West Sussex Safeguarding Adults Board

Safeguarding Adults Review in respect of Robert

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Date: August 2022

Version 3 | August 2022
*Robert is an anonymised name

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1. Foreword

1.1. The West Sussex Safeguarding Adults Board (the Board) has published a Safeguarding Adults Review (SAR) in relation to Robert.

1.2. The Board and the Independent Reviewer express their sincere condolences to the family and friends of Robert. The family have contributed to this Review and requested for the report to be anonymised. With their agreement, the anonymised name of Robert is used.

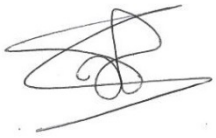
1.3. Robert was a 61-year-old man who enjoyed arts and crafts, shopping, visiting cafes, attending church, social events, and holidays. Robert had moderate to severe learning disability, a diagnosis of schizophrenia and depression, and a number of other complex health issues. Robert lived in Harwich House Care Home for over 10 years, during the last few of which he experienced a number of safeguarding concerns. 6 weeks before he died, Robert moved to a different care home, but was soon admitted to hospital where he sadly died. The cause of Robert's death has been determined to be inanition and right fractured neck of femur.

1.4. The purpose of a SAR is to identify how lessons can be learned, and services improved for all those who use them and for their families and carers. This Review looked into the circumstances prior to Robert's death and examines the actions of involved agencies. Recommendations from this Review will enable lessons to be learned and contribute to service development and improvement.

1.5. The Review identified key findings in relation to; health oversight and coordination, person-centred planning, safeguarding responses, and staff skills and knowledge. The Review made five recommendations in relation to; multi-agency working, safeguarding, workforce skills and knowledge and communication.

1.6. The Board and the SAR Subgroup, which reports to the Board, will monitor progress on the implementation of all recommendations by the agencies involved. The purpose of this is to reduce risks and ensure that the necessary development of systems and procedures continue to improve practice.

1.7. The Board will also ensure that the learning from this Review is widely shared and that the outcomes of the learning will lead to improved services in West Sussex.



Annie Callanan
Independent Chair

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2. Introduction

2.1. The Care Act 2014, Section 44, requires that Safeguarding Adults Boards (SABs) must arrange a Safeguarding Adults Review (SAR) when certain criteria are met. These are:

2.1.1. When an adult has died and the SAB knows or suspects that there may be abuse or neglect, or has not died but may have experienced serious abuse or neglect, and;

2.1.2. There is a concern that partner agencies could have worked more effectively to protect the adult.

2.2. SARs are required to reflect the six safeguarding adults' principles, as defined in the Care Act. These are empowerment, prevention, proportionality, protection, partnership, and accountability.

2.3. The aims of the SAR are to contribute to the improved safety and wellbeing of adults with care and support needs and, if possible, to provide a legacy and support family and friends.

2.4. There are clear review objectives which have been addressed to achieve these aims. Through a shared commitment to openness and reflective learning, involved agencies have sought to reach an understanding of the facts (what happened), an analysis and findings (what went wrong and what went right), the recommendations to improve services and to reduce the risk of repeat circumstances, and a shared action plan to implement these recommendations. It is not the purpose of the Review to re-investigate the suspected abuse or neglect, or to apportion blame to any party.

2.5. The Review process to meet these aims and objectives has followed a clear path. The Independent Reviewer has chaired an initial panel meeting to agree the Review terms of reference; conducted research by critically analysing chronologies and relevant records held by involved agencies and by interviewing representatives of agencies; culminating in a planned SAR Outcome Panel meeting and presentation to the West Sussex SAB (WSSAB).

3. Overview of the case and circumstances leading to the Review

3.1. A referral was made by the Learning Disability Mortality Review programme (LeDeR) and Sussex Partnership NHS Foundation Trust on 12 January 2022.

3.2. The SAR subgroup acknowledged that there were areas of improvement identified for the planning and coordination of multi-agency care. This included there having been a need to consider the timely reviewing of Robert's care needs and placement in context of his changing health care needs. Given Robert's multi-agency care needs did not appear to be sufficiently met by multi-agency professionals, the subgroup considered that the criteria for potential neglect by agencies is met.

*Robert is an anonymised name

3.3. The scoping period for this Review is from April 2019 to April 2021.

4. Key themes identified for this Review

4.1. These themes are reflected in the following terms of reference:

4.2. Effectiveness of the multi-agency needs assessment and communication in relation to Robert. This is to include:

- the need for holistic assessment
- identification of any delays in care and the impact of this
- multi-agency planning and intervention
- coordination of care
- risk assessing and reviewing of urgency of identified care needs

4.3. How effective the Safeguarding Adults responses were in relation to the concerns raised and, in reducing the risk of abuse and neglect. This is to include:

- actions taken/not taken following safeguarding concerns raised

4.4. How compliant were agencies in meeting statutory and procedural requirements?

5. Pen picture of Robert

5.1. Robert was a 61-year-old man with moderate to severe learning disabilities, a mental health diagnosis of schizophrenia and depression, and a variety other complex health issues, namely:

- Chronic constipation
- Megacolon (abnormal dilation of the colon often accompanied by paralysis of the peristaltic movements to the bowel)
- Sigmoid volvulus (where a loop of intestine twists and results in obstruction)
- Hyperprolactinemia (a state characterized by high levels of a hormone called prolactin in the blood)
- Retinitis pigmentosa (2006-registered blind)
- Falls risk
- Dysphagia (swallowing)

5.2. Robert lived in Harwich House Care Home for over 10 years until 6 weeks before his death when he was moved to a different care home. From here he was soon admitted to hospital where he subsequently died.

