Adult Social Care & Health
Management Associates

Safeguarding Adults Review

in the case of Mrs E

January 2021

Contents

1. Reviewers

Mandie Jane Lavin – Personal Profile

Mandie is a Registered Nurse and Practising Barrister, she qualified at Guys Hospital in 1987. She is a member of Middle Temple, having been called to the Bar in 1993. As a nurse she worked in London and after qualifying as a Barrister she worked in medico-legal roles in Peterborough and in the Anglia and Oxford Region. At the UKCC, now the NMC, she was in charge of fitness to practise of nurses and midwives then progressed to a range of standards and regulatory roles across accountancy, law, pharmacy and optics. She has contributed to a range of public enquiries, including the Shipman Enquiry. She has conducted reviews of serious adverse incidents and dealt with Inquests.

Mandie is an experienced CEO having served as CEO in the legal, healthcare and funeral sectors. She has a national profile in regulation with expertise in strategy, governance, transformation and professional ethics. Mandie serves as a Chair of the Registration Panel of the General Medical Council and works for several professional associations as an adviser and reviewer in areas such as appointments, strategic planning and compliance.

Vic Citarella – Personal Profile

Vic is a registered social worker with a substantive practice background in residential childcare and the management of social services provision and commissioning. He is a former Director of Social Services and worked in personal social services for 25 years in Cardiff, London, Sussex, Bristol and Liverpool. Since leaving local government in 2000 he has built a consultancy business advising and supporting local authorities, NHS bodies and private and voluntary social care providers with improvements in standards and quality.

His current work includes serious adult reviews, expert opinion, improvement support to providers and commissioners, mentoring, governance and leadership advice to small businesses and not-for-profit providers. Vic has supervised several safeguarding adults' reviews (often young adults who have been in care), co-authored the Winterbourne View Hospital report. He is chair of a safeguarding scrutiny committee for a housing and care provider.

Vic is particularly known for his work to support improved workforce planning and better training in the social care sector having served on the boards of various Skills Councils for both children's and adult services as well as for local government and the voluntary sector. He is an active member of both the Associations of Directors of Adult Social Services and of Children's Services. Vic served the Social Care Association for many years as chair of its practice committee and for a three-year presidential cycle. He is a trustee of the UK charity Residential Forum curating and editing their knowledge and blog website.

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sector skills bodies and service providers as well as commissioners and regulators to continually improve practice and leadership.

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The Independent Reviewers would like to offer their deepest sympathies to the family. It is our sincere wish that this report does not contribute to any further pain and distress. We would like to thank them for their invaluable contribution and comprehensive engagement with the Review.

The Safeguarding Team at the Local Authority gave every support to the Review. The Reviewers would like to thank them.

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2. Introduction, Background and Acknowledgements

Mrs E's life before and after she went to live at the Care Home

2.1. Mrs E was born in London, in the 1930's. She grew up there and as a young girl, she learnt to dance, and it became her life's passion. At 12 years old, she went on tour with a famous dance troupe and met her husband at a dancing competition. During the war she was evacuated to Devon. She married at 16 years old. In later years Mrs E assisted her husband with running a large haulage company. She had a son and a daughter. She experienced loss in her life, as her son died aged 42 years of cancer and her husband died when he was only 40 years old. She had lived in the West Indies and Florida. She led a fulfilling life and was a loving mother. She had a life of achievement and was dearly loved, at no time was this more evident than when her health started to deteriorate. In 2012 she was diagnosed with Alzheimer's Dementia.

2.2. She had a range of other clinical conditions, Type 2 diabetes, dementia, high blood pressure, cerebrovascular disease, chronic kidney failure and a risk of falls. She had asthma and low thyroid function as well as double incontinence. She lived with her daughter and her family for several years, they had cared for her diligently and wanted the best for her. Over time it became more difficult to manage until it became untenable following a deterioration of her dementia, which included physical violence and disinhibited outbursts. Her daughter, who was supported by other family members, found it hard to manage her mother's condition at home. When Mrs E started to suffer sleep disturbance and was posing a risk to those in the house, some difficult decisions needed to be made.

2.3. Mrs E first moved to a residential home when she left her daughter's house. Her condition worsened in 2015 when she was admitted to hospital with aggression and visual hallucinations. She was stabilised and transferred to the Care Home in March 2015, when she came under the care of her GP. It was with great reluctance that her family recognised that she needed specialist round-the-clock care. Mrs E spent a short time previously in another home and her family commented that although it had plush furnishings it did not feel homely or deliver what their mother had needed, and they brought her home again. They looked at several other homes and took care in choosing the home, it mattered to them that she should be in the right place with the right people caring for her. Even now, with everything they have experienced, they feel that the decision they took for their Mum to live at the Care Home was the right one. They were able to look beyond soft furnishings and see what the care looked and felt like. The family had immense respect for the staff and the work they did and were grateful for the care their mother received.

2.4. Prior to Mrs E's admission to the Care Home, she had a pre-admission assessment which was conducted by the Deputy Manager of the Care Home. She was assessed as having high dependency and was reassessed on her admission to the Care Home on 24 March 2015. A "Do Not Attempt Resuscitation Order" was put in place on 27 March 2015, with the knowledge and acceptance of her family.

2.5. She was identified as being on a range of medication including Bisoprolol (for blood pressure), Sertraline (for depression), Risperidone (to help with symptoms of dementia), Loratadine

(antihistamine), Ranitidine (to help prevent gastric disturbance) and Movicol (to help manage her constipation). Throughout her time in the Care Home her medication was kept under continuous review and she was frequently seen by a specialist psychiatrist and GP. She took time to settle into the Care Home and had problems sleeping and could become agitated and, at times, distressed. Mrs E was independently mobile, although was unsteady, and at high risk of falls. Mrs E had a history of unpredictable and challenging behaviours, including hitting staff and residents.

2.6. She had several falls and was seen by the GP regularly. A referral was made to the Specialist Community Mental Health Team for Older People and she remained under their care until the time of her death. A review was held into Mrs E's care as she was becoming more agitated. On 26 January 2016, the specialist consultant recommended that there was an emerging need for one-to-one support. There was a meeting on 24 February 2016, with Mrs E, her daughter and granddaughter, the Social Worker from the Local Authority and representatives from the Care Home. It was agreed that one-to-one support would be put in place for Mrs E from 20.00hrs. to 08.00hrs. Mrs E's family were paying for her care at that time and made provision to pay for her extra hours of care.

2.7. Mrs E was well known to the Older Persons Mental Health Team, who prescribed medication to manage her behaviour. There was a Continuing Healthcare Assessment (CHC) in August 2016. On 20 September 2016, CHC funding was agreed and confirmed in a letter dated 21 September 2016. The Clinical Commissioning Group (CCG) agreed funding for the placement and one-to-one care between the hours of 20:00hrs. and 08:00hrs. daily. The funding letter explained that there would be an initial review in three months' time, but Mrs E had not been reviewed at the time of her death on 23 January 2017. It has not been possible to find out why that did not happen.

Hospital Admission

2.8. On 26 November 2016, Mrs E was admitted to hospital due to coughing up phlegm which was causing her distress. Prior to that admission her feeding assessments had identified that she needed encouragement to eat at mealtimes and she could feed herself but sometimes needed assistance. Mrs E did not have her own teeth, nor did she have dentures. On 16 September 2016, the CCG Decision Support Tool, following Mrs E's initial assessment noted that:

2.9. "Mrs E takes a normal diet and fluids and generally eats well, she mostly feeds herself but, at times, needs feeding to ensure adequate dietary intake."

2.10. On 28 November 2016, during her hospital admission she was assessed by the Hospital Speech and Language Therapy Service (the Service). It was concluded that Mrs E required risk feeding to include "fork mashable diet"; they added "sit as upright as possible; regular mouthcare; help to feed; allow time to swallow; liquid medication where possible; crushable options". Multiple risk factors for aspiration were noted in her records including reliance on others for her daily living activities which included mouthcare; dysphagia[1]; cognitive impairment; and reliance on others to reposition.

[1] Difficulty in swallowing

2.11. The agreed actions were summarised as firstly, the Speech and Language Therapy Service to liaise with the Nursing Home and "if necessary" to notify the Community Speech and Language Therapy Service. Secondly, her medication was to be reviewed. At 20.16hrs. on 28 November 2016 a discharge letter was prepared which summarised "Mild/moderate oropharyngeal dysphagia characterised by delay swallow trigger of diet with risk of airway. The document describes: "Oropharyngeal dysphagia[1]-MDT[2] and family decision for patient to be risk feeding-to ensure quality of life" The letter concluded "Community/ Specialist Services: Advanced Care Plan has been made and will be provided with discharge summary to prevent further admissions to hospital."

2.12. The Care Home did not receive the document containing the specialist care plan and risk feeding guidance. No information about the assessment that was carried out was transferred to the Care Home. The patient discharge information from the Hospital addressed to the GP stated "Impression: 1. Mild to Moderate Oropharyngeal Dysphagia characterised by delayed swallow trigger of diet with risk of airway. 2. Left Sided Community Acquired Pneumonia. 3. End stage dementia." There was no mention of dietary needs although the airway risk had been identified.

Discharge from Hospital

2.13. On the 28 November 2016, the Care Home was notified of a delay in Mrs E's planned discharge. Therefore, it was not until 29 November 2016 that Mrs E returned to the Care Home from the Hospital. Some confusion appears to have arisen due to the delayed discharge and the fact that two discharge letters were prepared. One letter was prepared on 26 November 2016 and another on 28 November 2016. It later emerged that the discharge letter of 26 November 2016 was the Accident and Emergency record of the discharge from A & E to the ward. There was a Do Not Attempt Resuscitation (DNAR) document dated 26 November 2016, as well as the community DNAR of the 27 March 2015. The Discharge Summary records that a plan for "risk feeding" was put in place, there was no other information in the Discharge Summary regarding a change to dietary requirements or a copy of the Speech and Language Therapy Service Assessment. This was a crucial omission.

2.14. On the evening of 22 January 2017, at approximately 20:30hrs. Mrs E was in the Care Home within the Local Authority area when the Health Care Assistant (HCA) left her to make her a cup of tea. The HCA realised that something was wrong when she heard Mrs E making a noise. When she went to help Mrs E who was clearly unwell, she did not press the Emergency Button, instead she went to find the Nurse in Charge of the Unit. He did not come immediately and at the time of his arrival on the scene Mrs E was breathing and conscious. As the Emergency Button had not been activated, he did not respond with the degree of urgency merited. Accounts by those present, of the immediate steps taken to respond to Mrs E's condition varied and had some degree of inconsistency. The Nurse did not stay with Mrs E but instead returned to put the medicines trolley away. About 20-25 minutes elapsed before the ambulance was called. At the inquest, HM Coroner termed it "a window of opportunity." Mrs E was choking and all present at the time agreed subsequently that she was very breathless, although the account of choking was not accepted by everyone who witnessed what happened. What is certain is that the carers that

[2] MDT (Multidisciplinary Team)

were with her called for help and summoned the Nurse in Charge and he did not respond immediately and denied that he was alerted to the situation as an emergency. The Nurse confirmed his reluctance to call an ambulance at the inquest. The emergency call was eventually made to the London Ambulance Service (LAS) at 20.50hrs, the duration of the call was 8 minutes and 9 seconds. The LAS team arrived at 21.02hrs, this was within the eight-minute timeframe which is set for the call, which was correctly categorised on the information given. At that time 75% of emergency calls were expected to arrive within 8 minutes, on this occasion, the crew were outside the building in 7 Minutes 55 Seconds. It was categorised as a Category A, immediate life-threatening call. On arrival, the paramedics had difficulty accessing the building, this led to a further delay. When they did gain access, they were not taken immediately to Mrs E. They located her at 21.08hrs, she was in the lounge. By the time they arrived by her side, she was unconscious, unresponsive and not breathing. The Nurse in Charge was not present and active steps were not being taken to help her. The Paramedics started cardio-pulmonary resuscitation. There was confusion about whether Mrs E was breathless and having difficulty breathing or was choking. A second LAS team was called out, as per the protocol. They were despatched at 21.14hrs and arrived at 21.21hrs. In the end Mrs E's airway was found to be blocked with a bolus of food which was removed with forceps. They achieved cardiac output.

