Safeguarding Adults Review - Andrew

Executive Summary

Independent Reviewer: Pete Morgan

Executive Summary prepared by Guy Jackson – Business Manager of the Brighton and Hove Safeguarding Adults Board – based on the Independent Review Report.

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1. Introduction

1.1. This Executive Summary is being published following a Safeguarding Adults Review that was commissioned in relation to a gentleman who is being referred to as Andrew for the purposes of this review.

1.2. Under Section 44 of the Care Act 2014 Safeguarding Adults Boards (SABs) must arrange a Safeguarding Adults Review (SAR) when certain criteria are met. These are:

- When an adult has died because of abuse or neglect, or has not died but experienced serious abuse or neglect, whether known or suspected, and;
- There is a concern that partner agencies could have worked more effectively to protect the adult.

1.3. The Brighton and Hove Safeguarding Adults Board (BHSAB) received a SAR referral in respect of Andrew in August 2020. There was a significant delay in the referral being received with Andrew having passed away in December 2019.

1.4. Summaries of information received from partner agencies identified that a significant level of activity had already been undertaken in seeking to learn from what took place, including section 42 enquiries, a Serious Incident review, as well as Police investigations.

1.5. The BHSAB commissioned a discretionary SAR in the form of a 'Desk-top Review' with the purpose of the Independent Reviewer critically analysing these investigative processes, chronologies, and relevant records to identify and share multi-agency learning in seeking to prevent a similar situation occurring again in the future.

1.6. Since the Independent Reviewer completed their desk-top review report further information and clarification has been provided and the Executive Summary has been updated to include this.

2. Background

2.1 Andrew was a 51-year-old white, British man who had a severe learning disability in addition to a range of longstanding health difficulties and reduced mobility. He had been living in a small local authority Residential Care Home for adults with learning disabilities in Brighton and Hove for over twenty years and was supported by the Specialist Community Disability Service, the learning disability service that sits within the Families, Children and Learning directorate within the local authority.

2.2 Andrew's communication skills were described as 'non-verbal', and he had consistently been assessed as being unable to make capacitated decisions regarding his care and support needs. It was reported though that he was able to make his wishes known in relation to day-to-day needs. Andrew had been under Deprivation of Liberty Safeguards (DoLS) authorisations for several years. There had been significant concerns regarding his nutritional intake and weight loss in recent years.

2.3 Andrew was initially admitted to hospital on the 28th October 2019 after being pushed over by another resident who had moved to the Residential Care Home in May 2019. This resident is being referred to as Brian for the purposes of this review. There had been two previous examples of Brian being physically aggressive towards Andrew, which were recorded by the Residential Care Home but these had not been reported as safeguarding concerns or followed-up. They were subsequently reported to the CQC in November 2019.

2.4 Following Andrew's hospital admission he was found to have significant injuries that included a fractured hip, pubic rami (pelvis) and rib. A section 42 safeguarding enquiry was commenced by Brighton and Hove City Council's Specialist Community Disability Service in relation to the physical abuse he had experienced. This was not concluded until September 2020.

2.5 Due to contracting pneumonia whilst an inpatient as well as significant concerns regarding his nutritional intake Andrew's hospital admission continued until 30th November 2019. During this period Brian was moved to an alternative Care Home setting and a best interests decision made, in consultation with Andrew's sister and learning disability staff from both health and the local authority, that he return to the Residential Care Home. Whilst there remained significant concerns regarding Andrew's nutritional intake it was identified these needs would be supported by the Residential Care Home alongside additional health, dietary and therapy support.

2.6 Four days after discharge, on 4th December 2019, the registered manager of the Residential Care Home raised concerns with the GP regarding Andrew's weight loss and his reduced eating and drinking. He attended the Accident and Emergency (A&E) department at the hospital for blood tests, which were normal, and discharged the following day with no additional concerns raised.

2.7 Over the following week various interactions took place between health professionals with different approaches were undertaken to encourage fluid and nutritional intake. The registered manager contacted the GP surgery on 13th December 2019 requesting both a medication and speech and language therapy (SALT) review and contacted the surgery twice more on the 16th December 2019.

2.8 On the evening of the 16th December 2019 the GP contacted the Residential Care Home but with the registered manager not there they advised that Andrew should be brought to the surgery the following morning. When Andrew was taken to the surgery the following morning the GP immediately arranged for him to be readmitted to hospital for a second time. However, with his condition felt to have become palliative treatment was withdrawn and Andrew passed away on the 21st December 2019.

