Ronald Safeguarding Adult Review Report

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Executive summary

Initiation of the review

This Safeguarding Adults Review (SAR) was initiated by Walsall Safeguarding Partnership (SAB) following agreement that, in accordance with section 44 of the Care Act (2014)[1] the criteria for a mandatory SAR in this case were met. Ronald was 74 when he died. Ronald was a White British male. Ronald had a diagnosis of mild learning disability, autistic features and recurrent depressive order. The causes of death were given as:

1: Frailty
2: Learning Disability and Parkinsonism

In the months following Ronald's death a LeDeR[2] review was undertaken grading the care as below standard[3]. It was felt that actions or lack of actions may well have contributed to Ronald's death. Due to this a Multi-Agency Review (MAR) was undertaken which concluded Ronald's death was potentially avoidable and recommended a SAR be conducted.

Succinct summary of the case

Ronald had a mild learning disability, autistic features and recurrent depressive disorder. When frustrated or anxious Ronald used behaviour as a form of self-expression, which could put him and others at risk of harm. Ronald had close relationships with his sister, brother and extended family. Concerns regarding nutritional intake, evident prior to the scoping period, continued to cause concern. Swallowing, and choking issues were under investigation.

At the beginning of the review period three safeguarding concerns were raised within a month. On the first occasion concerns pertained to alleged neglect/acts of omission as well as psychological abuse by a carer. The second occasion, Ronald had been moved to alternative accommodation. Concerns related to the conditions within the property and that Ronald was sleeping on a sofa bed. The third, Ronald presented with cuts and bruising to his face and was alleging he had been assaulted, both verbally and physically, by a staff member. Ronald displayed aggressive behaviours. Ronald was losing weight. Ronald continued to have support from Speech and Language Therapy (SLT), community dietetics, a Cognitive Behavioural Therapist and the Learning Disability Team. It was thought the cause of Ronald's rapid deterioration was likely to be a combination of both physical and psychological factors.

With Ronald's agreement he moved to a new care provision where he settled and his food and fluid intake initially improved. Over a few weeks Ronald's care requirements changed and he was deemed to require 2:1 care. Ronald continued to display aggressive behaviours, reacting to changes beyond his control. Requests for MH Act assessments were made by both ASC and the Police.

Concern mounted regarding nutrition. A dysphagia review assessment was conducted. Mental capacity assessments and Best Interests meetings were held in relation to Ronald's eating and drinking looking at risk and texture modification with alterations being made however, weight loss continued; Ronald was referred to Hospital. Tests were performed.

A further delayed safeguarding concern was raised as Ronald had choked on food that was not in line with his swallowing plan. This was not received by ASC.

Ronald experienced issues with constipation, urinary retention and a prolapsed bowel. Ronald found the latter particularly distressing. Ronald had a sigmoidoscopy.

Latterly Ronald's weight decreased significantly and he was admitted to Hospital. Ronald's carers continued to provide care in Hospital. Ronald was not able to tolerate a nasogastric tube. Ronald became increasingly frail. Two weeks later and with family involvement, a best interests decision

[1] Care Act (2014) legislation.gov.uk

[2] Learning Disability Mortality Review (LeDeR) Programme

[3] This LeDeR review was undertaken under the previous LeDeR programme which was overseen by the University of Bristol. This programme has since been replaced by the NHSEI led LeDeR programme which considers the life and death of a person with a Learning Disability.

was made that Ronald should receive palliative care and be moved to a hospice/nursing home. A week later Ronald was transferred to a nursing home for end of life care, where he passed away days later.

Summary of learning

1. Following the three safeguarding referrals, immediate action was taken by health, social care and the care provider to safeguard Ronald in accordance with his expressed wishes. However, the wider ramifications for Ronald, the service, and service users, were not given sufficient consideration. The care provider policy in place at the time is no longer available for consideration, however the current policy and the West Midlands Position of Trust Framework and the Multi-agency policy & procedures for the protection of adults with care & support needs in the West Midlands has been reviewed and is clear that whenever a safeguarding referral is received by the LA, be they for the client, the carer or other residents, the wider ramification must be considered. The reviewer has identified the need to make explicit that when the concern questions whether a carer has harmed their client, the police must be notified so a thorough criminal investigation can be undertaken, and a standalone meeting held. Consideration should be given to any support or additional therapeutic interventions the client may benefit from. In this case relevant practitioners were not always attending or being routinely informed of safeguarding referrals either past or present, the reviewer learned this was not unique to this case. Whilst it is appropriate that copies of referral are not shared, there should be appropriate and proportionate sharing of information across the partnership.
2. The time taken for GP records to be transferred from one practice to another is impacting on GP's being able to assimilate new information in the context of the patients previous health and social care information. This is not a new issue. Discussions are taking place between health partners and Primary Care Support England to strengthen the arrangements for records retrieval to address this.
3. Whenever a client/patient is refusing food and fluids, a robust multi-agency plan of care needs to be developed, which focusses on all the potential reasons for food refusal and the risks. Where it is thought the issue may be due to psychological reasons, this should be explored in tandem with medical causes. A clinical Psychologist should be allocated to support the client and advise the MDT. There needs to be an identified lead professional, from the lead agency, driving the plan; treatment and timescales should be tailored to the severity of the situation.
4. There is a lack of evidence that the MCA was being consistently applied at key decision making points across all agencies/providers. Practitioners are not making best use of legislation to aid their decision making in relation to their clients' needs. The reviewer learned that whilst there has been training for practitioners, the issue is one of application of the MCA in practice; currently this is variable. Some services have demonstrated good understanding and some usage of the legislation, others have not and it continues to be an area for development. The legal option of an application to the Court of Protection should be a routine consideration in such cases but is not. Consideration of MCA should be integral within all MDT meetings for persons with cognitive impairment.
5. There is a need for greater managerial oversight when a person in care provision is admitted to hospital and a shared care arrangement is made. It is essential that a comprehensive and reasonable plan of care, with clear lines of accountability and responsibility for both agencies, is established. Currently there is no shared care protocol in place. Walsall Healthcare NHS Trust has done work on clarifying the roles when carers are going into hospital to support a person who is an inpatient.
6. Ronald's family were an integral part of Ronald's care and support network. The agencies who were represented as part of this review have been unable to identify where there was a breakdown in communication. However, good practice would always be for Practitioners to afford families the time and space to speak with them individually not only in meetings. Any query raised should have led to a response.

