STOCKPORT SAFEGUARDING ADULT BOARD

SAFEGUARDING ADULT REVIEW

OVERVIEW REPORT

CONCERNING

Ivy

September 2020

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Index

1 Introduction

1.1 This report is a summary of a Safeguarding Adult Review which has been commissioned by Stockport Safeguarding Adults Board (SSAB). The purpose is to review information already gathered by SSAB during preparatory work for the case and establish whether there is any learning arising from the circumstances surrounding the death of Ivy, a resident of the Stockport area.

1.2 Ivy was 62 years old at the time of her death. She had complex medical needs, was morbidly obese and had recently been diagnosed with endometrial cancer. Ivy lived in her own home, was bed bound, and received personal care from a care provider four times a day.

1.3 0n 16 April 2019 Ivy was seen at home by a GP following concerns raised by her care provider. Ivy was taken to the Emergency department at a local hospital where she was seen by medical staff. Ivy was taken home by NWAS Patient Transport Service the following day.

1.4 On 29 April 2019, NWAS Patient Transport Service attended at Ivy's home to transport her to hospital for an outpatient appointment. Ivy was found in a collapsed state. Ivy was admitted to hospital and died a few days later. A criminal investigation was undertaken. No criminal charges have been instigated in the case.

1.5 All those involved in the learning review wish to express their condolences to Ivy's friends and family.

1.6 A Home Office post-mortem was undertaken, and the cause of death was established as;

1a. Sepsis

1b. Pneumonia, pyelonephritis[1], limb ischaemia[2], pressure ulcers and epithelial[3] damage due to prolonged contact with urine.

[1] Pyelonephritis is inflammation of the kidney, typically due to a bacterial infection

[2] Acute limb ischaemia (ALI) occurs when there is a sudden lack of blood flow to a limb. Acute limb ischaemia is caused by embolism or thrombosis, or rarely by dissection or trauma

[3] Epithelial cells are a type of cell that lines the surfaces of your body. They are found on your skin, blood vessels, urinary tract, and organs.

II Obesity and type II diabetes.

An inquest has been opened and adjourned on the case.

2 Establishing the Learning Review

2.1 Decision to Hold a Safeguarding Adult Review

Section 44 Care Act 2014 Safeguarding Adults Reviews says:

(1) A SAB[4] must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether the local authority has been meeting any of those needs) if-

(a) There is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

(b) Condition 1 or 2 is met

(2) Condition 1 is met if-

(a) the adult has died, and

(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether it knew about or suspected the abuse or neglect before the adult died)

2.2 On 12 June 2019, the chair of Stockport Safeguarding Adult Board confirmed that the case met the criteria for a Safeguarding Adult Review.

2.2 Methodology

2.2.1 An independent safeguarding professional was commissioned by SSAB to complete a review of the case. Their work involved developing Terms of Reference, interviewing staff involved in the case and arranging for appropriate agencies to complete Independent Management Reviews of their agency's involvement in the case. Summary reports of that work were completed. The initial work and summary report took several months, and work was then interrupted by the restrictions put in place as a result of the national response to the Covid -19 virus.

2.2.2 On 29 June 2020, Ged McManus and Carol Elwood-Clarke were commissioned to write the Safeguarding Adult Review and provide a report setting out learning from the case. Neither has worked for any of the agencies contributing to the review and they were

[4] Safeguarding Adult Board

judged by the Chair of Stockport Safeguarding Adult Board to have the experience necessary to conduct an independent and thorough enquiry.

2.2.3 The review will focus on the original terms of reference as identified prior to the authors involvement in the case. See 3.1

2.2.4 The review authors have had access to the following reports for the completion of this review –

- Final Overview Report
- Final Resource Pack
- The Process2
- ABACUS Care Home[5] IMR[6]
- Greater Manchester Police[7] IMR
- Mastercall[8] IMR
- NHS Stockport Clinical Commissioning Group[9] IMR
- North West Ambulance Service IMR
- Stockport Adult Social Care IMR
- Stockport NHS Foundation Trust[10] IMR

2.2.5 The authors have not been involved in SAR panel meetings in relation to the case and have not discussed the information provided with professionals from any of the agencies involved. Information is drawn where appropriate from the preliminary work undertaken on the case.

3 Parallel Reviews

3.1 Stockport NHS Foundation Trust and NWAS have undertaken STEIS[11] investigations in relation to their contact with Ivy. The GP practice has conducted a Significant Event Analysis[12] The result of those investigations has been used to inform the IMRs submitted to the review.

[5] http://abacushomecare.net/
[6] Individual Management Review: a templated document setting out the agency's involvement with the subject of the review.
[7] https://www.gmp.police.uk/police-forces/greater-manchester-police/areas/greater-manchester-force-content/au/about-us/
[8] http://www.mastercall.org.uk/contact
[9] http://www.stockportccg.nhs.uk/contact-us/
[10] https://www.stockport.nhs.uk/
[11] https://improvement.nhs.uk/resources/steis/
This system facilitates the reporting of Serious Incidents and the monitoring of investigations between NHS providers and commissioners.
[12] A method of formally analysing incidents which may implications for patient care

3.2 An inquest has been opened and adjourned. The coroner is likely to hold a hearing later in 2020.

4 Terms of Reference

4.1 It was agreed with Stockport Safeguarding Adult Board that this report would focus on the original terms of reference identified for the Safeguarding Adult Review. The purpose of the Learning Review is neither to investigate nor to apportion blame. It is to:

- Establish whether there are lessons to be learnt from the circumstances of the case about the way in which local professionals and agencies work together to safeguard vulnerable adults;
- Review the effectiveness of procedures of both multi-agency and individual organisations;
- Inform and improve local inter-agency practice;
- Improve practice by acting on learning and developing best practice.

Specific Terms of Reference

1. The effectiveness of the care provided to Ivy in the community; with a focus around assessment, care planning and multi-agency communication and information-sharing.
2. What was the understanding of external agencies remits regarding planned or unplanned attendances at hospital?
3. How were effective risk assessments for vulnerable people with complex needs completed and documented?
4. What were the checks and balances in place to support vulnerable patients who had autonomy over their care which included their wishes and feelings whilst maintaining “person-centred” care?

4.2 Family involvement

4.2.1 The review authors have not engaged with Ivy’s family or friends in undertaking this work. The authors have taken cognizance of the contact that has already been made with family and friends during the Safeguarding Adult Review process and determined that further contact was not appropriate for the purposes of this review.

4.3 Time period under review

4.3.1 1 January 2019 to 1 May 2019.

This time period was selected in order to provide a four month review of agencies involvement with Ivy prior to her hospital admission in April 2019 and her death in May 2019.

4.4 Glossary of agencies contributing to the review

ABACUS Care Home

Abacus Homecare is a Domiciliary Care Agency which has been established in 2009 to respond to the needs of Service Users requiring care and support in their own homes. ABACUS offer personal care, domestic tasks, and home and garden maintenance services.