5.3. **Early years:** Robert's brother provided significant insight into his life and personality. He was born in 1960 and lived with his mother, father, and younger brother. He had a happy and fulfilling early childhood that set the scene for some of his lifelong interests and hobbies. His early years up until secondary school were healthy and he thrived at school and home; he was active within the Salvation Army choir from an early age and enjoyed activities such as singing and camping.

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5.4. **Teenage years:** Robert started to experience difficulties at secondary school, initially with his communication and he did not adjust to his new school environment. This resulted in him being transferred to a school for special educational needs. He was then admitted to hospital aged 14 where he experienced a traumatic set of investigations and treatments with no clear diagnosis or conclusion. Health professionals continued to be perplexed by Robert's presentation.

5.5. **Post-school years:** When Robert left school, he attended the Burnside Training Centre in Burgess Hill before being admitted to Brighton General Hospital in March 1978. He was subsequently transferred to Forest Hospital in Horsham where he lived for the next 11 years.

5.6. **Adult life:** In the mid-1980s Robert received a diagnosis of schizophrenia and he moved to Aspen Lodge which was a 24-hour staffed bungalow with a small group of residents. Robert spent the next 21 years there and this time is described as happy, active, and fulfilled. He was able to enjoy multiple activities and continue with his love of cars and music.

5.7. **Harwich House:** In 2010 Robert moved to Harwich House in Littlehampton where he spent the next 11 years. He was very happy at Harwich House and his brother describes how he was very engaging with people including the care staff; he enjoyed arts and crafts, shopping and visiting cafes. He continued to attend church regularly during this time. Robert's care plan includes these activities and in particular described how he liked to choose gifts for his brother when he went shopping.

5.8. Robert was sociable and regularly attended social events and liked to party. He continued to attend the Salvation Army at Bognor Regis and enjoyed singing and remembered the words to the songs from his childhood. He loved to go on holiday and went on trips to Scotland, the West Country and to Whitley Bay in the Northeast in 2013 where he was able to visit his family. He also instigated a holiday in Greece after watching an advert on television. Harwich House describe how he became animated following an advert and sought staff attention who responded to this by getting several brochures. Robert was very clear in his decision in picking Greece as his holiday destination.

5.9. His care staff describe how Robert was impacted when he lost his mother and father, and his presentation was observed to change at that point. However, he was very close to his brother who was very active in his life and about decisions relating to Robert's health and needs.

5.10. Throughout Robert's life he was generally a physically healthy person who was sociable, active, and mobile. However, during the last 18 months of life his health deteriorated in a number of ways and this period of time will be considered in this Review.

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5.11. In view of the challenges during this time, Robert moved to a different care home in February 2021 shortly prior to his death. This move was due to multiple safeguarding concerns about the quality of care at Harwich House which, at this time had a service Quality Improvement Plan in place. He lived within Sheepfold Care home for only 3 weeks before he was admitted to Worthing Hospital. His family were able to be with him during his final days.

5.12. Robert was described by all that knew him as a person who enjoyed his life and brought much enjoyment to the people who spent time with him. Despite his many challenges he was very resilient and lived his life to his full potential.

5.13. Achieve Together were asked to obtain some feedback from the staff who knew Robert well. The following feedback was received from his care team:

5.14. *Robert was a lively character who could make anyone smile. For a gentleman with limited verbal communication, he certainly knew how to hold a tune. You could play anything from ABBA to Queen and he would sing it word for word. He was also partial to a hymn and previous to lockdown very much enjoyed attending church with the Salvation Army. Robert loved being outside enjoying the sunshine and would sit and swing for hours with staff singing. He liked a shandy on the warmer days and would often shout 'come on Robert' when he was happy and excited about something. Robert was a very strong character at Harwich and would often have everyone smiling when he walked into a room and there was plenty of laughter too. I remember Skype calls with his brother Philip. You would see Robert's eyes light up with happiness and he would lay on his bed and smile at the laptop because he could see and hear Philip. Their relationship was truly magical and was witnessed by us all at Harwich.*

6. Engagement with family

6.1. Engagement with family members and listening to their perspectives and experiences is essential to develop learning when undertaking a SAR. A focus on their understanding about how their family member was supported on a daily basis and their experience of services and whether they found these to be helpful, provides a more personal insight into how agencies managed events.

6.2. The statutory guidance requires early discussions with the individual (where possible), family and friends to agree how they wish to be involved. It further requires that families should be invited and understand how to be involved, with their expectations managed appropriately and sensitively[1].

6.3. Robert's brother contributed significantly to the Review, providing a whole life context to the information that was available. This contribution provided a rich and meaningful understanding of Robert's personality, life experiences and quality of life at different times.

[1] Department of Health and Social Care (2020) Care and Support Statutory Guidance: Issued under the Care Act 2014. London: The Stationery Office (section 14.165)

6.4. His brother reflects that Robert had been very happy during his time at Harwich House, however during his last 18 months there was something different in the leadership of the home which was, in his view exacerbated by COVID and he had a lack of confidence at this time in the overall organisation and how it was managing the improvements that were indicated.

7. Summarised chronology

7.1. The Review is focusing on the events of the 24 months prior to Robert's death in which there were several key events and opportunities identified.

7.2. The number of safeguarding concerns raised started to be notable in February 2019. Within the timeframe of this Review (April 2019 to the time of Robert's death) there were multiple incidents which are articulated below.

