were also aware that Jack was struggling to use his mobile phone and were proactive in making calls for him to ensure that this did not prevent him making necessary appointments. However, these issues do not appear to have triggered consideration around cohesive safety planning to mitigate the imminent risk to Jack, should an emergency arise.

4.29. Jack's discharge records should have indicated whether he had a safe and sound pendant or other emergency aides. In light of Jack's immobility, ambulance staff should have ensured that his mobile phone (if any) and drinking water were in easy reach for him and that his clothing/bedding were appropriate for the weather conditions and comfortably arranged in a way that did not restrict his movement. Importantly, they should have ensured that his safe and

sound pendant was around his neck. Given his age, frailty, and recent hospital admission, if this had not been in his possession on discharge from hospital, ambulance staff should have asked him for its whereabouts and if unable to find it, immediately notified social care to ensure a replacement was immediately provided and additional safety measures implemented.

4.30. It was equally important that any resulting safety plan should be accessible to hospital staff to facilitate safe discharge planning and to enable vital information to be passed to patient transport or ambulance staff. In the event that data protection concerns arise in respect of sharing the safety plan with ambulance staff, consent to disclosure in appropriate circumstances could be obtained at the point the safety plan is drawn up, or, in the event of those who lack mental capacity, a best interest decision can be taken.

4.31. Managers believed that there were some limitations in the extent to which patient transport could reasonably be expected to be involved in safety planning as this was not a specific commissioned service but rather a process. Generic patient transport in low-need cases was unlikely to involve trained medical staff - it was very common for arrangements to be made for patients to travel home by taxi and drivers were likely to simply drop the individual at the front door. Leaders will need to assure themselves that the assessment process as to whether a patient can safely be returned home by taxis is robust, as another SAR nationally has identified this as a safeguarding risk, as it is unreasonable to place an onus on taxi drivers to provide a safeguarding response.

4.32. However, where a patient was transported using hospital staff or the Ambulance Service due to immobility, frailty or vulnerability, a duty of care will apply, even though ambulance primary care attendants are not trained paramedics. Given the nature of this service and its integral role in safe discharge, consideration should be given by managers of the patient transport service to how the process of safety planning should be adapted to ensure hospital or ambulance staff involved with transport understand their role in preventing harm, employ practices that reduce or mitigate risks and act in a way that complies with wider safeguarding and safe discharge responsibilities.

4.33. One of the two ambulance primary care attendants who transported Jack home was interviewed by police as a witness as part of their investigation. The attendant recalled using a sheet and carry chair to transfer Jack into his house and left him loosely covered with his duvet. District nurses explained that when transporting patients, ambulance staff would use sheets to comfortably secure their arms and legs to ensure that the patient is not injured while being moved. However, the police officer who attended the home reported that the sheet was so tight, ‘cocooning’ Jack so that it would have been difficult for anyone, even someone healthy, to free their arms and was an immediate safety issue. Jack should not have been left restrained and alone in this manner and patient transport systems need to ensure that in circumstances where a patient is immobile, patient transport is always met by carers. If their carers are not present when the patient arrives home, the attendant should not leave the home until the carers arrive to ensure a safe handover.

4.34. District nurses considered that the fact that Jack’s catheter bag had not been hung up was not a cause for concern, as this would not be appropriate for someone who was not trained to do so. They explained that providing food or drink for a patient when they have not been explicitly asked to do so could present its own risks, as some patients may only be able to drink thickened fluids if they are at risk of choking, which is common for dementia patients, or patients may require a specific diet or have allergies.

4.35. Practitioners also noted that because there is a monthly service cost for the safe and sound alarm service, many people on a low income will chose not to commission the service even if they need this for safety reasons, so the fact that someone is frail or immobile will not automatically mean they have a safe and sound alarm. Again, they commented it may not be

appropriate for transport staff to intrude on the person's privacy by searching for a safe and sound pendant when they have not been asked to do so. There was no 'one size fits all' safe discharge approach that could be applied for all patients returning home.

