Safeguarding Adult Review of Carol

Presented to the West of Berkshire Safeguarding Adults Board

On

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Report Author:

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Endorsed by the West of Berkshire Safeguarding Adults Board on the 7/9/2020, virtually.

1. Introduction

1.1 Following the death of Carol, West of Berkshire Safeguarding Adult's Board made the decision to commission a Safeguarding Adult Review (SAR) under Section 44 of the Care Act (2014). This was because Carol passed away at home after discharge from hospital and her package of care had not been restarted.

1.2 The Board noted that there were a number of agencies involved with supporting Carol in the period before her death and that the Board should explore what learning can be identified for individual agencies involved in this case and for the wider partnership.

1.3 This report will be published on the Board's website and the Board will consider how to implement learning identified in this review.

2. Summary of the case

2.1 Details of the person subject to the Safeguarding Adult Review

Name: Carol (pseudonym)aged 58 years

2.2 Family composition

At the time of her death, Carol lived alone. Carol was a widow and there was no known family. There is reference to a brother in-law in this SAR, who was the brother of her ex-husband. It was agreed by the SAR Panel that the brother-in-law was not involved with Carol so would not be contacted.

There is also reference to a neighbour in this SAR. It is not clear who this neighbour is and therefore they could not be contacted to discuss this SAR.

2.3 Timeframe

Following discussion at the SAR Panel on 9th August 2018, the period under review was agreed to be the six-month period between January and June 2018. This gave an opportunity to understand the involvement agencies had with Carol prior to her admission to hospital.

2.3 Evidence used for review

Key agencies were requested to complete a chronology of involvement with Carol from the 1st January 2018 – 19th June 2019. The agencies asked to submit the Chronologies were:

- Royal Berkshire NHS Foundation Trust (RBFT)
- Domiciliary Care Provider
- Reading Borough Council (RBC)
- Carol's GP
- Emergency Duty Service (EDS)
- Berkshire Health NHS Foundation Trust (BHFT)

These chronologies were used to provide the overview of the case and to answer the questions set within the Terms of Reference.

The Coroner was contacted to confirm the date and cause of Carol's death. This was confirmed following post-mortem as: Myocarditis, Severe Steatosis of the Liver, Type 2 Diabetes Mellitus

Thames Valley Police (TVP) confirmed that there was no police involvement following Carol's death.

The author, Ms Lynne Mason, Business Manager for the West Berkshire Safeguarding Adults Board with the permission of RBC, used RBC's case management system to obtain further information.

3. Overview of the Case

Carol was living with Schizophrenia [1] and had been known to the Community Mental Health Team (CMHT) since January 2012. There were concerns regarding Carol's living conditions, self-neglect and significant alcohol use. Carol had received support from the drug and alcohol service back in 2016, which raised safeguarding concerns regarding her living condition and personal care. A safeguarding enquiry concluded that Carol's home was 'reasonably' habitable, and Carol did not appear to have neglected herself. The investigating officer evidenced consideration of Carol's mental capacity.

On the 16th March 2018, Carol attended hospital due to a fall at home three days earlier; Carol was diagnosed with a broken shoulder and was sent home with a collar and cuff. It was noted that Carol drinks alcohol but not daily. A discharge letter was sent to Carol's GP. This was not logged by the GP until the 26th March 2018; on the 24th March 2018. Carol failed to attend GP appointment for a medication review.

Paramedics attended a call on the 23rd March 2018 for Carol's husband, due to a suspected cardiac arrest. He passed away at the scene. Carol did not live with her husband, they lived a few doors away from each other, but Carol was present at the time. Carol's husband was referred to as her main carer. South Central Ambulance Service (SCAS) submitted a safeguarding/vulnerable person's form as a result of this call, raising concerns they had for Carol regarding neglect due to environment, self-neglect and alcohol use. It also stated that Carol had no family or friends nearby. TVP also raised a Safeguarding concern, raising the same concerns about Carol, providing a lot of detail. They also stated that Carol has a broken arm (Carol had attended A&E on the 16th March 2018 where she was diagnosed with a Broken Shoulder) and that Carol said she had Schizophrenia. There are no records of any safeguarding contact forms being completed on the IT system, as a result of the contact made by TVP and SCAS.

