Essex Safeguarding Adults Board

ESSEX SAFEGUARDING ADULTS BOARD

SAFEGUARDING ADULTS REVIEW REPORT

Case of Sonia, died September 2017

Report author: Althea Cribb

Final Report completed: May 2022

CONTENTS

1. THE SAR PROCESS 3
2. TERMS OF REFERENCE FOR THE SAR 3
3. PARTICIPANTS IN THE SAR 4
4. INVOLVEMENT OF FAMILY 4
5. AUTHOR OF THE REPORT 5
6. PARTNERSHIP LEARNING EVENT 5
7. ABOUT SONIA 6
8. SUMMARY OF THE CASE 6
9. INFORMATION FROM THE FAMILY 9
10. FINDINGS 10
11. LESSONS TO BE LEARNED 17
12. ORGANISATION LESSONS TO BE LEARNED 22
13. RECOMMENDATIONS 25
14. APPENDIX: LEDER RECOMMENDATIONS THAT REQUIRE UPDATES 27

1. THE SAR PROCESS

1.1. This report outlines the process undertaken by the Essex Safeguarding Adults Board in reviewing the period of care prior to the death of Sonia.

1.2. Sonia died in September 2017, aged 60. She lived with her brother, who also had care and support needs.

1.3. The cause of Sonia's death was given by the coroner as "natural causes (1) Deep-Vein Thrombosis (2) Pulmonary Embolism".

1.4. The SAR process began with the decision of the Essex Safeguarding Adults Board to hold a Safeguarding Adults Review (SAR). The Southend Essex and Thurrock Safeguarding Guidelines state the Board must arrange a SAR "when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult."

1.5. All agencies that potentially had contact with Sonia were asked to confirm whether they had been involved. Chronologies were requested from relevant agencies and a composite chronology was created.

1.6. The initiation of the SAR was delayed due to the completion of the LeDeR review and report first. Once that had been finalised, the ESAB SAR Committee agreed in April 2020 that a SAR was needed due to the LeDeR not covering all relevant services involved in Sonia's care. A further delay took place due to the impact of Covid on organisations being able to resource SAR processes, and it began in 2021.

1.7. A Partnership Learning Event was held with representatives from the agencies (see section six). The representatives met again to review and agree the draft report. The report was reviewed at the Safeguarding Adults Review Sub-Committee in April 2022 where amendments were requested, and an amended version shared with the Sub-Committee in May. The report was then reviewed at the Essex Safeguarding Adults Board on 18 July 2022, where it was approved, and publication agreed.

2. TERMS OF REFERENCE FOR THE SAR

2.1. The SAR considered the period 1 September 2016 to the date Sonia died in September 2017, to gain an understanding of the period when Sonia had most contact with a range of agencies.

2.2. Based on the information gathered from agencies, the following terms of reference and key themes were identified:

- Develop an understanding of Sonia's vulnerabilities, her health and care needs, capacity to care for herself and her level of independence and consider:
    - How she was supported through existing adult safeguarding procedures.
    - How effective was inter-agency collaboration, communication and information sharing in providing support for Sonia.
    - Whether different approaches could have been considered.

- What preventative actions could have been taken by agencies that may have reduced the possibility of Sonia's health deteriorating.

- Identify whether agencies complied with any safeguarding protocols that have been agreed within and between agencies including protocols covering: raising safeguarding concerns; information sharing; and risk assessment, management, and review.
- Identify any difficulties agencies encountered when supporting Sonia that impacted on the case.
- To what extent did practitioners listen to the voice of Sonia? Were her wishes and feelings heard and considered?
- Explore the extent to which Sonia's brother was involved in his sister's care; to what extent was information from her brother, whom she resided with, sought, and considered by practitioners involved in Sonia's care?
- How effective was inter-agency collaboration, communication and information sharing as both Sonia and her brother, living in the same household, had care and support needs?
- Identify any best practice that was in place.
- Identify lessons to be learned to improve future professional practice, including reviewing the investigations/reports already completed and incorporating the findings.

3. PARTICIPANTS IN THE SAR

3.1. The following agencies participated in the SAR:

- Basildon and Brentwood Clinical Commissioning Group (CCG)
- Sonia's General Practice (GP)
- Essex County Council Adult Social Care (ECC ASC)
- Essex Partnership NHS Foundation Trust (EPUT)
- North East London NHS Foundation Trust (NELFT)
- Summercare

3.2. A care provider for Sonia, Dial A Carer, is no longer operating.

4. INVOLVEMENT OF FAMILY

4.1. Sonia's brother was invited to contribute to the review by his allocated ECC ASC Social worker and the ECC ASC SAR Panel representative (a Service Manager). This approach was chosen by the SAR Panel to ensure that, given the time that had elapsed between Sonia's death and the SAR taking place, the discussion took place

with someone already known to Sonia's brother. Specific questions were set by the SAR lead reviewer, to be used within the conversation if needed.

4.2. Sonia's brother agreed to speak about the time before Sonia passed away and the Service Manager made him aware that if at any time it was upsetting or he wanted to stop, they would do so. The Service Manager set the context to the SAR, explaining that we wanted to understand not just about how Sonia had died but also to review the care she had received prior to her death.

4.3. While Sonia's brother understandably became upset at times when speaking, he appeared to enjoy the company and having a chat. The Service Manager explained the reason for undertaking a SAR and Sonia's brother said that he would like a copy of the report. When asked how he would want to receive this, with some options provided, he thought it would be good for his allocated worker to bring round and support to go through. This will be arranged once the report has been finalised.

4.4. Sonia's brother's views have been incorporated into this report.

4.5. Sonia's brother also provided the pseudonym used in this review.

5. AUTHOR OF THE REPORT

5.1. The independent report author was Althea Cribb. This is Althea's third SAR as Lead Reviewer. Althea has also delivered over 20 Domestic Homicide Reviews since 2013, including a number which have covered adult safeguarding concerns and issues, through which Althea has developed expertise in this area.

6. PARTNERSHIP LEARNING EVENT

6.1. Due to the time passed since Sonia's death, participating organisations were not able to identify members of staff who had worked directly with Sonia. They were therefore represented by appropriate managers or safeguarding leads.

6.2. For the learning event, the lead reviewer gathered the available information from agencies to facilitate discussions with participants to attempt to understand Sonia's lived experience, and to identify the good practice and learning in relation to the Terms of Reference.

6.3. Due to the length of time between Sonia's death and the SAR (four years), the Partnership Learning Event reviewed and discussed the learning identified with a focus on what had changed since Sonia died, and what learning still required action.

6.4. Following the learning event, the lead reviewer wrote the report, and a draft was shared with participants and discussed at a further meeting.

7. ABOUT SONIA

7.1. Sonia was aged 60 when she died. She lived with her brother in a property that had previously belonged to their parents and had passed to Sonia and her brother when their mother died in 2006 (their father died in 1996).

7.2. Sonia was described as a sociable woman who enjoyed the company of others. She enjoyed reading magazines, newspapers and occasionally books, especially about dogs. She enjoyed watching soaps, police dramas and gardening programmes.

7.3. Sonia told practitioners she had been with the police cadets and had then worked at a hospital for several years, a job she had taken great pride in. She had not worked since leaving that job in the 1980s. She left her job after an incident in which she was attacked. She experienced anxiety after this when out in the community and relied on her mother to be with her.

7.4. Following their mother's death, both Sonia and her brother were known to ECC ASC and Sonia had care and support plans in place from October 2006. Sonia's needs included her mental health following the death of her mother and an earlier nervous breakdown (linked to the event in the 1980s); mobility; socialisation; finances; transport / independent travel. Sonia's brother's care and support plan started following a stroke in 2011 and was increased following a second stroke some years later. In 2011 Sonia's care and support plan was increased. There were times when Sonia and her brother did not want to receive care, including declining to allow carers into their home.

