Overview Report

Safeguarding Adult Review into the death of Patricia

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1. Introduction

1.1. The subject of this case is Patricia. At the time of her death Patricia had been bedbound for over 10 years, was bariatric and had a range of complex health conditions. Patricia had a package of care funded[1] by the NHS and she and her husband lived in extra sheltered accommodation.

1.2. At the beginning of the scoping period for this review, a duty doctor at Patricia's GP Practice prescribed her a course of antibiotics after learning from Patricia's care provider that Patricia was experiencing hallucinations and presenting as unwell. The duty doctor did not attend Patricia at her home but informed the care provider that in the event of no improvement, the GP Practice should be re contacted, or 111.

1.3. The following day, carers found Patricia unresponsive and contacted emergency services. An ambulance attended but due to Patricia's bariatric status, ambulance crew were unable to use the lift. A further concern was that there was a broken fire door[2] in the building but ambulance staff extricated Patricia safely down the flights of stairs and out of the building using an EvacPro stretcher.

1.4. After three days in hospital, Patricia was discharged home. Owing to demand upon the East of England emergency ambulance service, a private ambulance company was commisisoned by the hospital. The double manned crew of which, upon reaching Patricia's accommodation, attempted to stand her. Patricia collapsed and got stuck in the ambulance and another ambulance crew (from the same private ambulance company) had to be called to help. Patricia was taken back to hospital the same day, where she was found to have a number of fractures.

1.5. Patricia was in a lot of pain and sadly died in hospital 10 days later.

1.6. At a meeting in September 2023, those present at the Safeguarding Adults Review Panel sub group for Cambridgeshire and Peterborough Safeguarding Adults Partnership Board unanimously agreed that the criteria was met[3] for a mandatory Safeguarding Adult Review under The Care Act 2014.

1.7. The purpose of a Safeguarding Adult Review is clearly defined in the Care Act 2014. It is to promote effective learning and improvement actions to prevent future deaths or serious harm occurring again. The lessons learnt for this case should be applied to future cases to ensure continuous improvement of practice. It is not the purpose of this review to hold any individual or organisation to account. Other processes exist

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[1] NHS Continuing Healthcare is a package of care for adults aged 18 or over which is arranged and funded solely by the NHS. In order to receive NHS Continuing Healthcare funding individuals, have to be assessed by integrated commissioning boards according to a legally prescribed decision making process to determine whether the individual has a 'primary health need'.

[2] The broken fire door had been brought to the attention of the housing provider on the 28th of February 2023 and a contractor had attempted to fix it on the same day but was unable to. The location manager was advised to raise a five day repair, and this was done. This was not deemed an emergency repair because there were two alternative exits.

[3] Safeguarding Adults Reviews

(1) A SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—
  (a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and
  (b) condition 1 or 2 is met.

(2) Condition 1 is met if—
  (a) the adult has died, and
  (b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

(3) Condition 2 is met if—
  (a) the adult is still alive, and
  (b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

(4) An SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

(5) Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to—
  (a) identifying the lessons to be learnt from the adult's case, and
  (b) applying those lessons to future cases.

for that, including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation.

1.8. This report has been authored by Allison Sandiford. Allison is an independent safeguarding consultant with no links to Cambridgeshire and Peterborough Safeguarding Adults Partnership Board or any of its partner agencies. Allison gained experience in safeguarding whilst working for a police service. Since leaving the force in 2019, Allison has conducted serious case reviews in both children's and adults safeguarding, and domestic homicide reviews.

2. Confidentiality

2.1. Patricia's family has requested that Patricia's name be used within this report.

2.2. Once agreement for the final report has been given by the Cambridgeshire and Peterborough Safeguarding Adults Partnership Board and its partner agencies, the overview Safeguarding Adult Review report and a briefing sheet will be available on the Board's website.

2.3. Upon publication, partner agencies will be made aware, and the action plan will be shared with the agencies involved and the Adult Statutory Case Review Group.

2.4. The review has been assured by Cambridgeshire and Peterborough Safeguarding Adults Partnership Board that the learning will be disseminated:

- a briefing sheet and PowerPoint slides will be produced and shared with agencies, and
- a multi-agency workshop highlighting the case will be delivered

3. Methodology

Terms of Reference

3.1. The panel[4] identified the following key lines of enquiry for the review:

- How were Patricia's care needs being met? Was there a robust personal evacuation plan in place - and who was it shared with?
- What was the role of the Continuing Healthcare funding and how was Patricia's care plan reviewed?
- How were agencies assured that Patricia had the mental capacity to make decisions about her own health and care?
- How did agencies support Patricia's unpaid/family carers?
- Explore agency response and decision-making to Patricia becoming unwell.
- Explore the decision-making around Patricia's ambulance transfer, what information did ambulance staff have and what risk assessments were put in place. Was the direction and commissioning of the service appropriate?
- What are the views of the family?
- Identify areas of positive practice

3.2. It was agreed that the review shall look at the period from the 3rd of March 2023 (when Patricia became unwell) until the 17th of March 2023 (when Patricia sadly died). But in addition, the report will include background information re any significant events and safeguarding issues prior to the scoping period if agencies consider that it would add value and learning to the review.

Involvement of Family and Wider Community

3.3. The Independent Reviewer and Cambridgeshire and Peterborough Safeguarding Adults Partnership Board would like to offer their condolences to the family and friends of Patricia.

[4] See Appendix 1 for panel membership.

3.4. Patricia's daughter was notified of this review by Cambridgeshire and Peterborough Safeguarding Adults Partnership Board and invited to participate. The subjective experiences of support and services provided to the deceased, from the point of view of family members, is an important aspect of the Safeguarding Adult Review process and the Independent Reviewer would like to thank Patricia's daughter and son in law for agreeing to meet with her. Their invaluable contribution is woven into the body of the report.

Limitations to this Review

3.5. There have been some limitations to the review:

3.5.1. The care provider and private ambulance provider though invited, did not attend the learning event.

3.5.2. The care provider service stopped providing care to the accommodation's residents in March 2023 and a different care provider service took over the contract. The latter care service has informed this review that they do not hold any documentation to support the Safeguarding Adult Review process. When the initial care provider was contacted for information, the provider responded to Cambridgeshire and Peterborough Safeguarding Adults Partnership Board stating that; following checks being made no information was available. In addition, the provider said that '*all colleagues that were involved with the residents and running of* the accommodation *no longer work for the organisation therefore we have no one in our employment with a knowledge of Patricia or her care during the time period identified'*. The Independent Reviewer is concerned that neither provider has any information or records of what care was provided to Patricia; all care providers have a legislative responsibility to create and maintain records and under the Data Protection Act 2018, residents' personal data must be kept securely but not kept longer than required. When a care provider closes, the service provider retains legal responsibility for the work they have done and the records that have been created. This responsibility applies to the preservation, sharing and discarding of records. The Independent Reviewer has previously contacted the Care Quality Commission for guidance on how new providers should be retaining the records from old providers and was directed to regulation 17[5] and informed that guidance can also be sought regarding the transfer of records, from the Information Commissioner's Office. In addition, regarding a care provider's involvement with safeguarding reviews, section 45 of the Care Act 2014 gives Safeguarding Adults Boards the power to obtain information in support of its functions – and the person to whom the request is made, must comply.