Greater Manchester Police

Greater Manchester Police (GMP) is the territorial police force responsible for law enforcement within the metropolitan county of Greater Manchester in North West England. GMP is the fourth largest police service in the United Kingdom after the Metropolitan Police Service, Police Scotland and Police Service of Northern Ireland (PSNI); and is the second largest force in England and Wales.

Mastercall

Mastercall provides a range of innovative, high quality, safe and effective urgent scheduled and unscheduled health care services to meet the national 'out of hospital' programme.

The services provided offers an alternative to a hospital admission by providing care in the community, and support earlier discharge from hospital, where clinically safe and appropriate, than otherwise would have been possible.

NHS Stockport Clinical Commissioning Group

NHS Stockport Clinical Commissioning Group (CCG) is a group of GPs from every practice in Stockport with responsibility for designing and buying health services for the local population. These services include –

- Planned hospital care
- Rehabilitation care
- Urgent and emergency care
- Most community health services
- Mental health and learning disability services

North West Ambulance Service
Emergency responders, patient transport providers and NHS 111 urgent care and advice givers.

Stockport Adult Social Care
Adult Social Care is about providing personal and practical support to help people live their lives. It's about supporting individuals to maintain their independence and dignity. There is a shared commitment by the Government, local councils and providers of services to make sure that people who need care and support have the choice, flexibility and control to live their lives as they wish.

Stockport NHS Foundation Trust
The Trust runs Stepping Hill Hospital, and other specialist centres, as well as community health services for Stockport. The Trust is part of the Stockport Together partnership to integrate local health and social care services and deliver more care closer to people's homes. It is also a specialist `hub` centre for emergency and high risk general surgery, one of only four in Greater Manchester and covering the South East sector of the region.

5 Background information

5.1.1 Ivy lived alone in a ground floor flat, she was morbidly obese, and bed bound. She had diabetes, high blood pressure, bilateral cellulitis and had recently been diagnosed with endometrial cancer. Ivy was catheterised, which resulted in repeated visits by medical staff due to problems with the catheter, such as bypassing. Ivy was classed as a bariatric patient[13].

5.1.2 Ivy had suffered significant bereavement in her life. Both of Ivy's parents had died within six months of each other. In between these deaths, Ivy's dog had died. These bereavements resulted in Ivy being sick from work with anxiety. In addition, Ivy's brother had attempted suicide on a number of occasions before his death in 2017.

5.1.3 Ivy first became known to Adult Social Care in 2010 when adaptations were undertaken in her home. Over the years a range of adaptations were undertaken following assessments by a Moving and Handling Co-ordinator and Occupational Therapist. The adaptations included –

[13] Stockport NHS Foundation Trust – Guidelines for the management of bariatric patients. Bariatric refers to the area of medicine that concentrates on the treatment and management of obesity and disease associated with obesity. Defining patients that come under the bariatric heading is extremely difficult, patients with a Body Mass Index over 30, (see below for calculation) as defined in the NICE clinical guidelines 43 (2006.) Obesity: identification, assessment and management Clinical guideline [CG189] Published date: November 2014

- Level access shower
- Tilt in space shower chair
- Mobile hoist and ceiling track hoist
- Slings, including a bed sling system

5.1.4 In 2014, Ivy received further support from Adult Social Care following a period of self-neglect. Ivy's property was deep cleaned, furniture removed, and new floor covering (lino) installed.

5.1.5 In 2016, Ivy was admitted to hospital for two months, due to falls within the home. Ivy underwent a period of bed based Intermediate Care. During this hospital admission, Ivy lost some weight, she required two people to help her stand, and did not engage with physiotherapy.

5.1.6 Ivy received a commissioned package of care from Adult Social Care which was reviewed on 3 March 2017, 9 October 2017, and 6 March 2019. ABACUS Home Care provided the care to Ivy, and they remained as her care provider from this time until her death. The care package consisted of –

- Four calls seven days per week.
- Access to a telecare alarm pendant.
- 45 minute morning call to support with personal hygiene tasks, support with continence care, change clothing, medication administration, application of creams, breakfast and a drink. To ensure safety and pendant and that the flat is secure.
- Monday, Wednesday and Saturday morning calls are 90 minutes to enable carers to support Ivy accessing the shower. Carers use ceiling track hose and glide about shower chair.
- 30 minute call lunch time to support with lunch, drinks, medication, administration of cream, personal and continence care, safety and use of pendant and to ensure that flat is secure on leaving.
- 30 minute bed call to support with medication, administration of cream, personal and continence care, safety and use of pendant and to ensure that flat is secure on leaving.
- Weekly 2 hour shopping/cleaning support on Wednesdays.

5.1.7 In 2017, NWAS raised a safeguarding concern and requested that Ivy be assessed for an alternative bed. Ivy had been discharged from hospital the previous day. As a result of the contact from NWAS, the duty social worker contacted ABACUS Home Care who stated that they had not been made aware of the discharge. Staff from ABACUS had called that day to check on Ivy 'just in case' and had found her in a soiled bed. Ivy told

them that she had nothing to drink or eat in the last 24 hours. Ivy's phone was out of her reach. This incident was raised by the Social Worker with a Manager. It was intended that the incident would be raised with the hospital Social Work Team. The outcome of this incident is not recorded, and the staff involved cannot recollect anything further about action taken.

5.1.8 In April 2018, Ivy's case was brought to the neighbourhood triage/multi-disciplinary team meeting by the District Nurses due to Ivy's social isolation. A Social Work assessment was undertaken. Ivy agreed to further rehabilitation and she was referred to Active Recovery[14] by her Social Worker. The assessment identified the outcomes that were to be implemented between the Social Worker, Occupational Therapist and Moving and Handling Co-ordinator. There was a delay in these being implemented. The outcomes were listed as –

- Provision of a chair
- Provision of a specialist wheelchair
- Provision of rehabilitation/physiotherapy

5.1.9 Between August 2016 and March 2019, there were 5 separate referrals to wheelchair service. Ivy was not provided with a wheelchair.

5.1.10 Ivy was discussed at the Enhanced Case Management meeting [also known as a Triage meeting] 9 times between April to November 2018. The purpose of which was to reduce social isolation.

5.1.11 On 8 September 2018, Ivy was admitted to hospital. Adult Social Care received an assessment notification, there was evidence of multi-agency communication prior to Ivy being discharged. Ivy's care package was reinstated upon discharge.

5.1.12 On 25 October 2018, Ivy was referred for physiotherapy by her Social Worker. Ivy did not engage with the physiotherapist, records state that Ivy preferred to be bed bound. There was no further involvement from physiotherapy.

[14] https://www.stockport.nhs.uk/servicesdetail.aspx?id=843
The Active Recovery Service provides free, short term physical, social and emotional support that will:
- help you avoid a stay in hospital, when you can be safely supported at home or in another appropriate community setting
- help you following a stay in hospital

This support will be provided for a period of time appropriate to your needs, and can include:
- rehabilitation services, to help you gain and keep more independence
- services focused on improving your health and well being
- support that can help you connect, or reconnect, with your local community and activities

5.1.13 On 6 November 2018 Ivy was referred to the District Nurses for a pressure cushion, to allow her to 'sit out'. This request was followed up with several orders to the equipment provider. The pressure cushion was delivered on 28 March 2019.