7.5. Over the period reviewed, Sonia was recorded by practitioners as having a 'learning disability' or a 'mild learning disability'. These views were formed through professional interactions with Sonia, who had not been assessed or diagnosed as having a learning disability: when first in contact with ECC ASC in 2006, both Sonia and her brother told staff that they did not have any learning difficulties or disabilities. This is explored in the learning section below.

7.6. In 2015 Sonia fell, leading to a long period in hospital. During this time, she was prescribed bariatric equipment. Once she returned home, she stopped using the upstairs of the house and became housebound. She didn't have a wheelchair because the existing ramp was too small for an appropriately sized wheelchair (this situation developed, outlined below).

7.7. At about the time Sonia returned from hospital, she and her brother acquired a dog. This was a great comfort to them as they had previously had a break-in and felt vulnerable. Caring for the dog was difficult for them both: they struggled to exercise it, and deal with accidents within the home. Sonia expressed a wish to be able to go out and walk the dog.

8. SUMMARY OF THE CASE

8.1. NELFT: The Integrated Community Team (ICT) District Nurses provided care and treatment to Sonia from May 2015 to her death, undertaking regular visits to treat leg

ulcerations. They conducted a Root Cause Analysis (RCA) shortly after Sonia's death that examined the contact from mid-2017 to Sonia's death.

8.2. EPUT: The Learning Disability Team (EPUT-LD) were involved in Sonia's care from December 2016 following a referral from an ECC ASC Social Worker. Sonia had contact with an Occupational Therapist (EPUT-LD-OT) and Physiotherapist (EPUT-LD-Physio) up to shortly before Sonia's death. They produced an IMR covering their contact.

8.3. Essex County Council Adult Social Care (ECC ASC) were involved with Sonia and her brother from January 2006 onwards. The IMR reviewed the response from September 2016 when NELFT ICT reported concerns that the property was unclean, which led to a referral to the Working Age Adult Team (WAA) South that was subsequently transferred to the WAA Mid Team. The ECC ASC Service Placement Team (ECC SPT) were also involved due to care being commissioned.

8.4. Sonia's General Practice's (GP) involvement was reviewed within the NELFT RCA, and within the SAR partnership learning event which they attended.

8.5. Summercare provided the care package for Sonia, commissioned by ECC ASC SPT, up to December 2016.

8.6. Dial A Carer provided the care package for Sonia, commissioned by ECC ASC SPT, from January 2017 to when she died. They are no longer in operation.

8.7. This section presents key events from September 2016 to September 2017.

2016

8.8. In September 2016 NELFT ICT District Nurses, who were attending frequently to treat Sonia's leg ulcers, contacted ECC ASC Countywide Duty Team with concerns over Sonia's property: that it was unclean with dog faeces and urine soaked into the carpets. This impacted the District Nurses' ability to fully assess Sonia's legs. The Duty Team confirmed the situation with Summercare and referred Sonia to the WAA South Team. A review should have been prompted by this but was not, it is unclear why.

8.9. NELFT ICT continued their visits, including requests to Sonia to ensure the home was clean enough for the District Nurses to carry out the required support and care. This was not done and so a mental capacity assessment was completed in November 2016 to ensure Sonia understood the safety issues. The outcome recorded was that Sonia had capacity and a learning disability; the latter was not a formal diagnosis but the perception of staff.

8.10. In November 2016 Summercare gave ECC SPT notice that they would withdraw care provision to Sonia and her brother due to internal capacity issues. As a result, a WAA South Team Social Worker visited Sonia and her brother to review their care and support needs. They found that Sonia and her brother supported each other to meet some of their outcomes. Sonia required equipment, adaptation, and support to meet specific outcomes and was struggling to access the community, to maintain a habitable home environment, and maintaining her personal hygiene. Sonia was recorded as requiring an Occupational Therapy assessment and both Sonia and her

brother would benefit from a further review to promote their independence. Care packages were commissioned from a new provider by ECC ASC SPT.

8.11. A further review by ECC ASC took place in December 2016, with a different Social Worker from the WAA South Team. During this review, it was identified with Sonia that an element of her care plan was not being utilised because she was not accessing the community. It was also recorded that Sonia's brother met some of Sonia's needs. Sonia's care package was reduced from 14 to 3.5 hours; the rationale was not documented.

8.12. The referral to Occupational Therapy, indicated in the review in November 2016, was made in December to the EPUT Learning Disability Health Occupational Therapy Team (EPUT LD-OT). The referral was for a functional assessment of Sonia's daily living activities to support independence and inform ongoing care and support needs plans. This was screened by EPUT, and contact made in January 2017.

2017

8.13. The new care provider began provision to Sonia and her brother in early January 2017 (a different provider had covered the support required in the interim).

8.14. EPUT LD-OT visited Sonia in February 2017. The outcomes were not clear in the records, but staff reported to the IMR author that conversations were had with ECC ASC WAA South Team, including the need to widen the doorway in the home to improve accessibility for Sonia. She was referred internally for a mobility assessment.

8.15. The LD-OT recorded in March 2017 that Sonia had physical limitations due to ulcers, oedema, bandages, and fear of falls leading to anxiety and lack of confidence around her mobility. She required an outdoor wheelchair, and wider doorways.

8.16. ECC ASC WAA South Team conducted a telephone review in April 2017 in which Sonia was recorded as happy with her care package. She stated she had not noticed the reduction in hours, because she also had the support of her brother's carers when they visited him, including support with all kitchen tasks. Two weeks after the review, the Social Worker requested input from Dial A Carer on the review with regard to Sonia. They responded stating both Sonia and her brother would benefit from a review and offered to do this jointly with the Social Worker. The Social Worker responded that the review was already complete, and requested Dial A Carer's views, which they provided:

"Sonia lives with her brother […] and they help each other with some personal care needs, however these needs are not met to a high standard. Regular carers for Sonia both feel Sonia may benefit from a tea call as carers are doing this at present out of good will during [her brother]'s call. Sonia also has a dog whom carers are letting in and out, cleaning up after and exercising him, he has accidents on a regular basis, Sonia gets very upset when the dog has accidents as neither her [sic] or her brother can clean up after dog. Sonia doesn't appear to mobilise."

8.17. The Social Worker uploaded this 'views of others' form onto the system.

8.18. WAA South Team noted that Sonia and her brother paid council tax in a different area of Essex than covered by the Team, and in April 2017 their cases were transferred to the WAA Mid Team. A telephone call was made by the Senior Social Worker in South to the WAA Mid Team, advising the case would be transferred ready for the annual review, due in 2018. The transfer took place.

8.19. Throughout May, June, and July EPUT continued to have contact with Sonia regarding her mobility, including discussions and attempts to progress the door widening, and access a suitably sized wheelchair to enable her to leave home. NELFT ICT also continued to attend frequently to treat Sonia's leg ulcers. Sonia was discharged by the EPUT mobility service in August 2017, with a request for re-referral once the works were done and wheelchair provided. The EPUT LD-OT continued to have contact with Sonia.

8.20. In August 2017 Sonia reported possible financial abuse from an informal carer/friend. This progressed to a joint visit by WAA Mid Team and Essex Police in September 2017, the outcome of which was for Sonia's brother to take over the management of Sonia's finances.

8.21. The EPUT LD-OT completed their functional assessment of Sonia in September 2017. It had been delayed by the need to know the exact measurements for Sonia's wheelchair and requirements for home adaptations. The report was sent to ECC ASC WAA South Team, which passed it on to the WAA Mid Team and informed the EPUT LD-OT. The LD-OT replied asking who to contact to progress the report's recommendations, and this was also forwarded to the WAA Mid Team.

