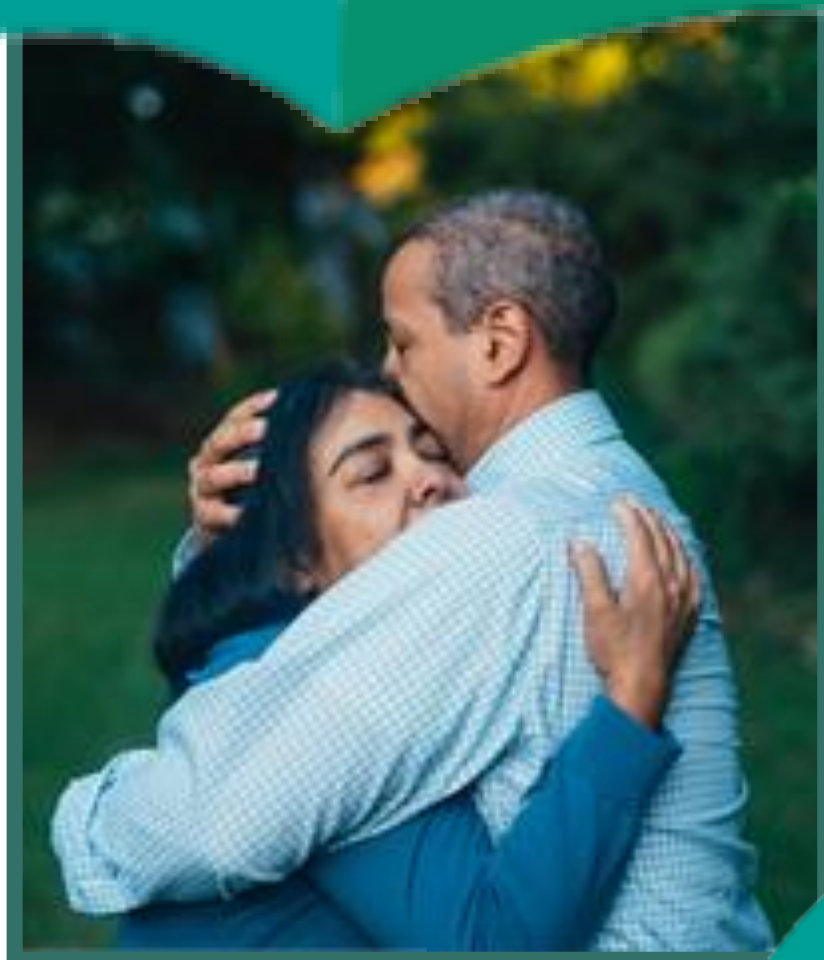
Southampton Safeguarding Adult Board

Safeguarding Adult Review

Name - Robert Date – December 2023



SSAB

Report by Nicola Brownjohn

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2 REASON FOR REVIEW

2.1 Robert died on 9 November 2021 as a result of falling from the 4th floor balcony of his flat. He lived in an extra care property owned and managed by Southampton City Council (SCC). Robert was receiving a package of care which was being delivered by Apex. SCC housing support also provided housing related assistance. Robert's family had raised concerns, including a number of complaints, including on the days just before Robert died, regarding the level of care being provided.

2.2 Robert was almost blind with partial sight in right eye after developing Glaucoma. He was on the sensory visual register and noted as prone to recurrent eye infections which triggered low mood. He had long standing mental illnesses, including a history of psychosis, panic disorder, paranoid schizophrenia, and visual hallucinations. He was open, at times during his life, to the community mental health team (CMHT).

2.3 Robert moved into the extra care property in June 2021. He was granted a tenancy of a property on the 4th floor. It is understood that this was with the consent of the family as there was more light than lower floors. The Care Provider raised some concerns in September 2021 about Robert residing on the 4th floor given his sight impairment.

2.4 In Autumn 2021 Robert began to experience further ill-health. He had recently had tests referred by the GP, which did not indicate any sign of cancer. However, Robert was experiencing pain which became severe and required an admission to University Hospital Southampton, where he was diagnosed with late-stage cancer. Robert was discharged from hospital, prior to commencing his treatment, with involvement from the SCC Hospital Discharge Team (HDT), who were also in liaison with the Care Provider around changes to his care needs.

2.5 On the morning of 9 November 2021 Robert was found deceased on the ground below his 4th floor flat. The alarm was raised by a resident who pressed their

telecare alarm, reporting they had seen an object on the ground. A resident who was walking in the garden found Robert on the ground. The on-site carer called 999. A wooden chair was found tipped over on the balcony of Robert's flat. No CCTV images were available. SCC undertook a property inspection and a report concluded handrail and the window bars was found to be in compliance with the building regulations.

3 METHODOLOGY

3.1 The methodology used is based on a system and learning from cases approach[1]. The main aspect of this methodology is to engage with practitioners to view the situation from their perspective. This enables practitioners to talk about what drove their practice at the time. There are three lenses: individual, organisational, and wider system, which inform this methodology. This requires a safe environment for practitioners to talk about what happened to facilitate them to gain maximum learning and to inform the wider learning for the SAB to take forward.