3.5.3. During the review process, it came to the attention of the Independent Reviewer that staff members who had worked to support Patricia, now worked for the new care provider service at Patricia's accommodation. Cambridgeshire and Peterborough Safeguarding Adults Partnership Board further contacted the current provider on many occasions and requested that the staff members meet virtually with the Independent Reviewer to discuss the learning. Though agreed, staff proved unable to meet with the Independent Reviewer prior to the end of the review process. Consideration was had to delaying the review whilst further attempts to facilitate a meeting were attempted but it was decided that it was not proportionate to delay the learning. Consequently the review would ask that this report be shared with the care provider and that the care provider be asked to feedback their subsequent learning to Cambridgeshire and Peterborough Safeguarding Adults Partnership Board.

3.5.4. Similarly, the private ambulance transport service has not responded to requests for information, and this has been escalated as a concern.

[5] Regulation 17: Good governance - Care Quality Commission (cqc.org.uk)

Learning 1: The effectiveness of this review has been constrained by not all of the agencies/organisations, who have worked to support Patricia, providing the information as requested by the Safeguarding Adult Partnership Board.

Question 1: How can Cambridgeshire and Peterborough Safeguarding Adults Partnership Board promote a better understanding of Safeguarding Adult Reviews amongst private providers in their area, and improve engagement with future safeguarding reviews?

Parallel Reviews

3.6. A Comprehensive Level Serious Incident Investigation Report was undertaken by Cambridge University Hospitals NHS Foundation Trust to identify the causal factors and key learning from the incident and to use this information to significantly reduce the likelihood of future harm. The conclusions of the report can be found at Appendix 2.
3.7. The housing association undertook a review of their involvement with Patricia following receipt of the Safeguarding Adult Review referral. The conclusion of which can be found at Appendix 3.
3.8. The concerns regarding Patricia's care and injury in the private ambulance transport were referred to Adult Social Care and a section 42 enquiry was opened - the conclusion of which can be found at Appendix 4.
3.9. Patricia's death was referred to HM Coroner. The Coroner's Inquest had not concluded at the time of writing this report.

4. Analysis and Response to Key Lines of Enquiry

Following:

- examination of the information gained from the agency reports/documentation shared with this review, and
- discussions with professionals at a learning event[6],
- discussion and analysis with panel members in meetings[7], and
- conversations with Patricia's daughter and son in law,

the subsequent responses have been generated to the Key Lines of Enquiry.
Lessons learned are stated, along with (where the lesson remains unaddressed) a question for Cambridgeshire and Peterborough Safeguarding Adults Partnership Board to consider; the answers to which will drive Cambridgeshire and Peterborough Safeguarding Adults Partnership Board and its partner agencies to develop an action plan that will respond directly to the learning.

How were Patricia's care needs being met?

4.1. Patricia was a rental tenant (under a tenancy agreement) in extra care housing accommodation[8] which offered a 24 hour on-site care provider[9].
4.2. The housing provider was responsible for the management and maintenance of the property and in addition to providing the accommodation, delivered some support by means of morning welfare calls, signposting to external agencies for support if required, and offering a 24/7 emergency helpline that was accessed via pullcords and pendants.

[6] See Appendix 5 for details.
[7] Panel met on three occasions.
[8] Managed by a charitable housing association which is regulated by the Care Quality Commission and Regulator of Social Housing.
[9] Commissioned by the council and provided through a third-party company.

4.3. The housing provider employed an on-site Location Manager who was on-site Monday to Thursday from 08:00 until 16:00 and Friday from 08:00 until 14:00. The Location Manager duties included managing the building, managing contractors, ensuring the building was compliant in relation to all health and safety matters, conducting quarterly property checks, dealing with complaints within the service, and signposting residents to services for support.
4.4. On-site care was provided through a third party company – commisisoned by the council - the housing provider did not provide the regulated care service or review Patricia's care.
4.5. All of Patricia's care needed to be provided whilst she was in her bed as she was bariatric, immobile, non-weight bearing and experienced pain on movement. Patricia was unable to lie flat and had very poor sitting balance in bed. Her daughter has described how her mum had no feeling from her waist and had developed fixed flexion contractures[10] in her lower limbs. This review has learned that Patricia was able to feed herself and drink from a cup with support (Patricia had meals delivered to her door which were then prepared by carers) but because she was immobile, she needed to be 'turned' every few hours and required support with her personal care as required[11].
4.6. In summary, Patricia was fully dependent on others to meet her basic needs.
4.7. Patricia was entitled to continuing healthcare funding to fund her private care. The most recent continuing healthcare assessment, which dates from December 2021, informs that the care Patricia was receiving at the time was two carers attending her in the morning to assist with personal care and medication, one at lunch, one in the afternoon and another at teatime, with two carers at bedtime and one in the night.
4.8. Notably this package did not offer two carers to reposition Patricia every 3-4 hours. This was discussed with Patricia's daughter who informed that whilst she frequently asked the care provider for two carers to be provided – and a review of the continuing healthcare information evidences that a change was ordered to the care package in February 2022 (for two carers to attend four times a day) - this wasn't ever achieved due to the care provider's resources. Instead, Patricia's husband would assist a carer to turn Patricia, and he also supported his wife with her personal needs when a carer was not in attendance.

Was there a robust personal evacuation plan in place - and who was it shared with?

4.9. In order to address this Key Line of Enquiry, it is necessary to consider the support offered to Patricia pre the scoping period of this review when, in 2015, Patricia spent a period of time in hospital.
4.10. Upon Patricia's discharge from hospital, one of her daughters explained that her parents lived in a second floor flat and whilst the daughter accepted that there was no ground floor accommodation available for her parents; she had concerns with regard to the implications of evacuating her mum from the flat in an emergency.
4.11. It is important to acknowledge here that the housing provider has informed this review that when Patricia first moved into their property she was in a wheelchair and that the lift could accommodate a wheelchair – hence not being on the ground floor did not pose a problem at that time. When Patricia's health deteriorated and she became bedbound, Patricia and her husband were offered a property on the ground floor, but this was declined.
4.12. At the time that Patricia's daughter raised her concern, the continuing healthcare team were completing their initial assessment and after identifying that Patricia was eligible for the continuing healthcare funding, a member of the team contacted the Location Manager at the property and asked that an evacuation assessment be completed prior to Patricia's discharge. This is documented to have been done.
4.13. The housing provider has informed that their Personal Risk Evacuation Plan for Patricia was held on their internal system (Be Safe) and that also in the foyer of the property was a master key safe that emergency services could access. This safe contained a list of the residents who required assistance to evacuate, and the housing provider has stated that the Fire and Rescue Service were aware of this safe, and the list. The Fire and

[10] A flexion contracture refers to a bent joint that cannot be fully straightened actively or passively.
[11] Patricia was doubly incontinent and unable to change her own pads – she required two carers for continence care.

