EXECUTIVE SUMMARY

SAFEGUARDING ADULT REVIEW

CAROL

Coventry Safeguarding Adults Board

November 2023

1.0 Introduction

1.1 This is the Executive summary of the published report made by the Coventry Safeguarding Adult Board (CSAB) following a Safeguarding Adults Review (SAR). This SAR was commissioned in order to investigate the death of Carol in October 2020.

1.2 Carol was 64-year-old women with a complex medical history including drug-resistant epilepsy. She had a mild to moderate learning disability and some physical health challenges. These included long-standing lymphoedema and a misaligned left ankle fracture which was unable to be surgically corrected. She was cared for by her family and was then moved to a nursing home during the Covid-19 pandemic.

1.3 Carol's physical and mental health was reported to have deteriorated during her stay at the care home, and in October 2020 she was admitted to University Hospital Coventry and Warwickshire following episodes of her lymphoedema worsening.

1.4 Carol then died at the hospital, and the coroner noted her cause of death as sepsis and multiple organ failure.

2.0 Practice issues:

There are areas and opportunities for learning. These key themes can be broken down as follows:

2.1 *The Impact of Covid-19*

Carol was transferred from Hospital to a Rehabilitation Unit and then to the Nursing Home in the first wave of the Covid-19 pandemic. During this time there were emergency arrangements for discharge from hospital and joint Health and Social Care funding, some of which enabled bureaucracy to be bypassed. This also meant that face to face assessments could not take place and the potential risk that the specific needs of a patient may not be accurately communicated due to an overreliance on written information. In Carol's case, the implications of this were that vital information about the management of her lymphoedema and epilepsy was not passed on and did not feature in the care plan sent to the Nursing Home.

Covid-19 placed a significant strain on staff in all agencies who worked through the pandemic caring for their patients and service users. Individuals and organisations had to adapt their normal working practices to be safe and avoid contracting or spreading infection. Workers were frequently fearful for their own health and the risk of infecting family members.

2.2 *The interface of services between Birmingham and Coventry*

Carol moved from services in Birmingham to a nursing home in Coventry in the first phase of the Covid 19 pandemic. However, whilst Carol's address may have changed her need for services remained the same and it was significant that, except for the Complex Epilepsy Service, she was unable to access the other services which had supported her in the past and enabled her to live at home.

It is common practice for local authorities to place service users in neighbouring authorities. Therefore, although there were new and relatively untried processes such as the Covid 19 pathway used to place Carol, the need for accurate and comprehensive information should have been well understood and embedded in practice. The lack of face-to-face assessments undoubtedly had an impact on the quality of the exchange of information. Much of the relevant information about Carol was contained in her medical records and these were not effectively shared between the social worker in Birmingham, the CHC staff and the Nursing Home in Coventry.

2.3 *The role of the GP*

The GP made a referral to the lymphoedema service in Coventry on 19th August 2020 and prescribed antibiotics to treat the infection on the 25th September 2020. The responsibility for following up on this referral seems to have been delegated back to the staff at the Nursing Home who made several attempts to contact the service. At no point did anyone clearly explain to the staff that there was no available service and they were in effect chasing a non-existent referral.

The GP should have been aware of the services they were referring to, and because of their misunderstanding about the commissioned service from outside of the City, this resulted in a delay in Carol receiving treatment. In this situation, they could have asked for help from the Lymphoedema Clinic in Birmingham which had been helping and supporting Carol for many years. Although the Birmingham clinic would not have been able to see Carol as a patient, they were able to advise them about her care and knew the correct service that Carol should have been referred to.

2.4 *The role of Social Care*

Carol had an allocated social worker from Birmingham Adult Social Care for most of the time she was in Coventry. Carol was an unallocated case for approximately one month in August/September 2020. This meant that there was no management plan outlining Carol's care needs to support the original referral from the Rehabilitation Unit.

However, due to the pandemic social workers were not conducting any face-to-face assessments and support from Social Care was extremely limited. A social worker from Birmingham began the social care assessment by telephone on 20th May 2020. Apart from the desire to move closer to her family in Birmingham, the assessment did not record any concerns. The social worker does not appear to have continued to have oversight of the case as Carol's allocated social worker to remain involved and ensure that the safeguarding concerns were addressed.

2.5 *Epilepsy*

Whilst Carol's epilepsy was controlled with medication her family have reported that she would usually have 2 to 3 minor seizures per month and infection or serious illness could cause a more serious seizure.

Carol's epilepsy went unrecorded whilst at the Nursing Home. The care plan provided no details of how Carol's seizures presented and what staff needed to look out for. The monitoring of her epilepsy was a vital part of her ongoing treatment and the requirement to keep an epilepsy seizure diary should have been included in her care plan. The Nursing Home believes that Carol did not have a seizure while she was in their care, although it is possible that minor seizures were not recognised for what they were, or that these occurred when she was alone. Given the previous frequency of her seizures, it is highly unlikely that she could have 6 months without a seizure.

Carol attended an appointment with the consultant neuropsychiatrist who had been treating her epilepsy for many years on the 8th October 2020. He noted that the current seizure frequency was unclear and requested that a seizure diary be kept at the Nursing Home.

2.6 *Lymphoedema*

The key components of managing Lymphoedema are wearing compression garments (stockings in Carol's case), taking good care of the skin and moving and exercising regularly. Treatment may also include using specialised massage techniques. The most common complication of lymphoedema is cellulitis which is a bacterial infection of the deep layer of skin. It can be serious if it is not treated quickly.

It was clear that staff were aware that Carol needed the compression stockings for her lymphoedema because it was raised by the GP. On the 26th May 2020, a referral was made to the GP to request new stockings and these were prescribed and issued on the 28th May 2020.

On the 19th June 2020 staff communicated that Carol was not wearing stockings but the advice from the GP was that they must be worn all day and that this should be added to her care plan and care notes. When the records were reviewed there was no Care and Risk Management Plan for Carol's lymphedema, but there was a record in the behaviour plan that stated stockings needed to be worn daily. At this point, a Mental Capacity Assessment should have occurred as family reported that she had previously never refused to wear stockings.

3.0 Recommendations

1. The Adult Safeguarding Board should ensure that placing authorities can demonstrate that their teams proactively ensure the welfare of service users through regular checks and liaison with care providers and family members.

2. Agencies making referrals for Nursing Home placements for service users with complex health needs should consult with the relevant community health services before placement to ensure that adequate provision is available.

3. Care plans should specify the services which are needed to deliver adequate treatment and care, and ensure they are in place before a placement is made.

4. The Adult Safeguarding Board should seek assurance from constituent agencies about the standards of the quality and content of training on the Mental Capacity Act 2005 for providers of services to adults.

5. The Adult Safeguarding Board should seek assurance that workers in all agencies have professional support and supervision available to challenge decisions if the needs of the service user are not being met.

6. Agencies should ensure that their workers are aware of escalation procedures when they are dissatisfied with the response from other agencies.