5.1.14 Between November 2018 to March 2019 there was no involvement on Ivy's case by the Social Worker and Occupational Therapist. This was due to the prioritisation of high-risk cases and workloads.

5.1.15 On 12 March 2019 Ivy's case was re-allocated to a Moving and Handling Co-ordinator due to maternity leave. In March 2019, the Social Worker completed a long-term assessment, and a new support plan was agreed, with an agreement for longer calls to Ivy. On 15 March 2019, the Social Worker closed Ivy's case. There was no record as to who was overseeing the completion of the outcomes on the plan. The pressure cushion had not yet been delivered. Ivy was deemed to have capacity in relation to her care and support needs. Ivy was adamant in her wish to remain at home. Discussions had taken place with Ivy in relation to residential care, but Ivy had not wanted to progress this further.

5.1.16 On 15 April 2019, Ivy's case was closed to the Occupational Therapist. The Moving and Handling Co-ordinator was not aware that they had responsibility to oversee the outcomes on Ivy's plan.

5.1.17 On 16 April 2019, Ivy was seen at home by her GP. The GP requested an ambulance, due to Ivy's presentation, and she was taken to the Emergency Department of a local hospital. Ivy was seen by medical staff who deemed that Ivy did not need to be admitted to hospital. Ivy remained in the Emergency Department overnight as there were no beds available in the Clinical Decision Unit, and no bariatric transport available to take Ivy home.

5.1.18 On 17 April 2019 Ivy was taken home by ambulance services.

5.1.19 On 23 April 2019, a Practice Nurse attempted to telephone Ivy to discuss her diabetic review. There was no answer. A note in Ivy's GP records indicated that she was in hospital.

5.1.20 On 29 April 2019, Patient Transport Services attended at Ivy's home to take her to an outpatient appointment. Ivy was found in a collapsed state. Ivy had not been seen by a practitioner since returning home on 17 April 2019. Ivy was admitted to hospital.

5.1.21 On 1 May 2019, Ivy died whilst an inpatient at hospital.

6 Notable events

Set out in the following table is the notable events identified by the reviewers. They are listed without commentary. The full list appears at Appendix A.

Date	Event
04.01.19	Patient Transport Service transported Ivy to and from home address to outpatient appointment.
15.01.19	Community Nursing Team contacted GP regarding Ivy's catheter.
15.01.19	Operations Manager at ABACUS Home Care spoke to District Nurse regarding Ivy's catheter.
21.01.19	Office Manager at ABACUS Home Care left message for District Nurses.
23.01.19	Community Nursing Team visit Ivy. New catheter inserted.
23.01.19	Office Manager at ABACUS Home Care contacted District Nurses.
25.01.19	Ivy visited by Community Matron. Enhanced Care Management discussed.
29.01.19	GP – Pharmacy Team. Request for medical equipment.
31.01.19	GP – Pharmacy Team. Discussion with carers regarding cream.
04.02.19	GP – Pharmacy Team. Discussion with carers regarding cream and medical equipment.
08.02.19	Community Nursing Team - query received from hospital regarding blood results.
11.02.19	Carer from ABACUS Home Care telephoned Community Nursing Team regarding Ivy's catheter.
12.02.19	Community Nursing Team – Ivy re-catheterised.
13.02.19	Community Nursing Team - Ivy seen by Podiatrist.
13.02.19	Ivy telephoned GP and discussed medical matter.
22.02.19	GP received lab results.
06.03.19	Adult Social Care - Review of package of care with agency. New Assessment and Support plan completed and increase in support plan for showering agreed.
08.03.19	Ivy seen by Staff Nurse and Health Care Assistant, from the District Nurse Evening Service regarding catheter.
08.03.19	Patient Transport Service transported Ivy to and from home address to outpatient appointment.
10.03.19	Community Nursing Team. Ivy re-catheterised.
11.03.19	GP received letter from radiology with appointment details.

12.03.19	Community Nursing Team - Ivy seen by Health Care Assistant.
13.03.19	GP received lab results.
15.03.19	Adult Social Care - Increased care agreed by senior management. Case closed.
15.03.19	Operations Manager at ABACUS Home Care leaves message for District Nurse regarding pressure care.
17.03.19	Community Nursing Team - Ivy seen by Health Care Assistant.
18.03.19	Carer requested GP visit. Visited by GP. Ivy declined admission to hospital.
19.03.19	ABACUS Home Care telephoned Community Nursing Team regarding Ivy's glucose monitoring machine.
20.03.19	Practice Nurse issued new glucose machine.
20.03.19	Community Nursing Team – Ivy seen by Health Care Assistant. Carers also present. Contact made with GP.
20.03.19	Community Nursing Team – Ivy re-catheterised.
22.03.19	Ivy seen by Health Care Assistant.
25.03.19	Physio (moving and handling co-ordinator) discussed case with District Nurse. Case had been allocated on 12.03.19.
26.03.19	Carer requested visit by GP. Visit made by GP. Carer present.
02.04.19	Ivy telephoned GP.
02.04.19	GP - Practice Nurse sees Ivy at home for diabetes review.
03.04.19	Community Nursing Team - Health Care Assistant visits Ivy.
05.04.19	Carer contacted Community Nursing Team regarding Ivy's catheter.
07.04.19	Community Nursing Team – Ivy re- catheterised.
08.04.19	Patient Transport Service transported Ivy to and from home address to outpatient appointment.
09.04.19	Ivy seen by Podiatrist.
15.04.19	Occupational Therapist closed case.
15.04.19	Ivy contacted Overnight District Nursing Service regarding catheter. No evidence Ivy seen by District Nurse.
15.04.19	Carer contacted Community Nursing Team regarding Ivy's catheter. Telephone call made to Ivy from CAT's team.
16.04.19	GP - Practice Nurse – telephoned Ivy. No answer.
16.04.19	ABACUS Home Care contacted GP and requested home visit. Ivy seen by GP. Ambulance called and Ivy taken to Emergency Department.
16.04.19	Ivy seen in Emergency Department.

16.04.19	ABACUS Home Care record that Ivy admitted to hospital.
17.04.19	Ivy transported to home address by Patient Transport Service.
23.04.19	GP - Practice Nurse – telephoned Ivy. No answer.
29.04.19	Ivy found at home by Patient Transport Service in a collapsed state. Ivy admitted to hospital. Safeguarding concerns raised.
01.05.19	Ivy died. Criminal investigation commenced.

7 Analysis

This section will focus on the timeframe of 1 January 2019 to 1 May 2019.

Term 1

7.1 The effectiveness of the care provided to Ivy in the community; with a focus around assessment, care planning and multi-agency communication and information-sharing.