Rescue Service has also confirmed that calls evidence that when incidents have been telephoned through to them from this address, the housing provider has advised how to access the property and how to locate the key safe.

4.14. The housing provider has helpfully further explained the Personal Risk Evacuation Plan to this review; The Personal Risk Evacuation Plan is a process (created and adopted by themselves) that has been ratified by their Primary Authority Partnership London Fire Brigade during a full review of their Fire Management System completed in 2023. The Personal Risk Evacuation Plan is not a legal requirement - it is primarily based on the code of practice for the provision of premises information boxes in residential buildings, developed by the National Fire Chiefs Council and Fire Industry Association. The primary purpose of their Personal Risk Evacuation Plan process is to provide information to attending Fire Services in an emergency, which would ordinarily form what is called an 'Emergency Response Pack'. Within the Emergency Response Pack, locations would be asked by local Fire and Rescue Services to provide 'information on residents with mobility, cognitive or sensory impairment(s)'. And this is what the Personal Risk Evacuation Plan summary report, held within our risk management system called BeSafe, achieves. The local managers are asked to print this off and store in their locations master key box or Secure Information Box for access by attending Local Fire and Rescue Services in an emergency situation.

4.15. Professionals at the learning event noted that when Patricia was taken to hospital early in the scoping period of this review, the Fire and Rescue Service were not needed to assist. Consequently, the Fire and Rescue Service were not in attendance to share the information with regards to the evacuation plan in the safe. And it was highlighted that the ambulance service (who don't carry any history of any individual they are required to attend) wouldn't have known to look in a 'key safe box' for details of Patricia's evacuation.

4.16. In addition, this review has learned that whilst the Fire and Rescue Service knew of the key safe, they did not have a marker against Patricia's property on their database - which would have immediately brought to their notice the fact that she was bedbound. Professionals representing the Fire and Rescue Service at the learning event explained that when a bedbound individual is brought to their attention, they attend the property to conduct a safe and well visit; in which they assess the situation[12] before adding a marker to the property on the database - to highlight evacuation issues.

4.17. It was further explained that Patricia wasn't ever brought to their attention until during the scoping period of this review - when the ambulance service who were taking Patricia to hospital submitted a request for a safe and well visit. This visit was attempted by the Fire and Rescue Service at the end of March 2023 with no response, but the Fire and Rescue Service now know that Patricia had sadly died.

4.18. Individuals can be brought to the attention of the Fire and Rescue Service by way of their referral system – which any agency can submit. Discussions were had around firstly, the responsibility of either (and both) the housing provider and the care providers to notify the Fire and Rescue Service of Patricia's circumstances, and secondly, how other agencies could have also notified; for example, the GP Practice could have brought Patricia - as a known bedbound individual, to the attention of the Fire and Rescue Service by means of a referral. The Fire and Rescue Service confirmed that receiving duplicate referrals for the same individual is not a problem and it is better to receive many, than none at all.

4.19. It was also discussed whether the continuing healthcare team could have reinforced their request for an evacuation plan to be developed, with a referral to the Fire and Rescue Service. However this review has been informed that the role of the continuing healthcare assessor is a clinical one and there are no care/case management responsibilities as their remit is entirely focussed on determining eligibility and the appropriate package of care that needs to be commisisoned to meet the client's needs.

4.20. As mentioned, this review has heard that the housing provider did discuss changing accommodation with Patricia and her husband as Patricia's mobility declined - but both had said that they didn't want to

[12] A Fire and Rescue safe and well visit would have provided Patricia and her husband with actions and advice to help make their home safer from the risks of fire, and it would also have included planning around should Patricia need to evacuate the property. Discussions would have also likely been had with Patricia, her husband and the housing provider around the suitability of their accommodation - given that it was not on the ground floor.

move. However, professionals should never be afraid to revisit decision-making around important aspects of safety and the more professionals that highlight such a risk, the better.

Learning 2: Agencies could have referred Patricia to the Fire and Rescue Service and requested a safe and well visit which would have included advanced planning of how Patricia could be safely extricated from the property in an emergency.

Question 2: How can the Fire and Rescue Service with the support of **Cambridgeshire and Peterborough Safeguarding Adults Partnership Board,** ensure that professionals from all services are aware that referrals can be made for a safe and well check?

4.21. The East of England Ambulance Service has also confirmed that they are able to add specific patient or location information markers onto their Computer Aided Dispatch software used within the Trust Ambulance Operations. Any professional can email the ambulance safeguarding team to request a marker be added to the system. If a marker is added, the information would become known to crews attending the address - as well as notifying dispatchers. After one year (and recurrently after that), a Computer Aided Dispatch Marker Administrator will check the system and remove the marker if the patient is deceased or has moved out of our operational area. If the marker is still valid, it will be extended for one year and the process repeated.
4.22. Notably, any marker would not be known to any private ambulance service providers called to the address.

Learning 3: Agencies could have informed the ambulance service safeguarding department of Patricia's circumstances. Consideration would then have been had of adding a Computer Aided Despatch marker as appropriate.

Question 3: How can the East of England Ambulance Service, with the support of **Cambridgeshire and Peterborough Safeguarding Adults Partnership Board,** ensure that professionals from all services are aware to **inform the ambulance service safeguarding department of individual's circumstances if a Computer Aided Despatch marker is required?**

4.23. This review has learned of how some areas within the UK have introduced Community Multi Agency Risk Assessment Conferences[13] to their practice. Community Multi Agency Risk Assessment Conferences are multi-agency meetings which convene to share information and develop action plans to support very vulnerable and high risk individuals whose personal safety is a concern. Such meetings are not currently utilised by agencies within Cambridgeshire and Peterborough, but it is possible that upon learning that Patricia and her husband did not wish to move to more suitable and safe accommodation, Patricia, as a bariatric bedbound lady, may have met the criteria for her circumstances to be discussed at such a meeting had a referral to a Community Multi Agency Risk Assessment Conference been an option.

Learning 4: If agencies within Cambridgeshire and Peterborough had a developed Community Multi Agency Risk Assessment Conference pathway, Patricia, as a high risk individual whose personal safety was a concern, may have been discussed multi-agency.

Question 4: How can **Cambridgeshire and Peterborough Safeguarding Adults Partnership Board, in partnership with the local authority learn more about Community Multi Agency Risk Assessment Conferences and explore whether there would be any benefit to introducing them, or something similar, into local practice?**

[13] Brent Community Multi Agency Risk Assessment Conferencing | Brent Council

What was the role of the Continuing Healthcare funding and how was Patricia's care plan reviewed?