2.15. She was taken to hospital, her family were contacted, but given unclear and inaccurate information. There were communication problems that resulted in the family setting off to the wrong hospital, when part-way there, they had to change direction and re-route to the correct hospital. On arrival at the hospital Mrs E was non-responsive, with fixed dilated pupils. Mrs E was fully assessed by the doctors at the hospital and a meeting was held with the family the following morning at 09.40hrs. They were told that Mrs E had irreparable brain damage and was dying. A management plan was devised to keep her comfortable, with appropriate medication and symptom control. The specialist palliative care team were involved in her care and her oxygen was reduced to a level that meant she was settled and comfortable. On 23 January 2017, at 17.40hrs, she sadly died.

2.16. A report was made to the Coroner and a post-mortem was conducted, and the cause of death was:

> "1. (a) Choking 1(b) Obstruction of the upper airways by food bolus
>
> 2. Other significant conditions were right lobular pneumonia, chronic kidney disease, hypotension, diabetes mellitus, generalised atherosclerosis, dementia and hypothyroidism."

2.17. In May 2018, H.M. Coroner convened an Inquest with a jury, and it lasted for three days. Evidence was heard from witnesses and Mrs E's family attended throughout. At the conclusion of all the evidence and submissions, the Coroner gave the jury several potential outcomes to consider including Accidental Death, Accidental Death by Neglect and a narrative conclusion. The Coroner asked the jury to consider "whether neglect arises in the second period, which is the period of 22 January 2017 itself." The Coroner directed the jury to consider the choking incident itself in the context of neglect and excluded other periods. The Coroner directed the jury not to consider the period other than the night of 22 January 2017.

2.18. H.M. Coroner gave the following definition: “Neglect in this context means a gross failure to provide adequate nourishment or liquid or provide or procure basic medical attention or shelter or warmth for someone in a dependent position because of youth, age, illness or incarceration, who cannot provide it for themselves. Failure to provide medical attention for a dependent person whose physical condition is such to show that he or she obviously needs it may amount to neglect, so it may be if a dependent person’s mental condition, which obviously calls for medical attention, in both cases the crucial consideration will be what the dependent person’s condition, whether physical or mental appears, to be.”

The conclusion of the inquest, as stated by the Coroner, was: "Accidental Death contributed to by Neglect." This conclusion is defined by a "gross failure" to provide basic medical care, and with that, a clear causal connection between the gross failure and Mrs E's death

2.19. This Review examines the circumstances that led to Mrs E’s death and identifies steps that can be taken to minimise risk in the future. Of necessity, this Review examines the events at a moment in time and recognises that much has already been done to ensure that the risk of choking is now managed in the Care Home. Even during the duration of this Review the awareness of choking risk has heightened nationally; this is reflected in the actions already taken by the various agencies that had a part in the care of Mrs E, this includes the Care Provider that ran the Care Home. This is acknowledged by Mrs E’s family.

Speech and Language Therapy Service (the Service)

2.20. During the inquest, the Service Team confirmed that the care plan and assessment regarding “risk feeding” was never sent to the Care Home. The Service Manager stated that she contacted the Care Home to discuss the risk feeding plan, but this was not substantiated, as there were no notes of the call at the Care Home. It emerged that there was a Service Record that the call had taken place on 7 December 2016. At the inquest, the Coroner invited the jury to consider whether the record of the follow up call was accepted and stated that other evidence had suggested the call was not made. The Service Manager had no recollection of who she had spoken to at the Care Home. The Care Home had raised no concerns about Mrs E, according to the Service Manager. The IT Contact system used by the service stated, “Not risk feeding” and stated that there was “no indication” for a referral to Community Services. This should have resulted in action especially when considered with the discharge letter that had been prepared and the summary diagnosis that had been arrived at, which clearly set out the need for risk feeding. The indication for action when the Care Home reported that risk feeding was not in place was missed.

2.21. A further referral to Community Services was not made and Mrs E was discharged from the Services caseload and there was no further follow up. After her discharge from the Hospital Mrs E preferred the soft option, normal diet. This was not recorded other than on a diet notification form which is undated. Nutritional assessments were completed on a monthly basis and the last assessment completed, was only 12 days before her death, on 11 January 2017.

Expected Standards of the Speech and Language Therapy Service (the Service) Care

2.22. There was never any indication from the Hospital to the staff at the Care Home that Mrs E was at risk of choking. After Mrs E’s death enquiries were made about the expected standard of care

and it was confirmed on 5 April 2017 that "the expectation is on the speech therapist to make contact with the nursing home one week after discharge to discuss whether the home have any concerns or have identified any issues since discharge."

2.23. There is a significant statement in that email from the Service Acute Lead at the Hospital, as follows: "The handover of patients who are risk feeding has already been identified as an area of the pathway that needs further scrutiny i.e., the decision-making process to identify who would benefit from community follow up. We are in the process of reviewing this with our community colleagues. This includes whether a phone call to homes from the acute team is enough to establish whether the risks have been understood, documented, disseminated and actioned. We rely on the home to reassure us the patient is at their baseline and that they have no concerns, that homes know how to seek further input from the Service, if the patient's condition changes over time or fluctuates. However, we acknowledge that this is no guarantee of effective management of safety and risks."

2.24. This means that in April 2017, the Hospital Trust Acute Service Team were aware of the risks.

Task and Finish Group of the Clinical Commissioning Group (the Group)

2.25. Following Mrs E's death and the identification of several other choking cases in the Local Authority area, a Task and Finish Group was set up. The work of the Multi Agency Choking Risks Group lasted for over a year and produced an Action Plan. The Group was convened at the request of the Safeguarding Adults Board (SAB) to address the choking risks across the agencies. The Family of Mrs E were unaware of the action that was taken and as the Group was set up due to four cases of choking, it is possible that other families may not have known about this important work.

2.26. The Group completed their meetings in June 2018, after a year of partnership working, the concern about "Failure of Care Homes to always refer to Speech and Language Therapy (SALT) when a patient is identified as being at risk of choking," has an associated action that is still graded amber. This is as follows: "Recommendation to CCG commissioners to review whether existing resource and capacity of SALT Team is sufficient to meet existing and predicted demand from nursing homes." The progress update on the Action Plan recorded that the CCG Director of Quality and Integrated Governance was to write to the Director of Commissioning to request a formal review of SALT provision.

2.27. Meetings took place with the Group and the Services to discuss referral pathways and operational issues around urgent, priority and non-urgent referrals as well as capacity and waiting times.

Acknowledgement

2.29. The Reviewer has been ably assisted by the family of Mrs E, the team at the Local Authority and all persons who have been approached have given freely of their time and expertise. Information has been readily provided and co-operation has been the hallmark of this Review.

3. The Commissioning of the Review

3.1. Having conveyed Mrs E to Hospital on the night of 22 January 2017, the London Ambulance Service (LAS) reported a Safeguarding concern to the host Local Authority regarding the Care Home, they were concerned about the level of care that Mrs E had received at the Care Home.

3.2. The Safeguarding Alert raised by the LAS on 22 January 2017 reported that they had attended Mrs E due to reported difficulties breathing. They stated that "On arrival, the patient was in a confirmed cardiac arrest. Registered Nurse and carers were on the scene, but no basic life support and stood behind patient."

3.3. The LAS reported that they had been informed that Mrs E was eating a sandwich unattended. The LAS further advised that "the patients carer stated that the patient was not breathing properly, and nothing was mentioned about choking." The LAS noted an obstruction in the patient's airway and having checked Mrs E's Care Plan observed that "patient should not be left alone while eating."

3.4. The LAS Alert then resulted in action from the Local Authority.

Statutory Duty to conduct a Safeguarding Adults Review

3.5. Section 44 of the Care Act 2014 places a statutory requirement on the Local Authority Safeguarding Adults Board to arrange a Safeguarding Adults Review where:

a) An adult with care and support needs has died and the Local Safeguarding Adults Board knows or suspects that the death resulted from abuse or neglect, or an adult is still alive, and the Local Safeguarding Adults Board knows or suspects they have experienced serious abuse or neglect, and

b) There is reasonable concern about how the Board, its members or others worked together to safeguard the adult(s).

3.6. Board members must co-operate in and contribute to the review with a view to identifying the lessons to be learnt and applying those lessons in the future. The purpose is not to allocate blame or responsibility, but to identify ways of improving how agencies work, singly and together, to help and protect adults with care and support needs who are at risk of abuse and neglect, including self-neglect, and are unable to protect themselves.

3.7. These mechanisms to support adult safeguarding are set out in section 2.10 of the London Multi-Agency Adults Policy and Procedures. The principles of SARs are contained in section 2.9.3. All Local Authority Safeguarding Adults Board members and organisations involved in the Safeguarding Adult Review, and all panel members, agree to work to the defined aims and underpinning principles. This Safeguarding Adult Review is about identifying the lessons to be learned across the partnership and not about establishing blame or culpability. In doing so, the Safeguarding Adult Review takes a broad approach to identifying causation and will reflect the current realities or practice.

Specific Areas of Enquiry and Time Period

3.8. This Review will look at the time period from 25 January 2015 when Mrs E first encountered the placing Local Authority through to her death on the 23 January 2017 only in so far as it is relevant to November 2016 to January 2017, which is the primary focus of the Review. The events that followed her death provide a perspective on her care and the communication with her family.

3.9. The following issues were identified as requiring more analysis:

a) How agencies worked together in terms of inter-agency communication and whole system care coordination
b) The support given to Mrs E when her family were no longer able to care for her at home
c) Mrs E's care in the Care Home
d) The communication issues arising following Mrs E's discharge from hospital on 29 November 2016
e) The emergency response to Mrs E's condition on 22 January 2017
f) The actions taken after Mrs E's death by all agencies
g) The communication issues with Mrs E's family
h) The issues arising and recommendations for action.

3.10. The approach and methodology utilised to address the Terms of Reference were intended to identify themes, solutions and achievable recommendations. The expectation was to contribute towards prevention of similar occurrences and to facilitate learning both specific to the incident, and more broadly from the life and subsequent death of Mrs E.

3.11. The approach recommended by the Reviewer and chosen by the Safeguarding Adults Board was as follows:

- Chronologies of involvement from all agencies who were involved in the care of Mrs E in the period of the review.
- Internal Management Reviews (IMR's) from the same agencies, addressing their involvement with Mrs E. The purpose of the IMR's was to enable each agency to reflect on their own involvement with Mrs E and to identify recommendations for change if necessary.
- The Reviewer set several questions and met with many individuals to fully understand their involvement, to clarify incidents mentioned or seek further information. Meetings took place with the Social Worker involved in the case, the Quality Assurance Manager from the Local Authority, the Chair of the Adult Safeguarding Board, the Safeguarding Lead for the London Ambulance Service and the Designated Nurse Adult Safeguarding from the CCG, Senior Lawyer from the Legal Services Team at the Local Authority and multiple meetings were held throughout the Review with the Safeguarding Adults Team in the Local Authority. A teleconference was also held with the Safeguarding Adult Advisor in the Deprivation of Liberty Safeguards (DoLS) Team.

3.12. SAR Panel Meetings were held on 18 January 2019, 17 May 2019, 16 August 2019 and the SAR Panel to consider the First Draft was held on 11 February 2020. Pandemic then struck and delays to the final report ensued. A further SAR Panel meeting was held on 18 August 2020 and a conference call was held with the Chair of the SAB on 26 November 2020.