8.22. From mid-September Sonia told NELFT ICT she felt increasingly unwell. This led to a request for antibiotics from the GP, which were issued three days later. The delay was due to the task not having been marked as urgent and therefore not seen immediately by the GP.

8.23. When Sonia's health further deteriorated some days later, an ambulance was called and she was taken to hospital, but sadly died the following day.

9. INFORMATION FROM THE FAMILY

9.1. Sonia's brother agreed to speak about the time before Sonia died, and the services she received.

9.2. Sonia's brother said that he wished his sister was still here, and that he wanted us all to know that he missed her very much. He also recently lost their dog and spoke fondly about when Sonia had wanted to get him.

9.3. Sonia's brother said that he did not think Sonia was getting enough help with food or with washing herself, also help with a little bit of cleaning. He told the Service Manager that his carers had ended up supporting with Sonia's meals. Sonia's brother explained that on one occasion an ambulance had come round to support Sonia with getting either back in or out of the home and she fell/slipped, nearly hitting her head. Sonia's brother said that from this point onwards Sonia was scared of

going out. He said before that, they did go to places together. Sonia's brother thought it would have been good for Sonia to have had support to go out.

9.4. Sonia's brother explained that Sonia's legs were in bandages, and he did think the nurses could have done more for her with her legs, in terms of getting her on antibiotics earlier; he talked about these needing to be intravenous.

9.5. Sonia's brother's feedback is gratefully received by the review, and helpfully adds to our understanding of what it was like for Sonia in her contact with services. It supports the findings below, particularly in relation to recording Sonia's and her brother's care and support needs separately and exploring Sonia's needs and wishes in a holistic way, including barriers to going out into the community.

10. FINDINGS

10.1. Individual agency and multi-agency findings have been collated into themes, presented below with reference to the six guiding principles underpinning the *Southend Essex and Thurrock Safeguarding Adult Guidelines v.5* (April 2019).

- Empowerment: Adults are encouraged to make their own decisions and are provided with support and information.
- Prevention: Strategies are developed to prevent abuse and neglect that promotes resilience and self-determination.
- Proportionate: A proportionate and least intrusive response is made, balanced with the level of risk.
- Protection: Adults are offered ways to protect themselves, and there is a co-ordinated response to adult safeguarding.
- Partnerships: Local solutions through services working with their communities.
- Accountable: Accountability and transparency in delivering a safeguarding response.

Sonia's vulnerabilities, her health and care needs, capacity to care for herself and level of independence

10.2. The SAR was able to gain a good picture of Sonia's physical health and care needs: her contact with agencies was largely focused on these. Practitioners recorded Sonia's health needs as Diabetes Mellitus Type-2, obesity, chronic leg ulcer and high blood pressure. She had a past medical history of Lymphoedema, Dependent Oedema, Anaemia, MRSA+ve, and Cellulitis.

10.3. Sonia's mobility was very limited due to her weight and overall poor health. Sonia's reliance on others, including her brother, was exacerbated by her need for, and use of, a bariatric size walking frame which did not fit through the doorways in the house or the front door. Sonia was therefore only able to complete tasks if all the items were brought to her and she could sit in her chair to do them. She got very short of breath with any physical exertion and had to rest before continuing. Managing her

personal care was also difficult due to access issues into the adapted bathroom as well as her size which prevented her reaching all areas for washing. The bandaging on her leg ulcers meant that she could not use the shower in order not to get them wet.

10.4. Sonia's package of care was reduced in November 2016 from 14 to 3.5 hours. While the reasoning was not documented, some of the reduction may have been, in part, due to Sonia not accessing the part of her care and support plan that was focused on support to access the community: her physical mobility prevented her from doing so. (Care previously included support with meal preparation, drinks, prompting medication, laundry, shopping (going out with the carer to get shopping) and accessing the garden.)

10.5. Sonia was able to provide some care for herself, and it was consistently recorded that she and her brother supported each other with tasks.

10.6. Sonia could maintain some level of independence within the home, including independently managing her relationships with practitioners, provided they adapted to her communication needs.

10.7. While she had not been assessed or diagnosed as having a learning disability and told ECC ASC in 2006 that she did not have one, practitioners formed the view that Sonia may have had a learning disability, and ASC responded to her in line with that understanding from 2006 onwards. This was done to ensure professionals sought the best ways to meet Sonia's needs. The EPUT LD-OT assessment found that Sonia needed practitioners to take time to explain new concepts, situations, and people to her. She needed support to sequence these, with clear language and minimising the amount of new information provided on each occasion. Supplementary pictorial information was needed to enable her understanding. Sonia needed experiential knowledge and would not accept change if she was not supported to understand how it provided her with a solution or benefit. Unplanned events, changes, perceived pressure, and adjustments would have overwhelmed Sonia quickly leaving her experiencing anxiety and frustration. At these times she would withdraw from or stop the event/task to minimise the negative emotional experience, even if this was to her overall detriment.

10.8. In the years leading up to Sonia's death, she was under the care of the ASC Working Age Adult (WAA) team, although as outlined in the previous paragraph, this had been informed since 2006 with perspectives on Sonia's possible learning disability. The structure for ASC now is neighbourhood teams, alongside specialist teams, where people will be allocated depending on their presenting need. This includes a Learning Disability and Autism Team and a Mental Health and Wellbeing Team[1]. Had she presented to services now, Sonia could have been allocated to either of these teams, or for example, to the physical impairment team.

10.9. ASC informed the review that the Learning Disability and Autism Team and the neighbourhood teams do not follow a medical model but focus on the adult's presenting need, which means that a diagnosis is not required as the focus is how to

---

[1] This Countywide service offers shorter periods of support as opposed to longer-term case management.

best meet the needs of the individual. The specialist team share expertise with neighbourhood and other teams, to ensure adults are appropriately supported.

Inter-agency collaboration, communication and information sharing in providing support for Sonia

10.10. This SAR has highlighted how several services were working with Sonia at the same time in 2016 and 2017: Summercare and then Dial a Carer, EPUT, NELFT, ECC ASC and the GP. Consistent communication between these services was lacking at times, and there was no attempt to bring all the services together to gain a full picture of Sonia's circumstances and needs.

10.11. There were instances during Sonia's care in which inter-agency communication was effective, for example, the referral from ECC ASC to the EPUT-OT service in November 2016; and the contact from NELFT ICT to ECC ASC about the condition of Sonia's home in September 2016. The EPUT-LD-OT also worked with Sonia's landlord to progress the adaptations required. Inter-agency collaboration was evidenced in response to the safeguarding concern (see 10.19).

10.12. At other times, this collaboration was minimal or lacking. It was positive for ECC ASC to request feedback from the care provider when the review of Sonia's care and support plan took place in April 2017, but they did not follow up on the suggestion of a joint review to ask why the care provider felt this would be beneficial. The provider also fed back concerns over Sonia's package of care, and these were not acted upon. The review was also an opportunity to communicate with NELFT ICT and EPUT-LD-OT who continued to be involved in Sonia's care. The ECC ASC IMR highlights there was a lack of communication and information sharing between ASC and NELFT.

10.13. Internal communication between the two WAA Teams (Mid and South) could have been more proactive at the time of, and after, the transfer of Sonia and her brother. The WAA South Social Worker recorded having contacted a Senior Social Worker in the WAA Mid Team about transferring the case to the WAA Mid Team, but there was no record of the discussion, and no transfer summary recorded. Learning and recommendations are outlined below (see 11.13).