2.9 A safeguarding concern was retrospectively raised by the Learning Disability Liaison Nurse based at the hospital in January 2020. This was in relation to neglect and omission regarding how his health needs were managed by partner agencies following his discharge from hospital. A second section 42 safeguarding enquiry was undertaken by the Specialist Community Disability Service in relation to neglect and omission, which concluded in August 2021.

2.10 Andrew had one sister who did not live locally but who has always been very involved in his care and support. She was invited to participate in this review but did not feel it necessary to speak to the Independent Reviewer. She advised that both she and Andrew had always been

very happy with the care he received at the Residential Care Home. However, concerns arose after Brian moved in and that the tensions this caused may have exacerbated Andrew's already variable eating habits with his weight loss becoming a significant factor.

2.11 A Coronial Inquest has taken place in the period since Andrew sadly passed away. This identified the cause of death as bilateral bronchopneumonia. Andrew's sister considered the Inquest conclusions to be fair based on the evidence available. The Coroner identified 'clear failings in the management at the Residential Care Home in the second half of 2019' and felt this review should consider record keeping and communications regarding the Residential Care Home and management chain, the delays in Andrew receiving care as his condition deteriorated as well as the issues with Brian not being dealt with more promptly and efficiently. Andrew's sister requested that she be informed of the outcome of the review.

3 Identified Themes

3.1 The Independent Reviewer identified 82 separate findings in their review report, which they grouped into seven themes. The seven themes identified are listed below with what the SAB believe are key individual points in relation to each theme. These have been summarised for the purposes of promoting effective learning to be taken forward by partner agencies.

3.2 The Independent Reviewer has noted that these seven themes are not discrete groupings but have porous membranes so that findings can fall into more than one theme.

4. Residential Care Home Practice

4.1 There was no evidence of any pre-placement checks being made regarding the admission of Brian, as a new resident. He had moved to the Residential Care Home following the death of his father but there is no consideration of the potential reaction this may have caused or of any previous behavioural issues. This may have identified that this setting would not be appropriate and had not been reflected in his assessed care and support needs.

4.2 Whilst there were statutory review processes that took place there was no evidence of any specific immediate post-admission Care Home review that identified issues occurring between Andrew and Brian. With an incident occurring between Andrew and Brian within the first four weeks of Brian's arrival, and then further acts of physical aggression occurring, raising these as formal safeguarding concerns or exploring how to manage their relationship through care and support planning may have reduced the likelihood of subsequent incidents occurring.

4.3 There were inconsistencies in the recording of the number of incidents that occurred between Andrew and Brian, as well as the reporting and escalation of these. The Independent Reviewer did not receive detail of all the incidents that apparently occurred and whilst they noted that some recording inconsistencies may be expected they identified concern that specific incidents of physical aggression were seemingly not recorded.

4.4 There were significant delays in some actions being progressed. This included raising and then responding to an initial safeguarding concern raised by a member of staff at the Residential Care

Home regarding alleged neglect in respect of Andrew's personal care routine by other staff. This was subsequently raised by a senior manager in the registered manager's absence, which is an instance of good practice. The Independent Reviewer identified that on at least two other occasions necessary decisions or actions were not taken when the registered manager was unavailable, and that staff felt unable to escalate concerns through alternative pathways when professional disagreement occurred.

4.5 Following Andrew's discharge from hospital in November a risk management/escalation plan was in place to support the Residential Care Home in meeting his increased care and support needs. Five incidents were identified by the reviewer as having subsequently occurred in which specialist advice and guidance would have been of benefit, but this risk management/escalation plan was only implemented on one of these occasions.

4.6 Records indicate that Andrew was being regularly weighed at the Residential Care Home between August and October 2019 (prior to his hospital admission) and had lost 6kg during this period. Despite his increased care and support needs, possibly exacerbated by his reduced nutrition and fluid intake, increased input from community dietician services was not included in the discharge risk management/escalation plan. Increased continence support needs and the impact these would have on tissue viability were also not considered as bruising developed on Andrew's right thigh.