3.2 Key Lines of Enquiry (KLOE)

- The effectiveness of transition planning from Robert's previous accommodation to the accommodation on the fourth floor.
- Was the package of care in place for Robert following his discharge from hospital, communicated to all relevant agencies involved in his care and felt to be sufficient to meet his needs?
- Where Robert was known to a number of different care agencies with subsequent changes to his package of care, what processes were in place to allow for a comprehensive handover?
- Is there evidence that agencies involved in Robert's care completed, implemented and monitored risk assessments and safety plans in

[1] Social Care Institute for Excellence Learning Together Model

relation to Robert's accommodation/living arrangements as well as his mental health?

- What was known about Robert's use of cannabis and the impact of this on his mental state?
- Is there evidence that agencies worked collaboratively and effectively together to help meet Robert's needs whist acknowledging his views and wishes?
- Following his diagnosis of cancer in September 2021 , was Robert given information and was the support available discussed with him?
- How were Robert's family involved and were the concerns from the family addressed adequately?

3.3 Evidence used

- Practitioner event (14 December 2022)
- SCC serious Incident report
- Combined Chronology – including timelines from:
- Hampshire Constabulary
- Southern Health Foundation NHS Trust
- South Central Ambulance Service
- Solent NHS Trust
- University Hospital Southampton NHS Foundation Trust
- SCC Housing
- Apex Prime Care
- SCC Adult Social Care
- Primary Care: GP

3.4 Family involvement

3.4.1 Robert's daughters were informed about the SAR and agreed to meet with the independent reviewer.

3.4.2 A virtual meeting was held on 14 November 2022 and the daughters' views are included within this report.

3.4.3 The reviewer is grateful to both of Robert's daughters for their contribution to the learning within this review.

4 ROBERT

4.1 Robert's daughters described him as '*brilliant and vibrant'* and *'fiercely independent'.*

4.2 Robert was a single parent who brought up his children alone. Until his health issues prevented him from continuing, he worked as a carpenter.

4.3 Robert had a diagnosis of schizophrenia. He had long term medication and experienced intermittent episodes of psychosis since 2003, the last being in 2015. He was under the care of the Community Mental Health Team (CMHT).

4.4 When he was in his late 40s, Robert developed glaucoma, causing blindness in one eye. He was registered blind. This meant he could no longer maintain total independence.

5 BACKGROUND

5.1 In 2012, Robert had been provided with care via Direct payments, to support him to meet all domestic care and personal care needs plus reduction of social isolation. In 2017 the direct payment, via SCC, was reduced following a review. A financial assessment led to Robert cancelling his direct payment and he began funding his own care. This meant that ASC ended their direct input, and their responsibility was taken via the CMHT for Robert's care and support reviews, under the section 75 agreement between SCC and Southern Health NHS Foundation Trust. They contacted Robert every 1-2 months.

5.2 In 2019, Robert's family raised concerns with the CMHT that he was not taking his medication and his behaviour was changing. He was admitted to hospital under the Mental Health Act 1983 due to deteriorating mental health.

5.3 On discharge, Robert started to have carers in daily to help him with his medication. He also continued to have monthly CMHT visits. Additionally, he had

family support as it was recognised that he was needing more help due to his deteriorating vision.

5.4 Robert paid for the carers himself as he had not been informed that he was entitled to S117 aftercare provision, despite having had been detained under Section 3 of the Mental Health Act in 2003. The serious incident report completed by SCC following Robert's death, concluded that Robert's potential eligibility for S117 aftercare was not identified by professionals involved with him until February 2021. At this point it was confirmed in an email by the Mental Health Administration Office of the SHFT and SCC ASC were informed and records were updated. This appears to be unrelated to the direct payment Robert had previously received.

5.5 In August 2019 Robert applied to SCC for a housing move. The outcome was for no priority and insufficient evidence to support need for ground floor accommodation. This led to Robert asking his GP to support the application for sheltered accommodation.

5.6 In October 2019, the care provider referred to ASC for an assessment of Robert's needs due to him having difficulty in funding the provision. The outcome of this was an assessment for extra care housing.

6 TIMELINE FOR ANALYSIS NOV 2019 – NOV 2021

6.1 Period 1: Pre-Pandemic: Nov 2019 - Feb 2020

The Community Independence Service (CIS) West assessed Robert's social care needs. Robert declined further help and reduced his care call time as he self-paid. During this period he had a cataract operation and was assessed by the CMHT as being of low risk in relation to his mental health needs.

6.2 Period 2: Early part of Pandemic: March 2020- Dec 2020

6.2.1 During this time, Robert stopped his care provision for a period, due to Covid-19. He had a CIS sensory assessment, and he asked for help to look at moving to supported living.

6.2.2 His GP noted Robert was struggling with medication for his mental health and his care provider made a referral to ASC due to the view that Robert was breaking down in terms of his mental health (MH) and not coping with the isolation of the lockdown periods.

6.2.3 During this period, there was an occasion when Robert called his GP about panic attacks and a fear of dying. Robert asked for counselling. The GP made a home visit which confirmed Robert's isolation and a need for move to accommodation with more social interaction.

6.2.4 The monthly CMHT monitoring continued and noted that Robert was unsettled but supported by GP and trying to move. It was considered that Robert had good insight into his mental health.