- The Reviewer discussed the case with Mrs E's consultant psychiatrist on 26 June 2019 and a conference call was held with Mrs E's GP on 4 December 2019.
- The Reviewer compiling this report met with Mrs E's daughter, son-in-law and granddaughter of Mrs E, the Reviewer did not meet Mrs E's grandson. She also had access to the statements that had been made to other agency investigations.
- The Reviewer visited the Care Home on five occasions, on 18 May 2019, 29 June 2019, 17 August 2019 and 28 September 2019 and then met with Mrs E's family at the Home on 17 November 2019. This was the first time they had returned to the Home since Mrs E had died.
- At the initial visit to the Care Home there was the opportunity to meet the current Care Home Manager, who was not in post at the time of the death of Mrs E, and the Executive Director of Nursing and the Director of Operations of the Care Provider. During the visits on 29 June 2019, 17 August 2019 and 28 September 2019 all documentation at the Care Home was considered, and copies of key documents were provided. The final visit to the Care Home by Mrs E's family on 17 November 2019 was facilitated by the Care Home Manager and the Care Provider. The visit was arranged as the family wanted to return to the Care Home and to hear about some of the changes that had taken place since their mother's death and it was an opportunity to ask questions and seek assurance.

3.13. The Reviewer attended that meeting and discussed the process and conduct of the Review. The Care Provider and the Care Home Manager were fully co-operative throughout the review and gave open access to all relevant documents and freely answered all questions asked. Due to corporate restructuring that had taken place in April 2017, some questions were not possible to answer, and key personnel were no longer employed by the Care Provider and were not accessible to the Reviewer. A letter of apology was sent to Mrs E's Family and the Reviewer was notified of this on 7 June 2019. This was in response to feedback given that Mrs E's Family were still in distress about what they felt was a lack of a profound and genuine apology.

- During the Review, five staff members at the Care Home who remembered Mrs E and her Family spoke to the Reviewer and a meeting took place with two of the five staff. The discussions with other staff were by telephone. The meeting with staff took place at the Care Home and they were happy to meet and answer questions, without the presence of the Care Home Manager. This presented an opportunity to ask searching questions about changes that had been made and to understand the impact that Mrs E's death had had on those who had cared for her. It also presented an opportunity to listen to the team and hear their views about how the circumstances that led to Mrs E's death might have been handled differently.
- Five large lever arch files full of documents were prepared by the Care Home and provided to the Reviewer, these included all care plans, risk assessments and care

records relating to Mrs E. They contained doctor's letters and other correspondence. All documents appeared to have been preserved and retained by the Care Home and were in reasonable order.

- Information was forthcoming from H.M. Coroner with the transcript of the inquest received on 5 July 2019 and the Coroner's bundle was received on 13 July 2019. This contained the Information gathered from the Coroner's Office, including the transcripts of the inquest lasting three days and the Coroner's Bundle.

3.14. In addition to the above, the Methodology included consideration of the full chronology and an analysis of events.

3.15. The evidence used within this Enquiry included:

- All London Ambulance Service (LAS) records provided by the Safeguarding Lead for LAS, including Patient Form (LA4).
- LAS Transcript of 999 call.
- Hospital Discharge Notification Forms.
- Safeguarding Investigation Reports from the Care Home including the report dated April 2018, completed by the Executive Director of Nursing of the Care Provider.
- Transcripts of the interviews and statements obtained from staff by the Care Home Manager (Including Nurse C and carers).
- The Care Home Care Daily Records.
- Care Plans.
- The Care Home Choking Risk Assessment.
- The Care Home Nutritional Care Plan and nutritional assessments.
- MAR Charts. (Medication Administration Records)
- Emails and documents from Hospital Speech and Language Therapists.
- CCG Decision Support Tool, NHS Continuing Healthcare Assessment and other Continuing Healthcare Documents.
- Community Mental Health Team for Older Adults – reports and correspondence including all letters sent after assessment visits and consultations with Mrs E.
- Dependency assessments in relation to feeding and nutrition.
- Multiple letters and correspondence from the large files of documents provided by the Care Home, including records of falls, risk assessments and multiple relevant clinical records.
- Care Quality Commission (CQC) Reports and documentation, including notifications.
- Information from Mrs E's GP and treating consultant.
- Information provided by Mrs E's daughter, son-in-law and granddaughter.

4. Key Dates and Chronology

After Mrs E's death a number of actions flowed from the LAS safeguarding report that was submitted to the Local Authority. These are set out below:

01/02/2017 Initial contact made with family to outline remit of Safeguarding Enquiry. Case allocated to Social Worker to undertake Enquiry. Information from London Ambulance Service requested.

02/02/2017 Visit to Care Home to collect copies of Mrs E's daily records, to fully inform of Enquiry and to discuss with Care Home Manager the role and remit of Enquiry Officer. Call to Community Team to ascertain which Health Services Mrs E was known to. Request to access Mrs E's Hospital records.

03/02/2017 Contact with Police for consideration as to potential criminal offence.

07/02/2017 Contact with Coroner's office for clarification on cause of death.

15/02/2017 Contact with Mrs E's daughter for information update.

20/02/2017 Contact with Care Home Manager re: Enquiry Officer's concerns regarding Unit Nurse, based on listening to 999 call. Call to 101 – referral to Police.

22/02/2017 Report made to the Police, with a view to a potential criminal investigation.

24/02/2017 Meeting with Police – reporting of a possible crime. Details of Safeguarding taken by Police.

10/03/2017 Initial Safeguarding Report received from Care Home Manager.

20/03/2017 A further Safeguarding Report completed by Care Home Manager is received.

21/03/2017 Contact with GP for medical information.

22/03/2017 Police agree to meet with Enquiry Officer on 24/03/2017.

24/03/2017 Meeting between Police and Enquiry Officer to discuss whether there is a criminal element to the Safeguarding Enquiry. Evidence provided to Police in accordance with Data Protection Act - Information sharing. Referral to Nursing and Midwifery Council based on level of concern and potential public interest in relation to Nurse involved in Safeguarding case.

29/03/2017 Case discussion with Speech and Language Unit re: Safeguarding Enquiry. Discussion with GP re: discharge summary reports received from the Hospital.

04/04/2017 Case discussion with case worker regarding referral. Contact from the Speech and Language Unit.

11/04/2017 Case discussion with Head of Safeguarding regarding further evidence relating to neglect.

09/05/2017 Notification from Commissioning that Nurse and Health Carer have been dismissed from Care Home.

25/05/2017 Mrs E's daughter updated on progress.

13/06/2017 Meeting to discuss the case with the Police and Enquiry Officer. Action plan agreed.

27/06/2017 CQC[3] updated on Safeguarding and Police investigations.

11/08/2017 Police advise that after careful consideration of the evidence there is insufficient evidence to charge the Nurse. CCG would address the choking matter with local providers through an action plan.

21/08/2017 Pre-Inquest Hearing at the Coroner's Court. Attendees: Coroner, Mrs E's daughter and son-in-law, NHS Trust Lawyer, London Ambulance Service Lawyer, Care Home Lawyer, Care Quality Commission (CQC) Lawyer. The Coroner introduced the hearing by setting out who should be invited to attend the Inquest (Interested Parties), and an agenda. Initially, it was questioned by the Coroner where it was appropriate for CQC to be an interested party, based on their broader agenda, considering potential prosecution.

The Coroner explained she had received the Safeguarding Enquiry Report, and the report writer, who was present, was asked to provide a summary of the report to all parties present.

Agreed actions:

- A secondary Pre-Inquest Hearing was to be scheduled approximately w/c 23rd October 2017.
- Enquiry Officer to speak with Legal Team to discuss legal representation for the next Pre-Inquest Hearing.
- Local Authority to provide consent to the Safeguarding Report and evidence to be disseminated to all relevant parties.
- Enquiry Officer to complete front page.

27/10/2017 Pre-Inquest Hearing Review held at 09:30am Coroner's Court. The Enquiry Officer was in attendance with Barrister representing the Local Authority (Interested Party). Mrs E's daughter and son-in-law were both present and not represented.

Agreed actions:

- A third Pre-Inquest Hearing Review was considered, due to the failure of relevant witnesses (Carer and Nurse) to attend the hearing.
- The Inquest will be held in the new year (2018).
- The Inquest will be held by a Jury.

[3] Care Quality Commission

- The Inquest will be heard over 4 days.
- The Enquiry Officer to liaise with Legal and Barrister re: available dates to attend.
- The Enquiry Officer to send all evidence to Legal and Barrister, which will be disseminated to interested parties.

21/05/2018 – 23/05/2018 Coroner's Inquest held with Jury. Outcome: "Accidental Death contributed by Neglect". This conclusion was described by the Coroner as a "gross failure" to provide basic medical care, and with that, "a clear causal connection between the gross failure and Mrs E's death

By analysing the Transcript of the Inquest dated **23 May 2018**, it is clear that the Coroner directed the Jury to consider two points in time, the first was the period of admission to hospital between **26 to 29 November 2016**. In identifying that period, the Coroner limited the consideration to the failure to transfer the relevant information about Mrs E's Speech and Language Therapy Assessment and Risk Feeding Guidelines to the Care Home on discharge and whether a follow up phone call took place. The Coroner directed that the issue of neglect did not arise in respect of this first time period.

In considering the second time period which was **22 January 2017**, the Coroner directed that neglect could be found. She separated the events into two parts, the involvement of London Ambulance Service and the nursing care home staff involvement. She directed that neglect did not arise in the capacity of the evidence heard about the London Ambulance Service. She directed that the neglect may arise in how Mrs E was cared for when she began to choke. She outlined the events that took place, the actions of the staff on duty, the process of calling for emergency help and the circumstances that led to the calling of the ambulance. The failures in calling for medical assistance were focused on as being the potential grounds for finding neglect. The Coroner outlined the cause of death for the Jury as being 1(a) choking, 1(b) obstruction of the upper airways by food bolus, 2. other significant conditions, right lobar pneumonia, chronic kidney disease, hypotension, diabetes mellitus, generalised atherosclerosis, dementia and hypothyroidism. The Jury accepted the cause of death. The Coroner identified the confusion reported at the home about the impact of a DNAR order which had led to the suggestion that because it was in place, basic life support measures did not need to be attempted. She referenced the LAS stopping the resuscitation methods and directed that the actions of LAS did not amount to neglect. Therefore, the finding of neglect was only in relation to a part of the second time period and limited to the failures to provide basic medical care.

5. The Care Home

Description

5.1. The Care Home is a large nursing home which is registered to accommodate up to 113[4] older people with dementia or mental health needs across six units. At the time of the incident there were 83 people living at the Home. As registered providers, they are subject to the legal requirements for registration and service provision. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. In addition, the Registered Person has responsibility for care delivery, compliance and working within the Regulations and Statement of Purpose. The Statement of Purpose sets out a clear definition of the services to be provided, the details of the facilities, staffing and care. People in care homes receive accommodation and nursing or personal care as a single package under one contractual agreement. The Care Quality Commission (CQC) regulates both the premises and the care provided. A Registered Manager is a person who has registered with the CQC to manage the service. The Care Home was part of the same corporate group throughout the period subject to the Review. However, changes within the group's responsibilities were cited as reason why a few records were not available to the Reviewer leaving some questions unanswered. This included some employment records, references, training records and policies extant at the time. Thus, their significance is not known.

5.2. The Care Home is located alongside a busy dual carriageway; it has limited parking and many staff rely upon public transport for their journeys to and from work. The entrance to the Care Home is not visible from the road and it is quite easy to drive past. The Care Home is not a purpose-built property and the initial use of the building was to accommodate children who had been excluded from school. The Care Provider confirmed that the Care Home operated under a lease agreement. At the time of the Reviewer's visits the Care Home needed updating/refurbishment work. The Care Home layout is divided into discrete units with linked corridors. At a recent visit to the Care Home there had been confirmation of plans for investment at the site.