5. Safeguarding Practice

5.1 There was a significant delay in deciding whether to raise an initial safeguarding concern regarding alleged neglect by the Care Home, leading to missed opportunities to consider Andrew's care and support needs more broadly at an earlier point. These missed opportunities included reviewing the actions of individual staff members at the Residential Care Home, consideration of multi-agency safeguarding procedures as well as failing to immediately notify the CQC.

5.2 The Independent Reviewer noted examples of inconsistency in the terminology used and a lack of clarity as to the status and function of meetings whilst multi-agency safeguarding procedures were underway. These examples included;

- the links between the hospital discharge planning process and section 42 enquiry that had been commenced into the physical abuse Andrew experienced in being pushed over by Brian. This could lead to relevant professionals not attending meetings or being aware of the outcomes of these.
- terms being used such as 'multi-disciplinary meetings under Care Management' and 'safeguards to prevent future similar incidents' outside of the section 42 enquiry process. This could lead to confusion as to under which processes actions were being undertaken.

5.3 There were also examples identified through the review process where it is considered there could have been improved legal literacy. These examples included; a safeguarding concern not being raised which meant there wasn't the opportunity for operational services to consider whether a safeguarding enquiry should have been undertaken under section 42 of the Care Act 2014 in relation to the initial concerns identified within the Care Home regarding alleged neglect in early October. These were not raised due to Andrew being 'no longer at risk of any abuse or

neglect'. However, the concerns identified were broader than one specific incident and a section 42 enquiry should be undertaken when a local authority has 'reasonable cause to suspect' that abuse or neglect has occurred.

5.4 A Safeguarding Adults Review (SAR) referral not being raised immediately following Andrew having passed away. Whilst it was good practice that formal safeguarding concerns were raised this should have been under section 44 of the Care Act to arrange a review in situations where a person has died or experienced significant harm as a result of abuse or neglect. It would have been beneficial for this to have been identified at an earlier point.

6. Care Management Practice and the Care Act (2014)

6.1 It is not clear from the records whether Andrew or Brian were being supported by an allocated case accountable worker during the period of review. However, they had both been previously assessed by the local authority as having care and support needs under section 9 of the Care Act (2014) and any change in needs or circumstances should have been reported to the relevant team or service within local authority. The timely review and management of placements is necessary to ensure that the local authority meets its responsibilities under the Care Act.

6.2 Andrew had previously been assessed as having a severe learning disability; as such he was likely to have required an advocate to support him in their s9 assessment under either s67 of the Care Act, or under the Mental Capacity Act. This also applies to Brian. Whilst Andrew's sister was informed and involved at various stages during the review period in not living locally and therefore not having day-to-day involvement and up-to-date knowledge the Independent Reviewer considered that her formal role is not clear in assessment or decision-making processes.

6.3 The Independent Reviewer was unclear from the information provided what role Andrew's case accountable worker within the Specialist Community Disability Service played in either internal Residential Care Home or hospital discharge planning meetings concerning his proposed return there.

6.4 Underpinning these points is a lack of clarity as to the role Andrew had in his assessments or decision-making processes.

6.5 From the information provided the Independent Reviewer also identified several queries in relation to Brian. These included the extent of the involvement of Brian, or his family, had in assessment and decision-making processes, the support provided to him following his bereavement and the information the Residential Care Home were provided with regarding previous behavioural issues prior to his move there.

7. Mental Capacity Act (2005)

7.1 Prior to his hospital admission Andrew had been the subject of Deprivation of Liberty Safeguarding (DoLS) authorisations for several years; having been assessed as being unable to make capacitated decisions regarding his care and support needs and how these were met. It was therefore unlikely Andrew would have regained capacity at a future point.

7.2 The Independent Reviewer noted that DoLS authorisations are not transferrable and therefore queried why an application for a DoLS authorisation was not made immediately following Andrew's hospital admission. This did not take place for a further four weeks and was then withdrawn as discharge arrangements were in place. This meant that in effect Andrew's 'detention' in hospital was illegal.

7.3 Excluding the DoLS authorisations there is no record of any formal assessment of Andrew's capacity being undertaken or of any Best Interest Meeting being held to decide any decision about his health and welfare at the Residential Care Home or his treatment, including the provision of pain relief, whilst a hospital inpatient.

7.4 The Independent Reviewer noted that Andrew's sister was informed of, and consulted about, decisions relating to his health and welfare, but she lives a considerable distance away limiting her potential involvement.