7. Whilst there is significant evidence of partnership working there are some exceptions. A number of disciplines were not well integrated in the partnership approach. The GP was not an integral part of MDTs, the police were not part of safeguarding enquiries and the accommodation provider did not see themselves as playing any part in Ronald's care and as such did not keeping record of their actions when called upon by the care provider to assist. Some areas have introduced Adult Multi-Agency Safeguarding Hubs to address the safeguarding enquiry issues at point of referral whilst others have opted for a single front door approach.

Recommendations

1. WSP and its partners to strengthen within policies, procedures and guidance the need for referrals and safeguarding meetings, regarding concerns about a Person in a Position of Trust, to include involvement of the Police Adult Care Abuse Investigation Team. WSP to request assurance from commissioners that a monitoring process is in place to ensure compliance with safeguarding policies relating to Persons in a Position of Trust by providers.
2. WSP and its partners to review and embed local guidance regarding when and how to request information regarding safeguarding enquiries and agree what is an appropriate and proportionate response.
3. WSP to request assurance following the PCSE and CCG investigation regarding resolution of the timely transfer of GP. WSP to consider raising the concern with NHS England if no progress has been made or no satisfactory resolution has been found.
4. WSP to introduce guidance setting out lines of accountability and responsibility for MDT meeting's pertaining to, a person with learning disabilities or a person with mental capacity issues. The guidance should include the need to:

- establish clarity regarding the lead agency,
- identify the lead professional,
- Explore attendance and contribution
- include timescales
- identify psychological support and,
- ensure risk is a clear focus of every meeting.

5. WSP and its partners to embed the current guidance and monitor compliance with the MCA. WSP to consider how best to promote and support all staff to increase their confidence and knowledge of when and how to conduct mental capacity and best interests assessments, and when to seek applications to the Court of Protection.
6. Walsall Healthcare NHS Trust to produce a shared care protocol and plan an audit to ensure this, coupled with the recent clarification of roles, is meeting patients care needs fully.
7. WSP and its partners to promote

- the proactive inclusion of all family members, who are actively involved in the care and support of clients, unless there is clear rationale not to so, and
- feedback to families post assessment or safeguarding enquiry
- families being provided with clarity on who they should report concerns to and where to go to gain support.

8. WSP and its partners to seek assurance from the accommodation provider and via ASC commissioners, that accommodation providers are adhering to the CQC standard for record keeping and sharing of safeguarding information pertaining to residents.

What will Walsall Safeguarding Partnership do in response?

The WSP will prepare SMART action plans which will describe the actions planned to address the learning points and strengthen practice in response to the learning from this Safeguarding Adult Review.

1. Introduction

1.1 About this review

1.1.1 A Safeguarding Adults Review (SAR) was commissioned by Walsall Safeguarding Partnership (SAB) following agreement that, in accordance with section 44 of the Care Act (2014)[4] the criteria for a mandatory SAR in this case were met.

1.1.2 In the months following Ronald's death a LeDeR[5] review was undertaken grading the care as below standard[6]. It was felt that actions or lack of actions may well have contributed to Ronald's death. Due to this a Multi-Agency Review (MAR) was undertaken which concluded Ronald's death was potentially avoidable and recommended a SAR be conducted.

1.1.3 A review panel was established and Nicki Walker-Hall appointed as reviewer. Nicki is an experienced author of both SAR's and children's safeguarding reviews; she has a background in health.

1.2 Subject of the review

1.2.1 Ronald was 74 when he died. Ronald was a White British male. Ronald had a diagnosis of mild learning disability, autistic features and recurrent depressive order. The causes of death were given as:

1: Frailty
2: Learning Disability and Parkinsonism

Ronald was described as a character. Ronald was slight of build, liked to dress smartly and kept himself and his home neat and tidy. Ronald was a collector of watches and tended to rush everywhere. Ronald had close relationships with his siblings and extended family and was a frequent attender at church. Ronald missed his parents.

1.2.2 During his life Ronald had transferred from living at home, to living in an institution, to living with his sister, and had eventually settled in a supported living accommodation flat on his own with carers support. According to his family, Ronald was very settled and happy there for the first five years, until a few months prior to the first safeguarding referral being made.

2.1 Methodology

2.1.1 The methodology used was a hybrid methodology which sought to:

- analyse the complex circumstances that practitioners work in
- provide opportunities for shared learning and
- lead to improvements in the way in which agencies understand their roles and responsibilities and work together to promote the safety and wellbeing of adults

2.1.1 The methodology incorporated aspects of a traditional case review model through chronologies and single agency summary reports, from those with direct

[4] Care Act (2014) legislation.gov.uk
[5] Learning Disability Mortality Review (LeDeR) Programme
[6] This LeDeR review was undertaken under the previous LeDeR programme which was overseen by the University of Bristol. This programme has since been replaced by the NHSEI led LeDeR programme which considers the life and death of a person with a Learning Disability.

involvement, and through an action learning approach via practitioner events. The following agencies were directly involved:

- Adult Social Care (ASC)
- Walsall Healthcare NHS Trust (WHT)
- Black Country and West Birmingham CCG (CCG)
- Black Country Healthcare NHS Foundation Trust (BCHFT)
- West Midlands Police (WMP)
- Care Providers (Liberty (1) Pegasus (2))

2.1.2 This review examined the period from the first recorded occasion where a safeguarding concern was identified, which partners felt appropriate to refer to the LA in December 2018, until Ronald's death in September 2019. Information prior to the review period, thought relevant to the terms of reference, has also been considered.