6.2.5 Robert was able to identify that the solution to his predicament of isolation and fragile mental health would be a move to extra care housing.

6.2.6 In December 2020 Robert was accepted by SCC Housing Allocations for Potters Court Extra Care Unit. By this time the care provider was visiting daily.

6.3 Period 3: Preparing to move: Jan 2021-June 2021

6.3.1 Prior to the move to Potter's Court, a care and support assessment was undertaken which concluded that Robert needed more than 15 mins care, daily for medication support. It was recorded that all other needs were being met by his family and Robert felt he was a burden, which was having an impact on his mental health.

6.3.2 Robert's needs were assessed as requiring 12 hours support per week for shopping, cleaning, laundry, community access and daily prompts for medication and personal care (appropriate clean clothes, hair combed etc.).

6.3.3 At this point it was also identified that Robert was eligible for S117 Aftercare provision and had been since 2003. The assessor informed Robert that he did not need to financially contribute to his care.

6.3.4 Subsequently, a new package of care with a different provider was offered but Robert declined and wanted to continue with the current privately funded care and his family support until his move to Potter's Court.

6.3.5 As the time for the move came closer, Robert's care needs were viewed, by his family, to be increasing and they felt unable to continue to support him. They reported that he was showing signs of mental health deterioration. He confirmed this to professionals but declined any additional care.

6.3.6 On one occasion, his carers were unable to access the building. The police were called but were unable to respond immediately", due to the high volume of incidents and it was recommended that the carer contact Fire service to gain entry.

6.3.7 It was at this time that Robert reported to his GP that he was not mentally well, sitting by himself, not letting in carers, not sleeping, not taking meds, not eating. Robert told the CMHT worker that he was worried about moving. Then he moved into Potter's Court and commenced with a new package of care provided by Apex Care.

6.4 Period 4: settling in new home: July 2021-Sept 2021

6.4.1 Robert was reported to settle in to his new flat and the care package was going well. He had support from housing and CIS for modifications to the home, prior to the CIS discharging him.

6.4.2 However, during these early weeks, Robert's family raised concerns with services about Robert not being able to cook or bathe. Both family and carers reported that Robert was finding it difficult to navigate the building. Carers were helping him, but his family considered that he should have ground floor accommodation.

6.4.3 In August 2021, Robert started to experience physical pain which increased over the following weeks. At this time, the carers reported that he appeared disorientated and was continuing to have difficulties using the lift.

6.5. Period 5: Deteriorating physical health: Sept 2021-Nov 2021

6.5.1 In September 2021, Robert's physical health deteriorated to the point that he was admitted to hospital.

6.5.2 Between September 2021 and the end of October 2021, Robert had three admissions to hospital.

- Admission 1: (17-18th Sept 2021) - lymphoma diagnosis and treatment plan
- Admission 2 (28 Sept-7 Oct 2021) – he was admitted as an emergency following review at the lymphoma clinic with obstructive jaundice and worsening abdominal pain. On discharge from hospital there was no change to his care package. The hospital noted that Robert had a twice daily package of care, and his daughter was moving in part time.

  Following the discharge back to Potter's Court, Robert's carers reported that he seemed to be having problems in managing his medication and was spilling water. On one occasion they reported that he took an accidental 'overdose'[2] of oramorph[3]. The carers reported that Robert had drunk directly from the bottle, and subsequently presented as more disorientated than usual. This led to admission 3.
- Admission 3: (13 -27 Oct 2021) Robert was admitted as an emergency after presenting at Macmillan Acute Oncology Service with abdominal pain. His daughter reported that he seemed more confused. On admission there was a safeguarding referral made due to the incident involving the oramorph. There was a delay in discharging Robert due to a need to increase his care package to four times a day.

  During his admission, Robert was reported to present as disorientated, with low mood and auditory hallucinations. He was seen by a psychiatrist who knew

[2] In the combined chronology there is an account from ASC records of a conversation with the hospital staff and Apex Care, in which it was reported that Apex Care used the terminology of 'overdose'.

[3] Oramorph = morphine, a strong painkiller for severe pain. Prescription only. Available in tablet, capsules, granules or a liquid for oral use. https://www.nhs.uk/medicines/morphine/about-morphine/

him and considered that he was disorientated due to he strange surroundings but that his mental health had not deteriorated.

6.5.3 Robert was discharged with a revised care package, but his family remained concerned about his increasing disorientation.

6.5.4 Over the following days, Robert's family raised concerns with the care provider that the carers were not supporting him. One of his daughters stayed with him most nights.

6.5.5 During this time, Robert was found wandering outside his flat. His family, and the carers requested respite care for him. Robert considered a move to a ground floor flat but, due to it being very dark, decided against it.

6.5.6 On the morning of 09 November 2021, Robert was found deceased in the garden under the balcony of his flat.

7 FINDINGS

7.1 The effectiveness of transition planning from Robert's previous accommodation to the accommodation on the fourth floor

7.1.1 Robert was assessed for his suitability for extra care housing in September 2020 by a Housing and Community Care Officer. This assessment included information about Robert's mental health needs and his sight impairment. It included evidence about his level of isolation and dependence on his family, in part resulting from his accommodation in a 3rd floor flat in a walk-up block.