The Safeguarding Adult Team (SAT) attempted to call Carol the same day but there was no answer or message facility. The SAT wrote to Carol on the 29th March 2018, after receiving advice from their manager, offering support, but stating that if they did not hear from her by the 13th April 2018, they would assume that Carol did not need their services. It is not clear how many attempts were made to call Carol and there appears to have been no attempt to visit Carol at her home address.

The mortuary was also in contact with SAT due to not being able to contact Carol regarding the funeral arrangements for her husband. The mortuary contacted SAT to state that Carol's brother-in-law was supporting with the funeral arrangements.

Carol visited the fracture clinic 3 days after her husband's death. Staff at the fracture clinic noted that Carol was unkempt. Carol also stated that she was unable to cope since the death of her husband and she did not wish to live. The fracture clinic followed this up with the psychological medicine service (PMS) who advised that Carol should attend A&E. A mental health review was completed by PMS. Carol confirmed that she had been drinking and had not been taking her medication Clozapine[2] for 3 days. Carol stated that she had suicidal ideation but was not planning on doing anything and was willing to engage with services. A referral was made to the Crisis Resolution Home Treatment Team (CRHTT) and CMHT requesting a review due to the significant change in circumstances. The fracture clinic wrote to Carol's GP highlighting that Carol had been feeling

[1] Schizophrenia is a severe long-term mental health condition. It causes a range of different psychological symptoms. Doctors often describe schizophrenia as a type of psychosis. This means the person may not always be able to distinguish their own thoughts and ideas from reality.

[2] This medication is used to treat certain mental/mood disorders (schizophrenia, schizoaffective disorders).

depressed and had suicidal ideation since her husband's death, along with the management plan for Carol's broken shoulder.

CRHTT made a referral to the Clozapine[3] Clinic that same day with a view to reintroduce the medication. A multi-disciplinary meeting was held the next day where her alcohol intake, physical health issues, environment and evidence of self-neglect were discussed. Carol contacted CRHTT to ask for an update on the plan for reintroducing Clozapine. Carol was told that they were arranging admission to a unit so it could be a supervised initiation and they would keep Carol updated and agreed a time for the next phone call. This plan changed the next day. The revised plan was to do an Electrocardiogram (ECG)[4] for a fast track reintroduction of Clozapine in the community. Carol was informed of this change and expressed satisfaction with this plan. The ECG was arranged for the following day however due to Carol's alcohol intake and the risks associated with Clozapine, Carol was told until she was alcohol free Clozapine could not be restarted, which was the correct procedure to follow. CRHTT continued to support Carol with daily visits.

On the 27th Match 2018 a plan was made for CRHTT to raise a safeguarding concern in regard to Carol's alcohol intake and fire risk due to smoking and clutter in the home. There is no evidence of this concern being raised. The case notes where the plan to raise a safeguarding concern was logged by an agency nurse. CRHTT no longer use the agency that supplied the nurse, so cannot investigate further why the concern was not raised.

A home visit was carried out by a CHRTT Home Care Assistant on the 1st April 2018 where it was noted that there was evidence of self-neglect; Carol also declined an offer of a referral to IRIS[5]. There was an opportunity to refer to safeguarding but this did not happen. A Multi-Disciplinary Team (MDT) meeting was held and it was agreed that care would be handed over from CRHTT to CMHT. This handover occurred on the 5th April, 11 days after the initial referral to CRHTT. The MDT processes have now changed since and the plans are now recorded at the MDT. There is now a clinical nurse specialist who oversees the Reading caseload and ensures plans are followed through.

The fracture clinic at RBFT saw Carol again on the 9th April 2018 and wrote to her GP on the 18th April 2018 regarding a treatment plan for Carol. It was noted by the fracture clinic that Carol's collar and cuff sling were very dirty and needed replacing and that she was very unkempt.