4.24. The Integrated Care Board (ICB) has a duty to assess adults with care needs arising from disability, illness, or injury to determine eligibility for NHS Continuing Healthcare (CHC) funding[14]. The Integrated Care Board's Continuing Health Care team is responsible for conducting assessments and allocating appropriate funding to meet assessed health needs.

4.25. Continuing Health Care eligibility is subject to periodic review to ensure funding remains aligned with the individual's needs. The process includes:

- An initial assessment, followed by a three-month review if eligibility is established.
- Annual reviews thereafter to reassess care needs and adjust funding as required.

4.26. Patricia was first assessed as eligible for CHC funding in 2015 following a hospital admission[15]. Her care plan was subsequently reviewed in line with standard CHC processes.

4.27. Reviews were conducted regularly, though the 2020 assessment was delayed due to pandemic-related constraints [16]. Her most recent review took place in December 2021 via virtual platform (Microsoft Teams), during which Patricia—experiencing anxiety about the process—consented to her daughter representing her.

4.28. The December 2021 review identified the following changes in Patricia's condition since her previous assessment in June 2019:

- Development of double incontinence.
- Flexion contractures.
- Recurrent skin infections
- Episodes of verbal aggression.
- Increased psychological withdrawal.
- Signs of cognitive decline.

No alterations to her CHC eligibility or care plan were deemed necessary at this stage.

4.29. The scheduled December 2022 review was postponed due to operational demands within the CHC team, with reassessment planned for March 2023. However, Patricia was hospitalised before this could occur. It is noted that:

- The CHC team operates an open referral system: Patricia, her family, or professionals could request an earlier review if her needs changed significantly.
- A care package adjustment (e.g. two-carer support) was implemented in February 2022 following such a request.

4.30. During the learning event, questions were raised about whether additional support (e.g., carer assessments or fire safety checks) could have been signposted earlier. However:

- The CHC team's primary remit is to assess funding eligibility and agree care packages, not to oversee day-to-day care delivery[17].
- While safeguarding is a shared responsibility, panel views varied on whether CHC assessors should proactively advise on non-funding-related support (e.g. carer assessments).

Question 5: How can the NHS Cambridgeshire and Peterborough ICB use this case in future CHC training to explore:

- **The balance between funding assessments and holistic support signposting.**
- **Strategies to enhance communication about available resources (e.g. carer assessments) without overstepping statutory remits.**

[14] Eligibility for continuing health care is based on assessed need rather than a particular diagnosis.
[15] Patricia continued to receive continuing health care funding until her death.
[16] This review has been assured that during this period the continuing healthcare team completed eight welfare calls to Patricia to check that she was ok.
[17] NHS continuing healthcare - Social care and support guide - NHS (www.nhs.uk)

How were agencies assured that Patricia had the mental capacity to make decisions about her own health and care?

4.31. At the beginning of the scoping period of this review Patricia was described by family and professionals as hallucinating and presenting with confusion. The GP Practice has informed this review that this was not unusual behaviour and on this occasion was indicative of an infection. When the ambulance crew conveyed Patricia to hospital she was described as being unconscious but very soon after being admitted into hospital and treated, she was more alert and no longer displaying signs of confusion.

4.32. No formal capacity assessments were completed with Patricia during this stay in hospital and this review has been informed that medical notes do not indicate any need for a mental capacity assessment for her consent to care and treatment; whilst Patricia was described as having some confusion upon arrival (documented to be due to low oxygen saturations) Patricia improved when transferred to a ward and she was described as orientated, alert, and coherent during ward rounds. There is nothing to evidence that she was presenting any differently at the time of discharge.

4.33. This review has attempted to understand how the crew of the private ambulance transport assured themselves of Patricia's mental capacity when they asked her to stand, but as mentioned in paragraph 3.5.4 the transport provider has not responded to requests for information and did not engage with the learning event. However, Patricia's daughter has informed the review that she felt Patricia would have had the mental capacity to decide if she could stand; and she feels sure that Patricia would not have attempted to. In addition, she spoke of Patricia having told her that she had repeatedly told the crew she couldn't walk. It therefore remains unknown how such a misunderstanding came about.

4.34. Having fallen in the ambulance Patricia was returned to hospital, where a few days before she sadly died, a capacity assessment was completed as she was presenting with delirium. This assessment concluded Patricia to lack the capacity to consent to her care and treatment at this time.

4.35. This assessment is the only capacity assessment undertaken during the scoping period but in conclusion, this review has not identified any missed opportunities to assess Patricia's mental capacity to make any of her decisions. However moving away from the Key Line of Enquiry slightly, this review has learned of concerns for Patricia's mental health which could have been afforded consideration during the scoping period.

4.36. Following readmission, it is reported that Patricia's daughter informed a doctor that Patricia could have dementia and that she was struggling to understand. The hospital report that there is nothing documented during the earlier admission of dementia and no diagnosis of dementia within Patricia's medical records. But regardless, this was a missed opportunity to explore Patricia's mental health and refer for any support that she needed.

4.37. Patricia's daughter informed that she (and her father) had been concerned for Patricia's mental health for some time. She described how her mum had become increasingly anxious and forgetful and had started to ramble. She also said that Patricia was losing interest in things. Patricia's daughter explained that she had been raising these concerns with carers, the GP and with hospital staff for a number of years.

4.38. There is an example of Patricia's daughter raising her concerns within the continuing healthcare review 15 months prior to the scoping period of this review, where it is documented that Patricia's daughter described changes to her mum's demeanour and said that she was concerned that Patricia's cognitive ability was deteriorating. Around the same time, Patricia's daughter also raised this concern to the GP. A GP subsequently assessed Patricia but concluded that she did not require a memory assessment.

4.39. Patricia's daughter informed this review that she was disappointed with this because the GP had notified her mum in advance of the assessment, and Patricia's daughter said that she considered her mum to be clever enough to conceal the decline in her mental health from professionals if pre-warned. This was a similar experience to a previous occasion that Patricia's daughter recalled when, in around 2015, Patricia had been in a rehabilitation centre and her mental health had been raised in a family meeting. However Patricia's

daughter explained how nothing changed following the meeting because her mum was very clever with her answers when professionals enquired, and her dad would back her mum up.
4.40. Patricia's daughter described how professionals supporting her mum would only have gained a 'snapshot' into her life and may therefore not have been able to recognise the mental health concerns; her mum was often able to present as managing - but a person not reaching a threshold for mental health services during a professional consultation, is not evidence of a person's ability to manage their mental health on a daily basis.

How did agencies support Patricia's unpaid/family carers?