2.1.3 Two learning events were held, with practitioners and line managers, on the 17th September 2021 and the 3rd November 2021 to explore the key lines of enquiry and consider support, organisational and human factors. All organisations except care agency 1 were represented.

2.1.4 The reviewer met with Ronald's sister and niece to gain an insight into the families experiences of the services provided.

2.1.5 The reviewer completed a draft report which was analysed by the panel.

2.1.6 Partner organisations via the Panel were given an opportunity to agree actions to address the learning identified.

2.1.7 The reviewer shared the report with Ronald's family.

2.1.8 It is intended learning from the full report will be made available to the public but only after consideration by the SAB.

2.2 Parallel processes and limitations

2.2.1 This case had been subject to a LeDeR review and MAR. The LeDeR review was postponed due to Covid-19, but was completed within the extended time period stipulated by NHS England. As a result of the LeDeR review a MAR was undertaken which suggested that the criteria for a SAR had likely been met. The case was referred to WSAB for further consideration. It was agreed to undertake a SAR. It is important to acknowledge the limitations in conducting a SAR two years after the index event, as the policies, procedures and practices across all agencies will have significantly changed.

2.2.2 Additional issues such as practitioners no longer in post and the impact of passage of time on memory should also be seen as limiting factors.

2.3 Key focus areas

2.3.1 Following consideration of the rich learning from the MAR, and in order not to duplicate, the following key focus areas and questions were posed:

- Consider the recognition and response to safeguarding concerns and the impact of any resulting intervention
- What consideration was given to the management of Ronald's nutrition (e.g. physical, behavioural, psychological, legal options)
- Examine the application of Mental Capacity Act, 2005 (MCA) at key decision making points, including

- robust assessments
- best interest assessments
- appropriate referrals

2.3.2 Additional areas for consideration were:

- Management oversight
- Family and adult involvement
- Partnership working
  - Was any other agency notified and the reason for that notification/no notification
  - Coordination of response

3. Summary of the case

3.1.1 Ronald had a mild learning disability, autistic features and recurrent depressive disorder. Family indicated that prior to the review period Ronald had good communication skills and was able to convey his needs and wants. When frustrated or anxious Ronald would use behaviour as a form of self-expression, which could put him and others at risk of harm; Ronald had a comprehensive positive behaviour support plan. Ronald liked established routines and had a close relationship with his sister, brother and extended family.

3.1.2 Concerns regarding nutritional intake were evident prior to the scoping period. Swallowing, and choking issues were under investigation by Speech and Language Therapy (SLT), meals of a relevant consistency were recommended. There is also record of aggressive outbursts in the months prior to the review period.

December – January

3.1.3 At the beginning of the review period three safeguarding concerns were raised within a month. On the first occasion the referrer alleged that Ronald was in a wheelchair wearing minimal, ripped clothing, whilst accompanied by a carer from support services. Ronald was reported to be cold and agitated, and refusing to get into the car with the carer. The carer was witnessed to be verbally aggressive and threatening to Ronald, and was not maintaining Ronald's comfort and dignity. Concerns pertained to alleged neglect/acts of omission as well as psychological abuse. Ronald later alleged, to his family, that the same carer had hit him in the leg and stomach and had threatened him after the incident.

3.1.4 On the second occasion, Ronald had been moved to alternative accommodation as his support service were short staffed. Concerns related to the conditions within the property and the fact that Ronald was sleeping on a sofa bed. There was a continuing deterioration in his presentation and behaviours.

3.1.5 On the third, Ronald presented with cuts and bruising to his face and was alleging that he had been assaulted, both verbally and physically, by a staff member. The referrer was unsure as to whether an assault had occurred, or whether Ronald's injuries had been sustained when falling and hitting out. The family were not aware of this referral.

3.1.6 Ronald was seen by a Psychiatrist; no changes were made to his medication regime and Ronald was referred to the Dementia Nurse for screening.

3.1.7 During the same period Ronald continued to experience difficulties eating and drinking, was having memory issues and was reportedly fixated on death.

3.1.8 Family indicated Ronald was always fixated on death around remembrance day due to a family member losing their life in World War 2, but was not generally fixated on death unless someone he knew died.

3.1.9 Ronald was referred to Behaviour Support and physical health checks and a review were conducted. The Learning Disability Intensive Support Team put a positive behaviour plan in place.

3.1.10 Ronald was referred to SLT; swallow and sensory assessments were requested.

3.1.11 Ronald continued to have periods of confusion, aggression and refusing food. Ronald was referred to community dietetics who once again advised soft foods.

3.1.12 Ronald was seen by the Cognitive Behavioural Therapist who felt the cause of Ronald's rapid deterioration was likely to be a combination of both physical and psychological factors. Ronald was to have an urgent CT scan.

3.1.13 Ronald was seen by SLT. Along with food refusal, Ronald started to refuse medication. Ronald was referred to dietetics.

3.1.14 Care provider 1 was supported by a Learning Disability Team nurse. The GP visited Ronald examining him, carrying out blood tests and a body check.