7.1.2 This assessment was used to inform decisions about Robert's suitability for the Potters Court scheme at a meeting held on 1st December 2020. At this point Robert was accepted within the scheme.

7.1.3 The SCC serious incident report found that there were no minutes or formal notes from the 'Panel Lettings & Allocation' meetings held in March 2021, which considered Robert's application to Potter's Court. However, a spreadsheet used by the panel noted 'any 1 bed' under Robert's name.

7.1.4 The sensory assessments undertaken at this time did not identify any concerns about the need for a ground floor flat for Robert. Subsequently, Robert viewed the 4th floor flat in June 2021 and proceeded to sign the tenancy.

7.1.5 In consideration of someone who was visually impaired, moving to a flat that required them to be able to navigate corridors and lifts to be able to get out into the community, there needs to be an assessment, and implementation, of any training needs to enable the individual to navigate their new surroundings. For Robert, he was assessed within his flat but not for beyond that. This was discussed at the practitioner event where it was explained that Potter's Court was a new complex. The top floor and ground floor were the first to be occupied. The ground floor flats were kept for those who were physically unable to be on a higher floor. As Robert's needs were urgent and there was good lighting in the flat viewed, this was chosen, and he was one of the first to move in. At the practitioner event, it was explained that, if there had been concerns about Robert getting to the lift from the flat, it would have been expected that this would have been raised by him at the viewing. The Apex carers explained that they helped him to navigate the complex. This was a missed opportunity to check with him when he moved in and for the carers to be advised on what options were available if Robert needed further support.

7.1.6 What happened at the viewing is not clear. There are conflicting views as to whether Robert was accompanied by one of his daughters at the visit. The Housing support officers who conducted the viewing remain adamant that there was a woman with Robert who seemed to be his daughter. However, his daughters are equally adamant that neither of them was there, due to Covid, and they had trusted the Independence Service worker to find the right flat.

7.1.7 In light of this review considering professional practice, the reviewer concludes that the record keeping of the housing and Independence services need to be strengthened in the future to ensure that there is clarity about family members and their understanding of what is happening for their loved one.

7.1.8 There seemed to be insufficient communication between the professionals responsible for Robert's transition to Potter's court and his family. It was reported at the practitioners' event that Robert was assisted by his family to

move into Potter's Court in June 2021. However, Apex Care found Robert wandering his flat, on the first evening, without his furniture being set up. This led to the carers having to put him in the show flat for the night.

7.1.9 From the chronology provided, there seemed to be assumptions made by housing workers about the extent to which the family could help Robert. For the family, they viewed Robert as having a care package and services to help him. There seems to have been some misunderstanding as to what the extra care tenancy would actually provide versus Robert's own independence. His family expected a care package, whereas the facility was set up for those individuals who needed limited support to maintain their independence.

7.1.10 From day one of Robert being at Potter's Court, the Apex carers raised concerns about how Robert could access the lift and they reported that he never went to the lift alone. There should have been a review of how he was managing within the first few days, with a contingency plan for any complications. In relation to the lift, this could have included some training for Robert to enable him to access the lift independently or tactile signage provided. Neither the documents considered as part of this review, or the practitioner event, were able to provide confirmation of what training Robert was offered. There were varying views of what Robert wanted at this time and it is difficult to see his voice in the records.

7.1.11 At the start of Robert's tenancy, and prior to his subsequent health problems, there were some concerns raised that he was not managing well in the extra care housing. In July 2021, the Housing Support Worker had notified the ASC Independence Advisor (IA) that Robert was struggling with day to day living due to his visual impairment and asked for an assessment in Robert's new environment. However, the IA reported that Robert told them that he was settling in, with the carers helping him and he had a one cup kettle to stop him from spilling water.

7.2 Where Robert was known to a number of different care agencies with subsequent changes to his package of care, what processes were in place to allow for a comprehensive handover?

7.2.1 The care packages were managed, initially by Robert himself. He was used to asking for changes to the provision, usually a reduction in the number of visits. Prior to his transfer to Potter's Court, he had 12 hours a week, including a shopping call, domestic support, community access and daily medication prompts. When he moved to Potter's Court, Apex Care received a risk and task plan from SCC care placements but did not receive any documentation in relation to his previous package of care. However, their initial assessment of Robert recorded that Robert agreed to manage his own medication with his daughters' support, plus supervision at night from Apex Care to ensure he had the correct medication put out for him to take. This seemed to a misinterpretation what had been in place with the previous carers. They had provided a daily medicines visit, in the evening, as this was when he took his prescribed medication.

7.2.2 Robert's daughters reported that he never had more than 7 hours a week whilst at Potter's Court, yet they thought he was supposed to have 12 hours a week as he had in his previous flat. Apex Care reported that Robert received between 8 ½ and 14 hours a week care during his time at Potter's Court. As he did not use the social time he was allocated, Apex Care agreed with Robert, at his 6 week review, that they would split the hours to provide 15 minutes pop ins, which they reported that Robert was happy with. They called in the evening to help with medication.