4.41. This review recognises that agencies' support of Patricia's unpaid/family carers would not have changed the continuing events described within the scoping period - or the outcome. But nevertheless, it is a very significant aspect of professional practice and therefore it is important that the review consider the support offered to Patricia's carers and identify any learning.
4.42. Whilst Patricia had paid professional carers to help with her care and support needs, it was clear that given her immobility she would be wholly dependent on her family (i.e., her husband and daughter) when paid carers weren't with her. For this reason, it was important that practitioners explored how Patricia's health, and her required care, could impact the whole family.
4.43. Patricia's daughter does not recall either her or her dad ever being offered a carer's assessment with regard to their care of her mum. In accord with this, there is nothing documented in agency case notes. This is despite a clear deterioration in Patricia's condition and abilities, which is described in the continuing healthcare review undertaken in December 2021 with Patricia's daughter and which must have been visible to visiting professionals.
4.44. When this was explored at the learning event, professionals debated what the caring requirements looked like for the family members, given that paid carers were attending to Patricia's incontinent pads, personal care, and dietary needs. But conversation with Patricia's daughter has highlighted that her father was still attending to much of Patricia's personal care and was supporting the carers when they attended. And in addition, Patricia's daughter (who had Power of Attorney) was ordering food, managing prescriptions, managing finances and ensuring that all aspects of Patricia's care was attended and that she had no outstanding support needs.
4.45. Patricia's daughter also described how much her mum came to rely on her for emotional support and whilst this is something she always wanted to offer her mum, she described how it could at times be difficult. This evidences how a caring role isn't always about physical care; it can be an emotional role which can be complex - particularly if the individual one is caring for begins to experience poor mental health or is in pain.
4.46. Prior to and within the scoping period of this review, there were missed opportunities for the housing provider, the care provider, the GP Practice, and members of the hospital staff who were considering a safe discharge for Patricia, to have discussed and/or referred both Patricia's husband and daughter for a carer's assessment. Had either family member (or both) agreed, it would have created an opportunity for professionals to,

- better understand Patricia's and Patricia's family's lived experiences,
- hear their voices, and
- gain an understanding of how Patricia's health and required care, impacted upon her family.

4.47. However even in the absence of a carer's assessment, professional curiosity should have still seen professionals exploring the emotional and physical effects of caring for Patricia upon her family. And though it is recognised that the priority for professionals who were entering the family home was to focus on the needs of Patricia, they should have utilised the opportunity to ask questions and to hear the family's voice.
4.48. Enquiring into how Patricia's husband was managing was especially important given that their daughter had disclosed that Patricia had started to exhibit some difficult behaviours (within the continuing healthcare assessment in December 2021) and in June 2022, had disclosed during a meeting with the manager of the

care provider that her parents were starting to argue a lot[18]. Following this disclosure a safeguarding referral was submitted to Adult Social Care. The referral did not progress to a safeguarding enquiry; this review has been informed that the plan was for carers (unpaid and paid) to monitor the situation and to make a further referral if it was felt that the situation was escalating or if there were concerns for either party. There was a missed opportunity when responding to this referral to explore carer stress with Patricia's husband and daughter and to offer support, including by way of a carer's assessment.

4.49. This review acknowledges that it is possible that either or both Patricia's daughter and Patricia's husband could have declined a carer's assessment had one been offered - but at the least they could have still been signpost to organisations for advice and support which they may have accessed at a later date if, or when, they felt ready. For example, to support individuals who care for another Cambridgeshire County Council provide information on their website[19]. Amongst other things, the information describes the carer's assessment and signposts to the Caring Together Charity[20] – an organisation which offers individuals support and advice with regard to their caring role. Notably, during conversations with the Independent Reviewer, Patricia's daughter said she was unaware of this information on the website.

4.50. Interestingly though, it was possible that even had they been aware, neither Patricia's daughter nor Patricia's husband would have looked for advice - because neither recognised themselves as carers in the first place. They didn't separate their caring role from their relationship. This is not unusual - particularly when the relationship is one of parent/child, or partner. The *Our State of Caring Survey* undertaken in 2022 by CarersUK found that *over a third of carers (36%) took over three years to recognise themselves as a carer*.

4.51. Without doubt, caring for someone (which often includes, as it did for Patricia's family, watching someone you love experience pain) must be one of the hardest things to do. It can therefore affect a person's own physical and/or mental health. In accordance with this, the CarersUK website[21] has highlighted that caring has been *identified as a social determinant of health by Public Health England* and this accentuates how crucial it is that unpaid carers be recognised and offered support. And how everyone has a role to play in helping carers to identify themselves.

4.52. This review has been informed that a lot of work has been undertaken by Adult Social Care since the scoping period of this review and there is now better recognition of carer stress which is being further strengthened by a carer's strategy and the appointment of a service manager with the lead for carers. There is also now guidance for staff in the form of a factsheet which is currently being updated.

Learning 5: There were missed opportunities to discuss support options for Patricia's daughter and Patricia's husband as unpaid carers.

Question 6: How can Cambridge and Peterborough Safeguarding Adults Partnership Board and partner agencies support all professionals in the area, working to provide care, to recognise unpaid carers and provide unpaid carers with information about the support available?

Explore agency response and decision-making to Patricia becoming unwell.

4.53. On the first day of the scoping period for this review, Patricia's husband contacted their GP Practice after Patricia had become unwell at home. He described Patricia as *ranting and raving* the previous night and afternoon and requested that Patricia's doctor contact her by telephone.

4.54. As Patricia's doctor was not working at that time, it was a duty doctor who saw the request and returned the call. The doctor spoke with the manager of the care provider who confirmed that Patricia was experiencing

[18] When Patricia was spoken to, she said that *she didn't know what all the fuss was about, and* whilst she *felt that he did get a bit frustrated with her during the Jubilee as he wanted her to get up and she didn't want to* (and couldn't), but she had no concerns.

[19] Looking after someone - Cambridgeshire County Council
[20] Caring Together | Carers' Support | Homecare | Cambs, P'boro and Norfolk
[21] Identification | Carers UK

hallucinations. A decision was made to treat Patricia's symptoms as a suspected urinary tract infection and an antibiotic script was issued.

4.55. The manager of the care provider explained that the script would not reach Patricia for several days as Patricia's husband was too poorly to collect it from the chemist, Patricia's daughter was recovering from an operation and the manager of the care provider was not authorised to collect it. Therefore it would be delivered by the chemist, but delivery would take a few days[22]. The doctor advised that if Patricia deteriorated in the meantime, 111 should be contacted or Out of Hours. The doctor did not attend to Patricia at her home.

4.56. The surgery Practice Leaflet informs that *Home visits can be carried out if needed when a patient is housebound, or too frail or unwell to travel, and needs to be examined*. The reason for not visiting Patricia at home was discussed at the learning event and the doctor in attendance explained that it was a very experienced doctor who had decided (with the manager of the care provider) that Patricia did not require examination - and therefore no home visit was required as based on her previous presentation it was common for Patricia to hallucinate with a urine infection and she had recovered in the past when treated with oral antibiotics. The doctor in attendance at the learning event confirmed that the decision was in line with standard practice.

