Bath & North East Somerset
Community Safety & Safeguarding Partnership

Safeguarding Adult Review: Cooper

Independent Overview Report Author: David Mellor

June 2022

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1. Introduction

1.1 Cooper (not his real name) died in hospital in June 2020. He was 71 years old. Cooper had a learning disability and had lived in residential care homes for people with learning disabilities for a number of years. His physical and mental health began to deteriorate around the time that the first national Covid-19 lockdown began and he was admitted to hospital, where his health improved after initially being placed on 'end of life' care. He was discharged back to the care home from which he had been admitted but his needs had increased and it was becoming increasingly clear that he was unlikely to recover sufficiently for the care home to continue to meet his needs. A further deterioration in his health led to a second admission to hospital where he died. During this second hospital admission, clinical examination disclosed a likely prior Covid-19 infection, although Cooper never tested positive for the coronavirus. The direct cause of Cooper's death was recorded on his death certificate as 'Clinical Covid-19 infection', with 'Diabetes, Stroke and Learning Disabilities' recorded as underlying causes.

1.2 Bath & North East Somerset (B&NES) Community Safety and Safeguarding Partnership decided to undertake a safeguarding adults review (SAR) on the grounds that neglect may have been a factor in Cooper's death and there were concerns that partner agencies could have worked together more effectively to protect him. A description of the process by which this SAR was conducted is shown at Appendix A. The SAR has also benefitted from the information gathered and analysed for a prior LeDeR review. The Learning Disabilities Mortality Review (LeDeR) programme is commissioned by NHS England to support local areas in England to review the deaths of people with a learning disability to identify common themes and learning points.

1.3 David Mellor was appointed as independent reviewer for the SAR. He is a retired chief officer of police and has over nine years' experience of conducting statutory reviews. He has no connection to any agency in B&NES.

1.4 An inquest may be held in due course.

1.5 B&NES Community Safety and Safeguarding Partnership wishes to express sincere condolences to the family and friends of Cooper.

2. Terms of Reference

2.1 The time period covered by the SAR is from 24th March 2019 until 3rd June 2020. Significant events which took place prior to this time period should be included.

2.2 The Key Lines of Enquiry for this review are as follows:

- What impact did Covid-19 have on Cooper's care and were there missed opportunities to prevent further decline in his health?
- Was the standard of care provided to Cooper equal and equitable compared to people without a learning disability?
- Was the treatment received at the Royal United Hospital (RUH) in line with Cooper's hospital passport, and did it follow the requirements of the Mental Capacity Act (MCA)?
- When Cooper was discharged from the RUH, who was involved in assessing and understanding his needs and how they were to be met; were they understood?
- How effectively was Cooper's voice heard by professionals and his views and wishes taken into account?
- Following discharge from the RUH, was Care Home 1 the most appropriate setting for Cooper's care and support needs given it was a residential care setting and not a nursing care setting?

3. Synopsis

3.1 Cooper was a White British 71-year-old man who had a mild learning disability from birth. He had good comprehension and was able to make his needs known and would contact a member of staff if he required any support throughout the day. He had a keen interest in music and enjoyed listening to his collection of vinyl records. He went to an Alice Cooper event in Birmingham during 2019. An important part of his routine was to visit the local Tesco store and buy a can of coke and a newspaper – which he would spend time reading on his return to the care home. He also liked to spend time on his own. He saw his brother, who lives in Essex, twice a year. He was supported to attend a local social and leisure club for people with learning disabilities, and the Church and local shops on a regular basis. He was reported to enjoy holidays organised by his care provider and had been looking forward to a planned holiday in Spain in 2021.

3.2 Cooper had Type 2 Diabetes for which he was prescribed Metformin. His mobility had been impaired by a stroke which affected his right side. He used a walking frame at home and a wheelchair when in the community. The stroke had also affected his hands which meant that he experienced difficulty in moving his hands to feed himself. He experienced hypertension (high blood pressure) which was reviewed annually. He had mitral valve disease which was under regular review. The mitral valve is a small flap in the heart which stops blood flowing the wrong way. A hernia was diagnosed in 2013 (unclear which type) which had been managed since then. A hernia belt had been tried in the past without success. He had previously experienced seizures as a result of epilepsy (in 2008 and 2009) but there had been no seizure activity since that time. His health needs were considered to be significant and the review has been advised that Cooper appeared much older than his chronological age.

3.3 Cooper required staff support to remain safe but appeared to have a basic understanding of danger. Behaviours described as ‘challenging’ were managed through staff support and noting the identified triggers.

3.4 From 2007 until November 2019 Cooper lived at Care Home A in Bristol which was a residential care home operated by Freeways. Freeways is a charity which was established in 1987 to provide services for people with learning disabilities across Bristol, North Somerset, South Gloucestershire and B&NES. As Care Home A service was closing, a new placement was required for Cooper.

3.5 On 20th November 2019 Cooper moved into Care Home 1 in the B&NES Council area, for which the provider is also Freeways. Care Home 1 provides accommodation and personal care for up to 14 people with a learning disability. The home is a large converted villa in a residential area and the accommodation is set out over three floors which are accessed via stairs to the front and back of the house. As with all the services provided by Freeways, Care Home 1 is currently assessed by the CQC as ‘good’. This was an ‘out of area’ placement commissioned by South Gloucestershire Council, Cooper’s ‘home’ local authority.

3.6 Prior to the move taking place, Cooper was supported to visit Care Home 1 on a number of occasions and was reported to enjoy his visits and to be happy to move there. During the process of moving and settling in to Care Home 1, Cooper was supported by an advocate. His South Gloucestershire social worker completed a care and support plan which identified what the new placement needed to achieve in order to meet Cooper’s needs. Funding was agreed for an additional 1 hour 1:1 support each day to facilitate a daily trip to the shop for essential items including his newspaper. Otherwise, Cooper was to be supported through shared staffing hours.

3.7 A Health Action Plan was completed in December 2019 which identified Cooper's health priorities as Type 2 Diabetes, mobility, foot care, dry skin on his legs and Hernia care.

3.8 Cooper's placement was reviewed on 19th December 2019. He had settled in well and built positive relationships with staff and other residents. He was eating and drinking well. In addition to his daily hour of 1:1 time, Cooper had a weekly life skills day. He was noted to experience difficulty in getting in and out of his armchair and confidently balancing himself. The home had completed a referral for a review from Physio/Occupational Therapy to assess Cooper for appropriate equipment in his bedroom/bathroom which was to be progressed. A raised chair was to be provided for Cooper in the communal living area. At this point the advocate planned to end his involvement with Cooper (although the safeguarding alert referred to in Paragraph 4.9 extended the advocate's involvement); and his South Gloucestershire social worker was to check that the necessary equipment had been provided for Cooper and thereafter the placement would be subject to annual review.

3.9 On 26th December 2019 a safeguarding alert was raised after Cooper told care home staff that an agency worker had pushed him in the shower. He later said that this had happened a few times. He had not sustained any injuries. Cooper was noted to 'get shaky' in the shower and needed support. The safeguarding alert progressed to a Section 42 Enquiry. The outcome was that the concern was not substantiated although Cooper's wish, that he no longer received support from the particular agency worker involved, was complied with. Cooper was supported by the advocate who had supported him during his transfer to Care Home 1 although the advocate was unable to attend the Safeguarding Planning meeting held on 15th January 2020 because of a prior commitment. The Safeguarding Planning meeting identified that there was a need to review risk assessments in respect of Cooper if the incident suggested that he was becoming less steady on his feet and the prior referral to Physio/Occupational Therapy was noted.

3.10 When Cooper was seen by his advocate on 16th January 2020 he was noted to have a new chair for his room, a seat to assist him with showering and a new record player.

3.11 On 17th January 2020 Cooper was seen by a Physiotherapist Assistant regarding the concerns that he may have become unsteady when showering and chair raisers and a more suitable shower chair were to be discussed with 'LD'. (In B&NES the Complex Health Needs Service (CHNS) provides assessment, advice, therapeutic intervention and support to adults who have learning disabilities and complex health needs. The provider of the CHNS at that time was Virgin Care. The provider recently transferred to and is now HCRG Care). It is worthy of note that Cooper's transfer from Care Home A in Bristol to Care Home 1 in B&NES, resulted in a change in the provider of the range of community learning disability services he needed. There is no suggestion that this change resulted in any adverse outcomes for Cooper, but following his transfer, he was supported by health professionals from the Complex Health Needs Service who did not have prior knowledge of him. An Occupational Therapy assessment for a possible wet room had also been under consideration at that time. However, on 12th February 2020 chair raisers and a smaller shower chair was provided.

3.12 Cooper continued to settle into the home over the next two months. During February 2020 a referral was made to the continence nurse as Cooper was incontinent of urine and occasionally incontinent of faeces. The continence nurse advised that Cooper should stop drinking carbonated or caffeinated drinks and needed to drink 1.5 litres of non-carbonated, non-caffeinated and non-citrus drinks daily to keep him properly hydrated. Care home staff were advised to persist in helping him with his pelvic floor exercises. Appropriate pads for daytime and night-time use were to be sent.

3.13 On 26th February 2020 Cooper was visited by a physiotherapist. During the visit the care home advised that Cooper had had an unwitnessed fall.

3.14 On 28th February 2020 Cooper's annual health check took place. This was conducted by a CHNS nurse who was concerned about his weight and requested his GP to refer him to a dietician. There is no record of the request for a dietician referral being received by the GP at that time. The action plan subsequently completed in respect of Cooper's annual health check documents that dietician services were not taking new referrals as a result of the pandemic which suggests that the dietician referral was not progressed until after Covid-19 restrictions began to affect service delivery.

3.15 The meeting to review Cooper's placement scheduled for 16th March 2020 was cancelled because of the Covid-19 pandemic. His social worker emailed the home to check the outcome of the referral to Physio/Occupational Therapy; to check how 1:1 support was going, whether opportunities for social activity were being provided and to find out about how his relationships with staff and other residents was progressing. The social worker received no reply to her email. The SAR has been advised that it was intended to conduct the placement review virtually but that this was superseded by Cooper's hospital admission and the subsequent need to respond to his increased level of need.