7.2.3 In regard to the support for medication, Robert's daughters raised concerns that Robert's medication was not locked away once he had moved to Potter's Court. It came to notice that his previous carers had locked the medicines away due to Robert's mismanagement. However, this was not shared with Apex Care, and it was not clear how this arrangement had been put in place by his previous carers. In his care plan it was stated that his medication was to be administered by the carers, but there was no mention of medication storage in the risk assessment.

7.3 Is there evidence that agencies involved in Robert's care completed, implemented and monitored risk assessments and safety plans in relation to Robert's accommodation/living arrangements as well as his mental health?

7.3.1 Following Robert's move to Potter's Court he was visited by the support services, including the CMHT and the sensory worker, to assess any need for changes. There was a sensory assessment, and this concluded that he was managing well and no amendments were needed. At the practitioner event, the worker spoke about the balcony, and this raised no concerns regarding Robert's ability to manage to use it, and that he was seen to navigate it well as his grandchild was sitting out there during the visit.

7.3.2 The CMHT did not note any concerns about the move and recorded that Robert was happy with his flat and had a good relationship with his family. In the CMHT's visits, it was noted that Robert was compliant with his medication and was supported by a daily visit by carers to do this. However, there does not appear to have been any liaison with the carers to ensure that they understood the importance of the medication.

7.3.3 There were reviews by Apex Care which indicated that Robert had settled well and was happy with the support. Despite there having been concerns raised by the Apex carers and the family about how Robert was coping. These discrepancies were not in evidence as being addressed within assessments undertaken during Robert's time at Potter's Court.

7.4 Was the package of care in place for Robert following his discharge from hospital, communicated to all relevant agencies involved in his care and felt to be sufficient to meet his needs?

7.4.1 In September 2021, Robert called an ambulance due to increasing physical pain. He was taken to hospital where investigations showed that he had lymphoma. The hospital clinical records noted that he was discharged four days later. There are discrepancies in the records in relation to the length of the first hospital admission as the hospital discharge team records suggest that Robert only stayed one night and then returned to the hospital during the subsequent days, as an outpatient. At the practitioners' event, the hospital discharge team

explained that Robert had not actually been admitted to hospital on this occasion and so had not been on the discharge pathway. It was confirmed by the clinical team that he was admitted to the Acute Surgical Unit, via the emergency department and diagnosed with lymphoma. There was a health multi-disciplinary team meeting held to discuss a further management plan. It was noted that the diagnosis was discussed with Robert and his daughter was updated about the prognosis and management options. There seems to have been no discussion with the Apex carers about his care package.

7.4.2 When Robert returned to Potter's Court, his daughters reported that he had no carers for three days as it was too late to add him to the roster. However, Apex Care report that his care was resumed immediately after all discharges from hospital. It is unclear as to why there was this difference in the perception of Robert's experience at this time. Within the hospital records, it was noted that Robert's family were with him when he was went home. As it appears that he was not formally admitted or discharged, because he went to the Acute Surgical Unit rather than a ward, there was no consideration of what Apex Care were providing at this point, or what communication needed to be made with them. This was a missed opportunity by the hospital services to ensure that an individual with care and support needs, who had just been diagnosed with cancer, was fully assessed and for liaison with the services already providing support to him.

7.4.3 When Robert was discharged from hospital on 7 October 2021, there was a request made by the housing and community care officer to the discharge team for an increase in the care package to be arranged prior to discharged. This was declined by the hospital discharge team. It was reported, at the practitioners' event, that the Apex carers asked about an increase in the care package but reported that the hospital ward staff said he would have his daughters with him. His daughters confirmed to the reviewer, that they increasingly stayed with him at night, following his diagnosis, due to their worries for him, he was scared and devasted at the diagnosis but wanted to fight to keep living. However, the hospital discharge team records note that there was a request for an increase in the care package, and the response that a new referral would

need to be added to the discharge system. Subsequently, the final discharge checks were put in place for Robert to continue with his previous care package. The reason for this was that the hospital discharge officer had confirmation from Apex Care that they were happy to have Robert back with the same level of care he had previously, as the family would be staying with him.

7.4.4 Following discharge, Robert had become increasingly confused and was reported to be mismanaging his medication, at times. This included, on one occasion, taking an accidental 'overdose' of oramorph. It was reported at the practitioners' event that the carers had not been aware that he had oramorph oral solution, only morphine tablets. This would indicate insufficient liaison between the hospital, GP and care provider. Given that one of the long term, key aspects of Robert's care package was for support in managing his medication, this should have been a priority in his discharge plan.

7.4.5 In the 3rd admission to hospital, there was a recognition that Robert needed an increase in his care package. This led to a delay in him being discharged whilst this was put in place. The care package was increased to four times a day. Robert's family commented that although the care package was increased, it was supposed to be 12 hours a week anyway, yet he was still not getting the time he needed. However, at the practitioners' event, the carers reported that the family turned them away as they wanted to support their father himself. This meant that there was a difference in the recording of what care he was offered, and what he accepted. There were periods during the day when Robert was alone, he struggled to find the toilet and was becoming disorientated in his flat. His daughters reported that they would find him sat in darkness, in wet clothes when they returned in the evenings.