4.57. It is recognised that when to undertake a home visit is a patient by patient decision[23], but professionals at the learning event deduced that whilst Patricia may not have required a physical examination, given that she was bedbound and had multiple comorbidities, a home visit may have proved worthwhile. This is because a home visit could have better explored how Patricia's condition was to be checked overnight in her home – particularly given that

- medication was going to take a few days to reach her, and
- the manager of the care provider had mentioned that Patricia's husband was at the time unwell himself - which should have raised concerns with regard to who would be able to take ownership of watching Patricia for any signs of deterioration and respond to any attempts she may have made for help.

4.58. In the absence of attending the home address and speaking with Patricia's husband, an assumption was made by the GP that Patricia's husband was able to look out for signs of deterioration and keep an eye on the situation alongside the one scheduled visit from the carers. More professional curiosity could have been had by the GP during the telephone conversation with the manager of the care home with regard to how often a professional carer would be checking on Patricia in the night and how capable Patricia's husband was, in his unwell state, to call for help if required.

4.59. Similarly the manager of the care provider, who knew Patricia and her husband, and had a better understanding of their circumstances, could have asked the doctor for more help, i.e., requested a home visit or asked questions with regard to what deterioration could look like.

4.60. Without further conversation, or a triangulated conversation between the GP, the carers and Patricia's husband, it was not ever established if all parties concerned understood who was taking ownership of watching Patricia for signs of deterioration and/or whether those involved knew the signs to look for.

4.61. The GP Practice has assured this review that since the scoping period of this review, safety netting with regard to who is going to care for a patient, has improved as the surgery has conducted multiple learning events and a Multi-Disciplinary Team meeting regarding Patricia's case, specifically in terms of safety netting. All medical staff have been made aware how to appropriately conduct safety netting for safeguarding patients - especially patients in independent living accommodation. Staff have:

- been made aware of the extra support available in the community that can be provided by a Social Worker which could include, the monitoring of a patient at moderate risk of deterioration, and where there is insufficient care/support needs to monitor the health of the patient, the offer of a short term placement into a nursing home or residential care, a living in carer or waking night care.

[22] Patricia's daughter has confirmed that in actual fact she did manage to collect the prescription the same day.

[23] Patricia had been seen at home twice by healthcare professionals from the Practice in January 2023.

- been reminded to ensure patients are able to take their antibiotic medication etc – whilst Adult Social Care will not accept a referral to give medication (as this is done by the district nurses), medication will be administered by them as part of a bigger package of care if the patient has other social care needs.
- been reminded to consider sepsis. Signs of sepsis have been printed and copied into the duty doctor room, and
- been given emergency numbers; they have been put on the board - including Adult Social Care and safeguarding.

4.62. A further option that was available to the GP with regard to initial assessment was a referral to the Joint Emergency Team. This team supports people over the age of 65 or with long-term conditions in their home environment when they become unwell. The team offers an urgent response and, post assessment, will develop a care plan in liaison with the GP. The Joint Emergency Team practitioners can provide up to two weeks of care in the home.

4.63. The GP Practice has agreed that a referral to the Joint Emergency Team could have been made on this occasion to avoid hospital admission (given that medication was going to be delayed) and has assured the review that its doctors have been reminded to set a low threshold when considering the criteria for a referral to the team.

4.64. This review has been informed that Patricia's carers took it upon themselves to check on Patricia more regularly. This is an example of positive practice that can be learned from, but unfortunately, Patricia's deterioration still did not become apparent until the morning when, as mentioned, carers found Patricia to be unresponsive and called 999.

4.65. Notably, this review has been informed that all of East of England Ambulance Service ambulances are capable of bariatric transport and that all their staff are trained in bariatric care.

4.66. The first ambulance crew in attendance quickly called an additional crew as they recognised that they would struggle to pat-slide Patricia across the trolley-bed alone. They also recognised that the trolley-bed would not fit inside the lift and that Patricia would need to be 'scooped' down the main set of stairs as a carry chair was not possible due to Patricia being a bariatric patient.

4.67. A member of the second crew who arrived had recently completed his 'train the trainer' for a new patient moving device called the EvacPro[24] - which it was established is intended for this kind of extraction as it is dragged rather than lifted. The EvacPro would wrap around Patricia and secure her with much greater effect than a scoop. Consequently the first crew focussed their attentions on Patricia and supported Patricia's husband to pack a bag for her, whilst the second crew organised the equipment[25] and extrication.

4.68. The equipment was reportedly utilised with ease and a pre-alert was sent to the hospital who had a team waiting upon arrival. The extrication of Patricia from her home address to the hospital is an example of positive practice. However, the hospital has informed the review that it could have been helpful had the ambulance crew verbally informed hospital staff of the need to use the EvacPro equipment. Had they have done this; the information would then have been noted in Patricia's case notes and may have proved beneficial when arranging her discharge home. The ambulance service has drawn attention to the information being within their ambulance electronic patient care record, but professionals representing the hospital confirmed that staff do not refer to this post admission.

4.69. Patricia is reported to have recovered well in hospital with a short dose of non-invasive ventilation and was ready for discharge three days later. Patricia is described as having been very keen to get home and of showing tears of joy when the medical team discussed her discharge.

[24] EvacPRO | Professional Emergency Evacuation Stretcher | 3ET

[25] 1 x EvacPro is available at each hub station. There are 3 hub stations per sector.

Explore the decision-making around Patricia's ambulance transfer, what information did ambulance staff have and what risk assessments were put in place. Was the direction and commissioning of the service appropriate?

4.70. When Patricia was ready for discharge home an electronic Transport Order Form was completed by a hospital Junior Ward Sister. The order was then processed by the hospital transport team and forwarded to the East of England Ambulance transport contact centre.

4.71. To help ease pressures on the NHS Emergency Services, the NHS will sometimes subcontract non-emergency patient transport to external companies - hence when the ambulance transport contact centre doesn't have the capacity to provide a vehicle, the form is returned to the hospital transport team to be assigned to a private ambulance company.

4.72. The form was returned in Patricia's case, and so the hospital transport team placed the request with a private ambulance transport provider[26].

4.73. The hospital expectation is that all of the information they provide at booking is passed on to the private ambulance transport crew - and there is nothing to suggest that this did not occur on this occasion. However, scrutiny of the form exposes that the information provided was erroneous; whilst it correctly identified that Patricia needed to use a *stretcher* it did not elaborate any further and consequently it was not clear that Patricia was unable to stand/walk even short distances. In addition, the form stated that there were no access issues to Patricia's address (which was described as a private home), and furthermore Patricia was documented as not being bariatric.

4.74. There was a missed opportunity to check the information provided on the form when the ambulance crew were on the ward. Ambulance staff could have raised questions at this time, and likewise ward staff could have reiterated what they knew - but no further conversation was had between ward staff and ambulance crew with regard to Patricia's mobility[27]. There appears to have been a presumption from ward staff (possibly affected from the private ambulance transport crew having witnessed Patricia's transfer by pat-slide onto a stretcher/trolley in the ward) that the crew were aware of Patricia's mobility.