Date	Concern/activity	Outcome
03/06/19	Robert was assaulted by another resident, no injuries.	Criteria for enquiry not met.
17/06/19	Robert's arm was grabbed by another resident.	Criteria for enquiry not met but several actions were taken to coordinate oversight of residents.
31/07/19	Assaulted by another service user.	Criteria for enquiry not met.
02/08/19	A scratch noticed, possibly by another resident but hadn't been witnessed.	Criteria for enquiry not met; risk management plan revised to strengthen observation of residents.
25/11/19	Concern raised by Speech and Language Team (SALT) due to the eating and drinking plan not being adhered to. There was a perceived reluctance of staff to find a way of mixing thickened drinks due to lack of equipment and lack of communication across the team.	Criteria met for safeguarding enquiry. Brother gave consent for an independent advocate to provide Robert with support, closed with rationale that risk had been reduced and plan was now in place.
18/12/19	The SALT team raise concern that there was inadequate oversight and recording of bowel/urine and weight charts. Robert had recently had a Urinary Tract Infection (UTI) and was still displaying symptoms. Referral made to Learning Disability (LD) Nursing and Health facilitation to provide support.	Criteria met for safeguarding enquiry.
18/12/19	Robert assaulted by another resident.	Criteria for enquiry not met.

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18/12/19	Robert assaulted by another resident.	Criteria for enquiry not met.
10/01/20	Safeguarding enquiry - meeting held at Harwich House, noted significant delays in getting medications that had been changed, risk resolved.	Closed.
06/02/20	Pushed by another resident.	Criteria for enquiry not met.
07/02/20	Assaulted by another resident, harm sustained, black eye, cuts, and bruises. Care Quality Commission (CQC) notified, frequency of safeguarding concerns noted, Deprivation of Liberty Safeguards (DoLS) review as bedroom door was to remain locked, approved.	Closed on the basis that mitigation and risk reduction plan was in place.
13/02/20	Given food not in line with plan.	Criteria for enquiry not met.
17/03/20	Medication error.	Criteria for safeguarding enquiry not met.
23/04/20	Referral made from the Specialist LD Consultant expressing concerns that there had been increased challenging behaviour and changes in presentation that had not been communicated to the Multi-Disciplinary Team (MDT), this may have been indicative of pain relating to severe constipation.	Criteria met for safeguarding enquiry - urgent meeting to be arranged.
01/09/20	Enquiry closed due to activity and oversight and risk plan in place.	No further action (NFA).
03/09/20	Pushed by another service user, hit head on toilet.	Met criteria for safeguarding enquiry.
08/09/20		Enquiry closed.
26/10/20	Concern raised by LD team due to continuing issues of plans not being followed and issues not being documented or communicated to the MDT. There are also concerns about supervision and neglect. Additionally raised was the issue of the stoma bag which was being used for desensitisation programme in preparation for surgery. Concerns summarised as: Change in behaviour - not communicated; Desensitisation programme not followed; Supervision - unobserved incidents and falls; Supervision- there was an incident when Robert ended up outside in the rain (this was not reported).	Criteria for safeguarding enquiry met and to be fed into the Quality and Safeguarding Information Group (QASIG).

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23/11/20	Staff found Robert on the floor, this was an unobserved fall, and he sustained a cut to his head. It was noted that needs may be changing, and he may need 1:1 care due to "many falls".	Criteria not met due to pending full review (enquiry already open).
14/12/20	Wellbeing Review and reassessment carried out and reflected in "MY PLAN". Noted that Robert has had significant health input over the last year following hospital admissions after periods of severe constipation with faecal impaction. A number of safeguarding concerns have been raised by both the provider and health professionals working with Robert around the monitoring of his physical health.	Alternative home being sought.
16/12/20	Robert was found in the bathroom with two other service users, he had scratches and a laceration to his head, the incident was not observed.	Criteria for safeguarding enquiry was met and 1:1 supervision as a mitigation was put into place.
21/01/21	Concern raised by LD Specialist Consultant who visited Robert at Harwich House. A number of concerns were articulated - the home was asked to arrange for ambulance to take Robert to the Emergency department. It was reported that Robert looked "thin and miserable", he was noted to have a cough and to drool but no temperature. Robert was displaying aggressive behaviour which is usually associated with increased pain for Robert. Concerns summarised as - Poor COVID hygiene - Manager did not know who the Consultant was - No knowledge of where the desensitization stoma bag was - Reported aggressive behaviour for a few weeks but not reported - Cough, drooling - Incomplete input/output charts.	Criteria met for safeguarding enquiry.
08/02/21	Robert injured by another resident, not observed, care plan not followed CQC informed.	Criteria met for safeguarding enquiry.
11/02/21	New placement identified.	
18/02/21	Robert moved to Sheepfold.	

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7.3. Throughout the timeframe there were several hospital admissions due to bowel related issues and a UTI, and there were MDT meetings held throughout this time frame.

7.4. There were regular Mental Capacity, DoLS and Best Interests meetings and assessments held during this timeframe. The standard DoLS and Best Interests assessment are noted to have been held more frequently (6 monthly) due to the increased number of safeguarding issues.

7.5. Running alongside Robert's individual issues there was a Quality Improvement Plan in place with Harwich House. This was due to a CQC inspection in March 2020 that reported an overall rating as "Requires Improvement". Additionally, the high number of safeguarding incidents reported for multiple residents continued to be of concern.

7.6. Therefore, the key findings and subsequent analysis aligned to the terms of reference have been identified through scrutiny of the safeguarding chronology, consideration of the Quality Improvement Plan and oversight of the various assessments and MDT meetings through the timeframe.

8. Key findings

8.1. For reference, background, and context it is helpful to consider the relevant statutory process and their conclusions.