10.14. The EPUT-LD-OT report was sent to ECC ASC in September 2017 and uploaded onto the system by the WAA Mid Team. This was done without any record to demonstrate the recommendations had been noted; if this had been done, a review would have been required to account for the new information. While the EPUT-LD-OT did not indicate that the report was urgent, it should have prompted action by the Social Workers, at the least to read the recommendations and recorded in the case notes, and a plan for next steps. This SAR notes that the report was received four days prior to Sonia's death, so the service may have come to review the OT's report, but there is no indication that it was planned.

10.15. The NELFT RCA describes a situation in September 2017 in which the ICT District Nurses telephoned the GP to request a home visit and notify the GP of Sonia's poor health and situation. They additionally sent a task with this request to the GP. There was an issue with the GP viewing the task, and this slightly delayed a prescription

being made for Sonia. While it is unlikely to have impacted on Sonia's situation, it was an important point for the RCA and discussed with relevant staff and the GP. Actions have taken place to ensure tasks are sent to GPs in the most effective way, and telephone calls made when required. Discussions at the SAR panel demonstrated that contact between community health services and GPs has improved, but for both will always be a challenge due to time pressures and being available to make and receive phone calls in addition to the 'task' system.

How Sonia was supported through existing adult safeguarding procedures for risk assessment, management, and review

10.16. When the care provider (Summercare) informed ECC ASC in November 2016 that they would no longer provide care to Sonia, prompt action was taken by the WAA South Team to review Sonia's and her brother's care and support plans and to ensure new care was commissioned by ECC SPT.

10.17. There was a lack of curiosity demonstrated by the Social Worker who conducted the subsequent review in December 2016, which led to a significant reduction in Sonia's hours of care. Sonia's whole situation, and history, were not accounted for in this review, nor the reasons why she was not utilising the part of her care package that would help her to access the community.

10.18. The NELFT RCA outlines that there was a lack of holistic assessments by the ICT during two of their visits to Sonia shortly before her death in September 2017. Baseline observations should have been completed, prompted by Sonia's sickness and the suspected infection on her leg. This would have given practitioners a holistic picture of Sonia's health at that time, although it may not have had an impact on the overall situation or Sonia's death.

Agency compliance with safeguarding protocols within and between agencies, including protocols for raising safeguarding concerns

10.19. One safeguarding concern was raised for Sonia in the SAR timeframe, due to alleged financial abuse by an informal carer/friend of Sonia's. Sonia informed a Social Worker of this during a telephone call in August 2017; the Social Worker requested that the care provider, Dial A Carer (also present during the call) raise a safeguarding concern, which they did. Action by ECC ASC was delayed by waiting to hear from police on their action, and the joint visit to Sonia took place over a month after the concern was raised. The concern was resolved promptly and effectively through Sonia's brother becoming responsible for Sonia's finances. Sonia had said to the EPUT-LD-OT that the informal carer/friend also had access to Sonia's brother's bank account; this was not picked up in the meeting or addressed.

10.20. During the safeguarding home visit to discuss finances, no concerns were recorded about Sonia's health or the home environment. The care provider had requested a review at the same time as raising the concern. The ECC ASC IMR author outlines that the case file indicates the safeguarding enquiry and review were treated as two separate activities, to be undertaken by different WAA Mid Team members. This is

not in line with procedure which states a safeguarding concern should prompt a review.

10.21. ECC ASC informed the SAR that, while work is ongoing to ensure safeguarding enquiries always prompt consideration for a review of care and support plans and ensuring decision-making is clear and recorded, the need for a review can still be missed. This is an area of learning, and recommendation, below (see 11.19).

10.22. The EPUT-LD-OT contacted DIAL and Adult Social Care to discuss the safeguarding concern regarding financial abuse. On hearing of the alleged financial abuse, the LD-OT could potentially have raised a further safeguarding concern. Instead, they gathered information, and chased the concern that had already been raised to ensure it was progressing and kept up this contact until there was an outcome. All EPUT staff are now directed to contact the internal Safeguarding Team for advice in the first instance.

What preventative actions could have been taken by agencies, which may have reduced the possibility of Sonia's health deteriorating?

10.23. This SAR has highlighted that many of Sonia's needs were longstanding, in particular, relating to the impact on her mental health of the death of her mother, and the earlier incident that occurred at work. Both contributed to Sonia's anxiety when accessing the community. Sonia's anxieties were recorded but did not appear to have been addressed directly, e.g., through referrals to specialist services, and were still impacting on her in 2017.

10.24. It did not appear that any services were working with Sonia to address her weight, or to support her with healthier eating and living. The actions taken in 2017 to support her mobility were positive but could have been done alongside health promotion and disease prevention strategies to support Sonia to improve her overall health. All these actions could have started earlier (she had been housebound since 2015) to enable her to move around, and leave, her home comfortably.

10.25. GPs are now able to offer support with weight loss and management, and any practitioners could have the initial conversation and involve a GP if needed. The review panel was confident practitioners would now look at the whole picture due to the embedding of person-centred, personalised care.

10.26. A multi-agency meeting of all practitioners supporting Sonia could have enabled a more comprehensive picture of her situation and needs. If this had been done in 2015 or 2016, Sonia's mobility issues, and the changes and support needed to enable her to access all her home and the community, could have significantly improved her quality of life and possibly her health.

10.27. The poor condition of the home was noted on several occasions (although at other times it was reported to be clean). When the ambulance staff arrived to take Sonia to hospital shortly before she died, the home was described as unclean and unkempt. Sonia was assessed to have capacity by NELFT in November 2016 but was also understood to struggle with many everyday tasks due to her lack of mobility. There appeared to be a lack of focus on the condition of the home and whether the care

and support plan for Sonia, and the plan for her brother, were sufficient to address this.

10.28. SET has published Hoarding Guidance[2]. In Mid-Essex there is a multi-agency Hoarding Forum that can discuss cases referred by ASC and health providers (EPUT has adopted this guidance). Had this been in operation at the time, this could have been appropriate for Sonia and would have enabled a multi-disciplinary discussion.

Could different approaches have been considered?

10.29. There was a lack of coordination of approach and response for Sonia's care, and no joint meeting (see 10.26) was held that would have meant all agencies involved were aware of Sonia's full situation, and the responsibilities and actions of all practitioners.

10.30. Regarding the December 2016 review of Sonia's care plan, that led to a reduction, the ECC ASC IMR author concludes the Social Worker did not show professional curiosity when Sonia stated she was not accessing the community and that her brother's carers were also supporting her. A more curious approach to Sonia's responses could have led to a different approach to supporting Sonia's needs, in particular, her access to the community. This is covered in the learning below.

10.31. The SAR heard that community support teams and enablement teams are now in place and involved in care and support plans where relevant needs are assessed. This approach could have expanded the resources available to support Sonia in leaving her home that were not focused solely on her physical care needs.

Difficulties agencies encountered when supporting Sonia that impacted on the case

10.32. The ECC ASC IMR identified that there were times when Sonia and her brother would not allow carers to enter the house, and that their involvement with ASC varied. These actions can now be understood in light of EPUT LD-OT's assessment and Sonia's communication challenges. If practitioners were not aware of these challenges, it could have presented difficulties in supporting Sonia.

10.33. EPUT's and NELFT's involvement with Sonia was focused on specific aspects of her care and may not have consistently been aware of the 'bigger picture' for Sonia. ECC ASC held a role here in coordinating communication and information sharing between the relevant services, alongside the responsibility of all organisations to communicate and share information.