3.1.15 Ronald's became increasingly aggressive attempting to assault care provider 1 staff. Care provider 1 contacted the crisis team due to concerns with Ronald's presentation; they expressed concerns for both Ronald and staff members safety. A Mental Health Act assessment was completed. Ronald was not detainable. A recommendation was made to relocate Ronald, on a temporary basis, to a more appropriate environment pending further MDT actions to explore all the current concerns. The assessment identified that Ronald's behaviours posed a risk to himself and others. Ronald himself expressed a wish to move to alternative accommodation.

3.1.16 Ronald was admitted to care provider 2 as an emergency case.

3.1.17 A Continuing Health Care checklist was completed.

3.1.18 Ronald was deemed not to have dementia following screening by the dementia nurse.

3.1.19 Ronald was seen by SLT, a mental capacity and best interests assessments were completed in relation to swallowing. Ronald had a swallow risk assessment and a dysphagia review assessment. Ronald was found to have disordered and uncoordinated swallowing. Adding thickener to foods and holding a Best Interests Meeting were recommended.

3.1.20 Ronald's care requirements changed and he was deemed to require 2:1 care. At a blue light Care and Treatment Review (CTR) meeting it was decided Ronald should be moved on a permanent basis to care provider 2. Family were present.

February – March

3.1.21 After moving to care establishment 2, Ronald's food and fluid intake initially improved. The Continuing Health Care (CHC) checklist demonstrated that criteria for Decision Support Tool was met. Ronald's CHC care package was reviewed and his care transferred.

3.1.22 SLT visited Ronald as they continued to assess his swallowing. SLT completed a new mental capacity assessment. Ronald was noted to have a wet voice and was referred to his GP for saliva management.

3.1.23 There were a number of occasions when police were called by care establishment 2 due to the level of aggression Ronald was displaying, Ronald was reacting to changes beyond his control. Requests for MH Act assessments were made by both ASC and the Police. Appropriate follow up took place with Psychiatry.

3.1.24 A further Blue Light CTR Meeting was held with concerns regarding nutrition being discussed. A dysphagia review assessment was conducted. Ronald was coping well eating and drinking. A talking mat was provided to support Ronald's understanding and choice around drinks and food.

3.1.25 A Best Interests meeting in relation to Ronald's eating and drinking was held, with SLT and carers present, looking at risk and texture modification. Alterations were made to the types of food textures to be offered to Ronald.

3.1.26 Ronald had two attendances to A&E with chest and abdominal pain.

April – May

3.1.27 A Community Treatment Review Meeting was convened. It was reported that Ronald appeared to be settling well at Care provider 2. Ronald was to be discharged from the Dementia Nurse, as it was reported he had "no memory issues". Ronald was awaiting the appointment of a new Psychiatrist to review this decision following the Psychiatrist previously assisting Ronald leaving. Weight loss was continuing. Community CLDT SLT proposed to chair a best interests meeting regarding nutrition decision making. Ronald was still awaiting a CT scan. This had not gone ahead due to him being too agitated. The Social Worker was to update relevant parties regarding the safeguarding enquiry outcomes and to complete a mental capacity assessment in relation to Ronald's "care and support plan".

3.1.28 The best interests meeting regarding food and fluids took place with appropriate changes being made.

3.1.29 Care provider 2 received email confirmation of Ronald's long-term placement at care provider 2.

3.1.30 Ronald continued to have aggressive outburst resulting in the Police being called. Ronald was seen by Psychiatry and his medication regime adjusted.

3.1.31 Ronald was referred to Hospital as his weight continued to decline. The GP subsequently made a fast track referral to Gastroenterology.

3.1.32 A meeting was held to complete the Decision Support Tool to determine CHC eligibility; the criteria were met.

3.1.33 Ronald attended hospital "choking when eating". A barium swallow/endoscopy were performed.

3.1.34 A further delayed safeguarding concern was raised by a community nurse as Ronald had choked on food that was not in line with his swallowing plan. This was not received by ASC.

June - July

3.1.35 Ronald experienced issues with constipation, urinary retention and a prolapsed bowel. Ronald found the latter particularly distressing. Ronald had multiple attendances at A&E with the same. Ronald had a sigmoidoscopy. There were fluctuations in Ronald's food and fluid intake, Ronald was seen by the GP and blood

tests ordered. Ronald's GP tried to progress an earlier date for rectal surgery due to Ronald's distress.

3.1.36 Following the CHC decision regarding funding and case responsibility falling within health, Ronald's case was closed to ASC.

August - September

3.1.37 Ronald's weight had decreased significantly and he was admitted to Hospital. Ronald's carers continued to provide care in Hospital. Initially Hospital staff believed Ronald had mental capacity to understand the consequences of not eating and drinking; a mental capacity assessment completed three days after admission demonstrated he did not.

3.1.38 Ronald was not able to tolerate a nasogastric tube. The family understood three attempts would be made to insert the nasogastric tube but only one attempt was made. Further investigations and interventions were considered. Ronald's consultant requested an endoscopy however, the gastroenterologist indicated the as there had been nothing found on the previous recent endoscopy, this would not be helpful. Changes to Ronald's anti-depressant medication were made. A decision, a week into his admission, that Ronald was medically fit for discharge was challenged by practitioners and the family.

3.1.39 Ronald became increasingly frail and it was not thought to be in his best interests to fit a PEG as he was likely to pull it out and was not fit for surgery.

3.1.40 Two weeks later and with family involvement, a best interests decision was made that Ronald should receive palliative care and be moved to a hospice/nursing home. A week later Ronald was transferred to a nursing home for end of life care, where he passed away days later.

4. Single agency learning and conclusions

4.1.1 Each agency has produced their own single agency report which has examined in detail their agencies practice in relation to the key focus areas. Each agency has identified learning on a single agency basis and developed appropriate action plans that are being progressed.