On the 13th April 2018, nine days after the handover to CMHT, Carol's GP carried out a home visit and made a referral to the Health Hub [6] to request reablement services for Carol. An Assistant Therapist and Community Nurse from the Intermediate Care Team (ICT) visited Carol at home the same day. The assessment noted evidence of self-neglect and cluttering and not managing diabetes appropriately, this was fed back to Adult Social Care on the same day. There was no evidence of Carol's mental capacity being considered during this assessment. A rapid response care package was put in to support Carol which was:

- 2 care calls a day, to support with personal care and medication, a request had been made for 3 calls a day but there was not capacity to deliver this;
- referral to support with housing issues;
- Nurse to support with daily blood sugar monitoring;
- a request was made to social services for a deep clean of Carol's property

[3] Clozapine is a psychiatric medication (anti-psychotic type) that works by helping to restore the balance of certain natural substances (neurotransmitters) in the brain.
[4] An electrocardiogram (ECG) is a test which measures the electrical activity of the heart to show whether or not it is working normally.
[5] Agency that supports alcohol dependent individuals to stop drinking
[6] https://www.berkshirehealthcare.nhs.uk/ic/the-berkshire-integrated-hub/

On the 16th April 2018, three days after the care package started the RR team noted that Carol was declining support with personal care and meal preparation. It was noted that Carol had a history of alcohol abuse suffered from schizophrenia, was a heavy smoker and her husband had recently passed away. There was evidence of self-neglect and the home needed an urgent deep clean. A referral was made for a fire safety check on the 24th April 2018, nine days after this was reported.

Carol was discharged from the RR team on the 19th April 2018, after seven days input. It was recorded that Carol was happy with the care arrangements going forward. Her support package from the team ended on the 26th April 2018 A Community Reablement Team (CRT) holding package started immediately with two care calls per day.

On the 28th April 2018, a carer contacted Westcall (the out of hours GP service) as Carol was not herself. A home visit was conducted, and a decision was made to admit Carol to hospital. A neighbour agreed to wait with Carol until the Paramedics arrived. Carol remained in hospital until the 13th May. The A&E report states that self-neglect was evident with alcohol intake.

RBFT raised a safeguarding concern regarding self-neglect. This was received by RBC on the 30th April 2018, however was not logged on the IT System. The case was allocated to an ASC worker four days later. On the 31st May 2018, thirty-two days after allocation, (there had been two allocated workers during this period) the allocated worker was given a deadline by their manager of the 4th June 2018, to complete the enquiry. The worker planned to visit Carol to carry out an assessment, but this assessment did not take place as at the time the assessment was being planned by the worker, Carol was in hospital.

The manager was asked about this but does not recall this case and therefore cannot provide any further information. The GP contacted CMHT on the 30th April 2018, concerned about Carol's increased drinking and self-neglect. CMHT referred this to CHRTT for assessment. CHRTT did not accept this referral and requested that CMHT complete an unannounced visit. CMHT wrote to Carol with an appointment rather than the unannounced visit that CHRTT has requested. At the time this letter was sent, Carol was in hospital, so it is unlikely that Carol was aware of such an appointment request. After Carol did not attend her appointment the plan was to allocate a Social Worker to encourage Carol to attend an alcohol cessation group and there needed to be consideration for Supported Living.

A deep clean of Carol's property was offered whilst Carol was in hospital, to which Carol did not give consent. It was agreed that this would be reviewed after Carol has been discharged from hospital.

A discharge notice was made on the 9th May 2018 to which reablement services were requested. Carol appears to have requested support when going home but refused to have a deep clean. It is noted by the hospital that Carol appeared to have capacity. Carol did consent to a referral being made to the bereavement service CRUSE. Whilst Carol was in hospital her GP left a message for Carol to arrange a Diabetic review. Carol was discharged from hospital on the 13th May 2018.

A safeguarding concern was raised on the 9th May 2018 and logged on the ASC IT system. The referrer was logged as SCAS and concerns were noted about self-neglect. The risk was assessed as substantial; the interim plan was for Carol to receive support from CRT at the point of discharge and for Carol's case to be reallocated to another worker for assessment, this assessment did not take place. It was stated that the case did not meet the criteria for a safeguarding enquiry. The information on the ASC IT system appears incorrect; the concern was not raised by SCAS but by RBFT. The SAT confirmed that a safeguarding enquiry did not take place as it was agreed with the RBFT that issues will be resolved through a care needs assessment and provision of CRT services.