4.36. The attendant could not recall seeing Jack's safe and sound alarm and said that Jack did not ask for this or a drink when asked if he needed anything else. This seems inconsistent with the descriptions given by district nursing of Jack consistently checking to ensure his alarm was around his neck and that his drink and phone were in reach before care staff left after visits. It may be that Jack was still disoriented from his hospital admission when he was diagnosed with hypoactive delirium, which could have impaired his ability to make decisions about what he needed to be safe at home. However, the hospital did not carry out a mental capacity assessment prior to his discharge so this is unclear, although he was recorded to be 'alert'. Leaders noted that given his history and frailty, the journey home could also have left Jack susceptible to further disorientation. Conversely, Jack may have simply wanted some privacy after two nights in hospital, feeling safe in the understanding that his carers would arrive shortly.

4.37. However, there was an immediate need for Jack to be able to contact someone in an emergency. A clear, accessible safety plan that 'travelled' with Jack when he was discharged from hospital would have alerted the ambulance attendant to the fact that Jack did have an alarm and wished to ensure that this was always made available to him. If this had not been in his possession on discharge from hospital, ambulance staff could have asked Jack for its whereabouts, searched for it with his consent and if unable to find it or consent was refused, immediately notified social care to ensure a replacement was immediately provided or additional safety measures implemented.

4.38. Given the aging demographic in the UK, the care system is increasingly reliant on older people remaining independent in the community to manage care budgets, even where their frailty has increased to the point that they are immobile and unable to protect themselves in an emergency. An effective means to summons help in a crisis is absolutely essential for anyone who is immobile. Senior leaders may wish to explore how to efficiently mitigate these risks in circumstances where the person cannot afford the costs associated with a safe and sound pendant or mobile phone, with a view to the relative costs of care home accommodation for those who can no longer safely maintain their independence. This is of particular importance in light of the current cost of living crisis and rising inflation, which will disproportionately impact on those on low or fixed incomes and may result in many being forced to choose between heating costs or a safety alarm.

4.39. The circumstances of Jack's death were heart-breaking and one can only imagine the fear he felt as he waited alone, unable to call for help. His daughter Kim and all of the practitioners and managers involved in this review considered it imperative to ensure that lessons were learnt from this tragedy to ensure this never happens again.

Systems finding

4.40. Ineffective safety planning resulted in Jack being unable to summon help when his care service failed to restart. A clear, practical safety plan is essential to mitigate risks for people who are very frail, immobile, or suffering dementia and needs to be accessible to frontline practitioners at all stages of the patient journey, in particular those involved in hospital discharge processes.

Recommendation 5: *The Board should seek assurance from partners that tools to support effective safety planning are embedded in care planning, hospital discharge planning and patient transport procedures for immobile and frail people. Quality assurance processes should monitor whether the resulting safety plans are accessible at key points of the person's care journey and reviewed regularly to ensure that these remain effective as the individuals' needs change over time.*

Recommendation 6: *The Board should seek an assurance report from the patient transport service, clarifying how their procedures will be adapted to ensure safe care handovers and to ensure hospital or ambulance staff involved with transport understand their role in preventing harm and employ practices that reduce or mitigate risks to comply with wider safeguarding and safe discharge responsibilities.*

5. Glossary

ADASS	Association of Directors of Adult Social Services
BDCFT	Bradford District Care Foundation Trust
BTHFT	Bradford Teaching Hospital Foundation Trust
BRI	Bradford Royal Infirmary
BSAB	Bradford Safeguarding Adults Board
CCG	Clinical Commissioning Group
CGA	Comprehensive geriatric assessment
CMHT	Community Mental Health Team
CQC	Care Quality Commission
DNACPR	Do Not Attempt Cardiopulmonary Resuscitation
ECHR	European Convention on Human Rights
GDPR	General Data Protection Regulation
ICS	Integrated Care System
MAR	Medicine administration record
SAR	Safeguarding Adult Review