10.34. Services have different geographical boundaries to each other, and this presented challenges in responding to Sonia. NELFT deliver the District Nursing service for South West Essex; the same service in Mid Essex is delivered by Provide (and in South East Essex by EPUT and North East Essex Community Services in North Essex). The teams in ECC ASC cover different geographical areas, and communication between the services can vary across the county. This learning, and the actions taken to address this, is outlined below (see 11.14).

[2] https://www.essexsab.org.uk/media/2948/set-hoarding-guidance-dec-21-pdf.pdf

The extent to which practitioners listened to the voice of Sonia, and whether her wishes and feelings were heard and considered

10.35. The EPUT-LD-OT's report, seen by the EPUT IMR author, does not explicitly state Sonia's wishes and feelings, but the electronic records, and the IMR author's interviews with staff demonstrate that Sonia's wishes and feelings were sought and considered. This is evident in the practitioner's understanding of how to approach and communicate with Sonia in such a way that enabled her to continue to engage with the service.

10.36. In December 2016 when Sonia's care plan was reviewed by ECC ASC, her wishes and views were not recorded. This was significant as at this time her care was reduced from 14 hours to 3.5 hours per week. During the review in April 2017, Sonia was recorded as happy with the care, and had not noticed a difference because she was able to access support when carers visited to provide care for her brother. This does not address her needs and wishes in relation to accessing the community which she was still unable to do. While it is possible that a more in-depth conversation was had but not recorded, if the conversation had been that brief, then it was not a proportionate response to the significance of the reduction in Sonia's care and support plan and her responses should have been explored further. It is also of note that this review took place over the telephone; considering the significant change being discussed, it would have been more appropriate to conduct this face to face.

10.37. Sonia's brother informed the review that he and Sonia would have liked her to receive support to go out of the house.

The involvement of Sonia's brother in her care

10.38. Sonia's brother is mentioned frequently in service records, and he also had a care and support plan. He is not subject to this SAR, and it would not be appropriate to share information directly about him, but given their living arrangements and care and support needs, it is important to consider how he was involved in Sonia's care. Sonia's brother's feedback to the review made clear that they had a close and supportive relationship and that he understood Sonia's health and care needs.

10.39. On three occasions, ECC ASC reviewed Sonia's and her brother's care and support plans together. Procedures allow for reviews to be conducted jointly, where this is requested by the individuals concerned. Nevertheless, standalone documents must reflect each person's individual needs, to inform their own separate care and support plans. For Sonia and her brother, this would have specified the needs they met for each other, which would have highlighted areas of their individual care that would have been impacted if anything changed for either Sonia or her brother, for example, if one of them was suddenly unable to carry out activities for the other person.

10.40. This was important because records note how Sonia and her brother supported each other, to the extent that EPUT practitioners felt they would struggle to manage without each other. During 2017, following the reduction in her care and support plan, Sonia told ECC ASC that she was relying on her brother's carers to meet some

of her needs. This was also highlighted by the care provider, but not acted on by ECC ASC. The ECC ASC IMR makes a recommendation to address this.

10.41. In Sonia's brother's feedback to the review, it was clear that he was aware of Sonia's needs and how these were being met in part by his own carers and that this was not appropriate. There was no evidence that he was offered a carer's assessment, but it may be that the review did not have this information as it would have been noted on his records, which were not reviewed.

Good practice

10.42. The NELFT RCA highlights that ICT practitioners documented their assessments, which were completed and reviewed regularly.

10.43. The EPUT IMR author concludes that the EPUT-LD Team evidently established effective communication with Sonia through the expert development of a therapeutic relationship. This approach enables equality of access for individuals with additional learning and/or communication needs.

10.44. The EPUT LD-OT acted promptly and proactively in response to the safeguarding concern in August 2017. A concern had already been raised and so they did not raise another one, although they could have done; but they did chase ECC ASC Safeguarding and kept in contact with the care provider who had raised the concern until the situation had progressed.

10.45. The EPUT LD-OT worked proactively to progress the adaptations needed by Sonia to enable her to move about her home comfortably and leave her home at all. This involved working with other services including the housing provider.

10.46. The SAR Panel noted that some of the above examples of 'good practice' could be seen as 'standard' or expected practice. Nevertheless, they are worthy of noting. This balances the learning outlined above and highlight a recurring feature in the SAR Panel discussions, which is how the limitation of resources may reduce the response from teams, which is definitively not the preferred option for practitioners.

11. LESSONS TO BE LEARNED

11.1. This SAR has been mindful throughout that the care and support provided to Sonia was in 2017 and earlier, and that services have changed in the years since. Some identified areas of learning have since been addressed through service developments, and therefore will not need recommendations.

11.2. The learning themes are described, with recommendations where required, followed by the learning for individual services.

Sonia's perceived Learning Disability

11.3. Sonia was recorded by some practitioners as having a learning disability. There was no record of an assessment or diagnosis for this, and therefore the SAR felt that this

was an assumption by practitioners based on Sonia's presentation. This should have been clear in the records, not stated as fact; importantly, because it contradicted Sonia's own declaration to services that she did not see herself as having a learning disability, and her sense of her lived experience should have been respected in the recording. Additionally, practitioners could have returned to the question in the years since 2006 and discussed this as part of Sonia's needs.

11.4. The SAR Panel discussed whether such a situation would be the case today, and there was a strong feeling that practice has developed significantly; but that there is still work to do. The focus on person-centred, personalised care drives practitioners to understand individuals in a holistic way, including their challenges and strengths. A question remains over what response would be given to an adult without a diagnosis, and the Panel recognised that, as awareness and understanding of Learning Disability and Autism increase, that more adults may be identified as in need of specialist support, with or without a diagnosis. Their experiences and needs may be different from children and younger people with similar diagnoses.

11.5. For Sonia, practitioners often responded to her with a recognition that she may have challenges in communication and understanding, related to a possible learning disability/Autism, despite her not having a diagnosis and having stated that she didn't to practitioners. This was important in ensuring Sonia was provided with services in a sensitive and appropriate way, although the Panel recognised that in some cases, diagnoses can be required to access support.

11.6. This was not the case on every occasion, for example, the telephone review in April 2017 may have been more appropriately done face to face, given the communication challenges, and particularly considering the significant reduction in the care plan that was being reviewed. It is also not clear how these communication challenges may have impacted on the events leading up to Sonia's death.

11.7. A diagnosis is not required for practitioners to approach each person they work with as an individual, in a person-centred, open, and non-judgemental way.

11.8. The existence of specialist Learning Disability and Autism Teams in ECC ASC and EPUT highlight the need for specialist knowledge in working with individuals with such diagnoses. Yet it will be necessary for all practitioners to have some level of awareness of the needs of people with learning disabilities and/or autism, for all clients including those who are not diagnosed, and including the particular needs of older adults (NICE Guideline NG96 *Care and support of people growing older with learning disabilities*, 2018).

11.9. Organisations on the Review panel stated they deliver training for staff on person-centred responses, and on understanding and responding to learning disabilities and Autism, and a connection is made between the two. Recognition and understanding of learning disabilities and Autism are relatively new and constantly changing, which can present challenges for frontline practitioners, despite training, due to the varying needs of individuals they are supporting.

11.10. In ECC ASC a programme of work is in place called Meaningful Lives Matter[3], with a strategy and agenda to improve responses. ECC ASC, through the Essex Social

[3] http://www.essexlocaloffer.org.uk/meaningful-lives-matter-for-people-with-a-learning-disability-and-or-autism/

Care Academy, offers places on a Masters in Autism from the University of Sheffield to the ASC workforce, which enhances their knowledge, understanding, and ability to respond appropriately.