4.1.2 Learning has related to:

- development of joint pathways between acute and community services regarding nutritional support
- widening of involvement of professional groups in MDT meetings
- the need to raise safeguarding concerns in a timely manner and follow up the outcome of all safeguarding referrals
- involving relatives, significant persons and advocates in safeguarding enquiries
- involving the police when safeguarding concerns indicate a crime may have been committed
- the need for greater liaison with the Care Quality Commission and Contract Management Team when safeguarding concerns are suggestive of transferrable risks relating to a carer

- assessment of mental capacity to be made by the most appropriate professional when a person is refusing food or fluid, to inform MDT meetings and resultant care plans
- use of specialist legal advice when an adult is refusing food and fluids with consideration of referral to the Court of Protection
- clarity on the lead professional, roles, responsibilities, actions needed and timescales within MDT meetings
- use of psychiatrist specialising in learning disability to support decision making in Mental Health Act assessments
- clear documentation of completion and outcome of mental capacity assessments
- earlier involvement of Best Interest Assessors
- when assessing LD patients, BMI out of range should be a trigger for further assessment. Documentation of weight and quantifying food intake is necessary
- GPs to consider coding best interest decisions onto the problem list in order to highlight the need for such decisions
- tailoring staffing levels and increasing managerial support and supervision when managing complex cases
- management of safe and smooth transfer from once residence to another at the right time and with full information without a minimal hospital admission
- mild LD & Autism being his diagnosis meant he was not able to access alternative best practice solutions from other professional expertise areas
- medications - were not all liquids, could alternate methods have been offered
- clarity of roles and responsibilities when care is shared between the care provider and hospital staff

5. Partnership learning and conclusions

5.1 Consider the recognition and response to safeguarding concerns and the impact of any resulting intervention.

5.1.1 It is a positive that at the start of the review period, on three occasions, practitioners recognised safeguarding concerns and made referrals, all of which resulted in adult safeguarding enquiry completion in line with Care Act (2014) and were reported to the CQC.

5.1.2 Following the first safeguarding concern pertaining to the behaviours of a care worker allocated to care for Ronald, enquiries were made and the carer suspended. Ronald's wish for no further contact with the carer was taken into account, and all contact between Ronald and his alleged abuser ceased. It could be seen as a positive that the carer was required to access additional training and supervisory support; however, the wider thinking regarding this persons suitability to work in caring roles, does not appear to have been given sufficient consideration as part of the safeguarding enquiry. The incident was not notified to the police at that time. There is a Police Adult Care Abuse Investigation Team that are currently being underused. This was a missed opportunity. Notification to the police at that time, would have allowed for a full and thorough investigation as to whether an act of neglect or omission had taken place. This would have provided an opportunity to fully

understand the nature of any abuse, and to make a fuller assessment of the suitability of the carer to continue to care for vulnerable people. Two witnesses to the abuse, and Ronald's family, were not interviewed at the time making the response incomplete.

5.1.3 The reviewer learned that because there were already a number of meetings taking place regarding Ronald, no dedicated meeting with a particular focus on the safeguarding concerns took place. The discussion regarding the concern, and feedback on the referral, took place within an MDT meeting previously arranged by the Cognitive Behavioural Therapist. This meeting had been called to discuss changes in Ronald's behaviours and presentation, and took place six weeks after the incident; family and the professionals working with Ronald were present. Whilst this meeting could have provided an opportunity for further consideration of the actions taken and challenge, those in a position to challenge e.g. the GP, the witnesses to the event, and the police were not part of the MDT. This reduced the potential for those outside of the enquiry process to offer any challenge. The lack of a dedicated safeguarding meeting, following concerns regarding the carers treatment of Ronald, meant that all aspects of the incident were never fully discussed; the focus of the MDT was on Ronald's deteriorating health condition. According to records whilst the GP was not present at MDT meetings they did share and receive information before and after meetings.

5.1.4 Had a separate dedicated safeguarding meeting been arranged, wider thinking about who it might have been appropriate to invite should have taken place; the meeting should have been initiated and chaired by ASC. ASC reported that they often struggle to get the right people to engage, and that there is very often agreement that action needs to be taken but the people who are able to make the decisions are not at the meetings. This is a big gap and reported to be an ongoing problem.

5.1.5 Following the second safeguarding concern when Ronald had been placed temporarily in alternate, potentially unsuitable accommodation, swift action was taken by ASC, in collaboration with Ronald, clinicians and his relatives, to source appropriate accommodation to ensure Ronald's safety. Not all interested parties were informed/ engaged within the strategy planning discussion and whilst enquiries were made, and information was shared within an MDT meeting, there was no consideration as to whether this was a unique circumstance or whether any action had been taken against the provider by the Contract Management Team. The CQC were not informed at the conclusion of the enquiry.

5.1.6 Following the third safeguarding concern the S42(2) enquiry that followed was brief. The allegation that the same staff member as in the first incident had assaulted Ronald, was not fully explored; the allegation was put down to Ronald being unwell. The family were not made aware of the enquiry and the enquiry did not consider any possible transferable risks. Whilst it is not known where this member of staff is now actions/risks in relation to the staff member were considered at the time. Once again the police were not involved immediately but did subsequently interview the staff member.

5.1.7 On all occasions Ronald was moved to alternate accommodation. Whilst this was the right course of action and done in consultation with Ronald, the reviewer has not seen consistent consideration of the impact of this on Ronald in the context of his autism, and his reported preference for order and routine, or his past experiences of

abuse in an institution. Care provider 2 indicate there was a lack of information from care provider 1 at point of transfer; information which might have assisted care provider 2 to ensure all Ronald's care needs were seamlessly met. The LA did provide copies of Ronald's reviews. When changes of circumstance occur, practitioners must consider how any distress may manifest itself in the individual, and assess and monitor any impact (both positive and negative).