7.5 What was known about Robert's use of cannabis oil and the impact of this on his mental state?

7.5.1 There was no professional knowledge of Robert using cannabis oil, prior to his death. The only record of cannabis oil was when tablets were found when he was in hospital in October 2021. On the first occasion, 16 October 2021, several capsules were found all over the floor by Robert's bed. He was informed and

agreed to put them in the bin as they had been on the floor. He reportedly declined to give any details about the capsules. Then on 18 October 2021, 25-35 capsules were found in Robert's dressing gown pocket. These were put in a lidded container in his room, and it was documented in the nursing records that the doctor had been informed. There was a note in the medical records, on 21 October 2021, that Robert had started taking cannabis oil the previous week. However, it does not appear that there was a follow up to check about the impact of the cannabis oil on Robert's mental wellbeing, and in consideration of his other medication. Nor was any of the information, about the cannabis oil capsules, shared with any other agency. The carers who supported him with his medication were aware that he was taking vitamins, but he did not do this under their supervision as they informed his family that they could not as it was not within their procedures.

7.5.2 There were reports following his death that the police found cannabis oil (Rick Simpson oil)[4] in the flat. There were also reports, at the practitioner event, that a cannabis-based solution had been found in the hospital when he was admitted on the third occasion. However, this does not appear to have been checked with him or the family, but just put away in a cupboard. The type of cannabis oil being used is reported to be high in the psychoactive chemical in marijuana[5], however, in Robert's case it is not possible to know the purity and strength of the tablets in his cupboard. Given that Robert was known by this time to not be able to manage his medication and had, at least once, taken too much oramorph, there should have been exploration of how he was managing to take the cannabis oil. During this admission he was reviewed by liaison psychiatry due to concerns he was reporting hallucinations and seemed more disorientated. It was reported that Robert had declined several doses of his usual olanzapine and mirtazapine during admission and once these were

[4] Rick Simpson Cannabis Oil is advertised as being able to help cancer sufferers, including to reduce nausea during chemotherapy treatment. https://www.webmd.com/cancer/rick-simpson-oil-for-cancer-overview

[5] The oil, unlike other cannabis-based oils, contains high levels of tetrahydrocannabinol (THC), which is the main psychoactive chemical in marijuana. https://www.webmd.com/cancer/rick-simpson-oil-for-cancer-overview

recommenced his symptoms improved. It is not clear whether he continued to take the cannabis oil during this time.

7.6 Is there evidence that agencies worked collaboratively and effectively together to help meet Robert's needs whist acknowledging his views and wishes?

7.6.1 Throughout the chronology, there was evidence of Robert's views and wishes being heard by agencies. It was known that he was very independent. This seemed to be fully acknowledged and that he had the capacity to make unwise decisions.

7.6.2 There were gaps in the communication between agencies during the final year of his life. Prior to the move to Potter's Court, there was miscommunication as to what involvement the family had in the decisions and planning of the move. There was no plan in place to respond to the family and frontline carer concerns raised shortly following the move, that Robert was reported not to be able to manage on the 4th floor. This had the potential for him to be isolated, yet it was noted in the records of the agencies visiting him, and the Apex Care Review, that he had settled in well and was happy. Despite there being multi-agency liaison regarding Robert, the concerns being raised by this time by both his family and the frontline carers, did not appear, from the information provided, to have been sufficiently addressed. This might have been due to him telling housing, ASC and CMHT workers that he was fine. This raises the question of how family concerns are considered when an individual with care and support needs is reporting that they are satisfied with the provision.

7.6.3 Once Robert became physically unwell and was found to have cancer, it is the reviewer's opinion that agencies did not work effectively to support him. It was already known that he needed support to manage his medication and his mental health was affected by isolation. The agencies visiting him, and the hospital services, did not come together to consider the care plan for how his needs might change over the following months, during treatment. There was a perception that his family were caring for him and the carers were turned away, at times.

7.7 Following his diagnosis of cancer in September 2021 , was Robert given information and was the support available discussed with him?

7.7.1 There was information noted that Robert was seen in the Outpatient's clinic, with one of his daughters, to discuss the cancer diagnosis. During his admissions, he was spoken to, but his daughters reported that no clinician spoke directly to them, although it was noted in documentation that one of his daughters accompanied him to the Outpatients clinic.

7.7.2 Considering that this was during Covid restrictions, then the reviewer concludes that there were limited opportunities to discuss the diagnosis with Robert, when his family were allowed to be with him. Nevertheless, Robert was provided with information and his daughters contacted the GP to ask for a referral to a MacMillan Nurse. It would have been of benefit for the referral to have been offered in September 2021, following the diagnosis, to help Robert, his family, and carers, to understand what he would need in the way of home care during his treatment.

7.7.3 There seemed to be no link made with his mental health history and the impact that the cancer diagnosis, and chemotherapy treatment, might have on his mental wellbeing. The CMHT was involved at this stage but did not appear to have provided advice and support for Robert, in terms of the impact of his diagnosis on his emotional wellbeing.