3.16 On 24th March 2020 (which was the day after the first national Covid-19 lockdown began) staff noticed that Cooper was breathing heavily and when asked if his chest was hurting, he replied 'yes'. After consulting the care home manager, Cooper's keyworker rang NHS 111 for advice. The NHS 111 clinician advised to monitor Cooper's temperature, blood pressure and heart rate and call an ambulance if his temperature went lower or his heart rate increased. Later in the day, staff called an ambulance after Cooper's temperature decreased. The ambulance crew noted that Cooper periodically began to breathe heavily and appeared anxious. Staff said that Cooper had been upset by the change in his routine as a result of the Covid-19 lockdown. The ambulance service discharged Cooper back into the care of the care home and in the chronology of contact with Cooper they submitted to this SAR, the South West Ambulance Service (SWAST) state that they sent a note to the GP to consider anti-anxiety medication. The SAR has been advised that the GP practice has no record of being contacted by the ambulance service. The care home has advised the SAR that, whilst their records document that the ambulance service advised staff that Cooper's symptoms were likely to have been caused by anxiety, the care home's records do not document that any medication was recommended or follow up action required of the care home.

3.17 Cooper was monitored by staff over the next few days. After eating and drinking normally on 25th March 2020, his intake of food and fluid diminished over the following two days and he again appeared anxious. When asked if he felt sad, Cooper replied 'yes' but declined the offer of talking about his feelings.

3.18 On Saturday 28 March 2020 staff contacted NHS 111 over concerns about Cooper's food and fluid intake. The NHS 111 doctor prescribed Diazepam (2mg, 3 x daily) for Cooper's apparent anxiety and advised staff to contact his GP practice on Monday 30th March 2020 to discuss next steps.

3.19 The following day (Sunday 29th March 2020) Cooper remained in his room and appeared drowsy and lacking in energy. He was unable to lift his cup to his mouth and appeared to be unable to bear weight. Staff became concerned about the impact of the Diazepam on Cooper. They also noted a raised, red rash on his stomach.

3.20 On Monday 30th March 2020 staff continued to monitor Cooper and prompt him to eat and take fluids. He had a few sips of coke and staff attempted to feed him some soup which he refused after taking five spoonsful. Staff contacted Cooper's GP practice which advised that Diazepam should be stopped as it appeared to be making him too drowsy. An image of the rash was sent

to the GP practice and an antibiotic cream prescribed. During the evening, Cooper's keyworker rang NHS 111 after Cooper's condition worsened in that he looked very ill and weak and was refusing food and fluids. An Out Of Hours (OOH) doctor visited Cooper during the night and decided that a hospital admission was necessary. The ambulance service attended and conveyed Cooper to the Royal United Hospital (RUH) in Bath. The ambulance crew noted that Cooper had a low temperature, a possible urinary infection and was tachycardic (faster heartbeat). They believed his ECG reading was due to anxiety and possible infection. The crew gained IV access and gave sodium chloride for rehydration.

3.21 Cooper was admitted to the RUH on Tuesday 31st March 2020 and received treatment for atrial fibrillation, severe dehydration, low platelets and abnormal liver function. A Treatment Escalation Plan (TEP) was completed. A TEP is a communication tool to assist hospital staff when a person with serious illness has the potential for acute deterioration or may be coming to the end of their life. A do not attempt cardiopulmonary resuscitation (DNACPR) decision was made in respect of Cooper. A Mental Capacity Assessment was completed and the TEP and DNACPR decisions were documented to have taken place in accordance with Best Interest principles. However, the care home questioned the DNACPR decision as they were not consulted as part of the Best Interest process. The hospital liaised with Cooper's GP practice over the DNACPR decision and his GP felt this was appropriate after reviewing Cooper's notes. Cooper tested negative for Covid-19.

3.22 The care home and the hospital discussed Cooper's apparent depression prior to his hospital admission and one theory was that, given that reading the newspaper each day was an important part of Cooper's routine, media reporting of the pandemic may have made him fearful and anxious. Whilst he was in hospital, Cooper was also examined by a mental health nurse who felt that his mental health may have been adversely affected by delirium arising from his infection, although his mental health could not be assessed until he regained his physical health.

3.23 On 3rd April 2020 a safeguarding concern was raised in respect of the deterioration in Cooper's health in the days prior to admission to RUH and the lack of contact by the care home with health professionals during the 8-day period prior to his admission. The safeguarding concern was made by a CHNS community nurse following consultation with the RUH and Cooper's GP practice. Cooper's South Gloucestershire social worker also expressed concern that Cooper's increasing anxiety and self-isolation in the Home had not been shared with her at the time.

3.24 On 4th April 2020 RUH contacted the care home to advise that Cooper was very drowsy and not engaging, adding that if there was no improvement in his condition, palliative care was to be considered. He was put on the palliative care pathway the following day (5th April 2020) after review by the Consultant Geriatrician and telephone contact with Cooper's brother.

3.25 By 6th April 2020 Cooper had begun eating and drinking small amounts independently and his liver function had improved. He was taken off Priorities for Care (end of life pathway). Imminent discharge* from hospital was discussed with the care home which advised that they were concerned about their ability to meet his needs until these had been fully assessed. The RUH advised that following discharge from hospital, Cooper would need to be nursed in bed initially. The care home advised that their staff were not trained to administer the insulin which Cooper had been receiving for Diabetes whilst in hospital. It was agreed that district nurses could visit to administer insulin although the care home expressed concern about the current availability of district nurses. The care home was also advised that should Cooper be discharged to the care home and his health deteriorated again, it was unlikely that he would be readmitted to hospital and that the care home would be responsible for end-of-life care if that became necessary. The

care home discussed the feasibility of Cooper being discharged back to Care Home 1 with the CHNS and Cooper's South Gloucestershire social worker who began gathering information for an assessment of Cooper's needs to inform any decision about the most appropriate service to which Cooper should be discharged. The social worker expressed concern that Cooper had gone from Priorities for Care to 'fit for discharge' in a very short space of time and that there was a lack of clarity in respect of his long-term health prospects and whether he was likely to return to his original level of need.

*On 19th March 2020 COVID-19 Hospital Discharge Service Requirements (1) had been implemented, which required acute and community hospitals to discharge all patients as soon as it was clinically safe to do so. The Service Requirements were a response to the COVID-19 emergency and it was envisaged that 15,000 hospital beds would be freed up as a result. At the heart of the Service Requirements was the 'discharge to assess' model, which required acute hospitals to assume lead responsibility for discharging patients on 'Pathway 0' (50% of patients) which involved a simple discharge requiring no input from health/social care and required community health services to assume lead responsibility for assessing and providing care for patients on Pathways 1-3, once they were home. 'Pathway 1' (45% of patients) involved people who were able to return home with support from health/and or social care, 'Pathway 2' (4% of patients) involved people who needed rehabilitation in a bedded setting and 'Pathway 3' (1% of patients) involving people who had experienced a life changing event for whom home was not an option at the point of discharge. This was a very significant system change which had been implemented very recently.

3.26 On the same date (6th April 2020) a Safeguarding Planning meeting took place at which the terms of reference for a Section 42 Safeguarding Enquiry were agreed.

3.27 On 7th April 2020 Cooper was assessed by the RUH dietician and was noted to be eating independently. On the same date, Cooper's social worker contacted the RUH to gather information and was advised that he was 'absolutely skeletal' and had said he did not want to return to Care Home 1 but would not explain why. A referral was made for advocacy.

3.28 By 9th April 2020 his South Gloucestershire social worker concluded that Cooper's needs had changed substantially from when she previously assessed him, in that he now required support from two staff for all transfers and personal care, he was unable to bear weight as he was unable to find the strength and was also reluctant to do so. He was now doubly incontinent and needed nursing in a hospital bed with an air mattress. He would also need insulin administered daily. The RUH expressed concern that the longer he remained in hospital, the more likely that he was to contract Covid-19.

3.29 On 15th April 2020 Cooper was reviewed by the hospital dietician. Food charts demonstrated ongoing improvement with him now eating half of all meals, taking supplements and drinking milk. Prior to discharge a Transfer of Care document was completed as was a Discharge Summary. The latter document stated that a mental health review had been completed which disclosed possible hypoactive delirium in the background of infection with possible emerging depression and anxiety. Cooper had been commenced on 15mg Mirtazapine and his anxiety levels were documented to have begun to settle. This medication was to be monitored by his GP and could be titrated upwards if necessary. Cooper continued to decline to mobilise, wishing to remain in bed. A Best Interest decision, involving Cooper's advocate had been made for Cooper to return to Care Home 1. Cooper now said he would be happy to return there. An overlay mattress had been ordered to protect pressure areas which, at that time, remained intact. This was to be delivered the day after discharge. District Nurse support had been arranged to administer insulin from 17th April 2020. Hospital readmission would be considered if Cooper's condition deteriorated, with the 'ceiling of treatment' being IV antibiotics and IV fluids.

3.30 Cooper was discharged to Care Home 1 during the evening of Wednesday 15th April 2020. In the time available and given the fact that Cooper's South Gloucestershire social worker was on annual leave, it had not been possible for South Gloucestershire Council to complete a full discharge assessment. However, under the COVID-19 Hospital Discharge Service Requirements, the priority was to discharge Cooper as soon as he was medically optimised. However, the Service Requirements stated that a lead professional or multidisciplinary team would visit patients at home on the day of discharge or the day after to arrange what support is needed in the home environment and rapidly arrange for that to be put in place. The Service Requirements went on to state that should care support be needed on the day of discharge from hospital, this will have been arranged prior to the patient leaving the hospital site, by a care coordinator (2).