On discharge from hospital on the 13th May 2018, Carol received three care calls a day. This was provided by the Reablement Team until an external agency could be commissioned to deliver this

support. The external agency was commissioned by ASC and began supporting Carol on the 17th May 2018. The care provider was not made fully aware of Carol's needs at the time of bidding for the care package, the package of care stated that Carol sometimes self neglects. On their initial assessment the care provider identified that Carol had mental health issues, a history of falls, lived with diabetes, slept on her sofa and her property was in very poor condition.

On the 18th May 2018 a Community Psychiatric Nurse (CPN) from CMHT visited Carol, it appears that the CPN did not enter Carol's flat as Carol came out to see her after the CPN had rung Carol's neighbour's doorbell. The CPN noted that Carol was clean, tidy and dressed in appropriate clothing for that time of year and was free of alcohol. Carol stated that she was in a low mood due to her husband's death but didn't want any medication from mental health services. Carol asked the CPN to report her broken door bell and the CPN agreed but there is no evidence on the CMHT IT System of this having been reported. It was documented that Carol declined any input from CMHT. It was not clear what the CPN's plan was going forward or if Carol's capacity was considered.

From the 24th May- 25th May 2018, the care provider reported difficultly in visiting Carol as Carol was not opening the door. On the occasions when Carol did open the door to the carers Carol refused support with personal care.

On the 30th May 2018, eighteen days after Carols discharge from hospital, a visit was completed by BHFT to assess Carol's rehabilitation needs following the existing injury to her shoulder. It was noted that Carol was a vulnerable adult and neglects herself and her environment, as a number of safeguarding concerns had been raised in the past. There appears to have been no consideration to make raise another concern. An appropriate plan was put in place.

An Occupational Therapist (OT) visit took place on the 1st June 2018, where a shower board was fitted and demonstrated to Carol; the OT offered advice and support on dressing and noted that Carol was motivated to follow her exercise programme. It was planned for a review to take place in one weeks' time, which did take place. The OT assessed that Carol required an increase in support and contacted CMHT the same day to request a review of Carols needs. Carol was engaging with the treatment plan offered.

On 3rd June 2018, the care provider contacted the Emergency Duty Service [7](EDS) to state that they could not gain access to Carol's property for the evening call. The EDS call handler reviewed Carol's ASC notes and noted that this is not the first time Carol had refused support and that ASC were aware of this and there was an ongoing safeguarding investigating due to be completed on the 4th June 2018. A decision was made that a police welfare check was not proportionate. RBC was alerted to this call via a contact report on the same day, this was logged onto the ASC IT System, there is no evidence of any action being taken by ASC.

On the 5th June, the care provider were unable to gain access to Carol's home at 6pm, they attempted to visit again at 7:45pm, when the carer gained access to the building, Carol's front door was open. Carol was found on the floor intoxicated and an ambulance was called, and EDS alerted. The carer left when paramedics arrived. The care provider reported this incident to EDS and requested that they consider a key safe due to Carol not answering her door to the carers. EDS shared the incident report with RBC. There is no information on what happened after the paramedics arrived, Carol was not admitted to hospital

1. [7] The Emergency Duty Service is based in Bracknell, provides a response to social care crisis arising outside normal working hours, including providing an emergency social work service to the whole of Berkshire and to all social care groups.

On the 9th June 2018, Carol attended A&E via an ambulance, as she had had a fall in her garden. The A&E discharge report stated that Carol had not eaten much that day, had drunk a litre of whisky the day before and that Carol had been admitted to a ward. The care provider called EDS to state they couldn't gain access to Carol's home. EDS identified on the 10th June 2018 that Carol had been admitted to a short stay unit at the RBFT and advised the care provider to suspend calls; this was followed up with an email from ACS on the 11th June 2018. EDS informed ACS on the 11th June 2018 The EDS call handler did not follow internal policies and procedures to action calls within the same shift and handed over this case to the next shift resulting in a delay in confirming hospital admission.