4.75. Upon reaching Patricia's home address the ambulance crew recognised that they would be unable to get their stretcher into the lift, and the crew report that Patricia (who was unaccompanied by family) was asked if she could stand in order to get into a chair which would fit in the lift. The crew report that Patricia said she could. This is in contradiction to what Patricia's daughter has informed the review which is that her mum had told her that she had repeatedly told the crew she could not.

4.76. It is important to note here that whilst the private ambulance was a bariatric ambulance, the aforementioned EvacPro is not available to private transport providers. Private transport providers have to access an EvacPro via 999. In the absence of the transport provider engaging with this review it has not been possible to establish whether they considered trying to access an EvacPro or whether they considered contacting Fire and Rescue for support (which was another option available to them upon arriving at Patricia's home and recognising the problems with the stretcher).

4.77. However what is clear is that the transport provider did not have the correct information when they transported Patricia home. The Transport Order Form did not correctly detail Patricia's mobility or the access to her home.

Learning 6: The private ambulance transport crew were not in receipt of the correct information to support their decision-making.

4.78. The Comprehensive Level Serious Incident Investigation Report undertaken by Cambridge University Hospitals NHS Foundation Trust has already *recommended that the current Transport Order form is reviewed*

[26] The hospital transport team use a number of private ambulance transport providers and requests are placed with the provider dependent on their availability.

[27] No family members were present at this time.

by a multi-disciplinary team to look at ways it can be improved to help ward staff ensure the right information is captured.

4.79. The Serious Incident Investigation Report further identified that *the key to the handover process is ensuring the information provided on the written documentation (Transport Order Form) to the Ambulance crew contains all the relevant information that the Ambulance Crew would require to be able to anticipate any potential issues and provide a safe patient transfer.* However professionals at the learning event mooted that whilst it is now known that the information recorded on Patricia's form was not accurate, would the person filling in the Transport Order Form ever be in receipt of all of the information with regard to transferring an individual from and to their home address? Particularly as the experiences of the East of England Ambulance Service crew - as logged on the ambulance electronic patient care record, does not follow a patient through their hospital journey. The record is uploaded to hospital records - but this review has been informed that staff outside of the Emergency Department don't routinely consult it.

4.80. Ideas were put forward at the learning event and by panel members:

- Could staff completing the Transport Order Form be prompted to read the ambulance electronic patient care record? (Other professionals responded stating that time restraints would not allow this.)
- Could ward staff be prompted to read the ambulance electronic patient care record as part of their holistic assessment upon a patient's admission onto the ward? (Similarly, time restraints would not allow this.)
- Could a mechanism be introduced which would allow the ambulance crew to alert a hospital to difficulties/obstacles with regard to transportation - and hospital staff thereafter add a 'flag' to the patient's record?
- Could ambulance staff pass the information verbally for hospital staff to record on patient notes?

4.81. All of the ideas mooted are valuable, but the scale of work must be considered when amending or introducing any new policy/procedure. Average figures taken from June 2024 demonstrate that around 430 individuals attend the hospital emergency department every day, around 70 - 84 of these are admitted onto wards and around 110 – 130 individuals are discharged from wards every day.

Learning 7: The ambulance electronic patient care record is not routinely consulted by or available to hospital staff outside of the Emergency Department and therefore the information contained within it is not shared or applied to any future decision-making.

Question 7: How can Cambridge University Hospitals NHS Foundation Trust assure Cambridge and Peterborough Safeguarding Adults Partnership Board and its partner agencies of training with staff working in the Emergency Department around the documentation of any difficult extrications?

Question 8: How can Cambridge and Peterborough Safeguarding Adults Partnership Board and its partner agencies ensure that the learning from this review is shared with the hospitals within the locality and encourage hospitals to look at their own transport liaison processes?

What are the views of the family?

4.82. Patricia's daughter has informed the review that she feels grateful that investigations are on-going regarding her mum's care, and she reports feeling reassured that things will be looked at.

4.83. Patricia's daughter and son-in-law feel that things can firstly be improved with better communication. Patricia's daughter expressed feeling as if none of the organisations/professionals had listened to her with regards to her concerns regarding her mum's needs. She acknowledged that she isn't a nurse or a doctor but emphasised how nevertheless - she knew her mum better than anyone. And she knew that her mum needed help and tried to tell professionals; but she doesn't feel as if anyone listened. This frustration extends beyond the scoping period – starting with the aforementioned growing concerns around her mum's mental health.

4.84. Patricia's daughter explained that Patricia's stay in hospital during the scoping period of this review was particularly difficult. She visited her mum almost every day and had to watch her crying and sobbing in pain. She said that neither she nor her father were able to touch her mum to offer comfort because the pain was too much. They asked the ward staff for stronger painkillers other than paracetamol but were told that she couldn't have anything. Not understanding, and in desperation, Patricia's daughter said that she eventually contacted the palliative care team directly. She reports that their response was excellent. She felt as if they listened to her, and they arranged traction and a morphine pump for her mum. Patricia's daughter said that the relief this brought to her mum was clear.

4.85. Patricia's daughter expressed that what happened to her mum in the private ambulance, didn't need to. She doesn't understand how the incident occurred but is frustrated by

- the details of how her mum was transported to hospital by the East of England Ambulance crew not being effectively shared with the hospital or the private ambulance crew, and
- the hospital not sharing the information that was known to them accurately with the private ambulance transport provider.

4.86. Patricia's daughter hopes that no other family will have to go through what her family has.

Learning 8: Consideration should have been had to exploring Patricia's daughter's concerns of which she informed professionals.

Question 9: How can Cambridgeshire and Peterborough Safeguarding Adults Partnership Board explore whether professionals are effectively exploring concerns raised by family members, and if there is current concern; identify what steps can be taken to address it?

5. Positive Practice

Discussion around Patricia's care has highlighted some examples of positive practice[28] from the professionals involved with her, which is included within the body of this report. It is important that such practice is highlighted and further encouraged.

6. Developments Since the Scoping Period

The review would like to acknowledge that some agencies have already made some important amendments to practice since the scoping period of this review. Their developments have been included in the body of this report.

7. Lessons to be Learnt and Recommendations[29].

7.1. The lessons learned from this Safeguarding Adult Review commissioned by Cambridgeshire and Peterborough Safeguarding Adults Partnership Board are highlighted in bold text throughout this report, but for reference are repeated here:

[28] Positive practice in this report includes both expected practice and what is done beyond what is expected.

[29] By way of questions.