3.31 Cooper was not tested for Covid-19 prior to discharge on the grounds that he had been nursed on a non-Covid-19 ward, was not displaying any symptoms and his risk of having the virus was 'negligible'. As a precaution, Cooper was treated as Covid-19 positive and isolated in his room at Care Home 1 for 14 days in accordance with the guidance in place at that time. The CHNS completed a Community Treatment Escalation Plan and sent it to Care Home 1. There was a degree of confusion over Cooper's level of mobility which the CHNS Physiotherapist attempted to resolve by phoning the Hospital Physiotherapist.

3.32 On Friday 17th April 2020 Cooper was aggressive towards staff supporting him with personal care in bed, which was unusual behaviour for him. He was also struggling to use his knife and fork at mealtimes. After reviewing how care home staff had managed Cooper over the first weekend following his discharge from hospital (18th/19th April 2020) additional equipment was ordered including a commode style shower chair to reduce transfers, a manual handling belt, a pressure cushion and a cantilever table to assist with eating.

3.33 On 22nd April 2020 the CHNS contacted Cooper's GP practice in respect of dietary supplements and a referral to the dietician. The GP practice has advised that a conversation took place between the CHNS and a GP but has provided no detail of the content of the conversation or the outcome.

3.34 On 24th April 2020 Cooper's South Gloucestershire social worker requested authorisation for funding to increase his care at Care Home 1. A 28 day increase of 15 hours per week was requested as he required hourly checks and support to move as he was not currently able to support his own weight. He required 2-3 staff to support with moving and personal care – although it was anticipated that the arrival of equipment the following week would reduce this level of staffing. Cooper was currently doubly incontinent and required assistance to check and change his pads. He was described as very anxious and unwilling to let go of his bed. He needed 2-3 staff - one to support his arms, one to support with turning and another to support with personal care. Although this could be achieved with two members of staff, it was dependent on his level of anxiety and was currently taking around one hour. It was said to be too early to say how the recent prescription of Mirtazapine would assist. Cooper also required intermittent assistance with eating and drinking. He was able to eat finger foods independently but sometimes required assistance with a knife and fork.

3.35 The social worker added that, in her view, Cooper had been poorly discharged from the RUH without the appropriate equipment and sufficient consideration of the support his change in need required. She added that the hospital discharge notes stated that Cooper required hoisting, yet he was discharged without appropriate equipment. She noted that the equipment ordered by the CHNS - a commode/shower chair to reduce transfers, manual handling belt to assist with steadying, pressure cushion and cantilever table - was due to arrive within the next 7 days*. The social worker was hopeful that Cooper's mental and physical health would improve which could allow the level of support to be reduced.

*By 24th April 2020 most of the equipment had been delivered with the exception of the pressure cushion.

3.36 On 26th April 2020 Cooper appeared to be trying to get out of bed without success. He was supported with personal care and stated he wanted to go back to hospital as there were male nurses on duty. The care home advised the CHNS that managing Cooper was becoming increasingly difficult. The CHNS Physiotherapist phoned the care home to discuss the high risk of Cooper developing pressure ulcers. A Waterlow assessment (tool for assessing a person's risk of developing a pressure ulcer) was discussed and the Physiotherapist also sent the care home new exercises for Cooper to attempt.

3.37 On 28th April 2020 the care home contacted Cooper's GP practice as his arm circumference indicated that he was underweight. The information was used to calculate his BMI at '<20' indicating a dietician referral was needed. However, the GP practice understood that new referrals to the dietician were not being accepted at that time because of Covid-19 restrictions. It was decided that the GP who knew Cooper best would follow up on this issue, which she did on 30th April 2020 which resulted in bloods being taken by the district nurses.

3.38 Later the same day (28th April 2020) the care home contacted Cooper's GP practice due to his swollen feet, 'gunky' eyes, and signs of a developing pressure sore. The GP arranged for blood tests to be arranged urgently and an urgent referral was made to the district nurses. Additionally, the home was requested to monitor pre-meal glucose levels for a short period. Cooper was also prescribed antibiotics for suspected conjunctivitis. The district nurse later telephoned the care home to advise that they would visit Cooper on 30th April 2020. The district nurse documented the care home advised them that Cooper's skin was not broken and that they were applying Proshield (a moisture barrier to protect skin integrity from exposure to faeces and urine) to the affected area.

3.39 During the same day (28th April 2020) a Metformin tablet was found in Cooper's continence pad when he was being supported with personal care. The care home contacted the pharmacist who advised that Cooper would not be adversely affected by missing one Metformin tablet.

3.40 Later the same day (28th April 2020) the care home rang NHS 111 as they remained concerned about Cooper's presentation in that he looked very unwell. The ambulance crew spoke to Cooper's GP and concluded that there had been no acute change in Cooper's presentation since the GP contacts earlier in the day and that hospital admission was unnecessary at that time.

3.41 On 29th April 2020 the care home contacted Cooper's GP practice to seek advice as his blood sugars were low. The GP advised that this was likely to be the case as Cooper had come off insulin and moved onto Metformin. The GP practice diabetes nurse was to make contact with the care home on the same date. The issue was also discussed by the care home with the CHNS who advised care staff to use their professional judgement and also monitor for symptoms of hyperglycaemia. The merits of hoisting Cooper as opposed to bed care were discussed by the Physiotherapist and the Occupational Therapist.

3.42 On 30th April 2020 Cooper's period of isolation ended and he was supported to get out of bed, into his wheelchair and out to the community and the shops. This was seen as an indication of progress as Cooper had been struggling to mobilise. The CHNS Learning Disability (LD) nurse discussed Cooper with a CHNS psychiatrist, the outcome of which was that Cooper's GP would continue to oversee his health and medications and could make a referral to psychiatry if oversight and support was required. The LD nurse also discussed Cooper with her LD

manager. It was noted that the Dieticians were not taking referrals and that the GP was reluctant to prescribe supplements due to diabetes.

3.43 Also on 30th April 2020 the outcome of the safeguarding concerns raised following Cooper's admission to RUH was that allegations of abuse or neglect by the care home were unsubstantiated although a concern relating to food and fluid monitoring was substantiated and it was noted that Care Home 1 was working with CHNS to improve recording mechanisms.

3.44 Also on 30th April 2020 the CHNS LD nurse raised a safeguarding concern in respect of the (partially dissolved) medication found in Cooper's continence pad. This concern was deemed not to meet the criteria as no abuse or neglect appeared to have occurred. However, additional requirements were to be added to Cooper's care plan in respect of ensuring medication is taken and not 'stored' in the mouth.

3.45 On 1st May 2020 the results of Cooper's blood tests were checked by his GP practice. Several abnormalities were noted but nothing which required immediate hospital admission.

3.46 On 5th May 2020 Cooper's South Gloucestershire social worker contacted Care Home 1 to request an update and was told that Cooper had been 'OK' that week but that it took two staff to help him into his wheelchair and that he seemed 'really terrified' whilst this was taking place. He was not able to bear weight at all and on one occasion a visit into the community was abandoned after Cooper 'panicked' after arriving at the threshold of the premises.

3.47 Also on 5th May 2020 the care home contacted Cooper's GP to discuss his blood test results and blood sugars. There had an improvement in the blood sugars, but the blood tests disclosed low albumin (which can indicate a problem with the liver or kidneys), new anaemia and borderline CRP (a marker of inflammation). The GP had some doubts of how best to proceed and so sought advice from the Consultant Geriatrician which resulted in a plan which included prescription of nutritional supplements with further blood tests to be arranged in two weeks. A referral to Speech and Language Therapy (SALT) was made in an effort to support Cooper to share any reasons for his anxiety and the holding of medication in his mouth. Picture cards were created and delivered to the care home on 11th May 2020.

3.48 On 13th May 2020 the care home contacted Cooper's GP to seek advice on a pressure point on his back which looked like a 'urine burn'. He also had a similar 'patch' on his rib cage. Additionally, his hernia looked bigger and more painful. Advice was given in respect of the hernia and the GP practice arranged for the district nurses to visit Cooper. The district nurse attended and concluded that the suggested pressure sores were tears and most likely caused by the handling belt used for manual handling. The change in hernia presentation was thought likely to have been caused by weight loss. The care home documented that the GP would attend the following week to review Cooper's hernia, but GP records do not confirm this intention and there is no indication that the GP visited to review Cooper's hernia.

3.49 On the same date Care Home 1 raised a safeguarding concern in respect of pressure sore on Cooper's back. It was documented that the district nurses had said that this was a friction pressure sore caused by being in bed for a number of days prior to 7th May 2020. It was decided not to progress this issue as a safeguarding concern but to request the involvement of the tissue viability nurses in supporting the district nurses.

3.50 On 15th May 2020 Cooper's South Gloucestershire social worker phoned the care home and the staff she spoke to said they remained worried about Cooper, in particular his skin integrity. They said that repositioning at night would distress Cooper as he became panicky and began breathing 'really fast' whenever he was being repositioned. Waking him at night for repositioning would be challenging and require communications cards. He was also noted to hyperventilate when transferred. The care staff were very complimentary about the work of the physiotherapist in supporting Cooper. A support worker from Cooper's previous care home

would be working with Cooper to focus on building his confidence with leg exercises. The social worker suggested the care home make further contact with the district nurses in respect of their skin integrity concerns and the social worker also made contact with them.

3.51 On 16th May 2020 the care home called an ambulance after Cooper fell out of bed in the early morning. The crew found him to be uninjured but clearly in distress and hyperventilating intermittently. The crew felt Cooper may have a UTI and the OOH GP was called out and prescribed antibiotics.

3.52 On Sunday 17th May 2020 Cooper's care home key worker saw him and found that the district nurses had not visited Cooper as requested. The key worker contacted the district nurses to say that she was very worried about Cooper's skin integrity and received an apology that the matter had 'not been taken seriously'. A district nurse visited Cooper later in the day and concluded that the pressure sore on his spine was a Category 2 pressure sore. She examined two other sores but was unable to grade them. All pressure areas were dressed and the care home was advised to reposition Cooper every 4 hours if possible. The district nurses planned to visit Cooper every other day. After speaking to Cooper his key worker established that he had fallen out of bed the previous day after trying to get up without assistance. He was advised to press his buzzer to call staff when he wanted to get out of bed.