8.2. **Mortality panel 14/06/2021:**

8.2.1. The process for undertaking mortality reviews changed within the NHS to align with a new system called the Structured Judgement Review (SJR) process[2]. All Trusts and Foundation Trusts are required to implement the revised guidance which replaces all previous systems and processes. This process was applied to Robert after his death by the University Hospitals Sussex NHS Foundation Trust. The panel noted the medical history and the presentation during this admission, including sigmoid volvulus and a confirmed fractured neck of femur. The panel noted some gaps in care relating to decision making around surgery and feeding plans, they acknowledged that holistic, multi-disciplinary approaches could have been strengthened, and they found that there were some examples of good practice in relation to Best Interests' meetings.

8.2.2. The learning themes identified were:

- Missed fracture to the neck of femur
- Lack of leadership
- Delays in decision making regarding complex nutritional needs
- Difficulties in recognition/management of pain

[2] nqb-national-guidance-learning-from-deaths.pdf (england.nhs.uk)

8.3. Inquest hearing conclusion 21/09/2021:

8.3.1. Inquests are legal inquiries into the cause and circumstances of a death, and are limited, fact-finding inquiries[3]. The conclusion of the Coroner on Robert's cause of death was "Natural causes". The medical cause of death was noted as follows:

- Disease of condition leading directly to death: Ia Inanition
- Other disease of condition, if any, leading to Ia: Ib Right fractured neck of femur
- Other significant conditions contributing to death, but not related to the disease or condition causing it: II cognitive impairment schizophrenia

8.3.2. Inanition is defined as "the exhausted state due to prolonged undernutrition; starvation"[4]. The Notifications of Deaths Regulations (2019) made it a legal requirement for certain deaths to be reported to the coroner. The Royal College of Pathologists Cause of Death list notes inanition as one of these causes[5].

8.4. LeDeR Review January 2022:

8.4.1. Robert's death was reviewed as part of the "Learning from Life and Death Reviews" which the Integrated Care Systems are now responsible for, to ensure that Reviews are completed for people with a learning disability and people with autism[6].

8.4.2. The Review identifies some similar themes to the initial mortality review. It highlighted safeguarding concerns, organisational abuse as well as the issues below. A joint SAR referral was made by on 12 January 2022 by LeDeR and Sussex Partnership NHS Foundation Trust.

8.5. CQC inspections of Harwich House:

8.5.1. The CQC is England's independent health and social care regulator. Its goal is to make sure that health and social care services offer individuals safe, effective, compassionate, and high-quality care, and it continually encourages providers to improve their services. The fundamental standards of CQC are built on the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Care Quality Commission (Registration) Regulations 2009.

[3] Coroners | The Crown Prosecution Service (cps.gov.uk)
[4] Inanition | definition of inanition by Medical dictionary (thefreedictionary.com)
[5] G199-Cause-of-death-list.pdf (rcpath.org)
[6] NHS England » Learning from lives and deaths – People with a learning disability and autistic people (LeDeR)

8.5.2. The CQC conducts frequent inspections at care homes, which include discussions with employees, evaluating care, and examining documents. The goal is to gain a thorough understanding of the level of services delivered. The CQC bases its decision on two critical frameworks: the Key Lines of Enquiry (KLOEs) and the Quality Standards.

8.5.3. The KLOE are:

- Are they safe?
- Are they effective?
- Are they caring?
- Are they responsive to people's needs?
- Are they well-led?

8.5.4. Following a review of their findings, the CQC will assign a grade to the care provider based on its key line of enquiries. Harwich House was graded as follows:

- 2017: Good - the care provider is performing well and meeting expectations.
- 2020: Requires Improvement - the care provider is not performing as well as it should and the CQC guidance on how it could improve.
- 2021: Requires Improvement.

8.5.5. In 2020 there were no issues raised about "caring" however there were concerns within the other 4 key lines of enquiry including, keeping people safe, medication management, adequacy of training, person-centred care planning, and leadership.

8.5.6. The service was re-inspected in 2021 in light of continued concerns including the management of medicines, risk assessments, staff training, staffing levels, quality monitoring, governance and leadership, and a negative and closed culture at the service.

8.5.7. It was noted that the service was now registered under a new provider and improvements to systems and processes were acknowledged, however CQC at this time were unable to fully assess the effectiveness of the systems and their ability to deliver good care for people in a sustainable way. This is because the new systems were still in their implementation phase.

8.6. **Key missed opportunities and positive practice:**

8.6.1. Related to the terms of reference for this review, there are several key findings and several areas of positive practice:

8.6.2. **Key findings:**

- Inconsistent application of the multi-disciplinary care plan.
- Staff in the care home not always effectively documenting or communicating changes in presentation both behaviourally and from a physical health perspective so key health professionals were not fully cited.
- A high number of safeguarding incidents and concerns that Robert was not being adequately safeguarded in the home.
- Slow pace of change for required improvements (from CQC and Quality Improvement Plan)
- Voice - what was Robert's experience at this time, how did his behavioural presentation reflect his experiences?
- Falls management and risk assessment oversight.
- A "separation" of the care home and the wider MDT.
- Fragmented oversight of safeguarding incidents.

8.6.3. **Positive practice:**

- Strong evidence of the learning disabilities team advocating and communicating within the MDT.
- Comprehensive psychiatry reviews addressing physical health issues and including a comprehensive action plan for the MDT.
- Holistic, regular, and person-centred application of the Mental Capacity Act requirements.
- Holistic and person-centred wellbeing reviews reflected in "My Plan".
- Regular contact with family members to provide information, gain their views and decisions.
- High standard of safeguarding concerns from the LD team raising pertinent concerns and issues and capturing a holistic perspective.