7.5 As such they queried why decisions relating to his living situation were made via best interests on an ad hoc basis rather than by applying to the Court of Protection for a Deputy to be appointed. The principle that Best Interest Decisions should be made for emergency or short-term decisions not for long-term planning was established in the case of Steven Neary in 2011 by the Court of Protection.

7.6 The Independent Reviewer also reiterated that there is no evidence consideration was given to either Andrew or Brian being provided with an independent advocate to support them through their Care Act assessment. They note that it appears highly likely that they would both have been eligible for an Independent Mental Capacity Advocate (IMCA) under the Mental Capacity Act 2005.

8. Hospital Discharge Process

8.1 A further instance of good practice was in relation to hospital discharge planning meetings. Firstly, in that a discharge planning meeting was convened shortly after Andrew's admission to hospital, in line with the principle of good practice that discharge planning should commence as soon after admission as possible. Secondly, that a discharge planning meeting was sought by the social worker undertaking the section 42 enquiry into physical abuse to support safe and timely discharge.

8.2 The Independent Reviewer identified concern that hospital staff did not convene a hospital discharge planning meeting until 21st November, three weeks later.

8.3 In view of Andrew's increasingly poor nutritional and fluid intake it is not clear why the community dietician service was not involved in the hospital discharge planning process or were referred to in ensuring continuity of support to Andrew following discharge. There is also no evidence of community involvement in the hospital discharge planning process from the GP.

8.4 Andrew's reduced mobility and occupational therapy needs were identified as issues in returning to the Residential Care Home. However, with no additional support put in place the registered manager of the Residential Care Home had to arrange additional staff cover after his return.

These points give rise to concerns as to how comprehensive the discharge planning process was and the overall safety of Andrew's discharge from hospital.

8.5 The Independent Reviewer highlighted that case management and responsibility for leading the section 42 enquiry are separate processes. It is not clear how these two separate functions were managed within the hospital discharge planning process or following Andrew's return to the Residential Care Home. There is no evidence of a safeguarding protection plan being considered for Andrew, or Brian, or consideration of other residents at the Residential Care Home.

9. Multi-Agency Practice

9.1 The concerns regarding Andrew's nutritional and fluid intake were longstanding, with his weight being recorded by the Residential Care Home and at two hospitals during the review period. It varied by 7kg during this time but despite amounting to 16-20% of his total weight his BMI was consistently recorded at 16.

9.2 There is no evidence of Andrew's mobility issues, and the equipment he was identified as requiring in the hospital discharge planning process, being provided or that if this did occur Residential Care Home staff were supported in using this.

9.3 Following Andrew's discharge from hospital there were several occasions where advice needed to be sought from the GP, or referrals to specific health services made, but there was confusion as to how contact should be made.

9.4 Despite the registered manager of the Residential Care Home requesting on the 13th December that the GP surgery undertake a medication review as well as enabling a referral to the speech and language team (SALT) there is no evidence of either taking place before Andrew's admission to hospital on the 17th December.

9.5 The links between the various assessment, meeting and safeguarding process across the hospital and community setting are not clear. A community assessment was undertaken, and multidisciplinary meeting held, following discharge but the outcomes of these processes was not clear. It is not known whether either of these processes referenced the hospital discharge plan or the ongoing section 42 enquiry.

10. Good Practice

10.1 Despite the concerns identified, and the need for learning to arise from these, the Independent Reviewer identified several areas of good practice and that it is important these are also acknowledged.

10.2 The need for Andrew to be initially admitted to hospital was quickly recognised, with staff at the Residential Care Home ensuring a copy of his "My Care Passport" accompanied him and that he was additionally supported by Care Home staff and the learning disability service more broadly during his admission.

10.3 The actions of senior managers within the Specialist Community Disability provider service in raising a safeguarding concern promptly following Andrew's admission to hospital, clarifying the potential risks around his return visiting him and advising hospital staff he was not to be discharged prior to appropriate safeguarding arrangements being put in place

10.4 The initial section 42 enquiry was initiated promptly on receipt of the safeguarding concern and it was good practice that the Specialist Community Disability Service social worker sought to progress the hospital discharge planning process at an early point and attend hospital discharge planning meetings.

10.5 The actions of the Specialist Community Disability Service in ensuring that a dietician was part of the hospital discharge planning process (in considering Andrew's nutritional and fluid needs), as well as the development of a risk management/escalation plan to consider other care and support needs. It was also good practice they kept Andrew's sister informed and she was able to contribute to discussions and that Brian's care and support needs were reviewed following Andrew's admission to hospital.