7.1.1 Between 1 January 2019 and 16 April 2019 Ivy was seen by practitioners involved in the requirements of her care plan and in response to medical needs in relation to her catheter, medication, medical equipment etc. There is evidence of good communication between ABACUS Home Care, District Nurses and GP services. Ivy was transported for outpatient appointments by appropriate methods of transportation. At no stage during this time were any concerns raised regarding Ivy's care and support needs not being met, or evidence of self-neglect.

7.1.2 Ivy had been an open case to Adult Social Care since October 2018; however, there had been no involvement in her case between November 2018 and March 2019, when a review of her care plan was undertaken. The IMR Author for Adult Social Care commented –

'It is important to comment on the type of work undertaken by the Tame Valley Neighbourhood Team. The demographics and needs of this neighbourhood are known to have a higher proportion of domestic abuse, substance misuse, lower life expectancy, higher numbers of people with long term and co-morbid conditions and a higher number of people living chaotic high risk lives. The Team Manager described that at any time a Social Worker will be managing a caseload of 20 people, 5-8 will always be at very high risk of harm. This will include adults with significant and serious self-neglect, people who are resisting intervention, safeguarding issues and people with substance misuse who are at very high risk of harm. Multiple Team

Around the Adults meetings are held to share and manage risks. There were several people on the waiting list for assessments in the neighbourhood at that time and Social Workers are expected to take a new referral every week. Social Workers are therefore under pressure to prioritise their case load, work proportionally with people based on risk and close cases when a plan is in place'.

7.1.3 The support plan for Ivy was focused on her being able to – 'get out of bed and into a wheelchair and out of the flat'. To be able to achieve this outcome Ivy needed an appropriate chair, as Adult Social Care do not provide this equipment, this needed to be funded by Ivy. A chair was sourced from Council stock, but due the chair needing to be repaired, there was a delay of 3 months before the chair was received. In support of this equipment, on 6 November 2018, the Occupational Therapist made a referral for a pressure cushion for the chair. Due to several issues with the referral including delivery being declined and accessibility to Ivy's flat, the cushion was not delivered until 28 March 2019.

7.1.4 On 6 March 2019, the Social Worker completed a long-term assessment and recommended that Ivy's support plan be increased to assist with showering. On 15 March 2019, the Social Worker closed Ivy's case and recorded that there was a plan in place for the District Nurses and Moving and Handling Co-ordinator to work with Ivy regarding being able to sit out in her chair. However, at this time the referral for the pressure cushion was still outstanding.

7.1.5 On 15 April 2019, a month after the Social Worker closed the case, Ivy's case was closed to the Occupational Therapist. The case closure recorded that the chair was in place and that the Moving and Handling Co-ordinator would follow up in relation to the pressure cushion. This requirement was not known to the Moving and Handling Co-ordinator.

7.1.6 In considering the analysis by Adult Social Care, it is confirmed that there was a plan in place for Ivy and her case was not deemed to be high-risk. The care provider, ABACUS Home Care had been Ivy's provider since 2016, and therefore it could be assumed that they would raise any concerns with Adult Social Care if required. However, at the time the case was closed by the Social Worker and Occupational Therapist, no-one had overall responsibility for overseeing the implementation of the plan, and the requirements of the plan being achieved had not been communicated to those still involved in delivering Ivy's care and support needs.

Term 2

7.2 **What was the understanding of external agencies remits regarding planned or unplanned attendances at hospital?**

7.2.1 Ivy lived in a ground floor flat and access to the property was via a key safe box located outside of the premises. Where Ivy was required to attend planned hospital appointments there is evidence in agency records of the communication that took place between ABACUS Home Care and Patient Transport Services, ensuring that Ivy attended these appointments, as due to Ivy's mobility, she required bariatric transport, which had to be pre-booked.

7.2.2 On 16 April 2019, Ivy had an unplanned attendance at hospital. This was known to ABACUS Home Care, GP, North West Ambulance Service and Stockport NHS Foundation Trust. In reviewing agencies account of this incident, terminology and interpretation of that terminology, resulted in individual agencies having a different understanding of Ivy's 'status' whilst at hospital.

7.2.3 Ivy's carers reported to ABACUS Home Care, on the evening of 16 April 2019, that Ivy had been admitted to hospital, when in fact, Ivy had been transported to the Emergency Department at the hospital for assessment and triage. ABACUS Home Care suspended Ivy's care plan based on the information received from the carers. The following extract from ABACUS Care Home's contract states -

A7.7 Suspension or Termination of an ISA or PSA

A7.7.1 There are three main circumstances when there may be an unplanned suspension of the Service:

i. when a Service User is unable to receive the Service, eg hospital admission
ii. when the behaviour of a Service User makes it unsafe or unacceptable to provide the Service
iii. when there are circumstances which may put the Service Provider's workers at risk.

A7.7.2 When the Council suspends the Service because it is temporarily not needed, there is an expectation that the provider will restart the Service with the same workers to provide consistency to the service user. For an initial pilot period of 3 months, the Council will pay a retainer to providers working under the Ethical Framework for a maximum of 10 days where a service user has been admitted to hospital. The retainer will be calculated at a rate of £10 per hour of the support package that would have been provided to the service user. In addition, the downtime for workers associated

with a service user being admitted to hospital should be used to support training and community engagement as required.

A7.7.3 In order to comply with Delayed Discharge legislation and support the independence of the service user, when the Service has been suspended due to the hospitIvytion of the Service User, the Service must restart as soon as possible following notification that the Service User is ready for discharge. ***Where a service user is in hospital and where a retainer is in place, it is expected that providers will continue to visit and engage with the service user who is in hospital.*** *Providers will also need to be able to restart a support package for anyone who has been admitted to hospital within 4 hours, 7 days per week.*

A7.7.4 When a Service Provider is notified that a Service User who they have previously provided support to has been admitted to hospital is ready to return home, the Service Provider will satisfy themselves that they can still meet the Service User's needs safely and appropriately. This may be achieved through additional liaison with Stockport Adult Social Care or reassessment through an additional IMA, if necessary, carried out in the hospital. The additional IMA should be undertaken as soon as possible. At the latest, the IMA should be carried out on the next working day following notification of discharge.

7.2.4 This extract defines the circumstances when an individual has been **admitted** to hospital. In Ivy's case she had not been admitted, and therefore there was no requirement for the care plan to have been suspended. In addition, the IMR Author for ABACUS Home Care stated –

'We always heard off Ivy once she was in hospital and she would let us know when she was being sent home, she normally had to wait for a bariatric ambulance to pick her up which would sometimes delay her coming back home'.

7.2.5 However, it is the view of the report authors, that these comments are more than likely attributed to Ivy's 'planned' hospital visits and not in relation to any unplanned visits due to ill health, where there has been no admission. This can be evidenced by the incident in August 2017, when Ivy was discharged home following a hospital admission, and ABACUS Home Care had not been contacted by Ivy directly to inform them of the discharge.

7.2.6 Whilst at hospital Ivy was seen by several medical staff during the evening, night and following morning. Ivy is reported to have spoken freely to these staff members about her care package. It is recorded that Ivy had told staff that she had spoken to her carers to inform them that she would be back at home that day. What is not clear is

how Ivy made this contact, as she would not have been able to walk to a telephone, and there is no information that she had access to a mobile telephone whilst in the Emergency Department.