3.53 On 18th May 2020 Care Home 1 raised a safeguarding concern that Cooper had been neglected by the district nurses resulting in the friction burn on his spine deteriorated to a Stage 2 pressure sore. This concern was deemed not to meet the criteria for safeguarding. It was noted that the tissue viability nurses were visiting once a week to support the district nurses and a care plan was in place in respect of repositioning. However, the safeguarding referral would be reconsidered if it came to light that there was a lack of care and if the pressure sore(s) deteriorated further. The Tissue Viability Nurses liaised with the Physiotherapist and advised that Cooper was at high risk of skin breakdown.

3.54 Also on 18th May 2020 Cooper's care home key worker spoke to his GP practice about the outcome of the most recent blood tests. His anaemia was no worse and the CRP remained only slightly raised. The GP expressed frustration that the nutritional supplements prescribed and ordered on 5th May 2020 had not yet been delivered to Care Home 1. The key worker was advised to focus on nutrition with meals and the nutritional supplements. The blood tests would be repeated in 6 weeks.

3.55 On 19th May 2020 The physiotherapist visited Cooper who was unable to stand and experiencing dizziness. His blood pressure was low. On the same date Cooper's South Gloucestershire social worker contacted the CHNS to propose a professionals meeting to explore Cooper's long term care needs. The social worker noted that Care Home 1 had requested further funding for additional staffing to facilitate night-time waking and repositioning as a result of the grade 2 pressure sore.

3.56 On 20th May 2020 Cooper's South Gloucestershire social worker phoned Cooper's physiotherapist who advised that he had had little success with supporting Cooper to stand. Cooper was able to sit on the edge of his bed but refused to stand from that position. The physiotherapist felt that a combination of lack of physical strength and anxiety were factors in Cooper's refusal to stand and that a recent fall had adversely affected his confidence. He had been nursed in bed since this fall five days earlier. The physiotherapist went on to say that Cooper had reported feeling dizzy on several occasions using the communication cards supplied by SALT. The physiotherapist reflected that he had visited Cooper a month prior to his hospital admission and he felt that he had lost a lot of muscle mass and was significantly weaker than previously. The physiotherapist said that he had asked care staff to encourage Cooper to move as much as possible to increase his strength. He added that a hoist would not

be suitable as staff at Care Home 1, although fully conversant with general moving and handling, had not received training in using a hoist.

3.57 On 20th May 2020 the care home spoke to Cooper's GP about his dizziness and low blood pressure. The GP said that his anti-depressant medication was a likely cause of his lower blood pressure and so decided to prescribe Sertraline as an alternative. If this didn't help, the GP planned to review Cooper's metformin dosage.

3.58 On 21st May 2020 Cooper's South Gloucestershire social worker liaised with the district nurse to better understand his skin integrity and his moving and handling requirements. The district nurse said that Cooper was now in bed 24/7 and choosing not to transfer and so remaining in bed for a long time, whilst doubly incontinent, he would be left in a wet pad for 12 hours without overnight support. The wet pad was contributing to his skin integrity issues. She went on to say that he would require two 'wake in' staff to safely reposition him and change his pad. She said he weighed around 5.7 to 6 stone, his limbs were quite contracted and 4-6 hourly repositioning was required. She said that he had lost a lot of muscle mass. Because he was now so thin, greater care was needed to safely reposition him. The district nurse added that they were visiting Cooper three times per week and the grade 2 pressure sore was improving. The district nurse questioned whether Care Home 1 was going to continue to be able to meet his needs.

3.59 Later the same day (21st May 2020) the social worker requested senior management authorisation for a further 28 days increase in Cooper's care. The previously approved increase in support had been monitored but Cooper now needed additional support as he was spending the majority of his time in bed and needed two staff to ensure 4-6 hourly repositioning and the changing of his pad. The social worker added that Cooper experienced a mixture of anxiety and strength limitations and that in the middle of the night it was likely that he would be increasingly tired and delirious and not necessarily able to safely support the repositioning. The social worker went on to state that Cooper had a Rockwood frailty scale of 7 - with the highest point of the scale at 9. She added that someone with this level of frailty would be unlikely to bounce back easily from illness and that Cooper was completely dependent on staff for personal care. She went on to state that someone at scale 8 would not be expected to live for more than 6 months. The social worker concluded by stating that she had proposed a multi-disciplinary meeting with the CHNS, advocate, district nurses and GP practice to explore whether Cooper's needs could be met at Care Home 1 on a long-term basis or if a Nursing Home placement needed to be considered. She added that she had also requested that the district nurses complete a Continuing Healthcare (CHC) screening tool. It appears that this was a fast-track assessment for CHC where the patient's health is deteriorating quickly and they may be nearing the end of their life. The fast-track assessment is intended to ensure that a care and support package can be put in place as soon as possible – usually within 48 hours. In the event, the CHC screening tool was not completed prior to Cooper's death. The social worker initially phoned the district nurse service to request the completion of the CHC screening tool on 21st May 2020 but was unable to obtain a reply. She then asked Care Home 1 to ask the district nurses to complete the CHC screening tool the next time they visited the care home, as the social worker was about to go on leave. The social worker phoned the district nurses when she returned from annual leave on 26th May 2020 and the CHC assessment was due to take place on 28th May 2020, the day on which Cooper was admitted to the RUH for the second time.

3.60 Concerns about Cooper's deteriorating presentation continued during the week commencing 25th May 2020. On 26th May 2020 the care home manager spoke to Cooper's GP practice to discuss his poor oral intake. Swallowing difficulties made taking 2 Metformin tablets twice daily quite difficult and so it was decided to amend the prescription to 1 tablet three times per day. On the same date the CHNS physiotherapist and a clinical physiotherapist visited Cooper to review his 'bed mobility' and his rehabilitation potential. Cooper was noted to be anxious when

practicing rolling and standing. The care home staff were requested to encourage and support Cooper to roll and stand multiple times each day. Changing Cooper's bed was also discussed.

3.61 On 27th May 2020 the care home phoned the physiotherapist who said he would call the psychology team regarding Cooper's anxiety and advised care home staff to keep encouraging Cooper to drink, adding that if staff were concerned about further dehydration, they should call 999.

3.62 On the same date (27th May 2020) the care home manager spoke to Cooper's GP practice to seek advice on Cooper's dietary intake and weight loss and the fact that he rolled onto his back after being turned. The care home advised they had been unable to weigh him and therefore had no MUST score. (MUST is a screening tool to identify adults who are malnourished, at risk of malnourishment or obese). He was now on supplements – fortisip - but there had been a delay in starting them. The care home was advised to buy a non-spill cup to assist Cooper in taking fluids. Paracetamol was prescribed for pain management (pressure sore). The GP documented that Cooper's care needs seemed to exceed the care his placement was able to provide but that the district nurses appeared to have this in hand with an application for CHC. Another GP from the practice was to discuss the case at a GP practice MDT the following day. The GP practice later received a call from the physiotherapist to advise that Cooper was at high risk of hospital admission. A GP visit to Cooper was to take place the following day.

3.63 On Thursday 28th May 2020 the care home called the ambulance service via 999 as a result of Cooper's reduced fluid intake, frailty and emaciation and a concern that he had developed thrush in his mouth. The crew documented that Cooper was also refusing medication and that he became visibly anxious when they attempted to engage him in conversation. The crew diagnosed chronic and acute deterioration and conveyed him to the RUH. The care home manager notified Cooper's South Gloucestershire social worker. The social worker liaised with Cooper's GP practice and it was agreed that once he had been rehydrated in hospital he would require end of life care in a nursing home environment.

3.64 Cooper was admitted to the RUH on the same date. The hospital liaised with the GP practice and it appears that, at that stage, it was planned to transfer Cooper to a nursing home following the completion of a CHC assessment. An Emergency Medical Assessment Proforma for Older Adults was completed in the hospital emergency department (ED) in respect of a possible end of life event. A Treatment Escalation Plan was completed in Cooper's Best Interests following an MCA assessment. A chest x-ray was undertaken which showed bilateral consolidation consistent with a Covid-19 infection. Blood tests suggested the infection was likely viral. However, a Covid-19 swab was negative. Cooper was transferred to the ACE ward and then to Waterhouse (an older person's) ward. He was commenced on treatment for Covid-19 due to high clinical suspicion and radiological evidence. Cooper's Hospital Passport (dated 7.10.2019 and completed by his previous care home) accompanied him.

3.65 On Friday 29th May 2020 the CHNS manager advised Care Home 1 that as Cooper was being treated for Covid-19, the whole service (staff and residents) should be tested for Covid-19. The CHNS manager advised that Cooper had signs of viral pneumonia caused by previously having Covid-19 although it was not known when he contracted it. Testing was arranged through the Health Protection Team and all results were negative.

3.66 On the same date Cooper was commenced on the Priorities for Care pathway following telephone contact with his brother.

3.67 On Saturday 30th May 2020 Cooper experienced two tonic-clonic seizures and seizure-like jerking of the limbs was noted the following day (Sunday 31st May 2020) as was shallow respiratory effort. He was also noted to be experiencing high respiratory distress.

3.68 On Monday 1st June 2020 the RUH consultant spoke with the CHNS and advised that Cooper had contracted Covid-19, possibly 10-14 days previously, was now end of life and would be unlikely to tolerate treatment through a ventilator given his age. The CHNS sought clarification of whether next of kin, Cooper's advocate and the care home had been consulted in respect of end-of-life decision making. The advocate confirmed that he had not been involved.

3.69 On the same day the CHNS manager spoke with the Care Home 1 manager who advised that care home staff had been wearing full PPE following Cooper's discharge back to Care Home 1 from the RUH on 15th April 2020 and that this also applied to the district nurses and the physiotherapist who visited Cooper. The care home manager added that resident's temperatures had been taken twice daily and that Cooper's temperature went above normal only on 21st May 2020. The GP had visited him that day and advised that the fluctuations in Cooper's temperature could be due to his diabetes and anxiety.