5.3. When the Reviewer visited, the Home Manager visibly maintained staff morale and engendered a feeling of warmth and belonging in the Care Home. Staff greeted visitors and family members in a friendly and cordial manner. Whilst visiting the different units, staff were welcoming, willing to answer questions and keen to show the Reviewer the way they cared for residents. Their passion and commitment were palpable. Residents were settled in a comfortable and homely environment. During visits at mealtimes, the Reviewer was shown the kitchens and full details of the catering arrangements accommodating a range of dietary needs, including dealing with residents who had swallowing difficulties. The implementation of the International Dysphagia Diet Standardisation Initiative Framework (IDDSI) guidelines was evident and the arrangements for mealtimes were observed by the Reviewer. There was the opportunity to speak to residents and the Reviewer discussed the food and how they felt about their meals. The Reviewer spent

[4] The owners consider the capacity to be 93.

time observing and talking to staff. Staff reported that things had radically changed following the tragic events that had led to the death of Mrs E. Training had been provided which was well received and induction had changed to incorporate choking risks. A lot of attention had been given to emergency procedures with safety meetings and a focus on reporting incidents as well as "near misses."

Medical Care at the Care Home

5.4. Mrs E's Consultant Psychiatrist had seen her regularly from the date of her admission on 24 March 2015 and had visited her on at least 9 occasions at the Care Home. The last consultation with Mrs E had taken place on 30 December 2016, this was shortly before her death on 23 January 2017. In speaking to the Consultant, he concluded that Mrs E was content and happy at the Care Home. While caring for her she required regular medication reviews and adjustments of doses. The medication helped to manage her sleep disturbances and at times, her violent outbursts. He felt that the reviews of medication had enabled her to have a better quality of life. He was not aware of any swallowing issues and no one had brought them to his attention during his visits to the home.

5.5. He had been saddened to hear of her death and reassuringly thought that the Care Home was the right setting for her to be cared for. He stated that her needs were being met and he was always made to feel welcome when he visited her. Overall, he thought that the care delivered for some of the most challenging of patients under his care in the Care Home, was consistent and appropriate. He spoke with affection for the Care Home and quoted examples of residents arriving in there in a state of distress and being extremely unwell. He explained that within weeks they made remarkable progress. The Care Home was known for taking residents who had difficulties settling in other homes and had a reputation for its expertise in managing challenging behaviour and those with dementia. He was concerned that it was not always easy to find places for people to be cared for in circumstances where other homes had wanted them moved or when families had experienced periods of crisis. He valued their work and stated that the Care Home accommodated many residents that had complex needs and required a lot of care and support to live their lives.

5.6. He is still a frequent visitor to the Care Home and feels that it is now professionally managed and stable, he praised the current Home Manager and credited her with "making sure it did not go down again." At the time of these events, as he recalled, the Care Home had experienced some staffing issues, and stated that this is not unusual in the sector. He was aware of ownership changing and that the Care Home had been through a difficult period with no permanent manager for a time.

5.7. The last time he saw Mrs E was on 30 December 2016, he recalled she was "in good spirits". On that day he emphasised he was not aware of any issues with swallowing or specialist dietary needs. He spoke at length to the Reviewer and expressed his sorrow at what had happened and stated that he was always sure that when he met Mrs E that she knew he was her doctor and there to help her. She had moments when she would reach across and hold his hand. He clearly knew her well and assured the Reviewer that he had done everything that he could do to help her during the time he cared for her. He wanted to communicate his condolences to her family.

GP Contacts

5.8. On 4 December 2019, the Reviewer spoke to Mrs E's GP, she confirmed in the call that Mrs E was registered with the practice with an application to join being received on 26 March 2015 and she was accepted onto the GP's list on 27 March 2015.

5.9. Over the period of Mrs E's admission to the Home and throughout her stay there, the GP Practice supported the Home with weekly visits, which continued until the contract ceased in October 2017. During these visits, residents to be seen would be identified by the staff. The team at the Practice thought the arrangement worked well. A variety of GP's would do the visits and they worked with the staff at the Care Home to provide clinical care. Mrs E's GP thought that the visits played a major role in maintaining the wellbeing of the residents, to ensure that they did not have unnecessary hospital admissions. It also enabled the early detection of potential problems and contributed to the smooth running of the Care Home with good communication and the forging of professional trust. When residents were seen, details were always recorded of what prompted the consultation and the outcome, treatment plans, prescriptions and medication were discussed with the staff.

5.10. An overview of the number of occasions that Mrs E was seen by a GP in the period from 3 October 2016 to 12 January 2017 was submitted to the Reviewer. Over that time there were 9 consultations for issues including sleep disturbance, medication management and a couple of falls, where no obvious injury was sustained. The only other matters that appear to have been the subject of GP input were a chesty cough on 3 October 2016 and concerns about the side effects of Lorazepam in May 2016. According to the Encounter Report, (a report from the IT system at the Practice where consultations are recorded), which was received from the GP Practice on 28 January 2020, Mrs E was seen on 10 November 2016 for a flu vaccination which was administered in the Care Home. The last contact with the GP was a surgery consultation in relation to sleep disturbances which took place on 12 January 2017. This was the last time Mrs E saw a doctor at the Home. It was clear that there was regular contact between the Surgery and the Care Home, that any problems were brought to the GP's attention and that the weekly visits were working well.

5.11. The Reviewer sought information about the hospital admission and discharge in November 2016. The GP confirmed the information relating to Mrs E's discharge from the November 2016 admission and that they had followed their usual procedures.

5.12. Mrs E's GP confirmed that, after the discharge of Mrs E on 29 November 2016, a Discharge Summary was received by the Practice and scanned onto their IT system on 1 December 2016. Between the discharge date of 29 November 2016 and the date of the incident on 22 January 2017, the only record in the GP system, was in relation to a consultation for sleep disturbance on 12 January 2017.

5.13. Mrs E's GP stated that she would not necessarily have expected that a hospital discharge, of itself, would have led to a follow up visit or the resident's name being added to the weekly visit list that was prepared for the GP visit to the Care Home. Equally, nothing within the Discharge Summary from the hospital would have, in her view, have prompted a review. Mrs E's GP was

sad about her death and thought that the home was a valuable part of the community, caring for people. She acknowledged that it was a difficult job, she thought that the practice had played its part in supporting and helping the Home and the staff.

5.14. The Discharge Summary from the hospital admission of 26-29 November 2016, sent to the GP, was dated 29 November 2016. It listed under Presenting Complaint and Associated Diagnoses: "Community acquired pneumonia; dementia; oropharyngeal dysphagia."

5.15. Under the Discharge Information Section, it states: "Complaining of Oropharyngeal dysphagia: SNMCT 118714016, Reason for Visit, No Flag." (The acronym SNMCT refers to categories of definitions of conditions and findings.)

5.16. In the "Clinical Information" section it states: "Was reviewed by Speech and Language Therapy Service who discussed with family regarding risk feeding" under "Impression", it lists: "Mild/moderate oropharyngeal dysphagia characterised by delayed swallow trigger of diet with risk of airway." This Discharge Summary was received by the Reviewer on 25 January 2020 and is significant as it shows that the risk to airway was identified during the admission but not followed up. The Report that was later compiled for H.M. Coroner has a summary from the GP which states the following:

5.17. "She was admitted to Hospital with a lower respiratory tract infection in November of 2016. We received a discharge summary sent to us from the home which they had received from the Hospital and this was on 30 November 2016. Of note is that she was reviewed by the Speech and Language Team at the Hospital with a diagnosis of oropharyngeal dysphagia. From the discharge summary it was noted that this was discussed with the family following a Multidisciplinary Team Meeting, the advice was that they would continue to risk feed her rather than consider alternative forms of feeding such as PEG (Percutaneous Endoscopic Gastrostomy) feeding to ensure quality of life."

5.18. During the Inquest it was confirmed in oral evidence that the four-page Discharge Summary was faxed to the surgery. A witness told H.M. Coroner "I faxed it to the GP to take action". There were two Discharge Summaries, one dated 26 November 2016 appears to have been a summary compiled for the move from the Accident and Emergency Department to the ward. The substantive Discharge Summary sent to the GP was the document dated 29 November 2016. It emerged that the risk feeding guidelines document was never sent to the home or to the GP.

6. Care Quality Commission (CQC)

6.1. The CQC carried out a fact-finding investigation following Mrs E's death on 23 January 2017. This was primarily to establish if there were any issues within the Care Home that could affect the users. Their conclusion was that there were no acts or omissions to suggest a breach of regulations and their investigator recommended that there was no cause for a criminal investigation.

CQC Inspection dated 21 and 22 February 2017

6.2. "This inspection took place on 21 and 22 February 2017, was unannounced. The inspection was prompted in part by notification of an incident following which a person using the service died. This inspection looked at the safety of other people at the service." The inspection raised a number of concerns including: "There were failings in ensuring there were effective systems in place to assess, review, monitor and improve the quality and safety of the service, maintain accurate complete and contemporaneous records and to mitigate risks relating to the health, safety and welfare of people using the service." Other concerns related to "People's risk assessments were not always completed appropriately and were not always reviewed on a regular basis in line with the provider's policy to ensure they remained up to date and reflective of people's needs and risks." The service was found to be "not consistently effective" and "people's mealtime experiences required improvement." Further concerns related to compliance with the Mental Capacity Act 2005 and further improvements were ongoing to ensure people's capacity issues were appropriately assessed. There were also failures in leadership and the service was found to be "not consistently well-led."

6.3. The conclusion reached from this inspection was as follows:

"Overall rating for this service:

- Is the service safe? Requires Improvement
- Is the service effective? Requires Improvement
- Is the service caring? Good
- Is the service responsive? Good
- Is the service well-led? Requires Improvement"

6.4. As a result of the concerns highlighted during this inspection there was a request made for a report setting out what action would be taken and by when in relation to "the providers failure to assess the risks to the health and safety of service users and doing all that is reasonably practicable to mitigate any such risks." Enforcement action was also taken as a result of the inspection in relation to failings in ensuring "there were effective systems in place to assess, review, monitor and improve the quality and safety of the service, maintain accurate complete and contemporaneous records and to mitigate risks relating to the health, safety and welfare of

people using the service." A Warning Notice was served on the provider and registered manager with a requirement to become compliant by 26 April 2017.

CQC Inspection dated 6 July 2017

6.5. "A further focused inspection was carried out on 6 July 2017. At that time, the provider had addressed many of the concerns raised in the February 2017 inspection and there was deemed to be compliance with the Warning Notice that had been issued. There were newly implemented systems in place to assess, monitor and mitigate the risks relating to the health, safety and welfare of people using the service, to assess monitor and improve the quality and safety of the service and to ensure contemporaneous records were kept relating to the health, safety and welfare of people using the service. However, the ratings for the key questions - safe, effective and well led - at this inspection remained 'Requires Improvement' at this time, as systems and processes that had been implemented had not been operational for a sufficient amount of time to be sure of consistent and sustained good practice and to achieve the rating of 'Good'. As a result of improvements made however, the Warning Notice was rescinded.

6.6. The Short Observational Framework for Inspection (SOFI) was used on two units within the Home to observe people's experiences at mealtimes and throughout the inspection. SOFI is a specific way of observing care to aid understanding of the experience of people.

At this inspection improvements had been made.

"The Overall rating for this service:

- Is the service safe? Requires Improvement
- Is the service effective? Requires Improvement
- Is the service well-led? Requires Improvement".

CQC Inspection dated 10 May 2018

6.7. "A further inspection was carried out on 10 May 2018. The inspection was unannounced and carried out by three inspectors, a specialist advisor who is a Clinical Nurse and two experts by experience.