5.1.8 Research indicates that rates of aggressive behaviour may be higher in individuals with ASD compared to typically developing peers and those with other developmental disabilities, though this is inconsistently reported in the literature[7]. Ronald's family shared their opinion that Ronald had been experiencing abuse prior to any safeguarding referral being made and that the change in Ronald's behaviours before and at the beginning of the review period was likely as a result of abuse he was experiencing with potential flashbacks to previous abuse he had experienced.

5.1.9 There was no consideration of seeking support from advocacy services or referring Ronald to the Older Persons mental health team. Family members indicated that when they tried to broach the subject with Ronald he would physically indicate he needed to keep his mouth zipped; family report this was shared with practitioners. Additional support, and providing Ronald with opportunities to reduce his anxieties and promote the positive aspects of disclosure, might have brought greater clarity on any abuse.

5.1.10 A community nurse raised a safeguarding alert, and an incident form was completed, when it became apparent Ronald had accessed an inappropriate food stuff. Ronald was on 1:1 care, at that time and the food had caused him to choke. The community nurse discussed it with a SLT practitioner. The care home had not alerted any of the practitioners involved at the time of the incident. ASC indicate they have no record of this alert and therefore they did not respond to the safeguarding referral. However, appropriate action was taken by SLT to educate the care staff. A lack of response by ASC to the safeguarding alert should have brought about challenge by the referrer; such a challenge would have unearthed the nonreceipt of the referral.

5.1.11 The reviewer learned that not all practitioners working with clients will know if there has been a safeguarding referral, as records of safeguarding referrals are not routinely made available to practitioners. Practitioners reported that they are not always notified directly that there have been safeguarding concerns; sometimes it is a family member who offers the information. Other practitioners reported they may know about safeguarding concerns but might not know what stage an enquiry is at, or any detail about the incidents.

5.1.12 In this case, a request for a copy of the safeguarding referral by an involved practitioner was refused. The practitioner was told this would be against GDPR; this was not escalated internally. There was agreement across all practitioners that it was worrying that they could see a patient and not know relevant information regarding a safeguarding concern. The issue here appears to be what was requested. A copy of the referral would not be shared however, a request for relevant information might have received a different response.

[7] Fitzpatrick, S. E., Srivorakiat, L., Wink, L. K., Pedapati, E. V., & Erickson, C. A. (2016). Aggression in autism spectrum disorder: presentation and treatment options. *Neuropsychiatric disease and treatment*, *12*, 1525–1538. https://doi.org/10.2147/NDT.S84585

5.1.13 The reviewer has not been able to consider in full the GP response to the safeguarding concerns, as the records were not available to the single agency learning summary report author following Ronald's move to a new GP. GP's use EMIS (Eggerton Medical Information System). There is a GP2GP transfer system which will bring electronic records into the system from a previous practice. This is coordinated at Primary Care Support England. When a patient leaves, paper records are returned and an automatic upload of electronic records happens. This is passed down to the new practice based on the patients registration form via the practice. The new practice clicks to accept, and the full record that was visible at the old practice is now available to the new practice. The time taken for this process is variable, it can be days, weeks or months. It is not clear if there was delay in this case.

Learning point 1: Following the three safeguarding referrals, immediate action was taken by health, social care and the care provider to safeguard Ronald in accordance with his expressed wishes. However, the wider ramifications for Ronald, the service, and service users, were not given sufficient consideration. The care provider policy in place at the time is no longer available for consideration, however the current policy and the West Midlands Position of Trust Framework and the Multi-agency policy & procedures for the protection of adults with care & support needs in the West Midlands has been reviewed and is clear that whenever a safeguarding referral is received by the LA, be they for the client, the carer or other residents, the wider ramification must be considered. The reviewer has identified the need to make explicit that when the concern questions whether a carer has harmed their client, the police must be notified so a thorough criminal investigation can be undertaken, and a standalone meeting held. Consideration should be given to any support or additional therapeutic interventions the client may benefit from. In this case relevant practitioners were not always attending or being routinely informed of safeguarding referrals either past or present, the reviewer learned this was not unique to this case. Whilst it is appropriate that copies of referral are not shared, there should be appropriate and proportionate sharing of information across the partnership.

Recommendation 1: WSP and its partners to strengthen within policies, procedures and guidance the need for referrals and safeguarding meetings, regarding concerns about a Person in a Position of Trust, to include involvement of the Police Adult Care Abuse Investigation Team. WSP to request assurance from commissioners that a monitoring process is in place to ensure compliance with safeguarding policies relating to Persons in a Position of Trust by providers.

Recommendation 2: WSP and its partners to review and embed local guidance regarding when and how to request information regarding safeguarding enquiries and agree what is an appropriate and proportionate response.

Learning point 2: The time taken for GP records to be transferred from one practice to another is impacting on GP's being able to assimilate new information in the context of the patients previous health and social care information. This is not a new issue. Discussions are taking place between health partners and Primary Care Support England to strengthen the arrangements for records retrieval to address this.

Recommendation 3: WSP to request assurance following the PCSE and CCG investigation regarding resolution of the timely transfer of GP. WSP to consider raising the concern with NHS England if no progress has been made or no satisfactory resolution has been found.

5.2 What consideration was given to the management of Ronald's nutrition

5.2.1 The reviewer learned that Ronald was always a very 'slight' gentleman, but there was a marked decrease in his weight of a third over a few years, but in particular during the review period. Ronald's weight was reported to be subject to review by his care providers and his GP but did not receive the attention it required and is under recorded in both. Ronald's weight loss was known to all the services involved with him. Ronald's GP noted a low BMI but had no corresponding plan to promote or monitor weight gain. Health professionals attempted a number of investigations to try and identify or rule out any underlying physical health reason for his weight loss. Ronald sometimes declined the requested tests and there were no coherent plans to revisit these or suggest alternatives.