7.8 How were Robert's family involved and were the concerns from the family addressed adequately?

7.8.1 From the information provided, it was clear that there was no shared professional understanding of the family involvement, and a lack of evidence of effective communication with them. It is recognised that Robert had the capacity to choose whether to include his family in decisions, and he was noted to not want to burden them. Nevertheless, in the knowledge that his family were involved in supporting Robert, then agencies should have included them in plans for his care. This would have enabled a better understanding for the family as

to what was being provided and how they could communicate with agencies if they had concerns.

7.8.2 The views of Robert's daughters are vastly different from those of the professionals involved in his care. The reviewer's assessment of this is that there were assumptions made about the family involvement and their views were not sought in planning their father's care, throughout the preparation for his move to Potter's Court, until his death.

7.8.3 This has meant that Robert's daughters continue to have unanswered concerns about their father's care, whether valid or not, because services have not communicated effectively with them.

7.8.4 There seemed to be ineffective communication with the family prior to Robert's move to Potter's Court, which led to him being left without proper furniture on his first day there.

7.8.5 Robert's daughters told the reviewer that they were not spoken to by any clinical staff at the hospital when he was there, they were updated by Robert himself by telephone, due to the Covid restrictions.

7.8.6 Robert's daughters reported that they started to raise concerns, with Apex care, about the care of their father from when he moved to Potter's Court. They continued to raise concerns in August 2021, when he became disorientated, and reported that they raised formal complaints about the carers in September and October. As Robert's health deteriorated, his daughters were in almost daily contact with the GP regarding their concerns for his deteriorating health. Robert's daughters reported to the reviewer that they felt that no one cared and that they were constantly chasing for support. The extent of the family concerns was not evident in the professional records and was, reportedly, not known to all of the services involved with Robert's care during his final months of life.

7.8.7 Robert was discussed at the weekly housing meetings following his discharge from hospital on 27 October 2021. At a meeting on 8th November 2021, it was noted that the Apex carers were requesting respite care for Robert and reporting that his family had 'carers' fatigue'. This implies that it was viewed that the daughters had been providing care for their father. There was no clear care plan for Robert, as to what was provided, by whom and what needed to happen

if the care was not being provided, i.e., if his family were providing the additional care whilst he was having cancer treatment, it was not clear what arrangements were in place for if they were unable to continue this.

7.8.8 The SCC Serious Incident identified that Robert's daughters, although known to be actively involved in his care and support, were not offered Carer's Assessments at any point. This was a significant gap in the practice of all services involved in Robert's care. Mental health, primary care, acute health services, care providers and housing support should have identified that, as the daughters were involved in Robert's care, that there should have been a referral to ASC to offer Carers' assessments.

8 REVIEWER'S CONCLUSIONS

8.1 The reviewer has identified the following themes for wider learning for Southampton services. These conclusions were informed by the reflections of practitioners at the event in December 2022.

- **Communication and escalation**
- **Sharing information with care providers regarding client mental health presentations**
- **Safe discharge planning**
- **Hospital liaison with carers re medication**
- **Involvement of family members in care packages**
- **Use of cannabis-based alternative medication**

8.2 Communication and Escalation

8.2.1 The reflections of the practitioners at the event held in December 2022 were overwhelmingly that there needed to be changes in communication. This issue can be considered in terms of multi-agency communication in the planning for Robert's move, when he was diagnosed with cancer, and how agencies communicated with his family.

8.2.2 Inter-Professional Communication

8.2.2.1 In Robert's case, there was no lead confirmed to co-ordinate his care. He was open to the CMHT, but it was not made clear about the wider responsibilities

for the role of the team, beyond his mental health. There was no clear pathway of escalation for any concerns about his care, and therefore no MARM being considered.

8.2.2.2 When an individual has care and support needs which they need assistance to manage, there needs to be consideration of who will take responsibility for any concerns. Each agency should have knowledge of others involved in the care of an individual, with contact details of a named professional available to enable communication. This should include the promotion of the use of shared care plans to strengthen the communication between services to encourage seamless care to the individual.

Recommendation1: For SCC to demonstrate how they gain assurance that homecare providers ensure that their staff are aware of how to raise safeguarding concerns about the care of individuals.

8.2.3 Communication with families

8.2.3.1 There were numerous gaps in the communication with Robert's family. There seemed to be assumptions made about what care they were able to provide. There were accounts of care not being provided due to Robert's daughters saying that they would be there for him or refusing the care. Yet there was no exploration as to whether this was what Robert, or his family, wanted and what this meant for the services. This did not equate with the concerns being raised by the family.

8.2.3.2 It is important that families' views are heard, discussed and the outcomes recorded when an individual has a care package in place. The views of family members can help to evaluate the effectiveness of the care package and identify any gaps. Best practice is the use of the triangle of care[6] which promotes the recognition of the essential role of carers and how agencies

[6] https://carers.org/downloads/resources-pdfs/triangle-of-care-england/the-triangle-of-care-toolkit.pdf

should engage with carers, through a clear governance framework for safe information sharing.

Recommendation 2: SCC, the ICB, Southern Health NHS Foundation Trust, and Apex Care should review their procedures for how family, informal carer, feedback is used when there is a care package in place for an individual.