11.11. *Recommendation*: ESAB and Essex Safeguarding Children's Board Joint Learning and Development sub-group to develop and deliver an action plan that enables the learning identified here to be shared through, for example, joint learning events and training programmes. The work should link with the internal programmes of individual organisations, to draw on the work already ongoing, and to learn from each other. Gain feedback from the ECC ASC Meaningful Lives Matter, including staff completion of the Masters in Autism course, to understand the impact these have achieved. The sub-group to provide updates to ESAB on progress.

The need for multi-agency meetings

11.12. Multiple agencies were working with Sonia. This should have prompted a multi-agency meeting, even without any identified immediate concerns, to ensure all practitioners had the full picture of Sonia's circumstances and needs. There were also opportunities to bring practitioners together around the reviews that took place, instead of requesting feedback that was then logged, but not acted upon. A recommendation is made in the ECC ASC IMR to address this last point.

11.13. Contributors to the SAR noted that systems for multi-agency discussions have improved since that time, with greater use of regular multi-disciplinary team meetings and services encouraging their staff to arrange meetings when they are aware of multiple agencies involved with the person they are working with.

11.14. A multi-agency meeting could also have avoided the missed actions and information sharing that occurred when Sonia was transferred from the WAA South Team to the WAA Mid Team. This transfer was not completed effectively; there should have been a meeting of the managers of the two teams, and all practitioners involved in Sonia's (and her brother's) care should have been informed. A recommendation is made in the ECC ASC IMR to address this.

11.15. A continuing challenge to multi-agency working, highlighted by this SAR, is the way in which services are delivered within different geographical boundaries. Sonia's care was initially the responsibility of the WAA South Team, and she received care from District Nurses covering the south of the county (NELFT). When her (and her brother's) care was transferred to the WAA Mid Team, she continued to receive care from NELFT; but District Nursing in the mid area is delivered by Provide. The SAR panel were not confident that the WAA Mid Team would have relationships with NELFT in the same way that the WAA South Team have.

11.16. *Recommendation*: This learning has been addressed through actions by ECC ASC, in which a service manager has led the development of links between practitioners across borders, and discussions at the SAR Panel suggest this may already be having an impact. ESAB to be assured that the impact continues to be felt, and that communication improves across boundaries, through requesting feedback from each health provider, and ASC, six months from the completion of the review.

11.17. NELFT informed the SAR of changes they had made in response to the RCA following Sonia's death in relation to contact with GPs. This learning should be shared across the County to other providers who may encounter similar issues.

11.18. The SAR Panel highlighted that the NELFT learning in this case should be reviewed by the other Community Nursing providers in Essex, who have a responsibility to review learning from SARs and other reviews.

Holistic approaches to safeguarding concerns and reviews

11.19. While the safeguarding concern was addressed appropriately for Sonia, with a good outcome in relation to her finances, it did not take account of the bigger picture of Sonia's circumstances and needs, and the other people in the household, i.e., her brother. For example, Sonia had informed the EPUT-LD-OT that the informal carer/friend also had access to her brother's finances; this was not addressed. There were other concerns relating to the condition of the home, and Sonia's lack of mobility and overall poor health that could have been considered had a holistic view been taken.

11.20. A safeguarding enquiry should always prompt consideration of a review, and this would have been an appropriate and effective way to address all of Sonia's circumstances. The two processes should be connected, but the view of the ECC ASC IMR author was that they were seen by practitioners as separate. A recommendation is made in the ECC ASC IMR to address this.

11.21. A holistic view of Sonia's circumstances was also not taken during the review in December 2016 that led to a significant reduction in her care, with no documented reason. The learning in relation to this is both that justifications for changes in care and support plans should be explicitly recorded; and that the practitioner conducting the review should have taken more time to explore why that element of Sonia's plan was not being utilised. A recommendation is made in the ECC ASC IMR to address the first point, and professional curiosity is addressed in the section below.

11.22. Sonia's and her brother's care and support plans were repeatedly reviewed together. If the people in a household prefer to have their review meetings at the same time, practitioners must nevertheless ensure that the plans are reviewed separately, and that each plan outlines the separate needs of the individuals, and how these are being met. A recommendation is made in the ECC ASC IMR to address this.

The need for professional curiosity

11.23. An absence of professional curiosity was evident in this case when, for example, feedback and reports provided to ECC ASC by other services were uploaded onto the system without being acted upon; and in the December 2016 review. It was also evident in the way in which practitioners focused on the 'now' without taking account of Sonia's history in terms of her personal experiences and her mental health.

11.24. Absence of professional curiosity is a finding in many safeguarding reviews and its importance cannot be underestimated; it should be seen as routine practice rather than something that practitioners use or don't use at different times. Assessments

and reviews cannot be holistic or lead to positive outcomes without professional curiosity[4]. Findings from recent studies of SARs indicate that a greater degree of curiosity may have led to information or action that could have prevented harm[5].

11.25. Practitioners will be aware that they need to exercise curiosity when working with people they support, but there can be barriers in the way, and this was discussed by the SAR panel. Barriers included the time pressures and high caseloads of Social Workers and other practitioners. Stress and pressure work against professionals being curious because they don't feel they have the time to pursue a line of enquiry, or don't know how to ask difficult questions, or don't feel equipped to respond to what may come up.

11.26. Burton and Revell (2018) identified that invoking curiosity is challenging when the work environment is pressured and stressful. Practitioners who are stressed and overworked are much less likely to thoroughly research background information, show 'concerned curiosity', ask questions which may uncover situations that will require further action, dig deeper, or offer respectful challenge[6].

11.27. It was highlighted that ECC ASC Social Workers can find it difficult to review an individual's history because the case management system does not easily show a clear chronology. This has been highlighted for the development of the new case management system.

11.28. In ECC ASC, professional curiosity forms part of the Foundation of Practice training programme. A programme of systemic practice is also being rolled out to the workforce, starting with Team Managers. Training is also accessed through Research in Practice tailored support, including on professional curiosity.

11.29. EPUT informed the review that they have also incorporated professional curiosity into training, including exploration with practitioners of what is meant by the term, and what this would look like in practice. An example from the training that has struck a chord with participants is to "listen with fascination".

11.30. NELFT include professional curiosity within training, although it was recognised that this was mainly in relation to domestic abuse training.

11.31. Due to the frequency with which this finding is identified, and the work ongoing at practice levels to ensure practitioners are aware, the Review Panel felt that this learning needed to be directed at organisations' leadership, to explore what is being done to make professional curiosity possible in the context of stretched resources.

11.32. *Recommendation*: ESAB member organisations to review, at leadership level but involving practitioners and managers, the systemic factors that can impede practitioners from using their professional curiosity and identify actions to overcome these barriers. To report back to ESAB on progress after six months and then again as agreed at the Board.

---

[4] Morgan P (2017). A preventable death? A family's perspective on an adult safeguarding review regarding an adult with traumatic brain injury. Journal of Adult Protection, 19(1), 4-9.

[5] e.g., Preston-Shoot, M. (2017). What difference does legislation make? Adult safeguarding through the lens of Serious Case Reviews and Safeguarding Adult Reviews. Available online: https://ssab.safeguardingsomerset.org.uk/about-us/ publications/learning-from-serious-cases

[6] Burton, V. and Revell, L. (2018) 'Professional Curiosity in Child Protection: Thinking the Unthinkable in a Neo-Liberal World', *The British Journal of Social Work*, Volume 48, Issue 6, pp1508-1523

Learning from the LeDeR Report

The LeDeR review made recommendations that were considered within this review process. Most were covered by the learning in the review, with some that require updates from specific agencies, listed in the Appendix.

12. ORGANISATION LESSONS TO BE LEARNED

12.1. This section presents the recommendations made by individual organisations in their own reviews of practice in this case. Progress on all recommendations, including those marked complete, should be reported on to the SAR Committee, including demonstrating impact.