EDS noted that recording could have been more detailed, and that whilst appropriate advice was sought this wasn't documented on the call logs. When EDS informed the care provider of the admission, the information given was lacking and didn't state the reason for admission or expected duration of stay.

RBFT records state that Carol's stay in hospital was for an unplanned detox. ASC were informed of this and were told that Carol would remain in hospital for at least 2 days. RBFT asked if ASC were aware of the home environment to which they stated they were and that this would not delay discharge. During Carol's stay in hospital Carol was independently mobile and self-caring with hygiene and daily living needs.

A mental health consultation was sought whilst Carol was in hospital; the plan agreed was that Carol will require an assessment from PMS at the time of discharge. This took place and it was agreed that CMHT/ASC would assess and consider a supported accommodation placement.

A SBAR[8] tool on the 14th June 2018 stated that Carol was in hospital following a fall and for unplanned alcohol detox. It stated that Carol was independent but had a package of care to support with medication. On the 15th June 2018, Carol was discharged. It was an agency member of staff on shift, but they had access to SABR. It was noted that there were plans for a mental health referral and community alcohol services. RBFT did not inform ASC of Carol's discharge from hospital so Carol returned home without a package of care.

A carer from the care provider supporting Carol, saw Carol arriving home by ambulance, on the evening of Friday 15th June 2018.The care provider called EDS as they had not been advised to restart the care. EDS did not take any action, which was not in line with their policies and procedures.

The care provider followed their call up with ASC at 10:30 am on the 18th June 2018, four days after Carol's discharge. ASC instructed the care provider to restart the care package with immediate effect. Carol failed to answer the door to carers. This was reported to ASC at on the 19th June 2018 at 10:51am by the care provider. The care provider was not concerned as Carol had missed evening calls previously. The care provider was informed that this had been forwarded to the short-term team in RBC, it appears that no action was taken. The care provider arrived for the lunch call the same day to which Carol did not respond. Due to the number of calls being missed, the care provider called the police, who discovered that Carol had passed away.

The care provider contacted ASC immediately on the 19th June 2018 to inform them of Carol's death. When they did not receive a response, they alerted the RBC Contracts and Commissioning Team.

8 Situation, Background, Assessment, Recommendation -structured form of communication for staff handovers at RBFT,

In response to Carol's death a safeguarding concern was logged which had the outcome of a section 42 enquiry due to the possible transferable risk. This section 42 enquiry was not completed and cancelled on the IT system. A strategy meeting took place on the 4th July 2018 with an outcome of a SAR notification was to be made; no Section 42 enquiry was completed. The cause of death following post-mortem was:

- Myocarditis an inflammation of the heart muscle. There are various causes, but it is usually caused by a virus. Depending on the cause and severity, symptoms and possible problems can range from no symptoms at all, to life-threatening heart failure.
- Severe Steatosis of the Liver – cause can be excess drinking of alcohol
  Type 2 Diabetes Mellitus

It is not known exactly when Carol died.

4. What were agencies responsibilities to Carol and were these followed?

Carol was a vulnerable adult, who was not coping, was alcohol dependant and self-neglected. A number of agencies were involved in supporting Carol. Interactions between Carol and agencies did in general appear positive. There was however a lack of a co-ordinated approach which would have given professionals a more informed insight into Carol's situation, which may have in turn resulted in a more effective approach to supporting Carol.

Carol was struggling and saw a high number of professionals over a short period of time; it would have been difficult for Carol to know who to seek support from. There were times when Carol was willing to engage with services.

ASC did not comply with Section 42 of the Care Act; they did not act within the Pan Berkshire Policies and Procedures and failed to complete a section 42 enquiry.

5. Where there any gaps in the agencies actions that may have impacted on the outcome for Carol?

Safeguarding concerns that were raised by agencies were not logged as a safeguarding concern by ASC, meaning that the level of concern may have been diluted by anyone reviewing Carol's records. There was also an error in the detail on the safeguarding concern logged on the 9th May.

Carol's refusal to allow carers into her property was deemed normal behaviour and therefore not followed up. It was also considered 'normal' for Carol not to open the door to carers even though Carol has been left without support over a three-day period.