10.6 The registered manager of the Residential Care Home in rapidly arranging additional staffing to support Andrew's increased mobility needs and immediately including advice provided by the GP in managing his nutritional and hydration needs in staffing guidelines. This includes the Quality Assurance work undertaken and the protocols developed with health colleagues.

11. Conclusions

11.1 The Independent Reviewer identified a significant number of conclusions that referenced both their own findings as well as the outcome of the Coronial Inquest. The SAB has summarised these conclusions as below.

11.2 The Independent Reviewer identified that the arrangements put in place regarding multi-agency support post-discharge for Andrew, in particular communication and information sharing arrangements, were insufficient and that additional arrangements need to be considered in the future to avoid a similar situation occurring. It was also identified that those arrangements that were put in place were not always fully implemented.

11.3 The Independent Reviewer agreed with the outcome of the Coroner's Inquest that agencies failed to work together to best safeguard and care and support for Andrew during the review period. Individual staff members at the Residential Care Home, as well as health and social care professionals, endeavoured to provide Andrew with the best care they could, but systems and processes, or rather the lack of them, mitigated against this.

11.4 As a result, Andrew's quality of life in the review period was not of an acceptable standard nor of the standard that he had been used to. This may have contributed to his non-compliance with his dietary plan.

11.5 The Independent Reviewer did not have access to information concerning Andrew's second hospital admission but noted that the Coroner found no reason to make a Regulation 28 Report

to prevent future deaths to the organisations involved in respect of these events, or in relation to the care provided following his second admission to hospital. This included the proposed plan to manage Andrew's nutrition and fluid intake, which ultimately were not considered to be viable as Andrew would not tolerate the processes involved.

11.6 The Independent Reviewer acknowledged that they had access to an Action Plan created in July 2020 to take forward learning from the single-agency processes that have already taken place. They note that whilst most of these actions are reported to have been completed this does not demonstrate their effectiveness in ensuring improvements in service delivery or the safeguarding of adults with care and support needs at this point.

11.7 The Independent Reviewer stated that they had not had contact with Brian's family but that the care and support provided to him and his family in regard to the loss they suffered may require further consideration from the SAB. They also advised that they had not had access to information regarding any alternative placement that may have been available to Andrew.

11.8 While this Review has identified concerns in the support and care provided to Andrew during the Review Period the Independent Reviewer also acknowledged that his sister had been very happy with the care he had received in the previous almost 50 years. This reflects positively on the skills, motivation and compassion of the staff who supported Andrew throughout his life in care.

12. Recommendations

12.1 That the SAB seek assurance that the local authority's Residential Care Home's procedures and processes in relation to the admission of residents, the review and management of their care and support needs and recording have been reviewed and revised.

12.2 That the SAB seek assurance that all partner agencies, and the local authority's Specialist Community Disability Service department (within the Families, Children and Learning directorate) in particular, have appropriate procedures and processes in place to effectively respond to safeguarding concerns in a timely manner and that staff are developed and supported to enable evidence-based decision making in ensuring outcomes are line with the Care Act (2014) and Making Safeguarding Personal.

12.3 That the SAB seek assurance that the local authority's Specialist Community Disability Service department (within the Families, Children and Learning directorate) has reviewed and revised their procedures and processes to ensure that it is meeting their statutory duties under the Care Act 2014 with regard to arranging, managing, and reviewing Care Home placements in a timely manner and commissioning independent advocates where appropriate.

12.4 That the local authority's Specialist Community Disability Service (within the Families, Children and Learning directorate) and the CCG (as commissioner of the acute hospital provider) provide assurance to the SAB that they (the acute provider on behalf

of the CCG) have reviewed and updated their MCA policy and associated guidance to ensure that they are meeting their statutory duties under the MCA and accompanying Code of Practice.

12.5 The local authority's Specialist Community Disability Service department (within the Families, Children and Learning directorate) and the CCG (as commissioner of the acute hospital provider) provide assurance to the SAB that they that they have (the acute provider on behalf of the CCG) reviewed and updated joint policies and procedures to ensure effective multi-agency working arrangements to implement and review care and support plans.

12.6 That the SAB acknowledge the above examples of good practice and seek assurance that this has been brought to the attention of the relevant members of staff and their managers.