3.70 Cooper died on Wednesday 3rd June 2020. As previously stated, his cause of death was recorded as 1a - Clinical Covid-19 infection; 2 – Diabetes, Stroke, Learning Disabilities.

4. The Views of Cooper's Family

4.1 Cooper's brother contributed to this review through a telephone conversation with the independent reviewer.

4.2 The brother said Cooper had had a learning disability from birth and had spent a good deal of time in residential care. However, he recalled quite a substantial period of time during which Cooper was supported to live by himself in a flat in Bristol. The brother recalled that Cooper had 'done alright' during this phase of his life during which a carer had visited him every day. However, the brother said that this arrangement had ended after Cooper collapsed in the street after suffering a stroke. The brother said that this 'really frightened' Cooper to the extent that he no longer felt confident in living independently. It was following this period of living independently that Cooper's placement in Care Home A began.

4.3 When it became necessary for Cooper to be found an alternative placement after it was decided to close Care Home A, the brother said that he wanted Cooper to be found a placement near to where he lives on the Essex coast. The brother said that he was able to visit Cooper only two or three times each year because of the distance between his home and Care Home A and felt that if Cooper moved closer to him, he could 'keep more of an eye on him'. Initially, the brother said that it was his understanding that moving Cooper to a care home in Essex was rejected on the grounds of cost but later added that Cooper had been asked whether he wanted to transfer to be nearer his brother in Essex or remain with his friends, several of whom also transferred from Care Home A to Care Home 1, and Cooper had decided to stay with his friends. The brother added that 'in the end', this was the 'right decision'. Cooper's South Gloucestershire social worker has advised the review that cost was not a factor in considering a transfer to a care home in Essex. The care home in Essex was not a specialist care home for people with a learning disability. Additionally, the social worker has advised the review that no other Care Home A residents transferred with Cooper to Care Home 1 although Cooper may well have known some of the Care Home 1 residents.

4.4 The brother said that Cooper had been treated well at Care Home A but had been 'quite excited' to move to Care Home 1. He said that Cooper 'had seemed fine' at Care Home 1 but 'had a job getting about' and used a walking frame. He said that he had been informed about the safeguarding alert relating to the incident in which Cooper disclosed being pushed in the shower.

4.5 He said he didn't know what impact the pandemic had had in Cooper initially. The brother thought Cooper might have had difficulty in understanding what was happening. He expressed

doubt over whether he was able to read the newspaper he bought each day, adding that their parents always went out for a newspaper and brought it back to the house and he felt that Cooper had continued this particular routine from his earlier family life.

4.6 The brother recalled Cooper's first admission to the RUH at the end of March 2020. He said that he had been told that the hospital thought Cooper may have caught Covid-19 but that more tests were needed. (The independent reviewer checked that the brother was referring to the first, rather than the second RUH admission, and the brother said that this was what he recalled being told at the time of the first admission). The brother also recalled being consulted about the DNACPR decision and end of life care.

4.7 The brother recalled Cooper being discharged back to Care Home 1 but could not remember any discussion with him about whether or not Care Home 1 would be able to manage Cooper's needs. The brother understood Cooper to be 'getting better' before 'taking a turn for the worse' and being re-admitted to RUH where he died.

4.8 The brother said that he had no particular issue he would like the safeguarding adults review to explore. He said he had no complaints about the care Cooper received in either Care Home A or Care Home 1. He felt that the Covid-19 pandemic had caused many deaths including that of Cooper.

5. Analysis

In this section of the report each Key Line of Enquiry will be addressed in turn.

What impact did Covid-19 have on Cooper's care and were there missed opportunities to prevent a further decline in his health?

5.1 In this case it is particularly important to consider the national context. Cooper was admitted to the RUH on 31st March 2020. At that time the UK was responding to the Covid-19 pandemic, which represented the greatest peacetime challenge faced by the county in a century. In the days prior to Cooper's hospital admission non-essential contact and travel had stopped (16th March 2020), the first UK lockdown began (23rd March 2020) and the Coronavirus Act 2020 received Royal Assent (25th March 2020). One week prior to his 31st March 2020 hospital admission, care home staff had called an ambulance after Cooper began breathing heavily and complaining of pain in his chest. The ambulance crew decided not to convey Cooper to hospital on this occasion. This decision did not appear to be affected by the extreme pressure on acute hospitals anticipated at that time.

5.2 Government policy at that stage was to 'flatten the curve' of infections and huge emphasis was placed on 'protecting the NHS'. The House of Commons Health and Social Care and Science and Technology Committee's October 2021 report Coronavirus: lessons learned to date observed that 'protecting the NHS' 'essentially meant protecting the acute hospital bed base' (3) and in order to free acute hospital beds in anticipation of the first wave of the pandemic, NHS providers were instructed to urgently discharge all medically fit patients as soon as it was clinically safe to do so (4). Cooper was discharged from the RUH on 15th April 2020. His health had initially deteriorated to the extent that he was placed on Priorities for Care - when it is thought that a person may die within the next few days or hours (5th April 2020) but after being taken off Priorities for Care the following day, his imminent discharge from hospital began to be discussed with the care home. The RUH began to express concern that the longer Cooper remained in hospital, the more likely he was to contract Covid-19.

5.3 Cooper was not tested for Covid-19 on his discharge from hospital and returned to the care home. The House of Commons report observed that NHS providers were instructed to urgently

discharge all medically fit patients as soon as it was clinically safe to do so, and care home residents were not tested on their discharge from hospital at the beginning of the pandemic (5). However, the RUH provided a rationale for their decision not to test Cooper on discharge in that he had been nursed on a non-Covid ward, was not displaying the known symptoms of Covid-19 and his risk of having Covid-19 was said to be 'negligible'.

5.4 Cooper's South Gloucestershire social worker had begun gathering information for an assessment of his needs to inform his discharge destination and the level of care and support he would need on arrival on 6th April 2020 but was unable to complete a full discharge assessment prior to his discharge back to the care home on 15th April 2020. (Easter fell on the weekend of 10th -13th April 2020 which seems likely to have had an effect on staff availability even during the pandemic and the social worker had a period of annual leave). However, as previously stated, the COVID-19 Hospital Discharge Service Requirements had been implemented on 19th March 2020, which required acute and community hospitals to discharge all patients as soon as it was clinically safe to do so. In Cooper's case, the emphasis was therefore on assessing and providing care for him, once he was home. The manner in which the Service Requirements were applied to Cooper will be discussed later in this report. Additionally, the Coronavirus Act 2020 contained easements which, for a limited period, meant that some Care Act duties effectively became powers. However, this SAR has been advised that the strict parameters which applied resulted in only eight Local Authorities triggering easements (6). Government guidance on the easements stated that local authorities would not have to carry out detailed assessments of people's care and support needs in compliance with pre-amendment Care Act requirements but would be expected to respond as soon as possible ….to make an assessment of what care needed to be provided (7). This review has received no indication that the Care Act easements had any effect on the assessment of Cooper's needs on discharge from hospital, or subsequently although it seems possible that the number of people being discharged from hospital to care homes at that time may have increased the amount of assessments required. However, the House of Commons report found that between 17th March and 15th April 2020 the total number of people discharged from hospitals into care homes was smaller than in the preceding year due to significantly lower admissions (8).

5.5 On his return to the care home Cooper was treated as if he was Covid-19 positive as a precaution and isolated in his room for 14 days (from 15th to 29th April 2020). The House of Commons report found that many care homes lacked the facilities to safely isolate patients admitted from hospital (9). This was not the case in Care Home 1.

5.6 Having considered all the information shared with the Safeguarding Adults Review, it is considered unwise to speculate when Cooper may have become infected with Covid-19. The House of Commons report noted, with a degree of caution, a Public Health England report which estimated that only 1.6% of Covid-19 in care home outbreaks could be linked to hospital discharges (10) whilst accepting that the seeding of infections in care homes also happened as a result of staff – including agency staff - entering care homes and some staff being deployed to more than one care home (11). The House of Commons report also found that risk in care homes was further compounded by poor access to PPE during the early period of the pandemic and infection control measures which were more challenging to adhere to as a result of staff shortages (pre-existing and Covid-19 related) and a lack of relevant training (12). In their contribution to this SAR, Freeways, the provider of Care Home 1, reflected on the pressures experienced by social care providers during the pandemic including frequent changes to guidance, often with very little warning. The House of Commons report noted that the risk of infection from visits to residents of care homes was largely eliminated by the severe restriction of visitors for much of the first phase of the pandemic (13). This SAR has been advised that staff in Cooper's care home had been wearing full PPE throughout the period following Cooper's discharge from the RUH on 15th April 2020, that residents' temperatures were checked daily and that Cooper's temperature had only been above normal on one day –

on 21st May 2020. The SAR has also been advised that Care Home 1 did not allow visits from family during the first phase of the pandemic.

5.7 Formulating local recommendations based on actions taken as part of the response to a global pandemic is not a straightforward task but, on the basis of the learning from this case, B&NES Community Safety and Safeguarding Partnership may wish to ask the commissioners and providers of care homes and the RUH to identify lessons learned from the manner in which Covid-19 risks to care home residents was managed in the first phase of the pandemic with particular reference to infection control, the extent to which agency staff were used, the extent to which staff – including agency staff – were deployed to more than one establishment and the management of visits by relatives and friends of care home residents. Freeways takes the view that these lessons have already been learned.

Was the standard of care provided to Cooper equal and equitable compared to people without a learning disability?