Carols refusal of services was never investigated by ASC, which meant it was not understood why Carol was refusing care. A safeguarding concern where an assessment was deemed required, took four days to be allocated to a worker then thirty-two days after this allocation, the worker was given a deadline to complete this assessment and this assessment never happened.

EDS staff did not act in accordance with their internal policies and procedures, meaning that appropriate information was not passed on, on more than one occasion. This was most significant when a member of staff from the care provider, reported seeing Carol at home after discharge from hospital.

RBFT records regarding Carol's support at home did not fully reflect her complex needs, however they did specify that Carol received home care and Carol was discharged on the 15/06/18 without ACS being informed so that the package could be restarted. Carol's discharge was co-ordinated

based on her medical needs and how she presented in the hospital on that occasion, which gave false assurance regarding her ability to care for herself. On that occasion there appeared to be little or no consideration of Carol's history and how her complex psychological as well as her medical needs would be met at home.

There was lack of evidence regarding consideration to Carol's mental capacity.

CMHT did not respond to the CRHTT referral and did not follow advice given by them. CMHT wrote to Carol when she was in hospital inviting her to an appointment to which it was highly unlikely, she would receive, meaning that there was time wasted for CMHT and a delay in supporting Carol.

It appears that when the CPN visited Carol, the assessment was carried out outside of Carol's home; entering Carol's property would have given the CPN more insight into Carol's current situation.

There are conflicting accounts from ASC and the Care Provider on what was ASC policy when service users failed to open their doors to carers. The Care Provider's policy at the time of the incident was to report to the office and move onto the next call, the office would then inform ASC. The Care Provider has since updated this policy. However, it is claimed that this practise was endorsed by ASC. ASC were asked to explain the current procedure and advised that: there is not a formal policy, but the guidance would be for Care Providers to risk assess on a case by case basis & take appropriate actions and once these have been exhausted then calling the emergency services should be considered.

6. Were there any missed opportunities in supporting Carol?

The SAT did not respond appropriately to the safeguarding concerns raised by TVP and SCAS in March 2018 by writing a letter to a Carol. A visit to Carol's home should have taken place.

There was no consideration of independent advocacy for Carol.

Carol was in contact with other agencies when presenting with her broken shoulder however it took 29 days from when Carol broke her shoulder for a referral to be made to the CRT.

There were a number of missed opportunities for agencies to raise safeguarding concerns. There were also incidences where safeguarding concerns were not raised as there was an assumption that the SAT was aware.

By chance, EDS were alerted to Carol being discharged from hospital. If they had responded appropriately to this call, services may have been reinstated on the day of discharge (Friday) not three days later, on the Monday.

Carol was in hospital for an unplanned alcohol detox, following a fall at home. Was the RBFT decision to discharge Carol on a Friday, where there would be limited community support, with a referral to CMHT and community alcohol services appropriate? The SAR has concluded that this wasn't appropriate for Carol and this was not identified by RBFT staff as they only assessed the Carol that was presenting to them at the time of discharge.

Professional Curiosity, Carol refused a deep clean of her property on numerous occasions; the reasons behind this decision were not fully explored.

7. Areas of good practise noted

The RBFT Fracture clinic noted that Carol was struggling and sought further advice from the PMS, to which PMS conducted a review the same day. The fracture clinic also highlighted their concerns on two occasions with Carol's GP.

A carer contacted the out of hours GP as Carol was not herself; this led to a home visit and decision to admitted Carol to hospital. A neighbour waited with Carol until paramedics arrived. This led to a two-week inpatient admission to the RBFT. A safeguarding concern regarding self- neglect was raised on presentation to A&E.

A home visit by Carol's GP resulted in a referral to the Health Hub to which an assessment and services were agreed the same day.

CRT temporarily provided support to Carol so that a timely discharge from hospital could occur.

A carer from the care provider saw Carol returning home from hospital, by chance, and took the initiative to contact EDS. The care provider also followed this up with ASC on the Monday which is when ASC were alerted to Carols discharge.