5.2.2 Dietetic services are provided by Walsall Adult Community services, and whilst there is evidence of information sharing with BCHFT, strengthening this joint working may have been more productive at connecting risks of intake, behaviour changes and dysphagia in the context of continued weight loss and food refusal.

5.2.3 It is not clear whether there was any causal link between the safeguarding issues and Ronald's refusal to eat; family members indicated they were of the opinion there was a link but this is not evidenced within practitioners records. What might have been beneficial was greater consideration as to whether Ronald's continued refusal to eat and drink could be due to factors other than physical health for example, in direct relation to the alleged abuse reported in the safeguarding concerns raised, or as an act of self-harm. Whilst the family and some professionals did link the safeguarding concerns to the change in Ronald's behaviours, this was not being fully considered across the partnership. Of note. the death rate due to suicide among older people in Nursing Homes an Long-Term Care Facilities is high, especially among men[89].

5.2.4 A clinical psychologist was involved at commencement of the review period, and did suggest Ronald's food and fluid refusal may be due to either a physical or psychological problem; however investigation of a possible physical issue received greater attention. The reviewer learned it is standard practice to rule out physical causes first. A parallel approach to try to understand Ronald's food refusal in context of his learning disability, by investigating any underlying health cause at the same time as investigating a psychological cause, could have been beneficial. There was an unavoidable, but unhelpful, break in psychological input following the clinical psychologist leaving and Ronald's case being reallocated.

5.2.5 Ronald was refusing medication. Insufficient account was taken of the impact of Ronald not receiving medication on both his physical and mental health.

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[8] Manthorpe J, Iliffe S. British Journal of Social Work, 41(1), January 2011, pp.131-147. Oxford University Press

[9] Chauliac N, Leaune E, Gardette V, Poulet E, Duclos A. Suicide Prevention Interventions for Older People in Nursing Homes and Long-Term Care Facilities: A Systematic Review. J Geriatr Psychiatry Neurol. 2020 Nov;33(6):307-315. doi: 10.1177/0891988719892343. Epub 2019 Dec 16. PMID: 31840568.

5.2.6 After the first safeguarding incident Ronald became aggressive and reportedly fixated on his own death. The family reported whilst Ronald was fixated on death around remembrance day, it was a new development at this time of year. A review of qualitative studies[10] into understanding self-harm in older people understanding individual perceptions and experiences leading to self-harm may guide clinicians in delivering more sensitive, holistic intervention. Time was lost in waiting for investigations to take place and conclude, during which time Ronald's physical condition deteriorated to a point where treatment proved impossible. The reviewer poses the question what is the real risk for this person if the behaviours carry on. Dysphagia and anorexia are life threatening conditions in their own right. A more robust response, through a multi-disciplinary team (MDT) approach, had the potential to address the issues and increase Ronald's weight. Involvement of an eating disorder clinician and legal expert to advise, support and consider legal options might have been beneficial.

5.2.7 The reviewer learned that practitioners may lack clarity on who needs help with psychiatry/mental health if the client has a mild learning disability. However, in this case support was requested, and Mental Health Act assessments were completed on two occasions. The 'All age pathway' for people in crisis is due to be online in the next few months and it is hoped this will help to better educate professionals.

5.2.8 Whilst there is evidence of a significant volume of professionals working with Ronald and each other to address Ronald's eating and swallowing issues, what was lacking was a holistic view of the case resulting in a comprehensive care plan, with a clear focus on the risks if Ronald did not accept food, fluids and medication, and a co-ordinated approach with a lead professional driving the plan. The MDT approach would have provided an opportunity for sharing formulations and planning who was doing what by when, thus progressing the case at pace.

Learning point 3: Whenever a client/patient is refusing food and fluids, a robust multi-agency plan of care needs to be developed, which focusses on all the potential reasons for food refusal and the risks. Where it is thought the issue may be due to psychological reasons, this should be explored in tandem with medical causes. A clinical Psychologist should be allocated to support the client and advise the MDT. There needs to be an identified lead professional, from the lead agency, driving the plan; treatment and timescales should be tailored to the severity of the situation.

Recommendation 4: WSP to introduce guidance setting out lines of accountability and responsibility for MDT meeting's pertaining to, a person with learning disabilities or a person with mental capacity issues. The guidance should include the need to:

- establish clarity regarding the lead agency,
- identify the lead professional,
- Explore attendance and contribution
- include timescales
- identify psychological support and,
- ensure risk is a clear focus of every meeting.

[10] Wand A, Peisah C, Draper B & Brodaty H (2018) Understanding self-harm in older people: a systematic review of qualitative studies, Aging & Mental Health, 22:3, 289-298, DOI: 10.1080/13607863.2017.1304522

5.3 Examine the application of MCA at key decision-making points, including

- **robust assessments**
- **best interest assessments**
- **appropriate referrals**

5.3.1 It is clear that SLT practitioner's and those working in Learning Disability Liaison roles who work with adults with learning disabilities and/or dementia, understand, as part of their routine practice, the need to carry out assessments in line with the mental capacity act[11]. There is no evidence that the GP, dieticians, or care providers 1 & 2 carried out any MCA assessments. In the GP's case this may be due to the lack of records.

5.3.2 Ronald was reported by practitioners at the practitioners event to have capacity to make day to day choices around the clothes he wore, the food he ate and the activities he wished to partake in; this is not evidenced through MCA assessments. The family and some practitioners who had direct contact with Ronald, did not believe he had the capacity to understand the wider ramifications of not eating or drinking. Mental capacity is time and decision specific, therefore the reviewer would have expected there to be numerous mental capacity assessments.