8.7. **Key findings will be analysed under the following overarching areas capturing the TOR:**

- Health oversight and coordination
- Person-centred planning
- Safeguarding responses
- Staff skills and knowledge

8.8. Key improvements that have been implemented subsequently will be identified.

9. Analysis of findings

9.1. Health oversight and coordination:

9.1.1. Robert's needs were complex and multifaceted which required a large MDT to address his physical health needs whilst maintaining good mental health and robustly understanding his behavioural signs in order to hear his voice. This was within the context of a pandemic, restricted face-to-face contact and a care home who were experiencing significant challenges such as a change in leadership, a CQC inspection that raised concerns, a number of safeguarding issues and a Quality Improvement Plan.

9.1.2. In this context this required an exceptionally high number of contacts and coordination of multiple professionals.

9.1.3. Robert was registered blind, he was mostly non-verbal, with a moderate-severe learning disability and a diagnosis of schizophrenia. He also suffered with recurrent depression. He suffered severe constipation with faecal impaction and a recurrent volvulus which resulted in hospital admissions. When ill or in pain or upset and afraid Robert presented with behaviours that challenged, he would hit out or pinch carers and shout. He could not verbalise pain and there was a strong link between his pain and his behavioural outbursts.

9.1.4. It can be noted that Robert's physical health appeared to be deteriorating over the period of time the review is capturing, his behaviour and presentation changed and that this correlated with challenges that the care home provider was experiencing.

9.1.5. Robert had multiple professionals involved in his care including his GP, Psychiatrist, LD Nurse, SALT, and his care team at Harwich House. He had a Health Management Plan, a Hospital Passport and a person-centred "My Plan".

9.1.6. In all these documents, his constipation and bowel issues are mentioned. Interventions such as medication, bowel monitoring, balanced diet and hydration were included. He did have a bowel management chart, the purpose of which was to document his bowel movements, however, there were gaps, and these were highlighted on more than one occasion within a safeguarding concern. This led to widespread frustration across the MDT and despite many documented visits and conversations, adherence to the required care was not always of the standard that it could have been.

9.1.7. This may be because unqualified care staff may not have had sufficient training in managing bowels, which includes the importance of monitoring bowel movements and how severe constipation can lead to significant health care concerns. Whilst this was well known in Robert's case, the change in staffing and leadership resulted in the team not being as familiar with his needs and history as they had been previously.

9.1.8. It is important to acknowledge that Robert was not able to easily communicate fear, discomfort, pain, or distress. Those who knew Robert well would know how to interpret behavioural signs that all was not well, or that Robert was unhappy. Again, a change of staffing may have contributed to some of these signs not being recognised or communicated in a timely way to the wider MDT for consideration.

9.1.9. Collaboration between health and social care services and private providers is required to explore methods of preventing deterioration of individuals in care homes for people with complex health needs. This could support staff to identify deterioration early and improve effective communication so that people are cared for in the right place at the right time.

9.1.10. Often there may be a main carer/key worker who understands the person's needs, but robust processes should be in place to ensure if, and when that key worker is absent, all staff are able to provide person-centred support for health and social care needs. There is evidence that the staff at Harwich House were not as familiar with Robert as they should have been, latterly this included the Registered Manager who whilst new in post was not familiar with Robert's care plan and, therefore, the oversight of how care was being delivered fell short of the required standard.

9.1.11. In Robert's case there was a high amount of evident communication and meetings between health and social care professionals, however the connectivity with Harwich House is less evident. There is some evidence to demonstrate that there was confusion and miscommunication about elements of Robert's required care and monitoring, for example the requirement for thickened drinks and the lack of implementation of the stoma bag desensitisation plan.

9.1.12. In summary an impression from reading the available information and discussions with professionals and family is that Robert was being closely monitored by a range of medical and health care practitioners who knew him well. This is positive and robust practice. For example, his nutritional intake was considered, his medication was adjusted and different options with respect to his bowels were being explored, including the desensitisation programme with a stoma bag for the eventuality of bowel surgery.

9.1.13. However, less obvious is how all these assessments and reviews, including of his emotional wellbeing and mental health, came together and joined up with Harwich House in terms of clear expectations. It would appear that Harwich House were expected to deliver all aspects of daily care but without being an active member of the care planning group, hence the connectivity was poor.

9.1.14. It is important to note that the wider MDT consists of specialist clinical professionals and experienced social care staff who have a clear understanding of the range of complex conditions that Robert experienced. The staff at Harwich House are unqualified care staff and whilst they are experienced in the role they do, they may not always have the relevant training, skills, and knowledge to deliver or understand parts of a complex health management plan. Therefore, the opportunity for the care staff team to thoroughly understand the whole management plan and for the leadership team at Harwich House to ensure their staff are appropriately trained and experienced was not evident.

9.1.15. Therefore, the question of Harwich House often appeared to be why expected plans weren't being delivered or why monitoring wasn't taking place rather than to explore whether Harwich House had a true understanding of his overarching care plan and whether the team around him were skilled and knowledgeable enough to deliver it properly. **There will be a recommendation made against this area.**

9.1.16. Additionally evident within the information was the increased falls risk, indeed cited within the coroner's cause of death certificate was the finding of fractured neck of femur, whilst it is not now possible to identify exactly the occasion that this injury occurred, there is reference on several occasions within safeguarding concerns that Robert has fallen and this may be related to declining vision or increasing frailty, or both.

9.1.17. Elderly, vulnerable, or frail residents in a care home are generally at high risk of falling. Falls can occur for a wide variety of reasons including poor mental cognition, poor eyesight, weak muscles, poor mobility, high or low blood pressure, imbalance perhaps due to arthritis or a stroke, as well as certain medications which may increase the risk of falling. These are to name but a few reasons, several of which were applicable to Robert.

9.1.18. However, with proper care and supervision, residents who are known to be prone to falling, or who are at a greater risk of falling, should not be left unsupervised or allowed to mobilise on their own. The key preventative measure is robust falls risk assessment.