Since this incident the care provider has changed their policy when service users do not answer their doors. Previous policy was if the carer did not get a reply, they would inform the office who would inform ASC and move onto their next call. It is now the care agencies policy that carers will not leave a service users property until there is confirmation to why the service user is not answering their door.

8. What can the partnership learn from this case?

- That there is an emphasis on 'normal' behaviour when making decisions and that these decisions on 'normal' behaviour may not necessarily consider current circumstances. For example, being discharged from hospital without support, as Carol appeared to be coping in hospital.
- Carol's voice did not appear to be heard, Carol had to speak to a number of different professionals at a time of crisis, and advocacy was not considered.
- There was limited partnership working in this case. Agencies were working in silos, meaning Carol's situation was not fully understood.
- Self-neglect: it appears that agencies recognised it but were not clear on the most effective way to support Carol. A Strategy meeting was required.
- Bereavement: Carol was grieving and appeared to have very little support.
- Mental capacity: whilst it has been considered in chronologies it appears that capacity has been assumed and not tested further with reliance on: *A person is not to be treated as unable to make a decision merely because he makes an unwise decision.*
- Access of the Health Hub, better understanding of who can and when can referrals be made.
- There was a number of staff at EDS who did not follow their internal procedures. EDS have confirmed that an internal investigation into this incident has been completed and learning identified.
- There was a failure to recognise on discharge that further communication was required with Carol's social worker.
- Within ASC there were two different teams and therefore two different allocated workers and managers overseeing Carol's case, resulting in assessments not being completed at all or in a timely manner.
- Intelligence from this SAR and others along with SAR Panel member feedback evidences that safeguarding policies and procedures are not being followed.

9. Recommendations

- The Board to work with the partnership to effectively support people who self-neglect, by ensuring there are appropriate tools and training available, considering co-morbidities and how this can impact on self- neglect. Agencies were able to identify that Carol was self-neglecting and were making appropriate referrals and raising concerns to the SAT, however concerns raised were addressed in silos meaning that no one had a holistic view of Carols needs.
- To further promote the benefits and Care Act requirements regarding advocacy. Advocacy was not considered for Carol.
- The Board to support the partnership in regard to mental capacity to enable agencies to be confident in the application of the Act, particularly for those people that have fluctuating capacity.
- The Health Hub referral route to be reviewed to ensure referral routes are appropriate, revisions to be shared with the Board so awareness can be raised across the partnership.
- To implement a partnership wide Risk Management Framework, to allow agencies to effectively work together. Agencies identified that Carol was at risk of self-neglect but there was a lack of a multidisciplinary approach to support Carol.
- The Board to understand the offer of bereavement services for vulnerable people across the partnership and to consider how the workforce are trained to support people suffering from bereavement who are alcohol and/or drug dependent. Carol did agree to a referral being made for the bereavement service CRUSE; however, Carol was in crisis and would have required specialist support.
- RBFT to review its discharge procedures for people who have complex medical and psycho-social needs, considering if staff have the opportunities to have a holistic view on patients discharge, and what safeguards should be implemented to ensure that patients of this nature are discharged with adequate support.
- To seek assurances from agencies involved on what learning has been identified from internal investigations and how this learning will be implemented.
- The Board to seek assurances from SAT's that Safeguarding Policies and Procedures are being adhered to, an audit to be completed on those concerns that do not meet the safeguarding threshold. There were safeguarding concerns raised about Carol that were not logged correctly.

9. Glossary

A&E	Accident and Emergency
ASC	Reading Borough Council Adult Social Care
BHFT	Berkshire Health NHS Foundation Trust
CMHT	Community Mental Health Team
CPN	Community Psychiatric Nurse
CRHTT	Crisis Resolution and Home Treatment Team
CRT	Community Reablement Team
ECG	Electrocardiogram
EDS	Emergency Duty Service
ICT	Intermediate Care Team

MDT	Multi Disciplinary Team
OT	Occupational Therapist
PMS	Psychological Medicine Service
RBC	Reading Borough Council
RBFT	Royal Berkshire Foundation Trust
RR	Rapid Response Team
SAT	Safeguarding Adults Team
SCAS	South Central Ambulance
TVP	Thames Valley Police