5.8 Cooper does not appear to have been considered 'clinically extremely vulnerable' to Covid-19 but would appear to have been considered 'vulnerable' to Covid-19 in that he was over 70 years of age and had diabetes. However, the above mentioned House of Commons report concluded that people with learning disabilities entered the pandemic from a position of heightened vulnerability because of inequalities which pre-dated the pandemic, including a much lower life expectancy (females 59 years compared to average life expectancy of 86 and males 61 years compared to 83), a higher death rate from respiratory infection, as well as higher rates of diabetes and obesity, both of which are risk factors for Covid-19 (14). As previously stated, Cooper had diabetes. The House of Commons report went on to conclude that pre-existing risk factors were compounded by people with learning disabilities being more likely to struggle to access the healthcare that would normally be available to them (15). In Cooper case concerns arose that he was not supported to access healthcare during the 8 day period immediately prior to his first hospital admission (Paragraph 4.23) although these particular concerns were later found to be unsubstantiated (Paragraph 4.43). Following his discharge from hospital Cooper was supported to access substantial healthcare although Covid-19 restrictions meant that specialist advice on issues such as moving and handling was often provided to care home staff by telephone. Additionally, the Dietician service appeared to stop taking new referrals at the beginning of the first wave of the pandemic (Paragraph 4.37 and 4.42) which may have adversely affected Cooper's care. Cooper was reviewed by the hospital dietician during his first RUH admission when ongoing improvement in terms of eating half of all meals, taking supplements and drinking milk (Paragraph 4.28) was noted.

5.9 The SAR has been advised that, in order to address the pressures of the pandemic, staff were temporarily redeployed from a number of roles, including Nutrition and Dietetics services. Whilst lack of access to dietician care may not have represented an 'equal treatment' issue for Cooper, as dietician services were unavailable to all new referrals (although people with learning disabilities have higher rates of diabetes and obesity), it is recommended that B&NES Community Safety and Safeguarding Partnership request HCRG Care as providers of Nutrition and Dietetics services to advise the partnership on how Covid-19 affected the provision of Nutrition and Dietetics services, how any risks associated with not accepting new referrals has been addressed and what has been learned from the pandemic about maintaining business continuity.

5.10 The House of Commons report also observed that guidance on hospital visiting during the pandemic has also had an impact on the quality of care that people with learning disabilities experienced as they would normally be accompanied by a family member or carer who would be able to help them communicate with health staff if necessary. Due to infection control measures in hospitals, particularly at the beginning of the pandemic, family members, carers and advocates for people with learning disabilities were not allowed to attend hospital (16). In

Cooper's case his advocate was involved in the Best Interest discussion in respect of his hospital discharge destination (Paragraph 4.29).

5.11 The House of Commons report went on to observe that the impact of the non-pharmaceutical interventions introduced to mitigate the spread of Covid-19 had a disproportionate effect on people with learning disabilities, in particular the lockdowns and the loss of social support that accompanied them (17). In Cooper's case his daily routine of visiting the supermarket to buy a newspaper and a can of coke stopped and when he was discharged from hospital back to the care home he was isolated in his room for 14 days. These necessary measures seem likely to have affected Cooper's emotional health and wellbeing and may have been factors in his anxiety.

5.12 In November 2020, Public Health England concluded that the death rate from Covid-19 among adults with learning disabilities was 3.6 times the rate of the population as a whole (18).

5.13 A do not attempt cardiopulmonary resuscitation (DNACPR) decision was made in respect of Cooper following his first RUH admission (Paragraph 4.21). The Treatment Escalation Plan (TEP) and Resuscitation Decision Record are contained within a single RUH record. The RUH record states that Cooper was assessed as lacking capacity in respect of DNACPR. The hospital contacted Cooper's brother and also liaised with Cooper's GP practice over the DNACPR decision. After reviewing Cooper's notes the GP felt the DNACPR decision was appropriate. However, the care home questioned the DNACPR decision as they were not consulted. Freeways have advised this review that, in their experience, lack of consultation with care homes in the B&NES area over DNACPR decisions is not unusual, both prior to and during the pandemic.

5.14 The British Medical Association, Resuscitation Council (UK) and Royal College of Nursing guidance - Decisions relating to cardiopulmonary resuscitation - states that where adults lack capacity and there is no welfare attorney or other legal surrogate and the adult has not made an advance decision to refuse CPR, the treatment decision rests with the most senior clinician responsible for the patient's care. The decision must be made on the basis of the patient's best interests and 'those close to the patient must be consulted' and they should be informed of the resulting DNACPR decision and of the reasons for making it in the patient's specific circumstances (16).

5.15 Lasting power of attorney (LPA) had not been applied for in respect of Cooper. He had made no advance decisions in respect of CPR. He was assessed as lacking capacity to make a decision in respect of CPR. One would have thought that his care home provider would have been considered to have been 'close to the patient' as Cooper had been cared for by the same provider for several years. The aforementioned House of Commons report expressed concern about the lack of meaningful consultation with families or other professionals in respect of DNACPR decisions taken in respect of people with learning disabilities during the pandemic (17). The RUH consulted with Cooper's brother and his GP, but it was expected practice that his care home would also have been consulted. However, Cooper's care home provider was consulted in respect of Cooper's Treatment Escalation Plan. Given that the TEP and the DNACPR are contained within a single RUH record it is unclear why the care home was not consulted in respect of the DNAPR. There is a note on Cooper's TEP/Resuscitation Decision Record which states that discussion with GP/Carer/Next of Kin was 'pending'.

5.16 It is therefore recommended that B&NES Community Safety and Safeguarding Partnership obtain assurance from the Royal United Hospitals Bath NHS Foundation Trust that when DNACPR decisions are made in respect of adults who lack capacity, any care provider of the adult will be consulted in respect of the DNACPR decision in accordance with the British Medical Association, Resuscitation Council (UK) and Royal College of Nursing guidance referred to in Paragraph 6.14.

5.17 Additionally, the RUH has advised this SAR that although Cooper was assessed as lacking capacity in respect of DNACPR and TEP and decisions then made in accordance with best interest principles, RUH records of Cooper's admission do not include any documentation of capacity in respect of decisions relating to other treatment or decisions relating to discharge.

5.18 It is therefore recommended that B&NES Community Safety and Safeguarding Partnership obtain assurance from the Royal United Hospitals Bath NHS Foundation Trust that all Mental Capacity Act assessments and Best Interest discussions are appropriately recorded.

5.19 Just before the first wave of the covid-19 pandemic, Cooper had an annual health check. The annual health check is important for people with learning disabilities given the fact that they often have poorer physical and mental health than the general population. A key purpose of the annual health check is to identify problems early in order that they can be addressed. The CHNS nurse who conducted the annual health check for Cooper was concerned about weight loss, but it appears that a request for a GP referral may not have been made until after Covid-19 restrictions led to dietician services not accepting new referrals (Paragraph 4.14). The restriction on new referrals appears to have related to all referrals with no exceptions for patients from groups who may have been at higher risk.

5.20 The CHNS was unaware of Cooper's Tuesday 31st March 2020 hospital admission, or the concerns about his presentation which had preceded the admission, until the RUH doctor rang the CHNS LD nurse on Friday 3rd April 2020 (Paragraph 4.23). The CHNS LD nurse then contacted the RUH LD liaison team nurse who was also unaware of Cooper's admission. It is understood that the hospital LD liaison nurse was working from home at this time because of Covid-19 restrictions although this review has been advised that the hospital LD liaison nurse prioritises patients with the most complex needs.

5.21 A factor which contributed to these communication difficulties was that Cooper's hospital passport had not been updated to reflect his transfer to Care Home 1 and contained contact details only for Cooper's previous residential care home, his previous GP and his brother, although the Care Home 1 telephone number was handwritten on the document – presumably either by Care Home 1 prior to admission or RUH following admission. No details of the community learning disability team supporting Cooper had been included under the heading 'Who else is involved with me? (please give details) Education/Health/Social Services'. The hospital passport is intended to provide vital information to help hospital staff care for and treat the patient as effectively as possible. In Cooper's case the hospital passport had not been updated to reflect the fact that some aspects of his health and wellbeing had begun to decline. It also contained only brief advice on how to communicate with Cooper, stating only 'I communicate verbally, please speak calmly and clearly to me'. The subsequently completed Covid-19 hospital passport is more detailed and advises staff to ask Cooper 'what noise do the bells make?' to which Cooper would respond by making the noise which would make him smile and help him to became calmer. Given the unfamiliarity of the hospital environment, and the fact that Cooper was likely to be supported by a number of hospital staff who would have no prior knowledge of him, that Cooper would not know anyone in hospital and there was no possibility of family or care home staff visiting him at that stage of the pandemic, full information about his communication needs was vitally important.

5.22 The RUH has advised this review that it is far from unusual for patients who need hospital passports to be admitted without them or for hospital passports to be out of date or incomplete – as in this case. It is therefore recommended that B&NES Community Safety and Safeguarding Partnership obtain assurance that all providers of care to people who need a hospital passport ensure that hospital passports are completed fully and updated when the person's circumstances or needs change.

5.23 The Rockwood Frailty scale was used to assess Cooper's needs and make decisions about the support he required (Paragraph 4.59). However, this SAR has been advised that the scale is not sensitive enough to assess people with a learning disability. For example, some CHNS clients with Profound and Multiple Learning Disabilities (PMLD) are completely dependent on care staff for all aspects of their life which would generate a very high score on the Rockwood Frailty scale (probably a '7' as this corresponds with 'completely dependent for personal care'). The SAR has been further advised that there is not currently a tool which is widely use or adapted to be used with clients who have a learning disability. Greater reliance should be placed on the observations of professionals who know the person well and are thus able to notice changes in their presentation.

5.24 It is recommended that when the learning from this SAR is disseminated, the need for professionals to exercise caution when using assessment tools which have not been developed or adapted for use with people with learning disabilities is highlighted.