	Learning	Has the learning been addressed?		Question
1	The effectiveness of this review has been constrained by not all of the agencies/organisations, who have worked to support Patricia, providing the information as requested by the Safeguarding Adult Partnership Board.	No	1	How can Cambridgeshire and Peterborough Safeguarding Adults Partnership Board promote a better understanding of Safeguarding Adult Reviews amongst private providers in their area, and improve engagement with future safeguarding reviews?
2	Agencies could have referred Patricia to the Fire and Rescue Service and requested a safe and well visit which would have included advanced planning of how Patricia could be safely extricated from the property in an emergency.	No	2	How can the Fire and Rescue Service with the support of Cambridgeshire and Peterborough Safeguarding Adults Partnership Board, ensure that professionals from all services are aware that referrals can be made for a safe and well check?
3	Agencies could have informed the ambulance service safeguarding department of Patricia's circumstances. Consideration would then have been had of adding a Computer Aided Despatch marker as appropriate.	No	3	How can the East of England Ambulance Service, with the support of Cambridgeshire and Peterborough Safeguarding Adults Partnership Board, ensure that professionals from all services are aware to inform the ambulance service safeguarding department of individual's circumstances if a Computer Aided Despatch marker is required?
4	If agencies within Cambridgeshire and Peterborough had a developed Community Multi Agency Risk Assessment Conference pathway, Patricia, as a high risk individual whose personal safety was a concern, may have been discussed multi-agency.	No	4	How can Cambridgeshire and Peterborough Safeguarding Adults Partnership Board, in partnership with the local authority learn more about Community Multi Agency Risk Assessment Conferences and explore whether there would be any benefit to introducing them, or something similar, into local practice?
5	There were missed opportunities to discuss support options for Patricia's daughter and Patricia's husband as unpaid carers.	No	5	How can Cambridge and Peterborough Safeguarding Adults Partnership Board and partner agencies support all professionals in the area, working to provide care, to recognise unpaid carers and provide unpaid carers with information about the support available?

6	The private ambulance transport crew were not in receipt of the correct information to support their decision-making.	Yes - The Comprehensive Level Serious Incident Investigation Report undertaken by Cambridge University Hospitals NHS Foundation Trust has *recommended that the current Transport Order form is reviewed by a multi-disciplinary team to look at ways it can be improved to help ward staff ensure the right information is captured.*		
7	The ambulance electronic patient care record is not routinely consulted by or available to hospital staff outside of the Emergency Department and therefore the information contained within it is not shared or applied to any future decision-making.		6 7	How can Cambridge University Hospitals NHS Foundation Trust assure Cambridge and Peterborough Safeguarding Adults Partnership Board and its partner agencies of training with staff working in the Emergency Department around the documentation of any difficult extrications? How can Cambridge and Peterborough Safeguarding Adults Partnership Board and its partner agencies ensure that the learning from this review is shared with the hospitals within the locality and encourage hospitals to look at their own transport liaison processes?
8	Consideration should have been had to exploring Patricia's daughter's concerns of which she informed professionals.		8	How can Cambridgeshire and Peterborough Safeguarding Adults Partnership Board explore whether professionals are effectively exploring concerns raised by family members, and if there is current concern; identify what steps can be taken to address it?

8. Appendix 1

The Review Panel Members

- Independent Reviewer
- Case Review Officer from Cambridgeshire and Peterborough Safeguarding Adults Partnership Board
- Business Administrator from Cambridgeshire and Peterborough Safeguarding Adults Partnership Board.
- Representative from Adult Social Care
- Representative from Cambridgeshire and Peterborough Foundation Trust
- Representative from Housing
- Representative from the Care Agency
- Representative from the Integrated Care Board
- The GP
- Representative from the East of England Ambulance Service.
- Representative from the hospital

9. Appendix 2

Conclusion of the Comprehensive Level Serious Incident Investigation Report undertaken by Cambridge University Hospitals NHS Foundation Trust

This investigation has looked at the systems and processes in place at Cambridge University Hospitals with regards to the patient transfer to identify any potential contributory factors and for areas of improvement. The investigation found that the information provided to the Ambulance crew on transfer was inaccurate and not sufficiently robust, and this impacted on any human error in this case. The information provided in the electronic order form was incorrectly completed due to staff misinterpretation and there was a lack of handover on the *ward between ward staff and ambulance crew. The investigation team are of the view that handover on the ward can be variable based on circumstances (workload, patient factors etc.) and should not be relied upon to provide safety netting. The key to the handover process is ensuring the information provided on the written documentation (Transport Order Form) to the Ambulance crew contains all the relevant information that the Ambulance Crew would require to be able to anticipate any potential issues and provide a safe patient transfer. It is recommended that the current Transport Order form is reviewed by a multi-disciplinary team to look at ways it can be improved to help ward staff ensure the right information is captured. The outcome of the investigation by the private Ambulance Crew is currently outstanding and will be tracked via the Serious Incident Action Plan. Any additional learning identified for Cambridge University Hospitals will be taken forward via this route.*

10. Appendix 3

The Housing Authority Association concluded their review with the following points.

- There were two alternative exits and two stairways to exit the building on the day of the incident.
- The fire door in question was repaired shortly after the incident.
- The housing provider was not aware that Patricia was unwell and had no concerns in regard to her care and support.
- The scheme has identified the need to improve the working relationship with the care provider and plans to implement daily and weekly catch-up meetings to discuss any concerns re residents.

The Housing Authority Association also noted that it is standard practice, formalised via a working arrangement document, that monthly Care Review Meetings are conducted between The Housing Authority Association and the Care Team Manager across all their extra care locations, Additionally, a daily handover is completed to ensure that accurate and concise critical information is available to the Location Manager. The purpose of the Care Review Meetings is to discuss the service provided to all individual residents and to

address any concerns, such as safeguarding issues. These meetings are documented and recorded. However, at this location, around the time of the incident, the meetings were not consistently held due to the availability constraints of the Care Manager from the former provider. Going forward The Housing Authority Association will ensure that the escalation process to higher management is actioned where daily handover and monthly Care Review Meetings are not being completed as per working arrangement document.

11. Appendix 4

The section 42 enquiry concluded that:

- *following significant safeguarding enquires and internal organisation investigations, evidence suggests that Patricia sadly suffered neglect and acts of omission failures from various organisations in her last few weeks of life. It is clear that there was multiple organisations involved with Patricia and there has been significant learning and lessons learnt as a result.*

12. Appendix 5

Practitioner Learning Event

A virtual learning event was held and attended by the:

- Case Review Officer, Cambridgeshire & Peterborough Safeguarding Partnership Board
- Business Support Officer, Cambridgeshire & Peterborough Safeguarding Partnership Board (Minutes)
- Adult Safeguarding Lead (Multi Agency Safeguarding Hub) Cambridgeshire County Council
- Safeguarding Coordinator, Cambridgeshire Fire and Rescue Service
- Safeguarding Lead, East of England Ambulance Service
- Sector Safeguarding Lead, East of England Ambulance Service
- Designated Safeguarding Nurse, Safeguarding Children, Cambridgeshire & Peterborough Integrated Care Board (Also interim adult cover)
- Safeguarding Lead, GP Practice
- Adult Safeguarding Lead, Cambridge University Hospitals NHS Foundation Trust
- Senior Social Worker, Adult Social Care, Cambridgeshire County Council (Based at Addenbrookes Hospital in the social care team)