7.2.7 As Ivy had not been admitted to hospital, the medical staff did not contact Adult Social Care or ABACUS to inform them that Ivy was returning home. There was a delay in Ivy returning home which was linked to the lateness of the hour at her being assessed as clinically fit to return home, and the availability of appropriate transportation. Due to these factors Ivy remained in the hospital until the following morning despite there being no medical requirement for Ivy to remain at hospital. With no admission to a ward, full hospital discharge procedures were not invoked by staff in the emergency department, and the carers were not alerted to Ivy's return home.

7.2.8 Ivy was taken home by staff who had previously transported her to and from hospital for planned hospital appointments. It is reported within the NWAS IMR that during this journey Ivy informed the staff that she had contacted her carers, and that they would be visiting later in the day. This account from Ivy was not verified by the staff. NWAS only hold care plans for patients who are at end of life or have specific safeguarding alerts placed. NWAS held no information for Ivy.

7.2.9 Since this incident NWAS have instigated a trial process to collect care package information for all journeys booked. The review authors recommend that Stockport Safeguarding Adults Board receives an update in relation to this trial from NWAS and an assurance of their long-term position. See recommendation 6.

7.2.10 On 17 April 2019, the GP practice received a discharge summary from the Emergency department. The summary contained the comment – 'Home with GP follow up' which is recognised as standard terminology in relation to contact with a GP as and when needed. All discharge summaries are reviewed by a GP. In Ivy's case as there was no specific action for the GP, no further action was taken, and the discharge summary was filed. Ivy's file contained information that she was in receipt of a care package. No contact was made with Adult Social Care or ABACUS Home Care. The GP would not have been aware that Ivy's care package had been suspended.

7.2.11 A week after Ivy's attendance at hospital the Practice Nurse telephoned Ivy to discuss her diabetic review. There was no answer to the call, [it is indicated in records that Ivy had been admitted to hospital]. The nurse noted that Ivy had attended at the Emergency department the previous week and assumed that she had been admitted to hospital. There was no reference to the discharge summary, or contact made with the hospital to verify Ivy's admission.

7.2.12 On 29 April 2019, when Ivy was found by the Patient Transport Service, she had been at home for 12 days and during this time had not been seen by any professional. In reviewing those days since her attendance at the Emergency department it is evident that there was little or no communication amongst professionals regarding the current whereabouts of Ivy. As Ivy had not been admitted to hospital, she did not meet the criteria for discharge processes to be invoked. All agencies involved at this time, with the exception of her GP, have stated in their IMR's that Ivy had informed them or would routinely inform them when she was returning home.

7.2.13 Whilst at hospital Ivy was assumed to have the capacity[15] to make her own decisions and therefore appropriately no mental capacity assessment was undertaken by the staff involved in her care. Her assurances about contact with carers were taken at face value. Whilst this may have been reasonable the staff involved would have been better supported to care for Ivy holistically if a policy was in place to take account of such circumstances, which fall outside the hospital discharge protocols that apply once a person has actually been admitted to hospital after assessment. This is a learning point [paragraph 9.3 refers].

7.2.14 As highlighted at 6.2.3 ABACUS home Care's contract with Adult Social Care contains a requirement; ***Where a service user is in hospital and where a retainer is in place, it is expected that providers will continue to visit and engage with the service user who is in hospital.*** Despite ABACUS Home Care cancelling their involvement in Ivy's care plan they made no telephone calls to the hospital to check on her welfare or estimated timescales for discharge. The ABACUS home care IMR is silent on this point and the authors have no further information. However, if a call had been made to the hospital at any point during the time between Ivy being taken home on 17 April 2019 and being discovered alone on 29 April 2020, the fact that she was not in hospital would at the very least have prompted a further enquiry as to her whereabouts. Whilst the contract contains an expectation that the care provider continues engagement with the service user there is no guidance on the timescale or frequency of the expected contact. This is a learning point [paragraph 9.1 refers].

Term 3

7.3 How were effective risk assessments for vulnerable people with complex needs completed and documented?

7.3.1 Ivy had several plans in place in relation to her care and support needs. This included the completion of a long-term assessment in March 2019, which resulted in Ivy's care plan being updated and an agreement for additional support to be provided. Ivy's

[15] Mental Capacity Act 2005

Moving and Handling plan was also updated and a month after her case was closed by her Social Worker, the Occupational Therapist closed Ivy's case.
See 6.1.4 – 6.1.7.

7.3.2 The outcome was for Ivy to increase her mobility and be able to get out bed. Equipment to support this, had been ordered but not all elements had arrived at the time of Ivy's case being closed. So, despite, there being plans in place for Ivy, with a defined outcome, there was no individual professional or agency, overseeing the completion of the plan.

7.3.3 The IMR Author for Stockport NHS Foundation Trust identified that there was no indication of any tools used to measure vulnerability when Ivy attended at the Emergency Department. The Author has identified this as a missed opportunity for medical staff as there are multi agency models of risk management which could be considered. For example; Vulnerable Adult Risk Management [VARM] is used in a number of areas but has not been introduced in Stockport at this time. VARM is intended to be used when working with adults deemed to have capacity to make decisions for themselves, but who are at risk of serious harm or death through:

- self-neglect (Care Act 2014)
- risk taking behaviour / chaotic lifestyles or
- refusal of services

The VARM is a multi-agency adult assessment risk management process to:

- identify the relevant risks for the individual
- discuss and agree agency responsibilities/actions
- record, monitor and review progress with the agreed action plan
- agree when the risks have been managed and evaluate the outcome

The aim of VARM policy and practice guidance is to provide professionals with useful information and a framework to facilitate effective multi-agency working with adults who are at significant risk.

7.3.4 When Ivy was classed as being medically fit to return home from the Emergency department in April 2019, no risks assessments were undertaken. Medical staff and Patient Transport staff were assured by Ivy that she had informed her carers that she was returning home and that the carers would be visiting her later that day. Whilst the medical staff had no reason to dispute this fact, this was not verified with the care providers by medical staff.

7.4 **What were the checks and balances in place to support vulnerable patients who had autonomy over their care which included their wishes and feelings whilst maintaining "person-centred" care?**

7.4.1 The Care Act assessment dated the 6th March 2019, identifies that Ivy "Has the capacity to make decisions about care and accommodation at this time". The Social Worker recorded a discussion with Ivy about the decision to remain at home verses the decision to move to Extra Care, or residential accommodation. Ivy stated that she had initially thought a short stay in residential care would be a good idea as she thought this would include physiotherapy, (She had previously received bed based intermediate care where this service was included). When the Social Worker explained that standard residential care did not include physiotherapy services Ivy decided that she did not want to pursue short stay residential care.

7.4.2 On the Support Plan dated 6th March 2019, the Social Worker recorded that, "Ivy made it clear that, despite her level of need, she wanted to remain living in her flat where she had lived for many years. She did not want to consider residential care, or extra care housing at the time. She did not experience any confusion and had the capacity to make decisions about care and accommodation at the time".