6.8. During the inspection time was spent observing the support provided to people in communal areas and at mealtimes.

6.9. People's needs were reviewed and monitored on a regular basis. People were provided with information on how to make a complaint. There were effective systems in place to monitor the quality of the service provided. People's views about the service were sought and considered. People, their relatives and staff spoke positively of the management at the home."
"The Overall rating for this service:

- Is the service safe? Good
- Is the service effective? Good
- Is the service caring? Good
- Is the service responsive? Good
- Is the service well-led? Good."

Local Authority Action, post CQC Inspections

6.10. The Quality Assurance Manager at the Local Authority reported that during 2017 there were several managers at the Care Home during the absence of the Care Home Manager, leading up to the appointment of the current Home Manager who has been in post since January 2018. Management cover was considered patchy and not consistent at the time. The Quality Manager of the Local Authority advised the Reviewer that "During the period of the Warning Notice the Local Authority did not suspend placements to the service, kept it under close scrutiny and held regular Multi-Disciplinary Team Meetings to review on-going intelligence and gathered evidence and discussed progress against the Care Provider's action plan." Their role is to assure the quality of care for those who are living at the Care Home under the contractual arrangements. This duty extends to the identification of risks and the steps taken in mitigation. The ability of a Care Provider and a Care Home to learn lessons and take remedial action when there has been a serious adverse event and notifiable event is fundamental to maintaining the safety of residents.

6.11. Overall, the Reviewer found there to be a positive and productive relationship between the Quality Assurance Manager and her team at the Local Authority, and the Care Home and the Home Manager. There was evidence of mutual respect and appreciation of the respective roles of Quality Assurance and responsibility for delivery. The Home Manager stated that she felt she could turn to the Quality Assurance Manager and those who worked with her, for help and advice and it was clear that there was an appropriate balance between scrutiny and support. The Local Authority are to be commended for having built that relationship and the Reviewer emphasises the importance of that continuing. The Reviewer was heartened to hear of the CCG initiative supported by the Local Authority, where there is now additional primary care support to Care Homes in the area, with the effect of reducing conveyance and admission to hospital and maximising the care that can be delivered in the environment of the Care Home.

7. Involvement and Participation of Mrs E's family

7.1. Mrs E's Family felt well treated by the Local Authority, they had an excellent rapport with the Social Worker who had been the lead person in the case, and she had kept them informed at every stage in the process. They did not feel that communication from the Care Home was adequate and felt that they were disregarded. They did not feel that there had been an apology nor adequate expression of regret and condolence at the commencement of the Review.

7.2. During the Review, this was communicated to the Care Provider and on 7 June 2019, a letter of profound regret was sent to the Family and although late in the day it did assist family members. Family members reported feeling that after Mrs E's death, they felt as though their mother had just been forgotten. It was clear from the meetings and discussion with staff that Mrs E was certainly not forgotten by them. Her death had a big impact on staff and on two particular residents who had been close to Mrs E and had liked to sit with her. The staff were devastated about her death and reported feeling that more could have been done.

7.3. She was fondly remembered as the "Queen" of the Care Home and loved having her nails painted, her love of music and dancing had stayed with Mrs E since her early years as a dancer. She had a keen sense of humour and even when dealing with difficulties sleeping and behaviour changes, she was keen to communicate with others.

7.4. It is a testament to the dignified way in which Mrs E's Family have conducted themselves that they felt able to visit the Care Home on 17 November 2019 and meet and greet current residents with a smile, they spent time with the Care Home Manager who was willing and able to answer their outstanding questions.

8. The Responses

Care Home Initial Response

8.1. The Care Home completed their own investigation into events in March 2017 and compiled an investigation report which set out the course of events. The report was received by the Reviewer from the Care Home in response to the request for information. At the time of the incident the Care Home appropriately reported matters to the CQC and that report prompted the Inspection Visit that took place on 21 and 22 February 2017. The Investigation Report was initially prepared by the Care Home Manager. The Terms of Reference of that investigation had set out the need "to determine whether or not:

- Actions taken by staff in response to the choking event on 22.01.2017 were appropriate and called the emergency services at 20.50pm, following first aid attempt.
- Corporate protocols (including documentation and information sharing between SALT and the Care Home) were being adhered to.
- The level of care and the care plan provided to the resident by the 1:1 Carer was sufficient to meet her needs.
- To confirm and produce evidence of why the 1:1 carer was needed."

8.2. The Findings of the Report were as follows: "The level of care provided to the Resident appeared appropriate to meet her needs. She was on a one-to-one for which there was funding provided 8pm-8am (this was granted on 27.02.2016), where the resident was constantly monitored for agitation, aggression and preventing her from entering other residents' rooms, which-due to her increasing level of confusion- she didn't recognise as "hers."" The Investigation Report did not address the central issue of the care afforded to Mrs E at the time of the choking incident, despite that being part of the Terms of Reference. The Report outlined several Recommendations including training in Basic Life Support and Dysphagia, choking risk assessments to be updated monthly and care plans and dietary notifications to be updated monthly. Reminders about the use of the emergency call bell and SALT communications to be updated after hospital discharge also featured. Mrs E's carer who was due to take care of her from 20.00hrs until 08.00hrs, was late on duty and had a record of arriving late for shifts, she had been under disciplinary action and was heavily pregnant. This was the reason given for her not providing first aid. At the time of the choking incident the carer was out of sight and Mrs E was unattended. None of these matters featured and there was little detail about the emergency response.

8.3. The report offered no explanation as to why, when Paramedics arrived first on the scene at 21.02hrs, they could not access the Care Home. The Patient Report Form (LA4) recorded a delay entering the Care Home, due to a lack of response from staff to the doorbell. The Paramedics subsequently contacted the Emergency Call Centre, who in turn called the Care Home, and access was granted by staff from another unit. Once inside, the Paramedics attended Mrs E's room, only to find she was not there. The Paramedics found Mrs E in the lounge area. It is not clear from the report prepared why the member of staff that let the Paramedics in did not direct them to Mrs E. None of this was explored in the Report.

8.4. The initial diagnosis was 'Cardiac Arrest post choking'. The arrest, which Paramedic reports witnessing, followed pt... given tea/sandwiches by care staff". At 20:30hrs "a carer came to check on pt. and found she was having DIB" [Difficulties in Breathing]. Registered Nurse C came to assist care staff. They stated that she was having DIB – they checked the patient BP, but it was unreadable and therefore called 999". Paramedic reported Mrs E's airways were 'completely obstructed'. The reported sandwich was 'removed from airway with Magill forceps post laryngoscopy. OP size 2 inserted'.

8.5. A Safeguarding Alert was raised by the London Ambulance Service (LAS) on the 22 January 2017 following their attendance at the Care Home. The attending Paramedics reported being dispatched to Mrs E who it was reported was having difficulties in breathing [DIB]. The LAS reported 'On arrival, the patient was in a confirmed cardiac arrest. Registered Nurse and carers were on the scene, but no basic life support and stood behind patient.' It is reported by the Paramedics that on their arrival to the Unit, the carers were not helping Mrs E, who was sat in a chair. The Paramedics reported Nurse C was not present on arrival, however, subsequently arrived sometime after. The LAS reported then being informed that Mrs E was eating a sandwich unattended. The LAS further advised "The patient's carer stated that patient was not breathing properly, and nothing was mentioned about choking." The LAS noted an obstruction in the patient's airway and having checked Mrs E's Care Plan noted that 'patient should not be left alone while eating'.

8.6. The Care Home was offered training and support by the CCG in June 2017 but did not engage with the training offered "due to the long-term absence of the Manager".

8.7. A second investigation was conducted by the Care Provider and completed in April 2018. This was primarily prepared for the purposes of the Inquest and was disclosed to the Coroner. The Reviewer enquiries noted that Mrs E's family were provided with little information about these two investigations and of particular note is the fact that the Care Provider undertook to deliver an extensive training programme with all staff and incorporated information into induction training about choking risk.

London Ambulance Service (LAS) Call

8.8. The 999 call for an Emergency Ambulance was made by the Nurse in Charge, Nurse C, logged at 20:50hrs. During the call, there is a clear communication barrier between the Nurse and the Call-Handler, which affects the responsiveness of the information being logged. The Nurse is often repetitive, and his answers unclear. When asked what the problem was, Nurse C advises they were called by the carers, as Mrs E was presenting with breathlessness. Nurse C reports the carers expressed concern Mrs E was choking, however Nurse C states "but I don't see any indication for choking but she is very breathless". The Call-Handler asks for their name, and again queries "They said she was choking". Nurse C responds "Yes, no no, she not choking, I told you [C raises his voice at this point]. They suspected she is choking, the carer telling me, she is choked but she not eating anything. So therefore, we gave the first aid for choking but nothing there. But for any other reason she is breathless. She can't breathe". The call continues with Nurse C who confirms Mrs E's date of birth, and that Mrs E was presently with three Health Care Assistants. The Nurse is asked four times whether there is a defibrillator at the Care Home. Due

to the number of times Nurse C is asked; it is questionable whether Nurse C understood what a defibrillator is. There is a period during the call in which the Call-Handler asks Nurse C whether he had contacted the Hospital, whether he knew the destination and asked three times whether there would be an escort. During the call, the Call-Handler asks for Mrs E's name at the end of the call, although stated at the start of the call, and Mrs E's date of birth twice. The duration of the call was 8 minutes and 9 seconds, and the Call-Handler could be perceived as sounding exasperated with the caller. The Reviewer listened to the tape of the call on 7 occasions and had a transcript of the exchanges.

8.9. At the time of these events Nurse C had been employed at the Care Home since 27 January 2016. It was not possible to find out if references had been obtained prior to his employment as two referees were identified, but references were not on file.

8.10. At the Inquest, the Coroner commented that "we have heard the tape of the call-handler, we have listened to the evidence that perhaps it could have been handled slightly differently, but that appears to be quite minimal. So, I am directing you that neglect does not arise in the capacity of the evidence we have heard about the London Ambulance Service."

8.11. The emergency call was made to the London Ambulance Service (LAS) at 20.50hrs, the duration of the call was 8 minutes and 9 seconds. The LAS team arrived at 21.02hrs, this was within the eight-minute timeframe which is set for the call, which was correctly categorised on the information given. At that time 75% of calls were expected to arrive within 8 minutes, on this occasion, the crew were outside the building in 7 Minutes 55 Seconds. It was correctly categorised as a Category A, immediate life-threatening call.

The Local Authority Safeguarding Response

8.12. A Local Authority Strategy Meeting was convened on 1 February 2017, to consider the information received from the London Ambulance Service and the fact that Mrs E had died. As part of this process Mrs E's daughter was contacted and she confirmed that she wanted the matter investigated. Subsequent strategy discussions reviewed the inconsistences in information received and determined that a Safeguarding Investigation was necessary.

8.13. At the time of writing this Review, a former staff member from the Care Home who was involved in this safeguarding matter, is being investigated by the Nursing and Midwifery Council (NMC). As of 24 December 2020, the Fitness to Practise case is still ongoing. On 7 June 2017, an Interim Order Hearing took place at the NMC where the Nurse was suspended from Registered Nurse Mental Health Nursing (Level 2) registration which had been granted in September 1999. The Nurse remains under the interim suspension order. The Nurse was referred to the NMC following intervention by the Local Authority Social Worker. Mrs E's Family have been contacted as part of the NMC investigation. The Reviewer noted there was a suggestion that one of the carers should be referred through the Disclosure and Barring Scheme (DBS), but it was unclear whether that had been agreed or had happened. The Care Home were unable to confirm the final position.