9.1.19. It was recognised that Robert was at high risk of falls and that this risk increased over the timeframe of this review. This was evidenced in several safeguarding concerns and in reflective discussions. Despite that knowledge there is no evidence that "falls" was a main focus of care planning or risk assessment. In risk management terms, risk assessment is undertaken to identify what harm may occur and measures put in place to control and mitigate the identified risks. Whilst there is reference to a falls risk assessment, it did not appear that the risk identified had been transferred into consistent actions or observations.

9.1.20. NICE practice guidance evidences the benefits of applying a multi-factorial fall risk assessment. The aim is to reduce the risk and incidence of falls and the associated distress, pain, injury, loss of confidence, loss of independence and mortality[7].

9.1.21. Additionally, there is evidence that Robert's behaviour changed with occasions of him behaving in an aggressive manner which was indicative of increased pain. Assessing falls risk and responding to potential harm is an integral part of any care plan and it is not clear in this case the extent to which this was considered. **There will be a recommendation made against this area.**

9.2. **Person-centred planning:**

9.2.1. A striking point in the information and reflections provided for this Review is how well a number of people knew Robert, his likes, dislikes, and his personality. This has been reflected through his life and is testament to the big personality that Robert had. His social worker had a great rapport with him which is reflected in the reflective conversations within this Review. Therefore, the key learning point here is the centrality of relationship-based work, informed by the understanding from those who knew him best, including his brother.

9.2.2. Throughout the chronology and the other documentation made available to the Review, one captures glimpses of how Robert experienced his world and how he communicated to people. This tells a story of a period of time where care was not consistent, Robert was not always safe and there is indication that he was in pain on different occasions. At some point shortly before he died, he sustained a fracture which was not identified for at least 6 weeks when he was admitted to hospital. It is not known precisely where this incident occurred.

9.2.3. In summary, the information provided demonstrates that Robert's behaviour changed in the timeframe of this Review, providing an insight that all was not well, this may have been increased pain, or anxiety around feeling safe in view of the high number of safeguarding incidents.

9.2.4. Various professionals expressed during the course of the view that there were frustrations with Harwich House in terms of consistency of care, adherence to the care plans, documentation, and communication - this was particularly important in terms of nutrition and hydration and bowel management. The well-known signs that Robert would display when all was not well were not picked up, nor communicated to the wider team. This was highlighted in two high quality safeguarding concerns made by the LD Specialist Consultant.

[7] Tools and resources | Falls in older people | Quality standards | NICE

9.2.5. For at least the last 6 months of Robert's life there was consideration of a move of placement, and this was discussed with his brother with a view that a rushed process of moving him would be detrimental due to his complex physical health presentation.

9.2.6. This was well thought out and research based. Robert's Social Worker correctly assessed that the move would need to be planned thoroughly and risk assessed. Relocation of older people from one care setting to another is recognised to be particularly stressful and to have adverse effects on health[8]. Robert's specific set of complex issues increased his vulnerability to morbidity and mortality.

9.2.7. The information provided demonstrates that there was a robust health management plan, a team of professionals who know Robert well and conversed regularly. Scrutiny of regular Mental Capacity assessments, re-assessments of need and "My Plan" reflect a holistic and person-centred oversight.

9.2.8. Concerns with the care provided at Harwich House was identified during the course of the Review on many occasions, however the team at Harwich House did not seem to be integral to the health management planning and this may be a contributory factor to the lack of robustness in following the plan. There was a disconnect between the wider MDT and the team at Harwich House. **This is identified as a recommendation.**

9.2.9. Commissioners and service providers should be able to evidence that they have communication plans in place which ensure that information sharing with all agencies is easily accessible and person-centred. This can be through various methods such as Hospital Passports, Learning Disability flagging systems, Summary Care Records, "My Plan" and via MDT Hubs. The care home provider must also be an integral part of these processes. **There will be a recommendation related to this.**

9.3. **Safeguarding responses:**

9.3.1. It can be seen from the chronology within the body of this review that there were multiple safeguarding concerns raised. These included issues such as assaults from other residents, supervision of Robert, neglect, non-adherence to the care plan and poor communication. Each incident was considered and communicated to Robert's brother for discussion. In view of escalating issues and repeated instances a move for Robert started to be planned around 6 months prior to his death.

[8] Castle N, Relocation of the elderly, *Med Care Res Rev* 2001

9.3.2. Articulated within the Review is the status of the Care Home with CQC, the concerns raised within the multiple safeguarding concerns, many of which compounded the findings of CQC. In view of this a Quality Improvement Plan was put in place with accountability for oversight with the Local Authority Safeguarding team with contract and commissioning partners who were actively working with the CQC. The framework that this level of activity comes under is the "Operational Framework for Managing Provider Concerns".

9.3.3. This plan was not specific to Robert, instead it provided a whole view of Harwich House which included additional safeguarding concerns related to other residents. Indeed, it highlighted significant concerns about the compatibility of several residents and planned moves were made in some instances.

9.3.4. The safeguarding concerns and enquiries evidence a rationale for decision making for each concern raised and this was documented and formulated and there were re-assessments of need ongoing, however, it can be viewed that Robert's voice was lost in this process and the impact on his emotional wellbeing lost. Sometimes new concerns were raised whilst existing safeguarding enquiries were still in progress. There were 19 separate safeguarding concerns raised within 18 months and often they appeared to be viewed as individual incidents rather than a cumulative effect on Robert's overall wellbeing.

9.3.5. The activity surrounding the safeguarding concerns was vast, with multiple conversations, different meetings, and revised risk assessments. On one occasion a risk plan was put into place involving increased supervision levels and a new locking system for Robert's bedroom door; this required a DoLS assessment and prompted a full reassessment of need and overall was a good example of working practice.