7.4.3 The discussions in March 2019, reflect all professional recollections and records of Ivy in that she was able to articulate her wishes and was at all times considered to have the capacity to make her own decisions. The events in hospital leading to Ivy being taken home have to be seen in the context of a lady, who whilst she needed care and support was independent of mind and appeared to everyone to understand the issues facing her.

7.4.4 There is good evidence that Ivy was well cared for during her visit to the hospital. Although she was considered medically ready for discharge by late evening she was cared for overnight as it was not thought appropriate to take her home at such a late hour. Staff who cared for her the following morning prior to her transfer home say they were assured by Ivy that her care would be in place. They did not consider it necessary to make any checks to ensure that was the case.

7.4.5 Similarly, the NWAS Patient Transfer Staff who took Ivy home were assured by her that the carers would be coming later. These staff knew Ivy and indeed it was the same staff who discovered her in a state of distress twelve days later. Again, they did not consider it necessary to make checks to ensure that care was in place.

7.4.6 In summary there were no checks or balances in place during the events which led to Ivy being left alone. Her word that care was in place was accepted by at least two sets

of professionals and there was no policy or procedure in place which required checks to be made.

8 Diversity

8.1 Section 4 of the Equality Act 2010 defines protected characteristics as:

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race
- religion or belief
- sex
- sexual orientation.

Section 6 of the Act defines 'disability' as:

(1) A person (P) has a disability if—

(a) P has a physical or mental impairment, and

(b) the impairment has a substantial and long-term adverse effect on P's ability to carry out normal day-to-day activities.

8.2 The question of whether obesity is classed as a disability was raised in the European Courts in 2000[16]. Although this ruling was in relation to employees, the principles of this case can be reflected in Ivy' situations. Ivy's physical impairment (obesity) had a substantial and long-term adverse effect on her ability to carry out normal day-to-day activities. Ivy also had diabetes, which could, be identified as a disability. Even taking these facts into consideration the review found no evidence that Ivy was disadvantaged or prohibited from accessing services prior to the events which led to her death.

[16] https://www.disabilityrightsuk.org/news/2014/december/obesity-and-disability

9 Conclusions

9.1 The circumstances in which Ivy was found on 29 April 2019, was a tragic event for Ivy and those professionals who attended at her house and later cared for her in hospital up to the time of her death.

9.2 During the timescales of the review there is evidence of good communication between practitioners in responding to Ivy's care and support needs, emerging medical needs and planned hospital appointments. All practitioners were aware of who to contact and when.

9.3 This communication between agencies ceased when Ivy attended at the Emergency department due to a medical emergency on 16 April 2019. Ivy was incorrectly identified by ABACUS Home Care as having been 'admitted' to hospital which resulted in them following their contract and suspending her services. This suspension of the contract did not instigate any further communication with Ivy or another agency to check on Ivy's welfare or anticipated date for returning home, and her care package being resumed.

9.4 This outcome was then compounded further as Ivy was not actually technically admitted to hospital and it was not therefore necessary for the trust to invoke their discharge process. Ivy was reported to have told the hospital staff and transportation staff that she had contacted her carers to inform them she was returning home, and, the GP, when reviewing the Emergency Department discharge summary sheet, was not aware that the care plan had been suspended.

9.5 The review has identified the importance of communication between service users and professionals and the documentation that those conversations and agreed outcomes have taken place. This did not happen in Ivy's case. This is a learning point [paragraph 9.5 refers].

9.6 Whilst policies and processes cannot be created to cover every eventuality, there does need to be in place a process for those individuals who are not admitted to hospital, but do have care and support needs, to ensure that those care and support needs will be met, once they leave a hospital setting.

9.7 In supporting that policy and process, contractual arrangements between Adult Social Care, care providers and service users need to be clear on roles and responsibilities on obtaining clarification that a contract meets the criteria for temporary suspension, and the timescales on how and who will maintain contact with the service user during this time.

9.8 Agencies involved in this case have identified learning relevant for their individual agencies. The report authors recommend that Stockport Safeguarding Adult Board seeks assurances on the implementation of those individual recommendations. See recommendation 6.

9.9 The circumstances of a 2017 incident in which Ivy returned home from hospital without her care plan being reinstated bear a striking similarity to the circumstances which led to her death. The 2017 incident is beyond the scope of the commission for this review, but had lessons been learned and learning implemented at that time then the risks of a similar incident occurring could have been significantly reduced.
The learning from this case must be now be embedded into practice to prevent a similar situation arising again for someone else. See recommendation 7.

10 Learning

10.1 Narrative

The company responsible for providing Ivy's care suspended the care package in the belief that she had been admitted to hospital. Ivy was assessed but not admitted to the hospital.

Learning

A decision to suspend a care package for an adult at risk must be made on facts not assumptions.

Recommendation 2

10.2 Narrative

The Adult Social Care contract with care companies contains a general expectation that the company will keep in touch with clients who are admitted to hospital. It did not happen in Ivy's case.

Learning

All parties to a contract [including the third party client] can benefit from agreed specific expectations in the contract.

Recommendation 3

10.3 **Narrative**

Ivy's circumstances fell outside normal hospital discharge procedures as she was not actually admitted to hospital. Both hospital and NWAS staff were assured by Ivy that her care was in place when in fact it had been cancelled. This was not challenged or checked as she had the capacity to make her own decisions and express her wishes and feelings.

Learning

Clear policy can empower staff to ensure that risks are managed appropriately for clients who attend the Emergency department who are known to have care and support needs within the context of the Care Act 2014.

Recommendations 4 and 7.

10.4 **Narrative**

There is no evidence that a concern about an ineffective hospital discharge in 2017 was followed up.

Learning

Failure to investigate and record the outcomes of high risk incidents means that the risks remain and can recur.

Recommendation 5

10.5 **Narrative**

Conversations between professionals and service users, should be recorded, when discussions take place on how an individual's care and support needs will be met upon their return home. This includes, what outcomes have been discussed and agreed, and what actions professionals will take to notify care providers or other agencies.

Learning

Failure to record conversations results in professionals having no written documentation of agreed outcomes with service users.

Recommendation 6

11 Recommendations

11.1 All agencies that commission care packages should provide Stockport Safeguarding Adults Board with assurance that the learning from this case has been disseminated to all care providers in Stockport.

11.2 Adult Social Care should provide Stockport Safeguarding Adults Board with assurance that care providers are clear that a care package must not be suspended until confirmation has been sought and received that the client has been admitted to hospital beyond the assessment stage at the Emergency department.

11.3 All agencies that commission care should provide Stockport Safeguarding Adult Board with assurance that contractual arrangements with care providers are clear on how and when communication will be maintained with service users when contracts are suspended.

11.4 NHS providers in Stockport should provide Stockport Safeguarding Adult Board with assurances that policies and processes are in place to notify care providers of a patient's attendance for assessment or admission at hospital.