Clinical Commissioning Group Actions

8.14. In respect of this and other matters, the Safeguarding Adults Board (the SAB) initiated a review of all care and safeguarding concerns about choking and this led to a Choking Risks Task and Finish Group being established by the SAB. There had been four choking cases. The Group started their work before the inquest into Mrs E's death. Commentary about the work of that Group is contained earlier in this report at page 11.

8.15. A questionnaire was sent out to Care Homes to identify further training needs and determine the support that could be offered. There were concerns at the time that all Care Homes where choking incidents had taken place had high staff turnover. New guidelines were issued, and profile was given using the Care Homes Forum which has been well attended by representatives of the Care Home. The SAB actions in convening the Group was an appropriate and creative response.

8.16. The CCG had a broader duty to Mrs E; at the time of her death, she was being wholly funded following her Continuing Healthcare Assessment of needs. The duties as commissioners of her care were a separate avenue of responsibility that merited searching questions about post incident investigation and the accountability of the Care Provider to the CCG.

8.17. During the Review it became clear that finding homes for people with Mrs E's needs was difficult. One of the reasons the Care Home was so highly regarded by those who had contact with it, was the nature of the care they provided. Both doctors spoken to by the Reviewer were clear that this was a service that was valuable and valued. The care at the Care Home was at times not readily available elsewhere. One of the doctors, especially, wanted to emphasise during this Review that nothing should threaten this provision as it was of such importance to the community it served.

Other Investigations

8.18. The Metropolitan Police carried out an investigation into Mrs E's death which commenced on 3 February 2017. The investigation examined possible offences under S.127 Mental Capacity Act 2005 (Ill treatment) and S.20 Criminal Justice and Courts Act 2015 (Ill treatment or Neglect). The investigation considered the agency investigations that had already taken place, medical records, Care Home documentation and statements from staff at the Care Home, London Ambulance Service and family members. The Police investigation concluded on the 11 August 2017 where it was decided that the investigation had not found evidence that reached the required threshold and the investigation was closed with no further police action. Mrs E's Family commented that they had been kept informed of these developments by the Social Worker and that they understood why the police were unable to take forward the case. They were not critical of the police and appreciated the fact that they had investigated the case. They were especially grateful for the excellent communication throughout from the Social Worker, who they said dealt sympathetically and professionally with them and especially when breaking news such as this.

Inquest

8.19. An Inquest was held into Mrs E's death with proceedings on 21 August 2017, 27 October 2017 and 21-23 May 2018. After taking evidence from the Investigating Officer, Mrs E's Family and staff, the Coroner found that Mrs E had died from: "Accidental Death contributed to by Neglect". This conclusion is defined by a "gross failure" to provide basic medical care, and with that, a clear causal connection between the gross failure and Mrs E's death". The detailed chronology of the incident is taken from the witness statements provided to the Coroner by those involved.

8.20. The Coroner identified all interested parties and Family, the Local Authority, Trust, LAS, Care Home Provider, the nurse in charge on 22 January 2017 were all included. There were 13 witnesses in attendance by video-link or in person, with one witness not attending and evidence being added to the record in respect of 4 witnesses. The Local Authority, Trust, LAS, Care Home Provider and the nurse in charge were legally represented. Witnesses included Doctors who had cared for Mrs E, nurses and care staff from the home, the newly appointed manager of the Care Home and a member of senior staff from the Care Provider. The Manager of the Speech and Language Therapy at the Trust as well as another Speech and Language Therapist gave evidence at the inquest. The witnesses from LAS included a paramedic and a quality assurance manager, with additional evidence provided by the call handler, which was read into the record.

9. Conclusions and Analysis

Preamble

9.1. In analysing the findings of a Safeguarding Adults Review, reaching conclusions and ultimately recommendations, it is important to reflect of the Terms of Reference provided. These appear at Appendix One.

9.2. It is the conclusion of the Reviewer that many of the specific areas for review identified have been covered by other investigations and significantly by the inquest. Therefore, the analysis is shaped under three headings to assist the SAB consider and implement recommendations. They are gaps and deficiencies in care and treatment, issues of communication and care planning and the emergency response. The section concludes with a consideration of best practice, learning and improvement.

Gaps and deficiencies in care and treatment

Record Keeping and Documentation

9.3. The standard of records seen by the Reviewer was poor, many documents were incomplete, lacked dates and the identity of those completing forms was often indecipherable or absent. Mrs E's Care Plan relating to nutrition was unclear and there was little risk analysis. The risk assessments that did exist were often difficult to interpret and did not address the issues. There was also evidence of repeat entries in records which could be perceived as showing a lack of diligence. The records supporting the re-admission back to the Care Home after hospital admission were sparce and it is questionable as to whether Mrs E's return to the Home should have triggered a GP review on the weekly visits to the Care Home.

9.4. In March 2017, a Serious Incident Investigation was conducted by the Care Home Manager, it stated that it had undertaken a review of documentation including:

> "A review of the Residents care file, including nutritional care plans, choking risk assessment, dietary notification sheet and related supplementary charts" as well as;
>
> "A Review of post discharge records from {the hospital} in November 2016, both, to determine whether or not notification of management of resident's dietary needs was carried out in accordance with instructions received."

9.5. The investigation made no reference or recommendations about the quality of records or record keeping. The Reviewer, having considered the same documents, considers there were grounds for concern about records and recommendations should have emerged from the initial investigation in March 2017.

The investigation in March 2017

9.6. The Home Manager went off sick following the death of Mrs E, whether on related or unrelated grounds, it is not known, but steps should have been taken to initiate immediate and speedy investigation. The Terms of Reference of the initial investigation conducted by the Care Home had set out the need "to determine whether or not:

- Actions taken by staff in response to the choking event on 22.01.2017 were appropriate and called the emergency services at 20.50pm, following first aid attempt.

- Corporate protocols (including documentation and information sharing between SALT and the Care Home) were being adhered to.
- The level of care and the care plan provided to the resident by the 1:1 carer was sufficient to meet her needs.
- To confirm and produce evidence of why the 1:1 carer was needed."

9.7. The Findings of the Report were as follows: "The level of care provided to the Resident appeared appropriate to meet her needs. She was on a one-to-one for which there was funding provided 8pm-8am (this was granted on 27.02.2016), where the resident was constantly monitored for agitation, aggression and preventing her from entering other residents' rooms, which-due to her increasing level of confusion- she didn't recognise as "hers.""

9.8. The Investigation Report did not address the central issue of the care afforded to Mrs E at the time of the choking incident, despite that being part of the Terms of Reference. The March 2017 Investigation Report bears the name of the Care Home Manager at the time and that of the Regional Operations Director. The Reviewer did not find one consolidated document which set out all the steps that had been taken since Mrs E's death to address the seriousness of the circumstances. Some evidence was submitted and presented at the inquest but necessarily it had a narrow focus and was directed at the proceedings in hand. By the time a thorough investigation was completed it was April 2018, opportunities had been lost to make changes in the interim period. The family of Mrs E were not made aware of the investigations being conducted, the statements and accounts being documented or the content of the final investigation reports. The lapse of time between the two investigations meant that inconsistent accounts of events were given which raised confusion and concern. This was also referenced by the Coroner at the Inquest, "as memories fade and recollections of what happened will differ in any event." Appropriate Notification was made to the CQC and the involvement of the Regional Operations Manager at the initial stage investigation does indicate senior oversight and involvement. The need for a further investigation in April 2018 appears to have been precipitated by the Inquest which was scheduled for May 2018 and the requirement for evidence to be given about the events surrounding the death of Mrs E. There is every indication that the Care Provider co-operated with the Inquest process and the Coroner's enquiries.

9.9. At the time of these events the Nurse in Charge, Nurse C had been employed at the Care Home since 27 January 2016. It was not possible to find out if references had been obtained prior to his employment, as two referees were identified, but references were not on file. The decision to suspend from employment and report Nurse C to the NMC, appears to have been taken after the intervention of the Local Authority Social Worker.

9.10. Other agencies should have made enquiries about the outcome of investigations, LAS had been the source of the safeguarding alert in the first instance, the Reviewer found no evidence that they had followed through and contacted the Care Home or the Care Provider to see the initial investigation report of March 2017. Similarly, the CCG with their responsibilities for Mrs E's care did not seek out the Investigation Report. The Local Authority focussed on its safeguarding responsibilities and should have also looked, in more detail, to the Care Provider for details of

how they were meeting their accountability. The Quality Assurance role of the Local Authority had a part to play in seeking out the investigation outcomes and assuring itself that everything was in good order. The police investigation did encompass the initial investigation into their work and carefully reviewed the case to see if there was potential for the matter to go further. The threshold was not met for that to happen.

9.11. It was not until H.M. Coroner analysed the case that investigatory resources were mobilised, at the Care Provider, the Trust, LAS and at the GP practice. The Local Authority was already taking safeguarding action, and this was widely known about. In Mrs E's case H.M. Coroner played a pivotal role in ensuring that there was a full and proper examination of the death of Mrs E and that a jury had a chance to deliberate and come to a decision. This was highly valued by Mrs E's Family.

Communication and care planning

The transfer of SALT discharge information

9.12. On her discharge from Hospital on 28 November 2016, there was never any indication from the Hospital to the staff at the Care Home that Mrs E was at risk of choking. After Mrs E's death, enquiries were made about the expected standard of care. It was confirmed on 5 April 2017 that "the expectation is on the speech therapist to make contact with the nursing home one week after discharge to discuss whether the home have any concerns or have identified any issues since discharge." The Service Manager stated that she contacted the Care Home to discuss the risk feeding plan, but this was not substantiated, whether this contact took place was doubtful, there was a Service Record that the call had taken place on 7 December 2016, but no notes of the call by the Care Home were found. It was confirmed that the care plan and assessment regarding "risk feeding" was never sent to the Care Home. The IT Contact system used by the service stated, "Not risk feeding" and stated that there was "no indication" for a referral to Community Services. The vital trigger a week after discharge of "not risk feeding" was missed and should have led to action at a critical time. The Service did not notify others of the diet change and the required changes to medication from tablets to liquid.

9.13. This should have been an indicator for action especially when considered with the discharge letter that had been prepared and the summary diagnosis that had been arrived at, which clearly set out the need for risk feeding. The opportunity for action when the Care Home reported that risk feeding was not in place was missed. A key communication failure occurred in the discharge arrangements and information transfer.

9.14. The fact that there was no further referral or follow up after discharge was a serious concern to the Reviewer and indicated a failure of service in communicating, not just with the Care Home, but with community providers of the Service and the GP. After her discharge from the Hospital Mrs E preferred the soft option, normal diet. This was not recorded other than on a diet notification form which is undated. Nutritional assessments were completed monthly and the last assessment completed, was only 12 days before her death, on 11 January 2017. Had there been an onward referral and post-discharge follow up, the omission would have been identified. The failures in communication are to some degree compounded by the recognition of the risk by the Service Lead. The statement as set out below identifies the problem:

"We rely on the home to reassure us the patient is at their baseline and that they have no concerns, that homes know how to seek further input from the Service, if the patient's condition changes over time or fluctuates. However, we acknowledge that this is no guarantee of effective management of safety and risks."

9.15. The current state of communication on discharge merits investigation and scrutiny. This is the responsibility of the Trust and the Service Leads. The role of GP's has also been considered, however, in these circumstances there did not appear to be the clear indicators for GP intervention post-discharge.

Communication with the family of Mrs E

9.16. During the Review, the Family shared their experience of dealing with the Care Home and the loss of their Mother, which was more upsetting due to the circumstances in which she had died. The Family recalled the hospital admission of November 2016 and they recognised that Mrs E was taking a long time to swallow her food. She needed a soft diet and time to eat. On the evening that Mrs E was taken to hospital the Nurse in Charge called and said Mrs E had gone to hospital, he gave little information about why but said she had become ill "next door." The Family set off to the hospital and when called by the carer that had escorted Mrs E they re-routed to travel to the correct hospital. The Family of Mrs E were concerned about the lack of clarity of communication and the way they were spoken to by the Nurse in Charge. The Family recounted the events of the 22 and 23 January 2017 and their sadness at losing Mrs E. The day after Mrs E had died her Family visited the Care Home to collect her things and were busy sorting out funeral arrangements, in the end some of the staff came to say their goodbyes at the funeral. After approximately 3 days the Family rang the home as they had expected some communication. A letter of complaint to the Home Manager yielded no response. They felt as if their Mum "didn't matter".