9.3.6. Effective adult safeguarding involves all agencies and staff involved having a clear understanding of when legal rules may have a contribution to make towards prevention of protection from abuse and neglect. Recommendations, therefore, focus on understanding and application of legal rules involving, for instance, mental capacity, information-sharing, care and support assessments, and provider concerns.

9.3.7. During the timeframe of the review, the process for triaging safeguarding referrals changed. Previously referrals were triaged by the Life Long Services (LLS), and it can be noted that very few met the criteria for safeguarding enquiry.

9.3.8. In April 2020, a new process was implemented whereas the Adult Safeguarding Hub was introduced, and all safeguarding concerns were triaged via this process. It can be noted that from this point most met the criteria for safeguarding enquiry. This demonstrates a more robust application of S42 (Care Act 2014) criteria.

9.3.9. It is highlighted by Police that not all of the safeguarding concerns related to assaults to Robert are recorded on the Police system. From examination of the Adult Social Care records and cross correlation of the incidents there are some differences in how the dates of incident are recorded.

9.3.10. Additionally, there are some safeguarding concerns related to assaults that were not shared with the Police, however these were prior to the implementation of the Adult Safeguarding Hub.

9.3.11. The Adult Safeguarding procedures in West Sussex outline that, *"Where the local authority receives a safeguarding concern from a third-party agency or individual, consideration should be given if the information indicates that a criminal offence has or may have been committed. Where a criminal offence has, or may have, been committed and there is any doubt if it has previously been reported to Police, a referral should be made to the Police"*[9]. **There will be a recommendation made against this area.**

9.3.12. There is evidence throughout the information provided for this Review of application of legal rules. However, due to the number of concerns and the wider Quality Improvements, it was not consistently effective. Additionally, the Review cannot find evidence that all the people working with Robert were ever in the same (physical or virtual) room together. The LD team were the lead coordinators overall; it was not specifically clear throughout the information provided who the Harwich House key person was. Therefore, despite a high level of activity, there is no clear assurance that everyone was convened to share information, consider physical and mental health needs together and coordinate a strategy to minimise risks and plan for contingencies. Therefore, despite multiple efforts by different people at different times, full coordination of efforts was missing in this case.

9.3.13. There was an overreliance on "assurances" within the Quality Improvement Plan process and revised risk management plans, when in fact the incidents were increasing. At the same time that incidents were increasing, Robert's health was deteriorating, and his behaviour was changing. **There will be a recommendation made.**

9.4. **Staff skills and knowledge:**

9.4.1. Achieve Together do not employ qualified healthcare professionals to work in Harwich House on a daily basis as this is not part of their requirement as a care home. Collaboration between health and social care services and private providers is required to explore methods of preventing deterioration of individuals in care homes for people with complex health needs.

9.4.2. This could support staff to identify deterioration early and improve effective communication so that people are cared for in the right place at the right time.

[9] Safeguarding and criminal investigations

9.4.3. It is acknowledged by Achieve Together that there were leadership and staff changes, and despite how well staff had previously known Robert, the newer team may not have been fully prepared for the challenges that his complex physical and emotional needs presented. It is also acknowledged that residents at that time were not compatible, and this is an area of learning that they have acted upon.

9.4.4. The wider MDT continued with expectations that the agreed plan should be followed but when it was apparent this wasn't happening, the root case was not fully explored thus no sustainable changes happened. It would have been sensible to have considered what knowledge and skills those supporting Robert would need, and bespoke consideration for each residents' needs should indicate the level of training and qualifications of the staff involved.

9.4.5. Achieve Together acknowledge that at that time there was a lack of consistency of staff with a reliance on agency staff, the training and supervision models were not as robust as they could have been and there was a lack of escalation of issues within the organisation.

9.4.6. It was recognised that communication needed to be strengthened to ensure that all health care plans were being implemented in the right way and that all changes in presentation were communicated back to the MDT, therefore this should have led to detailed consideration of whether staff were appropriately trained to deal with his complex needs and how they might have been supported to coordinate care in Harwich House in a more robust way. Lack of scrutiny in these areas led to unnecessary delays in care delivery and increased safeguarding incidents.

9.4.7. There is a sense emerging from the reflective discussions with Achieve Together that the team were struggling and that some staff may have lacked skills, such as communication, active listening and understanding the crucial requirement to monitor nutrition, hydration, and bowel movements/patterns. Staff in this case needed more support and active supervision and this is an area that Achieve Together have recognised and acted on. **Whilst there is evidence of learning already being embedded within Achieve Together, there will be a recommendation relating to this.**

9.4.8. Although outside the terms of reference for this Review, consideration has been given to the impact of the Covid-19 pandemic in terms of delivery of care. This is because there was reference within the reflective discussions to IT challenges, additionally one of the safeguarding concerns mentions poor Covid measures related to a lack of hand gel. There is no evidence that Robert's care was significantly compromised directly because of Covid-19, there were no instances of outbreak and, therefore, aside from the challenges that most care homes experienced, there is no direct evidence that Covid-19 was a causal or contributory factor to the way services worked together in this case.

10. Improvements made

10.1. There are 5 recommendations to be made in this review against key areas of practice. However, it is encouraging to see the areas of improvement where learning has already been taken forward and implemented. These developments are all relevant to Robert's circumstances and ongoing assurance of effectiveness should be sought on a continual basis.

10.2. Progress to note is as follows:

10.2.1. Implementation of the Adult Safeguarding Hub where all safeguarding concerns are now triaged.

10.2.2. Achieve Together have provided evidence to improvements made in a number of areas:

- Implementation of a new framework for mandatory training compliance that encompasses service specific requirements, and this is managed by a performance framework.
- Toolkits for the following areas that have been implemented:
  - Falls prevention
  - Early warning signs
  - Eating/drinking
- Implementation of a lessons learned framework which is utilised for any service user death and will contribute to service improvements.
- Implementation of a risk enablement team to consider risk and placement compatibility.