11.5 All agencies should provide Stockport Safeguarding Adult Board with assurance that a robust system is in place for assessing, investigating and recording the outcome of high risk incidents.

11.6 Stockport Safeguarding Adults Board's constituent agencies and service providers should provide evidence to the Board that practitioners are recording details of conversations within agency records when discussing and addressing an individual's care and support needs.

11.7 Stockport Safeguarding Adult Board and it's constituent agencies should consider whether a Vulnerable Adult Risk Management policy [VARM] is appropriate within the context of services in Stockport.

11.8 Agencies who have identified individual learning within this review should provide evidence to Stockport safeguarding Adult Board that their recommendations have been implemented and embedded into practice.

11.9 Stockport Safeguarding Adults Board's constituent agencies and service providers to provide evidence to the Board that the learning from this review has been disseminated within their agency.

Appendix A

Events Table 1 Jan 2019 – 1 May 2019

Date	Event
04.01.19	NWAS – Patient Transport Service Transport from home address to X-ray outpatients and return.
15.01.19	Community Nursing Team Catheter by passing. Urine appears concentrated with some evidence of blood, GP informed, catheter not removed.
15.01.19	ABACUS Home Care Operations Manager spoke to the District Nurse and they confirmed they had been in the morning. Ivy has a water infection. Ivy refused to have catheter taken out. Water sample obtained. To await confirmation from the GP in relation to an infection or look out for antibiotics issued from pharmacy.
21.01.19	ABACUS Home Care Office Manager. Ivy's catheter has come out. Message left for District Nurse. To chase up District Nurses and monitor Ivy.
23.01.19	Community Nursing Team Catheter spontaneously expelled. New one inserted, urine appears clear and draining well when nurse is leaving.
23.01.19	ABACUS Home Care Office Manager. Follow up with District Nurses. To monitor and check with District Nurse's when they go out.
25.01.19	Community Matron. Visit to Ivy. Enhanced Care Management discussed. Goals of Care Record completed. Patient Activation Measure completed: - 'In the last six months, have you had enough support from your local services or organisations to help you manage your long-term condition?' Ivy reported Yes and scored 1 point. [Yes: score 1. To some extent: score 0.5 points. No: score 0 points.] 'How confident are you that you can manage your own health?' Ivy reported 'Fairly confident' and scored f 0.5 points. [Very confident: score of 1 point. Fairly confident; score 0.5 points. Not confident: score 0 points.]
29.01.19	GP – Pharmacy Team Patient/carer requesting more test strips for blood sugars.

Date	Event
31.01.19	GP – Pharmacy Team Discussion with community pharmacy and carers re: barrier cream requirements.
04.02.19	GP – Pharmacy Team Discussion with carers re: barrier cream requirement and blood glucose monitoring sticks.
08.02.19	Community Nursing Team Query received from hospital regarding blood results. Uploaded on EMIS.
11.02.19	Community Nursing Team Carer from ABACUS Home Care telephone regarding Ivy's catheter. Message uploaded on EMIS.
12.02.19	Community Nursing Team Ivy re-catheterised due to bypassing. Seen by 2 x Staff Nurse.
13.02.19	Community Nursing Team - Ivy seen by Podiatrist.
13.02.19	GP Telephone call from Ivy. Loose stools for a few weeks. Advised to ask carers to get a sample in to surgery. Able to demonstrate person centred care – Ivy ringing with her own queries when she wished to do so.
22.02.19	GP - SHH Lab – stool sample normal.
06.03.19	Adult Social Care Social Worker - Review of package of care with agency. New Assessment and Support plan completed and increase in support plan for showering agreed.
08.03.19	Community Nursing Team Staff Nurse and Health Care Assistant, from the District Nurse Evening Service visited. Catheter had come out. Staff unable to reinsert, some per vaginam bleeding noted, message left for the day staff.
08.03.19	NWAS – Patient Transport Service Transport from home address to Radiology outpatients and return.
10.03.19	Community Nursing Team Ivy re-catheterised. Seen by 2 x Staff Nurse. Draining clear urine and small moisture lesion noted on right buttock.
11.03.19	GP Letter from radiology. Appointment for CT scan of pelvis. Asking for U&E to be taken in advance of appt. Task sent to District Nurses asking them to do bloods.
12.03.19	Community Nursing Team

Date	Event
	Ivy seen by Health Care Assistant – Venepuncture.
13.03.19	GP - Hospital lab. U&E normal.
15.03.19	Adult Social Care Increased care agreed by senior management. Social Worker noted that Moving Handling Co-ordinator were working with Ivy regarding the chair and District Nursed were arranging pressure care. Noted that the plan to sit out will be a lengthy process and dependent on sitting tolerance and skin integrity. Case closed.
15.03.19	ABACUS Home Care Operations Manager. Ivy has a small wound on her buttock, possibly the start of a pressure sore. Message left for the District Nurse to see if they can assess it. To monitor and check. Liaise with District Nurse about pressure care.
17.03.19	Community Nursing Team Ivy seen by Health Care Assistant. Dressing renewed to moisture lesion. Noted blood on her sheets and Ivy states she has lower abdominal pain, information given to her GP.
18.03.19	GP Carer requested visit as leg swollen & breathless. Visited by GP. Diagnosed cellulitis. Noted to have abdominal pain & worsening per vaginam bleeding. Offered admission, but patient declined. Capacity was assessed and documented. Agreed letter to gynae to expedite out-patient assessment.
19.03.19	Community Nursing Team Home Care Agency telephoned regarding a problem with Ivy's blood glucose monitoring machine. Message uploaded on EMIS.
20.03.19	GP Message from District Nurses requesting new glucose machine – issued by Practice Nurse from practice stock.
20.03.19	Community Nursing Team Health Care Assistant - Moisture lesion improving to sacrum. Carers were present and showed that Ivy's uterine coil had come out and evidence of per vaginam blood loss. GP informed via EMIS task messaging. GP had discussed further investigations into per vaginam bleeding, but Ivy had declined any further investigations regarding this issue.
20.03.19	Community Nursing Team Staff Nurse and Health Care Assistant from District Nurse Evening Service visited. Catheter expelled. Re-catheterised

Date	Event
	by Staff. Ivy is a bariatric patient. Urethral catheter changed.
22.03.19	Community Nursing Team Health Care Assistant - Visit to carry out venepuncture. Blood sample obtained as requested by GP.
25.03.19	Adult Social Care Physio (moving and handling co-ordinator). Allocated case 12/3/19 due to maternity leave. Occupational Therapist had been unable to reach District Nurse's. District Nurse advised Ivy could sit out for 3 hours. If she sits out, she may be able to use commode and could have the catheter removed. District Nurse agreed to consult with Tissue viability regarding pressure care. District Nurse suggested that Ivy suggested that Ivy should be in a care home due to her complex needs.
26.03.19	GP Carer requested visit due to blisters on back. Carer offered time to be available to assist with manual handling to allow GP to see rash properly. GP assessed and diagnosed shingles. Script generated which carers would collect for her from pharmacy.
02.04.19	GP Telephone call from Ivy as rash still itchy, also coil had come out – noted due to see gynaecologist again at the end of the month.
02.04.19	GP Practice Nurse - Home visit undertaken for routine diabetes review. Carers in attendance also.
03.04.19	Community Nursing Team Health Care Assistant - Visit to carry out to redress moisture damage to sacrum. Noted at this visit area healed.
03.04.19	ABACUS Home Care Office Manager – Logged that Ivy has a hospital appointment on the 8th April. To ensure Ivy is ready for appointment and the right transport is arranged.
05.04.19	Community Nursing Team Care from Home Care Agency telephoned regarding Ivy's catheter. Message uploaded on EMIS.
07.04.19	Community Nursing Team Catheter had come out. Re-catheterised without any problems, clear urine draining. Ivy required personal hygiene and full body inspection carried out.