Learning from the ECC ASC IMR

12.2. The IMR for ECC ASC was completed in 2021, and made the following recommendations:

1. There is a need for robust handover when cases are being passed between workers and teams within ECC to ensure that outstanding actions are followed up. This can be achieved by ensuring Team Manager to Team Manager agreement and by ensuring case transfer summaries are recorded with any outstanding actions to be followed up.
2. When reports are received from Partners and other organisations by one part of the service that need to be transferred to the other part of the service, that the transferring team should highlight any actions/recommendations when appropriate to do so. This should be clearly recorded in a case note that is alerted to the allocated worker, if there is one and both the Deputy Team Manager and the Team Manager. If there is an urgency to the actions/recommendations, then there should be a phone call made to ensure these have been picked up.
3. Quality Assurance processes by Team Managers/Deputy Team Managers and Senior Practitioners need to ensure the following:
(a) That decision making as part of reviews are clearly documented, particularly when this relates to changes in care and support arrangements.
(b) In circumstances where ASC is providing support to two separate family members in the same household, support plans must reflect each adult's individual needs as if the other adult is not there. Where some element of a care visit can then be shared i.e., support with meals and managing a habitable home, it should be explicitly recorded on each support plan the time required for

	this visit regardless of whether both adults are present, and then explained if it is recorded as 30 mins, in that it is shared with the other family member.
	(c) Where family members are providing support to meet eligible need, this must be reflected in the care and support plan.
	(d) When seeking views of others as part of a review, these should be considered before a review is concluded particularly when the provider has raised issues/concerns. Furthermore, if there is unreasonable delay in getting responses back from a provider/partner after escalation, if when their views are received requesting a review, these circumstances should be followed up on with consideration to a further proportionate review of the situation.
	(e) When considering whose views to seek as part of a review, all family members, professionals and other third parties involved in the care and support of an adult should be sought, to enable joined up and collaborative approaches for information sharing and to avoid duplication. In Sonia's case this was a clear missed opportunity.
	(f) On receipt of information from other involved parties, team members receiving information should take time to read back over records to establish history and when necessary, formulate a chronology including themes, patterns, and concerns, to inform decision making.
	(g) Safeguarding enquiries need to evidence a review of care and support plans where these are in place, in considering the change of circumstance due to the safeguarding issues being investigated.
	(h) Safeguarding reports gathered from care providers should be scrutinised further from a position of clarity and curiosity.
4.	These recommendations will be discussed specifically with the teams and workers involved and shared at the ASC Practice Governance Board to inform future training and development needs.

Learning from the EPUT IMR

12.3. The IMR for EPUT was completed in 2021 and identified the following actions to be taken:

1.	An appraisal of the staff's confidence in the escalation of concerns – to re-empower and review the options available and each person's responsibility within it. Update: Action completed.
2.	An appraisal of the Team-Leads responsibilities as the responsible clinician of all cases in the team, their roles, and responsibilities regarding when and how to act on behalf of junior members of staff, to manage the overall resources

needed to manage a case more closely, escalate concern and risks to the appropriate agency.

Update: Action completed.

3. To develop an unambiguous and explicit system of risk identification and management plan that is easy to follow for all staff to be introduced within the LD records and this to be managed as part of the case management.

   Update: Action completed; There is an increased reporting of risk and concerns raised in one-to-one support and clinical meetings.

4. To develop a routine process that establishes the mental capacity of the carer, their role and provides an action plan for issues raised. This must state if there are no concerns.

   Update: This action has been challenging to progress due to responsibility largely sitting with ASC, but actions have been taken to support practitioners through one-to-one supervision, and MCA training.

5. To review the entire referral process and include:

   a. The minimum data set that is accepted from the referrer.
   b. To determine the minimum data set that must be completed on the referral screening process.
   c. To include a section related to risks, concerns, and carers.
   d. The effectiveness of the current process including the use of all staff on a rota system.

   Update: EPUT safeguarding procedures are under regular review and are highlighted in safeguarding adults training.

6. To explore the options for uploading clinical reasoning discussion and provide more evidence in the records for why rather than just factual what information.

   Update: This is an ongoing area of work, due to clinical discussions not always being documented. It has been highlighted during training, and is part of the ELDP plan moving forward.

7. Current Head of Service to complete the HIVE MIND.

   Update: current management is not aware of what this is, it is therefore assumed to be past practice and superseded.

8. Multi-agency escalation system of concerns pertaining to risk, safeguarding and capacity.

   Update: Multi-agency taken forward and led by another agency, ongoing.

9. Health and Social Care staff should have access to each other’s records.

   Update: Multi-agency taken forward and led by another agency, ongoing.

10. Escalation system that enables all staff to identify the need for multi-agency meetings. Update: Safeguarding procedures are under regular review by SET and internally by EPUT.
11. Identification of roles and responsibilities to be established with timelines. Update: Highlighted within safeguarding adults' Level 3 training.
12. Social Work and Health teams to be integrated more effectively. Update: Review of teams and working practices is ongoing to improve integrated practice.
13. To review the effectiveness of mainstream services to adapt their provision input when a person with additional needs is the client – are there processes in place so that other providers can be involved in the case where needed. Update: Action completed.
14. A review (or update) on the effectiveness of the Brentwood Community Hospital discharge procedure. Update: Action completed.

NELFT Learning

12.4. The Root Cause Analysis was completed in 2017/18 and all actions have been completed:

- ICT staff to leave a mobile number when sending a task so the GP can follow up with the staff regarding home visit requests.
- ICT staff to specify the priority of tasks requested by GP and contact numbers to be left for GP to contact staff if required.
- Staff to be reminded of the need to carry out risk assessments on each visit and observations in accordance with the presentation of the patient and local guidance.

13. RECOMMENDATIONS

NB: please also refer to the document explaining the identified themes for the 6 x SARs published in November 2022.

13.1. ESAB and Essex Safeguarding Children's Board Joint Learning and Development sub-group to develop and deliver an action plan that enables the learning identified here to be shared through, for example, joint learning events and training programmes. The work should link with the internal programmes of individual

organisations, to draw on the work already ongoing, and to learn from each other. Gain feedback from the ECC ASC Meaningful Lives Matter, including staff completion of the Masters in Autism course, to understand the impact these have achieved. The sub-group to provide updates to ESAB on progress.

(Links to Theme 3: The importance of a shared approach to setting high standards in safeguarding practice and oversight from ESAB & Theme 4: ESAB's oversight of outcomes from partner's quality assurance of safeguarding systems)

13.2. This learning (see paragraph 11.14) has been addressed through actions by ECC ASC, in which a service manager has led the development of links between practitioners across borders, and discussions at the SAR Panel suggest this may already be having an impact. ESAB to be assured that the impact continues to be felt, and that communication improves across boundaries, through requesting feedback from each health provider, and ASC, six months from the completion of the review.

(Links to Theme 5: Improving interagency communications between Health and Social Care)

13.3. ESAB member organisations to review, at leadership level but involving practitioners and managers, the systemic factors that can impede practitioners from using their professional curiosity and identify actions to overcome these barriers. To report back to ESAB on progress after six months and then again as agreed at the Board.

(Links to Theme 2: Improving Making Safeguarding Personal (MSP) and hearing the voice of the adult at risk & Theme 3: The importance of a shared approach to setting high standards in safeguarding practice and oversight from ESAB)

13.4. Connected with or alongside the previous recommendation, ESAB member organisations to review, at leadership and practitioner level, how joint planning and multi-agency working operates. Consider how practitioners are empowered to engage with multi-agency colleagues to share appropriate information, develop joint understandings, and achieve consensus about a situation before exploring and agreeing solutions. Within this, ensure that information is easy for practitioners to access on which teams to contact in partner organisations.