8.3 Sharing information with care providers regarding client mental health presentations

8.3.1 At the practitioner event, Apex Care stated that they were aware of Robert's mental health background prior to him arriving at Potter's Court, as it was included in the SCC risk assessment. However, they reported that he had not displayed any mental health deterioration during his stay and there were no concerns that would have led the carers to contact his mental health team. They reported that they would now ask to see mental health risk assessments to help them look at what support they needed to help a resident.

Recommendation 3: Southern Health NHS Foundation Trust should ensure that staff are aware that when an individual is known to have a significant history of mental health issues and is open to CMHT, the risk assessment must be shared with the social care provider, with the consent of the individual.

8.4 Safe discharge planning

8.4.1 In Robert's case, he was discharged, following the admission on 7 October 2021, on pathway 0.[7] This was despite a request from the housing allocations team for an increase to his care package to be activated by the hospital discharge team. The decision for him to not have an increased care package was due to it being confirmed that Apex Care were accepting him back on the previous level of care, and that his family were with him. This led to him being readmitted

[7] DHSC (2022) Hospital Discharge and Community Support Guidance. https://www.gov.uk/government/publications/hospital-discharge-and-community-support-guidance/hospital-discharge-and-community-support-guidance

within a week due to him being placed at risk. Other SARs have identified risks when discharging patients on this pathway who have changes to their care and support needs.[8] It is essential that discharges from hospital do not place an individual at risk of harm.[9] Yet discharge coordination is a prominent feature in SARs nationally, as well as failures to share information effectively.[10]

8.4.2 There needs to be more scrutiny of those individuals being discharged to assess on pathway 0, in which they either do not have a care package or no changes to be made. In these cases, there should be checks made with the care provider to promote a shared understanding of any changing needs.

Recommendation 4: There should be a review of discharge planning at UHS, between SCC, UHS and Solent to ensure that those being discharged on pathway 0, are those who do not have packages of care. This means that pathway 1 should be used for those who have packages of care, to ensure that they have the support they need, even if there are only minor changes to the package.

8.5 Medication Management

8.5.1 Apex Care report that they have strengthened the training for staff in relation to medication management. Robert had long term support to manage his medication, yet there was insufficient understanding of the reasons why he needed help. It seems to have been viewed as being due to not being able to see, but his family raised concerns, shortly before his death, that the medicines were not locked away. This would indicate that the reason was also Robert's mental health concerns, but this was not confirmed.

8.5.2 When an individual has a care package to support them manage their medication, there should be a clear plan for what is needed and how this will be achieved, alongside medication reviews.

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[8] Sutton SAB (2022) MR F Learning Review

[9] Red Cross (2018) In and Out of Hospital. https://www.redcross.org.uk/about-us/what-we-do/we-speak-up-for%20change/more-support-when-leaving-hospital

[10] Preston-Shoot, M. et al. (2020) *Analysis of Safeguarding Adult Reviews April 2017 – March 2019: Findings for sector-led improvement.* LGA.

8.5.3 When the medication plan changes, the prescriber must ensure that this information is provided for the care plan to be updated. Information sharing protocols between prescribing agencies and those responsible for an individual's care plan should reflect the need to undertake this.

Recommendation 5: Apex Care should undertake a review of care plans to evaluate the impact that learning has made on improving staff practice in helping residents with medication management. This should then be shared with SSAB, SCC and the local Care Provider forum, to be considered as a model for good practice.

8.6 Involvement of family members in care packages

8.6.1 The national report on SARs, found that families were frequently not included in the care planning for their loved one, despite their close involvement with the individual.[11] There needs to be a firmer commitment by all agencies working with individuals with care and support needs to speak to family members. This should promote the opportunities to check on the views and needs of those providing unpaid care.

Recommendation 6: For SCC, there needs to be a section to record the 'family views' in assessments and reviews for packages of care commissioned by SCC, or the individual's request not to include the family.

8.7 Use of cannabis-based alternative medication

8.7.1 This review has identified concerns regarding the potential impact of Robert's use of cannabis oil. Cannabis based alternative medication is available to buy online. However, there is insufficient evidence to demonstrate that they can be of benefit and are perceived to have the potential to be dangerous.[12] The oil that was found in Robert's cupboard seems to have been one that had high levels of

[11] Preston-Shoot, M. et al. (2020) *Analysis of Safeguarding Adult Reviews April 2017 – March 2019: Findings for sector-led improvement.* LGA.

[12] Some products brought online, including those called CBD oils, are likely to be illegal to possess. They might contain THC and may not be safe to use. https://www.nhs.uk/conditions/medical-cannabis/

tetrahydrocannabinol (THC), which is the main psychoactive chemical in marijuana.[13]

8.7.2 There needs to be awareness raising across all services about the need to check the safety of cannabis oil used by individuals who have been prescribed morphine as it can be contra-indicated.[14] Therefore, the prescriber should always be made aware to enable them to make the decision as to whether or not to prescribe morphine in these situations.

Recommendation 7: UHS must ensure that staff report to the prescribing clinician evidence of patients taking cannabis-based alternative medication, to produce a holistic clinical picture and to be able to assess any contra-indications with prescribed medication.

[13] https://www.webmd.com/cancer/rick-simpson-oil-for-cancer-overview
[14] https://www.nhs.uk/medicines/morphine/taking-morphine-with-other-medicines-and-herbal-supplements/