5.25 Cooper increasingly began to present with anxiety from late March 2020 onwards (Paragraph 4.16) and was initially prescribed Diazepam which was promptly discontinued by the GP when it appeared to be making him excessively drowsy. Cooper said he felt 'sad' but declined to talk about his feelings at that time. During his first hospital admission a mental health review disclosed possible hypoactive delirium in the background of infection with possible emerging depression and anxiety. He was commenced on Mirtazapine and his anxiety levels were documented to have begun to settle (Paragraph 4.29). Following his discharge back to Care Home 1, Cooper was isolated in his room for 14 days in accordance with the Covid-19 guidance in place at that time. This was a necessary precaution but may have adversely affected his mood and emotional wellbeing. Additionally, Covid-19 affected Cooper's routine in that he was no longer able to visit the local supermarket to buy his newspaper and care home staff felt that reading about the pandemic in his newspaper each day may have made him fearful and anxious (Paragraph 4.22). Cooper's brother felt that buying a newspaper each day may have been a ritual, having observed his parents having newspapers in the family home and the brother doubted whether Cooper was able to read the newspaper (Paragraph 5.5). However, from February 2020 onwards Cooper would have been unable to avoid frequent reporting about the pandemic on TV and radio. Research suggests that the pandemic and the restrictions introduced to tackle it have carried risks to mental health including those arising from social isolation, loneliness and a sense of uncertainty about the future (21).

5.26 The NICE guideline on Mental health problems in people with learning disabilities: prevention, assessment and management observes that common mental health problems such as depression and anxiety disorders are often overlooked and therefore untreated in people with learning disabilities and recommends that reliable and valid tools are developed for case identification of common mental health problems in people with learning disabilities, in primary care, social care and education settings (22). In Cooper's case his anxiety was far from overlooked but despite the assistance of SALT who provided the care home with communication cards, professionals struggled to clarify what may have been at the root of Cooper's anxiety.

Was the treatment received at the RUH in line with Cooper hospital passport, and did it follow the requirements of the MCA?

5.27 These issues are addressed in Paragraphs 6.13 -6.16 and Recommendation 3 (DNACPR), Paragraphs 6.17 -6.18 and Recommendation 4 (Mental Capacity Act) and Paragraphs 6.20-6.22 and Recommendation 5 (Hospital Passports) above.

When Cooper was discharged from the RUH, who was involved in assessing and understanding his needs and how they were to be met; were they understood?

5.28 As previously stated, at the time of Cooper's discharge from the RUH the COVID-19 Hospital Discharge Service Requirements had recently been implemented, meaning that acute and community hospitals were required to discharge all patients as soon as it was clinically safe to do so and community health services were required to assess and providing care for patients who required input from health and/or social care, once they were home. This was a major change in policy and practice which was implemented much more rapidly than would usually be the case because of the Covid-19 emergency.

5.29 However, these 'discharge to assess' arrangements did not preclude as much preparation for discharge being accomplished as possible prior to the point at which it became clinically safe to discharge them. Cooper's South Gloucestershire social worker began gathering information prior to his discharge and concluded that his needs had changed substantially, in that he now required support from two staff for all transfers and personal care, he was unable to bear weight as he was unable to find the strength and was also reluctant to do so. He was now doubly incontinent and needed nursing in a hospital bed with an air mattress. He would also need insulin administered daily (Paragraph 4.28).

5.30 A Best Interest decision was made for Cooper to return to the care home (Paragraph 4.29) although, appropriately, a key focus of this discussion appeared to be on Cooper's wishes, as he had initially said that he was reluctant to return there. There is no indication that Cooper's South Gloucestershire social worker was involved in the Best Interest discussion or that the, at that time, un-finalised safeguarding concern about the care of Cooper by the care home immediately prior to his RUH admission was considered.

5.31 The care home, the South Gloucestershire social worker and the CHNS physiotherapist expressed concern about the clarity with which Cooper's needs were communicated at the time of discharge from RUH. There was a degree of confusion over Cooper's level of mobility which the CHNS Physiotherapist attempted to resolve by phoning the Hospital Physiotherapist (Paragraph 4.31), whilst the social worker felt that Cooper had been discharged from the RUH without the appropriate equipment and sufficient consideration of the support his change in need required (Paragraph 4.35). Specifically, she said that the hospital discharge notes stated that Cooper required hoisting, yet he was discharged without appropriate equipment and noted that that the equipment ordered by the CHNS was due to arrive within the next 7 days.

5.32 The RUH Transfer of Care and Depart Summary relating to Cooper's discharge has been shared with this review. Under 'mobility details' the summary stated that 'assistance of two required'. Later, the summary states that Cooper was able to sit on the edge of the bed with assistance of two staff, but a hoist was needed to transfer. The summary also stated that an overlay mattress to protect Cooper's pressure areas had been ordered which 'should arrive tomorrow' and that district nurses had been organised to administer his insulin from 'tomorrow morning'. The summary concluded by stating that the CHNS, the care home, the social worker and Cooper's advocate were aware of his care needs.

5.33 The COVID-19 Hospital Discharge Service Requirements stated:

- That Hospital clinical and managerial leadership teams should maintain timely and high quality transfer of information to General Practice and other relevant health and care professional on all patients discharged.
- That Hospital discharge teams should train discharge staff (potentially those who no longer have to undertake CHC assessments) to operate 'Trusted assessments' for patients in

hospital from care homes, so they can return to their care home promptly, and support all care homes with these new discharge arrangements.

- That community health providers ensure that a lead professional or multidisciplinary team visit the patient at home on the day of discharge or the day after to arrange what support is needed in the home environment and rapidly arrange for that to be put in place. Should care support be needed on the day of discharge from hospital, this will have been arranged prior to the patient leaving the hospital site, by a care coordinator.

5.34 In practice arranging the support needed and rapidly arranging for it to be put in place took longer than the Service Requirements envisaged. However, the CHNS decided to review how care home staff managed Cooper over the first weekend following his discharge from hospital, following which additional equipment was ordered (Paragraph 4.32). This did not seem to be an unreasonable approach.

Following discharge from the RUH, was Care Home 1 the most appropriate setting for Cooper's care and support needs given it was a residential care setting not a nursing care setting?

5.35 Cooper's care home raised concerns about the capability of their staff to provide care and support to him once he was deemed medically fit for discharge from the RUH. The care home needed considerable support from primary care and the CHNS to meet Cooper's care and support needs during the period from his discharge from RUH (15th April 2020) and his re-admission (28th May 2020).

5.36 Cooper's South Gloucestershire social worker obtained authorisation for funding additional support for Cooper on two occasions. During the week following his hospital discharge she requested a 28 day increase of 15 hours per week for hourly checks and support to move as he was not currently able to support his own weight. He required 2-3 staff to support with moving and personal care – although it was anticipated that the arrival of equipment the following week would reduce this level of staffing (Paragraph 4.34). As the initial 28-day period was drawing to a close, the social worker requested authorisation for additional support as he was spending the majority of his time in bed and needed two staff to ensure 4-6 hourly repositioning and the changing of his pad. The social worker added that Cooper experienced a mixture of anxiety and strength limitations and that in the middle of the night it was likely that he would be increasingly tired and delirious and not necessarily able to safely support the repositioning (Paragraph 4.59).

5.37 The fact that a second authorisation for additional support was necessary suggested that Care Home 1 may be unable to meet Cooper's long term needs and the social worker proposed a multi-disciplinary meeting with the CHNS, advocate, district nurses and GP practice to explore this issue and consider whether a Nursing Home placement was more appropriate. Before this meeting could be arranged, Cooper was admitted to hospital for a second time and subsequently died. The SAR Panel also raised the question of whether Care Home 1 could have considered formally escalating their concerns about the challenges they were experiencing in meeting Cooper's needs. Freeways have observed that Care Home 1 may not have accepted Cooper's return had it not been for the exceptional circumstances of the pandemic.

5.38 Reflecting on the decision to discharge Cooper back to Care Home 1, this was a defensible decision because it accorded with Cooper's wishes and although it was clear that care staff at Care Home 1 were likely to struggle the needs which were evident at the time of his hospital discharge, it was not known at that stage whether his condition would improve, and additional support was provided to the care home. Additionally, any decision to transfer Cooper to Nursing Home placement would have need to be considered very carefully as such a significant change

– particularly for a person who valued continuity and routine – could have proved detrimental to his emotional health and wellbeing and longer-term health.

How effectively was Cooper's voice heard by professionals and his views and wishes taken into account?

5.39 Cooper benefitted from support from the same advocate for his transfer to Care Home 1, the safeguarding concerns and his discharge from hospital. He also retained the support of the same South Gloucestershire social worker as he transferred from Care Home A in Bristol to Care Home 1 in B&NES, although the transfer resulted in a change in the provider of the range of community learning disability services he needed.

5.40 Professionals attempted to understand why he began to present as anxious but were unable to get to the root of the problem. It was good practice to obtain the support of SALT to use communication cards in an effort to better understand Cooper's anxiety. There was some evidence of resistance to support and one incident of challenging behaviour (4.32). It was good practice to involve a support worker from his previous care home to work with Cooper to focus on building his confidence with leg exercises (Paragraph 4.50).

5.41 There is important learning from the manner in which information was obtained from Cooper about the incident in which he disclosed that he had been pushed in the shower (Paragraph 4.9). Firstly, he was asked a number of leading questions rather than being asked to describe what had happened in his own words and a clear record made of this. Secondly, he was asked to confirm what had happened on a number of occasions which led to slightly different accounts being given by Cooper.

5.42 It is not known whether the way in which staff communicated with Cooper when he made a disclosure of possible physical abuse indicates a development need for the professionals involved or a wider training need. However, B&NES Community Safety and Safeguarding Partnership may wish to consult people with learning disabilities and organisations which support them over how effectively people with learning disabilities feel that professionals communicate with them.

Additional areas of learning

5.43 After examining Cooper in the care home on 24th March 2020 the ambulance crew 'sent his GP a note' to consider the prescription of anti-anxiety medication. The GP practice has no record of being contacted by the ambulance service and so anti-anxiety medication was not prescribed at that time (Paragraph 4.16). This SAR has been advised that the South West Ambulance Service (SWAST) don't routinely notify GP practices when they are called out to their patients and use their judgement on whether the GP practice needs to be involved. There may be merit in B&NES Community Safety and Safeguarding Partnership seeking assurance from SWAST and the CCG that communication from SWAST to GP practices is effective.