9.17. There had been a lot of activity around the time of the inquest and the family were concerned that some key witnesses such as the Home Manager and a carer who had played a major role on the night were not present to give their accounts to the Coroner and the jury. Other staff from the Care Provider were there and answered questions. The failure in communication extended primarily to the management of the Home and it was some time afterwards before they realised that the Home Manager had gone off sick and had then left. They felt she "had just walked away." The Family's queries and complaints were not adequately dealt with and at no time did they receive a comprehensive analysis of what had happened to Mrs E. The Care Home and the Care Provider did not take adequate steps to engage with Mrs E's Family. The period of time after a critical incident and a death is crucial, establishing avenues of communication, being available to answer questions and dealing with grieving families with empathy is an integral part of high-quality care. The Reviewer carefully considered the Family's account and clearly more could have been done at the time and afterwards, this has been acknowledged by the Care Provider.

The emergency response

At the care home

9.18. The staff on duty on the evening of 22 January 2017 did not respond adequately to the circumstances that arose. The standard of Basic Life Support and emergency care afforded to

Mrs E fell below an acceptable standard. At the time when Mrs E was initially found to be in distress the appropriate action would have been to activate the emergency button. This was not done, and the decision taken by the carer to go and find the Nurse in Charge, caused delay. Further delay ensued when the Nurse in Charge failed to recognise the seriousness of the situation and did not immediately respond. The Reviewer found that about 20-25 minutes elapsed before the ambulance was called for Mrs E and all accounts given suggest that during that time, she was conscious and breathing, albeit in difficulty. The Nurse confirmed his reluctance to call an ambulance at the inquest. The reluctance on behalf of the Nurse in Charge to summon an ambulance has not been explained in evidence at the inquest nor in any written accounts seen by the Reviewer. What is clear is that he failed to appreciate the need for emergency assistance and the immediate steps taken to help Mrs E are also subject to differing recollections. The deficiencies in training of staff and their knowledge of procedures became evident at the inquest and witnesses displayed their lack of confidence in dealing with emergency situations. The Nurse in Charge expressed concern at the inquest about the level of responsibility he was expected to have and about the staffing arrangements.

9.19. At the Inquest, the period prior to calling the ambulance, was identified as a critical period, Mrs E was choking and all present at the time agreed subsequently that she was very breathless, although the account of choking was not accepted by all. It seems to the Reviewer that it was the Nurse in Charge, Nurse C, who cast doubt on the initial suggestion that Mrs E was choking, this was evident when the 999 call was made. The emergency call was eventually made to the London Ambulance Service (LAS) at 20.50hrs.

9.20. In questioning the procedures in place at the Care Home currently, assurance has been given by the Home Manager and that has been supported by staff, that the access and direction issue would not happen today, due to remedial steps that have been taken. When an ambulance is called staff are always waiting at the door and will direct LAS to the resident. The issues around failures in basic life support and resuscitation have been addressed through training, simulation and discussions at staff meetings.

Transcription of the 999 Call

9.21. The transcription of the content of the call onto the LAS form was incomplete as choking was omitted, even though, it was mentioned at the outset of the call and then replaced by breathlessness as being the reason for the call. The Nurse in Charge stated initially that the reason was reported to him as choking but he did not think it was. It was confirmed by LAS on 16 October 2019 that “the determinant for the call on the Patient Report Form’s for Mrs E was difficulty in breathing… it doesn’t say anything about choking.”

9.22. The LAS had a fundamental problem with the 999 call as the information being given was unclear. However, even the mention of choking should have prevailed as a reason for the call, as opposed to just difficulty in breathing. An obstructed airway can potentially be cleared, whereas a difficulty in breathing can have multiple causes and solutions. The call was difficult, and the Call Handler made multiple attempts to elicit even simple information, there was confusion about what was happening, the Nurse in Charge seemed unable to give clear, succinct, clinical information. When asked about the availability of a defibrillator the Nurse in Charge did not seem to know what it was. The Nurse’s command of English was limited and his ability to

comprehend questions asked and respond appropriately appeared to be impaired. Similarly, those communication problems were an issue at the inquest. Despite the challenge of finding out what the reason for the emergency call was, the call was correctly dealt with and the team despatched to attend. The LAS team arrived at 21.02hrs, this was within the eight-minute timeframe which is set for the call, which was correctly categorised on the information given. On arrival, the paramedics had difficulty accessing the building, this led to a further delay. It was only after a further call by the team back to the Emergency Call Centre, that staff gave the paramedics access. Once they were in the building no one directed them to Mrs E. They located her at 21.08hrs, she was in the lounge. By the time they arrived by her side, she was unconscious, unresponsive and not breathing. Through their efforts they achieved cardiac output.

9.23. The Nurse in Charge was not present and active steps were not being taken to help her. A clear account of the situation on arrival was provided by those who attended Mrs E and the lack of first aid and care, including basic life support was evident in those descriptions. “found patient sitting in a chair with staff all sitting behind patient.” The Paramedics started cardio-pulmonary resuscitation. There was a degree of confusion about whether Mrs E was breathless and having difficulty breathing or was choking. There had been differing accounts. A second LAS team was called out, as per the protocol, and in the end Mrs E’s airway was found to be blocked with a bolus of food which was removed with forceps. She was taken to hospital, her family were contacted, but given unclear and inaccurate information.

Interpretation of Do Not Attempt Resuscitation Orders (DNARs)

9.24. The Paramedics discontinued CPR when the staff produced Mrs E’s DNAR order, it is not clear whether this was due to her clinical condition or the emergence of the Order. It seems that they then decided to recommence CPR, the decision was made once the choking issue was identified. It was at that point they removed the bolus of food with forceps, but time had been lost. The account was as follows: “started CPR, was told that patient had a DNAR in place. Stopped CPR for approx. 1 minute. Was given DNAR and told patient was choking on a sandwich. Restarted CPR and called for second crew.”

9.25. The impact of having a DNAR order in place was not understood by those caring for Mrs E, and at the inquest there was a difference in views about the appropriate steps to be taken to assist her with Basic Life Support. The Reviewer was unable to conclude what steps were taken by the Nurse in Charge or by any of the carers at the time of the incident to administer first aid and Basic Life Support. The failure to demonstrate empathy in failing to comfort Mrs E, at what must have been a distressing time, is more difficult to understand and relates to the values that are needed in recruiting people with the qualities to care. There is the potential for differing interpretations of the meaning of DNAR Orders. In these circumstances it did not mean that Basic Life Support should have been withheld and the purpose of a DNAR Order is not to prevent life-saving measures in a case of choking. It is of note that the Paramedics did ask to see the original DNAR documents and would not rely on any other version. It seems to have been the imparting of the information about a possible choking that caused them to restart CPR.

Best practice, learning and improvement

9.26. The Reviewer found that the proactive approach adopted by the SAB, the Local Authority and the successful collaboration with the CCG meant that many areas of the Terms of Reference had already been addressed by the time of completion of this Report. The initiation of the Multi Agency Choking Task and Finish Group and the resultant Action Plan and its implementation had led to significant risk reduction and a heightening of awareness of choking risks.

9.27. The exemplary work of the Social Worker in this case merits recognition, her communication with Mrs E's family made their experience more bearable and she dealt with them with compassion and empathy.

9.28. The Metropolitan Police investigation and the ultimate decision to take no further action was understood by all and the Reviewer found no evidence of any criticism of their actions. Most importantly, Mrs E's family understood and accepted why that was the correct outcome.

9.29. The relationship of appropriate scrutiny and support that exists between the Quality Assurance Team at the Local Authority and the Care Home and Care Provider is worthy of mention, as all parties reported it as working well.

9.30. The Care Home and Provider have taken remedial steps on all aspects of choking risk, basic life support and choking training, HR, induction, documentation and mealtime practice. They have also addressed issues such as emergency calls for internal assistance, calling for an ambulance and enabling access to the home. They have initiated new methods of identifying and evaluating choking risk in residents and now have allocated staff time to discuss emergency scenarios and the appropriate responses. They have also changed their procedures to ensure better communication and post-incident contact with families.

Summary

9.31. In summary, while much has been addressed, the recommendations set out below highlight the areas where further attention is needed. The positive relationships that exist between all agencies will assist in ensuring that the recommendations can be addressed, and assurance be given to Mrs E's family and the wider public, that all appropriate action has been taken by all agencies. The recommendations arising from the Terms of Reference have been aligned with the actions that are primarily outstanding as so much has been achieved over the period of the Review.

10. Recommendations

The Recommendations that follow are wide ranging and require breaking down into defined tasks to be incorporated into an associated action plan. Once allocated to partner agency leads progress will be monitored by the SAB.

Record Keeping

Recommendation One: The Care Home and Care Provider should address standards of record keeping.

i) Staff should have record keeping training,
ii) The Care Provider and the Care Home Manager should conduct regular audits to ensure record keeping standards are maintained.
iii) Care Plans, risk assessments, SALT assessments and reviews and nutritional records should be prioritised by the Care Home and Care Provider, where there is a resident at risk of choking.
iv) The commissioning arrangements should make provision for scrutiny of records and this should be built into Quality Assurance processes during Local Authority visits.

Investigation

Recommendation Two: The Care Provider needs to consider how speedy and thorough investigation can be undertaken.

i) Robust policies should be in place to underpin the duties and responsibilities of Home Managers and staff.
ii) The Care Provider must ensure that appropriate regulatory action and referrals are made to maintain resident safety and public trust and confidence.
iii) The duty of candour should be part of staff induction and training.
iv) The investigation of incidents should be built into Quality Assurance Processes during local authority visits.
v) The Care Provider should review arrangements for all regulatory referrals, the Local Authority should monitor delivery of this recommendation.

Recommendation Three: The Local Authority should coordinate post incident investigation, with LAS, CQC, CCG, the Trust, GP, the Care Provider.

i) To be undertaken in the immediate days and weeks after a death.
ii) There should be clarity about following up on actions and when appropriate, decisions taken about closing the matter.

Transfer of SALT Discharge Information

Recommendation Four: Trusts and Community Services should review arrangements for discharge and follow up.

i) Trusts, especially the Head of Services for Speech and Language Therapy, should ensure that risk feeding guidelines are provided on discharge.
ii) Community Services should review arrangements for discharge and follow up. This should include post discharge communication with GPs and provision of risk feeding guidelines and risk assessments to the Care Home.

iii) Care providers must ensure that homes have systems for capturing and acting on discharge information.
iv) GPs should play a role in ensuring risks of discharge information being lost are minimised by post discharge follow-up.

Communication with Mrs E's Family

Recommendation Five: The Care Provider should review arrangements for investigation and communicating with families after serious adverse events and in relation to complaints handling.

i) This should involve the CCG, where they have responsibility in circumstances of continuing healthcare or be
ii) Overseen by the Quality Assurance Team at the Local Authority in other circumstances.

Emergency Response

Recommendation Six: The Care Provider should review HR procedures and practices to ensure sustained recruitment, retention, training and support of those with the right values to care for older people.

i) The Local Authority Quality Assurance Team should assist the Provider in maintaining practice compliance with the reviewed HR procedures.
ii) This should be audited regularly by the Local Authority Quality Assurance Team. The training and sound HR evidence should form part of the commissioning standards of the CCG.
iii) The practice of keeping training records should be checked.