(Links to Theme 5: Improving interagency communications between Health and Social Care)

14. Appendix: LeDeR Recommendations that require updates

Identified Issue	Learning	Recommendation to address issue	Comments from SAR
A prescribed bariatric walking frame that did not fit through doorways in the home further reduced mobility, with subsequent impacts on confidence and health issues.	Had the doorways and ramp been adapted in 2015, it may have been possible for Sonia to maintain better mobility and to leave the house (with support).	The prescription of any bariatric equipment whilst in hospital should either require a home visit prior to discharge or result in appropriate referral to social care for a full environment assessment to take place as soon as possible afterwards. There needs to be someone responsible for ensuring all subsequent tasks are actioned.	ECC: Update required. (The review did not look back to the hospital admissions in 2015 / earlier.)
It does not appear that there was any Community Physio (LD or mainstream) following the 2015 hospital discharge to support improved mobility and exercise once home & thus the prevention of further falls. This resulted in the continued low confidence and reduced mobility.	Had there been some physio involvement, not only could Sonia have better maintained her mobility and fitness, the issue with the walking frame may have been identified sooner.	Had there been some physio involvement, not only could Sonia have better maintained her mobility and fitness, the issue with the walking frame may have been identified sooner. Hospital discharges for people with LD should routinely consider referral to the LD Specialist Team. This needs to form part of the process related to the Acute Hospital Risk Register, together with the provision of enhanced care plans.	ECC: Update required. (The review did not look back to the hospital admissions in 2015 / earlier.)
ASC appeared only concerned with stopping and starting the care package when hospital admissions occurred. Opportunities to identify other changes or patterns were therefore missed.	Opportunities for addressing patterns of issues were not taken – such as repeated admissions for falls and issues with her leg ulcers. These were apparently seen as Health issues only.	ASC should be clear what the impact hospital admission and discharge has made for someone, and what the pattern of this is when re-establishing a service on discharge. 'Needs' may have changed in ways that need further exploring. Questions such as "What else has changed? What is the impact of this going to be?" could be useful.	ECC: Update required. (The review did not look back to the hospital admissions in 2015 / earlier.)
The number of falls and hospital admissions was not understood as indicative of a need for additional	A trajectory of reducing mobility, weight gain and leg ulcers/infections leading to falls	There should be an Acute Hospital Risk Register that identifies people who are at risk of acute admissions and which requires	NELFT & EPUT: Update required. (The review did not look back to the

Identified Issue	Learning	Recommendation to address issue	Comments from SAR
review of care arrangements in and prior to 2015, following which she became housebound.	and hospital admissions was not understood and action taken to change the situation and sequence of events that eventually led to her death.	a co-ordinated joint health and care review & plan of action to prevent further issues and admissions. This needs to include medium to long term tracking of people to ensure situations remain optimised over time.	hospital admissions in 2015 / earlier.)
The basic dietary advice given when the diabetes was diagnosed was not linked to the provision of MOW or support re the food shopping done	It is unclear whether changes to diet were implemented following the diabetes diagnosis	A diabetes diagnosis should trigger support to help understand eating requirements and the consequences of poor eating habits. Referrals to the LD Specialist Healthcare Service should be considered as a way of assessing how best this should be provided.	NELFT & EPUT: Update required. (The review did not look at the diabetes diagnosis.)
On 18/09/17 the District Nurse appears not to have left information for Sonia and her brother as to what to look for in terms of deterioration and what to do if that occurred. Their ability to follow through with this was therefore also not assessed. There appears to have been no consideration that feeling sick etc with the infection might lead her to be even less active/mobile with the associated risks this could bring.	The lack of information would appear to have left Sonia and her brother unaware of the seriousness of their situation.	Information needs to be left with the individual and/or their carers that provides appropriate information as to what to look for and what action to take. Traffic light system information would prove useful in this and other situations.	NELFT: Update required.
The ICT visit on 22/09/17 was a day later than stated in the Care Plan, and that due on 25/09/17 had not occurred prior to the OT visit in the afternoon that resulted in the ambulance being called.	The impact of delayed or postponed visits needs to be fully risk assessed. In both instances an earlier opportunity to intervene was missed.	The impact of delayed or postponed visits needs to be fully risk assessed.	NELFT: Update required
On 25/09/17 the Specialist OT visited. She did speak to the ICT Senior Nurse, but no vital signs were taken. The OT called an ambulance. However the	There was a long delay before a non-urgent ambulance arrived. Had the correct information been supplied a more urgent	Staff from any/all health provision need to have full medical histories in order to understand and make the correct risk/clinical decisions about interventions.	NELFT: Update required

Identified Issue	Learning	Recommendation to address issue	Comments from SAR
information received by the ambulance service only indicated that the person was stuck in the chair. Additional information that should have alerted them to the urgency of the situation appears not to have been given. This included that she had been admitted to hospital previously with sepsis secondary to cellulitis and was therefore at risk from this, together with the risk from being immobile for a period of days with a red infected/painful leg.	response would have been triggered, potentially resulting in saving her life.	Staff need to be trained not only in the identification of potential sepsis and deterioration, but also in the implications of other factors (such as being immobile). Staff need to be trained in how to take appropriate action, including what to communicate to the emergency services and what additional input/support should be provided to those involved.	
Despite calls made by the ambulance service to Sonia during the wait period, the seriousness of the situation was not understood.	There was an assumption that Sonia was providing all the relevant information to the emergency services.	Following from the above: Staff need to ensure that individuals are able to relay all the information needed. This may include leaving a 'script' of what to say, together with options should things change. This needs to include information about previous medical issues/admissions etc.	NELFT: Update required
The NELFT RCA did not include all the listed causes/contributory factors of the death. As such it did not consider that Sepsis was one of these and therefore the impact of staff not following their own internal procedures and processes. It did not include any reference to the potential risk of DVT from becoming more immobile. It's focus was on the actions of the ICT team, and how they related to the GP. It did not provide a full timeline of all interventions/events and therefore the	The investigation's remit to 'establish if the incident could have been predicted or prevented and whether there were any identifiable care and service delivery issues that may have directly contributed to the incident' was not fulfilled. The family were thus informed that the death 'may not have been preventable' with the lessons 'not considered to be contributing factors to this serious incident'.	Robust, whole system reviews of incidents need to routinely take place in order to fully map and understand the sequence of events, ensure learning is taken from them and implemented, and where appropriate individuals and/or organisations are held to account. Internal quality assurance processes should ensure that investigations are robust and appropriate before being signed off.	NELFT: Update required

Identified Issue	Learning	Recommendation to address issue	Comments from SAR
full sequence and impact of the actions/omissions by both health and social care staff.			
The ECC Adult Safeguarding Enquiry following her death focused on the conditions in the home, and relied on the Coroners decision it was natural causes, plus NELFT's internal review, and comments from other services as to the state of the home environment to decide that there was no neglect. It did not address the key questions (as per earlier section), and therefore did not fully examine whether the death was preventable or not and should be subject to further safeguarding action. ECC signed this off.	A sequence of information lead to the wrong question being investigated. A key issue as to how someone could be stuck in a chair for 3-5 days when being visited by services daily was not even posed.	As above, plus: Training for people undertaking safeguarding enquiries needs to include how to build an appropriate timeline, identifying all the events, inputs and impacts. In this way the initial allegation can be fully explored and any other/additional issues identified and addressed. Social Workers should have access to medical support in order to be able to knowledgably gauge medical reports they receive as part of safeguarding enquires. Quality assurance processes need to ensure that the right question/s have been identified and addressed within the enquiry.	ECC: Update required