Supply of nutritional supplements

5.44 On 18th May 2020 Cooper's GP expressed frustration that the nutritional supplements prescribed and ordered on 5th May 2020 had not yet been delivered to Care Home 1 (Paragraph 4.54). The nutritional supplements had been delivered by 27th May 2020 (Paragraph 4.62). The SAR has been advised that problems arose with the distribution of nutritional supplements during the early stages of the pandemic only and so no recommendation is considered necessary.

Management of skin integrity issues

5.45 Following his discharge from hospital, Cooper began to experience skin integrity issues for which he received care from the staff of Care Home 1 supported by the district nurses and the tissue viability nurse. Cooper's care home twice raised safeguarding concerns about the care provided to Cooper from the district nurse service (Paragraphs 4.49 and 4.53). On neither occasion did the concern meet the criteria for action under safeguarding policy. The second safeguarding concern was raised after the care home documented that the district nurse service apologised for the service they provided. It is accepted that an important factor in Cooper's skin integrity issues was the amount of time he was being cared for in bed and the difficulty care home staff experienced in repositioning him during the night (Paragraph 4.50). However, B&NES Community Safety and Safeguarding Partnership may wish to seek assurance from the provider of district nurse and tissue viability nurse services in respect of the effectiveness of skin integrity care where, as in this case, skin integrity care is challenging for the care provider to manage.

Good practice

5.46 There were many examples of good practice at a time when professionals were working under the pressures of the first wave of the Covid-19 pandemic, including:

- Cooper benefitted from the support of the same advocate Cooper for his transfer to Care Home 1, the safeguarding concerns and his discharge from hospital.
- Obtaining the support of SALT to use communication cards in an effort to better understand Cooper's anxiety.
- Involving a support worker from his previous care home to work with Cooper to focus on building his confidence with leg exercises.
- Care Home 1 was prepared to challenge decisions on behalf of Cooper such as consultation over the DNACPR decision.

6. Recommendations

Recommendation 1

That B&NES Community Safety and Safeguarding Partnership requests the commissioners and providers of care homes to identify lessons learned from the manner in which Covid-19 risk to care home residents was managed in the first phase of the pandemic with particular reference to infection control, the extent to which agency staff were used, the extent to which staff – including agency staff – were deployed to more than one establishment and the management of visits by relatives and friends of care home residents during this period.

Recommendation 2

That B&NES Community Safety and Safeguarding Partnership request HCRG Care as providers of Nutrition and Dietetics services to advise the partnership on how Covid-19 affected the provision of Nutrition and Dietetics services, how any risks associated with not accepting new referrals has been addressed and what has been learned from the pandemic about maintaining business continuity.

Recommendation 3

That B&NES Community Safety and Safeguarding Partnership obtains assurance from the Royal United Hospitals Bath NHS Foundation Trust that when DNACPR decisions are made in respect of

adults who lack capacity, the care provider of the adult will be consulted in respect of the DNACPR decision where appropriate.

Recommendation 4

That B&NES Community Safety and Safeguarding Partnership obtains assurance from the Royal United Hospitals Bath NHS Foundation Trust that all Mental Capacity Act assessment and Best Interest discussions are appropriately recorded.

Recommendation 5

That B&NES Community Safety and Safeguarding Partnership obtain assurance that all providers of care to people who need a hospital passport ensure that hospital passports are completed fully and updated when the person's circumstances or needs change.

Recommendation 6

When B&NES Community Safety and Safeguarding Partnership disseminates the learning from this SAR, the need for professionals to exercise caution when using assessment tools which have not been developed or adapted for use with people with learning disabilities is highlighted. Further, that providers of health care for people with learning disabilities should ensure that all staff understand what other tools and methodologies are available to ensure appropriate understanding of their medical and health care needs and treatment

Recommendation 7

That B&NES Community Safety and Safeguarding Partnership consider consulting with adults with learning disabilities and organisations which support them over how effectively adults with learning disabilities feel that professionals communicate with them.

Recommendation 8

That B&NES Community Safety and Safeguarding Partnership considers seeking assurance from South West Ambulance Service (SWAST) and the Bath and North East Somerset, Swindon and Wiltshire Clinical Commissioning Group (CCG) that when the ambulance service is called out to a patient and the ambulance service consider it necessary to communicate with the patient's GP practice, that communication between SAWST and the GP practice is effective.

Recommendation 9

That B&NES Community Safety and Safeguarding Partnership seek assurance from HCRG Care in respect of the effectiveness of skin integrity care where, as in this case, skin integrity care is challenging for the care provider to manage.

References

(1) COVID-19 Hospital Discharge Service Requirements – HM Government/NHS guidance published on 19th March 2020.

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(8) Retrieved from https://committees.parliament.uk/publications/7496/documents/78687/default/

(9) ibid

(10) ibid

(11) ibid

(12) ibid

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(19) Retrieved from https://www.resus.org.uk/sites/default/files/2020-05/20160123%20Decisions%20Relating%20to%20CPR%20-%202016.pdf

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(21) Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/973935/fifth-suicide-prevention-strategy-progress-report.pdf

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Appendix A

Process by which safeguarding adults review (SAR) conducted

It was decided to adopt a systems approach to conducting this SAR. The systems approach helps identify which factors in the work environment support good practice, and which create unsafe conditions in which unsatisfactory safeguarding practice is more likely. This approach supports an analysis that goes beyond identifying what happened to explain why it did so – recognising that actions or decisions will usually have seemed sensible at the time they were taken. It is a collaborative approach to case reviews in that those directly involved in the case are centrally and actively involved in the analysis and development of recommendations.

The membership of the SAR Panel was as follows:

Peter Edwards	Team Manager, South Gloucestershire Adult Social Care
Jackie Mathers MBE	Designated Safeguarding lead for Adult, Children and Domestic Abuse, NHS CCG.
Jenny McShane-Hicks	Principal Social Worker, Community Health and Care Services, Virgin Care
David Mellor	Independent Author
Ian Pope	Senior Manager, Freeways
June Thompson	Specialist Practitioner, Adult Safeguarding, RUH
Ella Uwadia	Social Worker, South Gloucestershire Adult Social Care
Helen Wakeling	Principal Social Worker, Safeguarding Adults and Quality Assurance, B&NES Council
Kirstie Webb	Business Manager, BCSSP
Laura Jones	BCSSP Administrator

Chronologies of contact with Cooper and his family and Agency Involvement forms were completed by the following agencies:

- Bath & North East Somerset Council
- Freeways
- GP practice
- Royal United Hospital Bath NHS Foundation Trust
- South Gloucestershire Council
- South West Ambulance Service NHS Foundation Trust
- Virgin Care
- Your Say Advocacy

The SAR has also benefitted from the information gathered and analysed for the previously mentioned LeDeR review.

The SAR was informed by a learning event to which practitioners who had been involved in Cooper's care were invited.

Cooper's brother also contributed to the SAR.

As a result of Covid-19 restrictions all SAR Panel meetings and the practitioner learning event were conducted by video conferencing and the contribution of Cooper's brother was by a telephone call with the independent reviewer.

Glossary

Best Interests - if a person has been assessed as lacking mental capacity, then any action taken, or any decision made for, or on behalf of that person, must be made in his or her best interests.

(NHS) Continuing Healthcare – some people with long-term complex health needs qualify for free health and social care arranged and funded solely by the NHS. This is known as NHS continuing healthcare and can be provided in a variety of settings outside hospital, including the patient's own home or a care home.

Hospital Passport - the aim of the hospital passport is to assist people with learning disabilities to provide hospital staff with important information about them and their health when they are admitted to hospital.

A ***Learning Disability*** affects the way a person understands information and how they communicate. This means they can have difficulty understanding new or complex information, learning new skills and coping independently. A learning disability can be mild, moderate or severe. Some adults with a learning disability can live independently, while others need help with everyday tasks, such as washing and dressing, for their whole lives. It depends on the person's abilities and the level of care and support they receive.

Making Safeguarding Personal - is a sector-led programme of change which seeks to put the person being safeguarded at the centre of decision making. It involves having conversations with people about how agencies might respond in safeguarding situations in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety. It is about seeing people as experts in their own lives and working alongside them. It envisages a shift from a process supported by conversations to a series of conversations supported by a process.

Mental Capacity Act (MCA) - The Mental Capacity Act 2005 provides a statutory framework to empower and protect people who may lack capacity to make decisions for themselves and establishes a framework for making decisions on their behalf. This applies whether the decisions are life changing events or everyday matters. All decisions taken in the adult safeguarding process must comply with the Act.

The presumption in the MCA is that adults have the mental capacity to make informed choices about their own safety and how they live their lives. Issues of mental capacity and the ability to give informed consent are central to decisions and actions in adult safeguarding. All interventions need to take into account the ability of adults to make informed choices about the way they want to live and the risks they want to take. This includes their ability to understand the implications of their situation, to take action themselves to prevent abuse and to participate to the fullest extent possible in decision-making.

Pressure ulcers are areas of localised damage to the skin, which can extend to underlying structures such as muscle and bone. There are four categories of pressure ulcer severity ascending in seriousness from category 1–4.

A ***category 2 pressure ulcer*** is defined as partial thickness skin loss involving epidermis (the upper or outer layer of the two main layers of cells that make up the skin), dermis (the thick layer of living tissue below the epidermis which forms the true skin, containing blood capillaries, nerve endings, sweat glands, hair follicles, and other structures) or both.

Section 42 Care Act 2014 Enquiry by local authority

This section applies where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there):

- has needs for care and support (whether or not the authority is meeting any of those needs),

- is experiencing, or is at risk of, abuse or neglect, and
- as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case and, if so, what and by whom.

Self-Neglect covers a wide range of behaviour including neglecting to care for one's personal hygiene, health or surroundings, lack of self-care to an extent that it threatens personal health and safety, inability to avoid harm as a result of self-neglect, unwillingness to seek help or access services to meet health and social care needs and includes behaviour such as hoarding.