LAS 999 Call

Recommendation Seven: The training programme for Call-Handlers should identify this type of risk and ensure accurate first accounts are taken and transcribed.

i) This should be subject to audit and scrutiny within LAS and embedded in quality standards.
ii) At LAS, there were issues with communication with Nurse C, the Call-Handler should have recorded choking as the predominant cause of the emergency call as it was given as the initial reason for the call, then discounted.

Do Not Attempt Resuscitation Orders

Recommendation Eight (a): LAS should review practice and procedures and ensure this is reflected in staff training programmes.

The London Ambulance Service (LAS) needs to consider whether greater clarity is needed about the impact of a DNAR Order being in place in these circumstances. The Reviewer would have expected resuscitation to have continued in circumstances of choking, even in the presence of a DNAR Order, but recognises that the considerable confusion that prevailed may have made decision making complex at the time. This has implications for the training of LAS staff

Recommendation Eight (b) Training for staff in the Care Home on the purpose and effect of DNAR's should be initiated, reviewed and evaluated by the Care Provider.

The Care Home Manager should conduct regular audits of staff knowledge and competence to ensure standards are maintained.

Appendix One: Terms of Reference of the Review

The set-up meeting had taken place on 24 October 2018 and the Terms of reference for this Review were agreed on 16 January 2019 and are set out below.

"Safeguarding Adults Review (SAR) Panel

Terms of Reference – Mrs E

Overarching aim and principles of the SAR

The purpose and underpinning principles of this SAR are set out in section 2.10 of the London Multi-Agency Safeguarding Adults Policy and Procedures. All the Local Authority Safeguarding Adults Board (GSAB) members and organisations involved in this SAR, and all SAR panel members, agree to work to these aims and underpinning principles. The SAR panel members are senior representatives of the three statutory agencies, Local Authority, CCG and Police and will arrange to meet as required to oversee the SAR process.

The SAR is about identifying lessons to be learned across the partnership and not about establishing blame or culpability. In doing so, the SAR will take a broad approach to identifying causation and will reflect the current realities of practice ("tell it like it is").

Legislation

Section 44 of the Care Act 2014 places a statutory requirement on GSAB to commission and learn from SARs in specific circumstances, as laid out below, and confers on GSAB the power to commission a SAR into any other case:

'A review of a case involving an adult in its area with needs for care and support (whether or not the Local Authority has been meeting any of those needs) if –

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

b) the adult had died, and the SAB knows or suspects that the death resulted from abuse or neglect…, or

c) the adult is still alive, and the SAB knows or suspects that the adult has experienced serious abuse or neglect.

…Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to –

a) Identifying the lessons to be learnt from the adult's case, and

b) Applying those lessons to future cases.

Governance and accountability

This SAR will be conducted in accordance with requirements set out in:

- Care Act 2014 and statutory guidance (DH 2014);
- Safeguarding Adults Reviews under the Care Act: implementation support (SCIE 2015);
- London Multi-Agency Safeguarding Adults Policy and Procedures;
- GSAB Procedures for Safeguarding Adults Review and Multi-Agency Reviews (2016)
- The General Data Protection Regulation 2016/679 implemented on 25 May 2018

As the accountable body responsible for its commissioning, GSAB will receive updates on progress of this SAR at Board meetings.

SAR subject

The summary of details of the subject of this SAR are:

Name	Age	DoD
Mrs E	82	23/01/2017

Brief summary of concerns that triggered this SAR

Mrs E was a resident in a nursing home receiving 1:1 support. The placement was fully funded by the CCG. Mrs E became ill and it is understood that staff thought she was having breathing difficulties. She had been assessed by the Speech and Language Therapy Service (the Service) and should have been eating fork mashable food, however it seems the person was choking on a sandwich or bread. Mrs E subsequently died.

There had been three further cases where a choking incident was a factor in the person's death.

Following much discussion with officers from the Local Authority and careful consideration, the SAB Chair agreed to write to the CCG stating that urgent action was required to give the Local Authority Safeguarding Adults Board assurance in the management of risk of choking. The SAB Chair asked NHS Clinical Commissioning Group to commission and undertake work to investigate the practice and training in this area at the three identified Nursing Homes and at all Nursing Homes in the Borough to ensure residents receive the appropriate nursing care. The SAB Chair asked that a report was presented to the Local Authority Safeguarding Adults Board on 22 June 2017.

In addition, the SAB Chair wrote to the Care Quality Commission to inform them of these concerns, advise them of the action being taken and to ask them what action they would be taking.

The SAB Chair wrote to the Local Authority Council asking them to review practice and training within residential Care Homes within the Borough and to report to the Local Authority Safeguarding Adults Board on 22 June 2017.

The CCG and Local Authority undertook a piece of work and have reported back to the SAB at every meeting from June 2017 onwards.

The case was considered following the outcome of the Coroner's Inquest where the jury concluded "accidental death contributed by neglect". The Inquest raised several concerns in relation to the Nursing Home, Hospital, Speech and Language Therapy Services and GP.

The SAB Chair agreed with the recommendation for a SAR on 23 August 2018.

SAR Methodology

It is suggested that review begins with a panel discussion and agreement about the most effective way to gather the information and data to undertake the SAR and meets its aims.

First impressions are that an incremental approach is the most likely to meet the need for flexibility whilst maintaining proportionality. (Agencies will have undertaken a lot of work in preparing for the Coroner's Inquest and assuming they consent to disclosure of the same it will save repetition).

So rather than requesting IMRs including a chronology for an agreed timeframe from all agencies that the Author undertake a desktop review of existing documents with a view to:

- *Preparing a chronology of the life and death of Mrs E that identifies facts, inconsistencies if they exist, gaps if they seem pertinent and queries where the facts seem uncertain or curious.*
- *Producing an issues paper which can request further information through either IMR type reports but with specified aspects, responses to written questions or an offer of an interview.*
- *Analysing the desktop review, the chronology and the responses to the requests for information in a draft SAR report for the consideration of the Panel.*
- *Asking and enabling the Panel to test the evidence for any findings or lessons identified plus advising on the shaping of recommendations.*
- *Inviting the Panel to agree the independent review for approval of the SAB*

The SAR should cover the time period from 25 January 2015 to the 23 January 2017.

Agencies are asked to provide information detailing their involvement during this period within their chronologies and provide a summary of any relevant information that falls outside of this period.

Chronologies and IMRs should not be anonymised initially, that will be undertaken at a later stage in the review process.

Guidance on methodologies can be found in Safeguarding Adults Reviews under the Care Act: implementation support.

Aims of Safeguarding Adults Review

To identify whether there were any gaps or deficiencies in the care, support and treatment of Mrs E.

To identify if Mrs E's death was predictable and/or preventable.

To identify areas of best practice, opportunities for learning across organisations and areas where improvements to services might be required which could help prevent similar incidents from occurring.

Specific areas for review

The SAR investigation (and by extension all contributors) will consider and reflect on the following:

Review the care and support, treatment and services provided by the Local Authority, hospital, Community Mental Health Trust, GP, CCG and Nursing Home and any other relevant agencies to Mrs E with specific attention to inter-agency working in relation to safeguarding Mrs E.

Review whether local Safeguarding Adults Policies and Procedures were properly followed, addressing the six principles of safeguarding.

Review the effectiveness of care planning for Mrs E.

Review and assess compliance with local policies, national guidance and relevant statutory obligations.

Review the issues raised by the Coroner's Inquest and any actions taken following this.

Review the work undertaken by the CCG and Local Authority as required by the Local Authority Safeguarding Adults Board, referring to the other three people in nursing homes where choking incidents were a factor in their deaths.

Provide a written report to the Local Authority Safeguarding Adults Board that includes measurable and sustainable recommendations.

Timescales for completion

This SAR will commence on 18 January 2019 and should if possible, be completed within six months, however there may be a delay in receiving IMRs and chronologies from agencies and therefore the six-month timescale may be extended where necessary.

SAR author

The SAR author commissioned should be sufficiently skilled and experienced in Safeguarding matters as set out in GSAB Procedure for SAR and multi-agency review 7.1. The SAR author should also have nursing experience. The independence of the author should be evidenced by the fact that they have never had direct or indirect involvement with the subject of the review; nor, line management responsibility for any staff writing a report for the SAR.

Confidentiality

In line with the confidentiality statement, all communication regarding this SAR that contains personal and/or sensitive information must be sent securely using the secure email addresses provided. Please contact the GSAB Manager with any queries as to how to securely contact another panel member. Requirements in respect of the General Data Protection Regulation

2016/679 implemented on 25 May 2018 will be adhered to throughout the process and legal advice will be sought regarding this matter prior to completion of the report.

Evidence and submissions to the SAR

It has been agreed that the following organisations are to be asked to submit evidence to the SAR:

Organisation/Service Area	***Nature of the evidence to be submitted***	***Deadline***
Local Authority		
Hospital		
Community MH Trust		
GP		
CCG		
Nursing Home		
London Ambulance Service		

SAR report and publication

Mandie Lavin (CPEA) has been appointed to author the SAR report, the content of which is to be in line with section 7.14 of GSAB Procedure for SAR and multi-agency review and the London Multi-Agency Safeguarding Adults Policy and Procedures. It must contain the transparency of analysis necessary for others to scrutinise the findings.

It is expected that an anonymised version of the full SAR report or the executive summary will be published on www.greenwichsafeguardingadults.org.uk unless there are exceptional circumstances meaning this would not be appropriate. On completion of the report, the SAR panel will recommend to the GSAB how to publish the report, setting out clear reasons for the recommendation.

Timings for publication may be affected by any criminal proceedings and court case, and the SAR report may be held for publication until such time as the proceedings/case has concluded it can be published. In the meantime, any lessons learned can be taken forward immediately.

Disclosure and confidentiality

Confidentiality should be maintained by all GSAB members and organisations involved in this SAR, in line with the confidentiality statement that forms part of these terms of reference.

However, the achievement of confidentiality must be balanced against the need for transparency

and sharing of information in order for an effective SAR to be completed in the public interest, in line with Section 44 of the Care Act 2014, section 2.10 of the London Multi-Agency Safeguarding Adults Policy and Procedures.

All GSAB members and organisations involved in this SAR commit to co-operate in and contribute to this SAR, including sharing relevant information to support joint learning. Where it is suspected that critical information is not forthcoming, GSAB may use its powers under Section 45 of the Care Act to obtain the relevant information.

The SAR Author may wish to review an organisation's case records and internal reports personally, request additional records and relevant policies/guidance, or meet with review participants. Individuals will be granted anonymity within the SAR report and the resident will be referred to as Mrs E.

Communications and media strategy

Communications advice will be provided, and the communications approach managed by the Local Authority communications department. All media queries will be referred to the Local Authority, unless criminal proceedings are ensuing in which case all media queries will be referred to the Metropolitan Police Service.

Legal advice

Legal advice to the Local Authority Safeguarding Adults Boards will be arranged by the Local Authority legal department to ensure the SAR process and final report complies with legal requirements and safeguards all parties.

Liaison with the police, criminal justice system and Coroner

The SAR Author in conjunction with the GSAB Manager will be responsible for ensuring appropriate on-going liaison with the Crown Prosecution Service, Coroner and the Police if and as required.

Links to parallel reviews

The SAR Author shall keep under review any links to other reviews of practice, such as domestic homicide reviews, serious incident reviews, Children's Serious Case Reviews or an SAR being conducted by another SAB, where known.

Funding and resourcing

The funding of this SAR will be provided by the GSAB.

Review of Terms of Reference

In the light of information that becomes apparent, these Terms of Reference will be subject to review. Amendments to the terms of reference may be proposed as the SAR progresses but must be approved by the Chair of GSAB. These terms of reference were approved at Safeguarding Adult Review Panel Meeting on 24 October 2018 and updated at the panel meeting 18 January 2019."