Date	Event
08.04.19	NWAS – Patient Transport Service Contractor named PAMS. Transport from home address to CT Scan Department outpatients and return.
09.04.19	Community Nursing Team - Podiatrist visit – diabetic foot care.
15.04.19	Adult Social Care Occupational Therapist - Case to be closed as chair now ready to sit out in and handed over to Moving Handling Co-ordinator.
15.04.19	Community Nursing Team Message received by Overnight District Nursing Service from Ivy informing her catheter was bypassing. Message left on District Nurse's land line. No evidence documented and the District Nurse staff cannot recall visiting Ivy following receipt of this message. As there was no further contact from Ivy or Ivy's carers a visit was not arranged.
15.04.19	Community Nursing Team Carer from Home Care Agency telephoned regarding Ivy's catheter. The CATs team contacted Ivy by telephone to ask if she has a replacement catheter. Ivy informed parties that she was wearing disposable continence products.
16.04.19	GP Practice Nurse – telephone call to patient about diabetes medication (routine following diabetes review 2 weeks prior). No answer, plan to try again next week.
16.04.19	GP Contacted by ABACUS Home Care - visit requested as Ivy clammy, not eating, does not look well.
16.04.19	Ivy seen by Mastercall GP. Admitted in view of confusion/drowsiness as not appropriate to wait until tomorrow to start antibiotics and too late to arrange this eve. Ambulance called, waited with patient until arrival. Ivy transported to Emergency Department by ambulance.
16.04.19	Emergency Department Patient Attendance Record. Ivy seen by Health Case Assistant, Senior Nurse x 2, Senior Doctor. The triage notes report a general decline of Ivy, with increased drowsiness and lethargy. The triage nurse recorded that Ivy had a package of care which included carers four times per day. A plan of transfer home with a GP follow up was formulated dependent on the results of one outstanding set of blood results. At 01:28 the results were reviewed and the plan for home was documented. Due to

Date	Event
	the time of night patients would not be transferred home requiring an ambulance, there were no beds available in Clinical Decision Unit (CDU). Ivy remained in Emergency Department for transport in the morning.
16.04.19	GP Records - A&E letter – confirming arrived Emergency Department 20:15, discharged 17/4/19 08:43. Notes for GP section stated ".". Clinical plan stated 17/4/19 00:26 "Repeat ochre sample (bloods). Urine sent off. If above OK = home with GP follow up. 17/4/19
16.04.19	ABACUS Home Care Office Manager – Ivy admitted to hospital. Two care providers rang for GP. GP has rung for ambulance. Ivy has a temp/high bloods and unwell. Suspected Sepsis. Calls cancelled. Calls taken off until further notice as admitted into hospital.
17.04.19	NWAS – Patient Transport Service Transport from hospital transfer hub to home address.
23.04.19	GP Records Practice Nurse – telephone call to Ivy about diabetes medication (routine following diabetes review). No answer but noted that Ivy an in-patient? as admitted last week.
29.04.19	NWAS – Patient Transport Service Records PRF Safeguarding concerns. Patient transport arrived at home address to take Ivy to a routine Gynaecologist appointment and found her in a collapsed state. At 10.09 crew called 999 for ambulance. Transport Crew also called the care company to find out why it appeared Ivy had not been having care visits. Clinical observations were taken it was noted that Ivy had necrotic tissue to her right arm. She had pressure sores on back buttocks and legs. Crew pre-alerted hospital and transported Ivy to hospital. A safeguarding concern was raised by the PES crew at 13.25 and by the transport crew at 18.43 (which was after they finished shift for the day and had the opportunity). Contact made with ABACUS Home Care by crew. Care provider not aware that Ivy had been transported home on 17.04.19.
29.04.19	ABACUS Home Care received telephone call from transport crew regarding Ivy. Operations Manager telephoned Adult Social Care, GP and hospital to report concerns and gather further information.

Date	Event
29.04.19	Adult Social Care received safeguarding concern from NWAS. ABACUS Home Care not aware of discharge of Ivy. Information gathering commenced. District Nurse data base records that Ivy was transferred to (Clinical Decision Unit) CDU on 17.04.19 but unclear of discharge destination. Safeguarding alert transferred to hospital team and Managers alerted. Appropriate screening and reallocation of safeguarding alert. Strategy meeting arranged for 02.05.19.
29.04.19	GP Records -A&E Letter – details of readmission to Emergency Department.
01.05.19	Ivy died whilst an inpatient on the Acute Medical Unit.
01.05.19	Greater Manchester Police commence criminal investigation.

Appendix B

No	Recommendation	Action to take	Lead Agency	Key Milestones Achieved in enacting Recommendation	Target Date	Date of Completion & Outcome
1	All agencies that commission care packages should provide Stockport Safeguarding Adults Board with assurance that the learning from this case has been disseminated to all care providers in Stockport.					
3	Adult Social Care should provide Stockport Safeguarding Adults Board with assurance that care providers are clear that a care package must not be suspended until confirmation has been sought and received that the client has been admitted to hospital beyond the assessment stage at the Emergency department.					
3	Adult Social Care should provide Stockport Safeguarding Adult Board with assurance that contractual arrangements with carer providers are clear on how and when communication will be maintained with service users when contracts are suspended.					

4	NHS providers in Stockport should provide Stockport Safeguarding Adult Board with assurances that policies and processes are in place to notify care providers of a patient's attendance for assessment or admission at hospital.					
5	All agencies should provide Stockport Safeguarding Adult Board with assurance that a robust system is in place for assessing, investigating and recording the outcome of high risk incidents.					
6	Stockport Safeguarding Adults Board's constituent agencies and service providers should provide evidence to the Board that practitioners are recording details of conversations within agency records when discussing and addressing an individual's care and support needs.					
7	Stockport Safeguarding Adult Board and it's constituent partners should consider whether a Vulnerable Adult Risk Management policy [VARM] is appropriate within the context of services in Stockport.					

8	Agencies who have identified individual learning within this review should provide evidence to Stockport safeguarding Adult Board that their recommendations have been implemented and embedded into practice.					
9	Stockport Safeguarding Adults Board's constituent agencies and service providers to provide evidence to the Board that the learning from this review has been disseminated within their agency.					