11. Summary

11.1. It is evident that the range of health and social care professionals worked well together and with Robert to ensure that there was a person-centred plan in place to address the range of complex issues that Robert experienced. Robert's brother was actively involved in decision making and when the complexity of issues increased, supported the input of an independent advocate where indicated. There were good levels of professional curiosity evident across the range of professionals, people knew him very well and this is reflected multiple times in care plans, reflective discussions and chronologies presented for this review.

11.2. There is no evidence of organisational abuse found in reviewing this case. However, panel members and the independent reviewer have concluded that whilst there was a robust health management plan in place, there was a lack of assurance and connectivity to ensure that this was delivered in the right way within the care home setting, leading to multiple safeguarding concerns and a cumulative impact.

11.3. It is outside the remit of this Review to make findings on the traction gained via the Quality Improvement Plan that was in place for Harwich House, however, the safeguarding responses often deferred to this Plan and Robert's individual issues on occasion got lost in the wider service issues and challenges and the cumulative effect of a high number of safeguarding concerns may not have been fully recognised. The Plan did not seem to be making an impact on the care delivered to Robert as concerns increased as time went on.

11.4. There was a wide team of professionals around Robert, but paradoxically the care home as his daily care provider appeared to sit separately to this, leading to frequent confusion and miscommunication impacting on delivery of care.

11.5. There are acknowledged gaps in training and reflective supervision within Harwich House and revised processes have been implemented to address this. It is important that assurance and oversight of this is robust to evidence effectiveness. This is not unique to Harwich House and should be applied as a routine method of assurance.

12. Conclusion

12.1. This SAR Overview Report is the WSSAB's response to the death of Robert, to share learning that will improve the way agencies work individually and together.

12.2. Robert had a complex presentation with several physical and mental health related conditions, and he was known to many different professionals. In view of the number of safeguarding concerns, the last year of Robert's life may have been distressing at times. Considering the findings of this Review, there is learning around how different parts of the system could more effectively work together. It is not possible without hindsight bias to comment on whether there could have been a different outcome, however Robert may have experienced an improved quality of life.

12.3. The Review has considered the degree to which this case highlights systemic issues. Robert was someone with very complex physical and mental health needs and there are many others. The conclusion reached is that this case reflects wider challenges regarding safeguarding oversight, wider system quality/safeguarding improvement plans and the knowledge and experience of staff responsible for meeting people's care and support needs.

12.4. The case also raises the question of who we mean when we refer to a "multi-disciplinary team", the daily care provider must be central to that and not separate to it.

12.5. It is hopeful that the outcomes from this Review will enhance and sustain support for people with learning disabilities and complex health issues. The findings and recommendations should be monitored for compliance, implementation, and assurance by the WSSAB.

13. Recommendations

13.1. It is noted that progress has been made in some areas of findings by Achieve Together and in the Multi Agency Safeguarding responses. However, the recommendations made in this Review should be applied as learning for the system where deeper and continual assurance is required.

13.2. Arising from the analysis in this Review the following recommendations are made to the WSSAB:

13.3. **Recommendation 1: Multi-agency working**

13.3.1. The WSSAB are asked to consider its approaches to multi-agency working to include practice guidance for the workforce and:

- Assurance of collaboration and inclusion of the wider/independent care sector
- Assurance of its effectiveness
- Escalation processes both single agency and multi-agency

13.3.2. And:

- To seek assurance from commissioning and provider organisations on supervision practice, with a particular focus on frequency and the degree to which oversight of cases is challenging as well as supportive.

- To seek assurance from statutory health and social care agencies regarding key working to ensure coordination and review of complex cases involving physical and mental health needs and learning disability. This should specifically ensure that independent providers of care are integral to ongoing care planning.

13.4. **Recommendation 2: Safeguarding**

13.4.1. The WSSAB are asked to seek assurance that safeguarding enquiries for individuals who are in a service being managed under the SAB Operational Framework for Provider Concerns, are in line with the key principles of Making Safeguarding Personal.

13.4.2. The WSSAB are also asked to ensure that the personal safeguarding plan takes account of both the concern raised for the individual, and any relevant wider provider issues, risks and actions needed.

*Robert is an anonymised name

13.5. **Recommendation 3: Safeguarding**

13.5.1. The WSSAB are asked to seek assurance that the Multi Agency Safeguarding Procedures are being followed with reference to Police referrals when there is an allegation of a criminal offence.

13.6. **Recommendation 4: Workforce skills and knowledge**

13.6.1. The WSSAB are asked to seek assurance from commissioners and providers on arrangements for ensuring that staff have the necessary knowledge, experience, and skills for meeting the health and social care needs of learning-disabled adults with complex physical health and mental health needs (the learning in this case applies specifically to the independent care sector). This should include consideration of bespoke individual training packages.

13.6.2. Commissioners and providers must ensure that there are agreed processes in place to support identification and escalation of deteriorating health conditions. With reference to the finding of this Review this should include consistent application of tools for:

- Falls prevention
- Nutrition and hydration
- Early warning signs (to effectively identify any deterioration)

13.7. **Recommendation 5: Communication**

13.7.1. The WSSAB are asked to seek reassurance that providers have communication plans in place which ensure that information sharing with other agencies is easily accessible and person-centred. Effectiveness of schemes such as Hospital Passports, Red Bag Scheme, Learning Disability flagging systems, Summary Care Records, and multi-disciplinary team processes should be reviewed and whole system approaches applied.