5.3.3 Guidance indicates specialist practitioners have a role in assessing mental capacity. i.e. if decision relates to understanding of the ramifications of not eating or drinking, it is felt that SLT/dieticians should have led such assessments in line with other partners and relatives on a continuum basis, in line with relevant evidence base.[12] BCHFT indicated the decision makers for overall nutritional input would usually be the Community Dietitian. In this case workers in community SLT had on two occasions completed MCA assessments and had convened two best interests meetings in relation to dysphagia, making changes to Ronald's diet and fluids. The community dietician did not complete any MCA or best interests assessments suggesting overall nutrition including wider food and drink intake issues were not being fully assessed.

5.3.4 When Ronald was admitted to hospital latterly, carers had a belief that Ronald had mental capacity to understand his decision not to eat and drink; it is not clear if this opinion was shared with hospital practitioner's but they appear to have formed a believe Ronald had capacity for complex decision making. Little consideration was given on admission to conducting an MCA assessment, consulting with family members or those who had additional expertise in this area.

5.3.5 The family reported that when they raised concerns regarding Ronald's food and fluid refusal, when Ronald was in Hospital, they were told by ward staff, "he has mental capacity"; they were not listened to. Available to all staff in Hospital are both a learning disabilities acute liaison nurse and a safeguarding team with expertise to advise on mental capacity assessments. The team report they are often underused, or not called upon until after a patient has been in hospital for a number of days. In this case Ronald was in hospital for three days before an MCA assessment was completed. A third best interests meeting was held when Ronald was in hospital.

5.3.6 Care establishment 2 staff were of the opinion Ronald had mental capacity to understand the consequences of his refusal to eat; indicating Ronald had stated he

[11] Mental Capacity Act 2005

[12] Eating and drinking interventions for people at risk of lacking decision-making capacity: who decides and how? (core.ac.uk)

wanted to die. This is in contrast to the first assessment in hospital where he was deemed to not have capacity. This is not unusual as capacity can and does fluctuate requiring repeat MCA assessments. However, some practitioners and family member who knew Ronald well, felt that he had never had capacity for such high level thinking. Differences of opinion are not uncommon but require further exploration at the time.

5.3.7 Appropriate decision specific MCA assessments were not always completed to inform MDT meetings where plans of care were being reviewed and changed, suggesting Ronald's wishes were not being fully considered. Whilst there were mental capacity assessments relating to dysphagia, there had been no assessments in relation to Ronald's mental capacity to make decisions pertaining to his nutrition before April 2019.

5.3.8 Inconsistent or lack of application of the Mental Capacity Act is not unique to services in Walsall[13]. A national study ten years after the MCA was introduced identified that "the MCA was not as embedded into the everyday practice of health care professionals due to the lack of knowledge, understanding and confidence in the application of the basic principles of the MCA in clinical settings." As a result it became a priority within the health agenda. However, seven years on there remains a variance in practice across the country.

5.3.9 The Social Care Institute for Excellence (SCIE)[14] have devised a set of quality standards for monitoring officers to use within domiciliary care agencies and care homes which are applicable for all providers to adopt. The quality standard for assessment of mental capacity states: there is a clearly recorded assessment of capacity with supporting evidence for people who lack capacity to consent to their care and support plan. The quality standard for the best-interests decision making process states: care planning documents demonstrate that any act performed for, or any decision made on behalf of, people who lack capacity is performed, or made, in their best interests.

5.3.10 There is evidence that once a lack of capacity was identified by community SLT, that a best interest assessments and meeting was held. Capacity assessments and best interests decision discussions regarding dysphagia were apparent. However, it was not clear if best interest meetings occurred in relation to wider food and drink intake issues, as dysphagia was not a sole factor.

5.3.11 Whilst there is evidence of consideration of the management of Ronald's nutrition from a physical, behavioural and psychological aspect, legal options were not explored; there was no consideration within MDT meetings of the legal options or a referral to the Court of Protection.

5.3.12 All agencies could have sought their own individual legal advice regarding legal options. Whilst ASC Legal Services offer regular "legal surgeries" to enable practitioners to discuss complex cases and to seek advice, in this case, as the issues related to nutrition it should have been down to health agencies to discuss this case and make any onward referrals.

5.3.13 An application to the Court of Protection can be made to challenge decisions relating to the mental capacity or best interests of a patient or relative. Whilst the family

[13] House of Lords, Mental Capacity Act 2005: Post-Legislative Scrutiny. London: House of Lords; 2014.

[14] https://:www.scie.org.uk/mca/practice/care-planning/monitoring-implementation

were not openly challenging any decision, wider discussion including consideration of an application to the Court of Protection would have been advisable.
Learning point 4: There is a lack of evidence that the MCA was being consistently applied at key decision making points across all agencies/providers. Practitioners are not making best use of legislation to aid their decision making in relation to their clients' needs. The reviewer learned that whilst there has been training for practitioners, the issue is one of application of the MCA in practice; currently this is variable. Some services have demonstrated good understanding and some usage of the legislation, others have not and it continues to be an area for development. The legal option of an application to the Court of Protection should be a routine consideration in such cases but is not. Consideration of MCA should be integral within all MDT meetings for persons with cognitive impairment.

Recommendation 5: WSP and its partners to embed the current guidance and monitor compliance with the MCA. WSP to consider how best to promote and support all staff to increase their confidence and knowledge of when and how to conduct mental capacity and best interests assessments, and when to seek applications to the Court of Protection.

5.4 Management oversight

5.4.1 As Ronald's behaviours proved more challenging for care establishment 2 staff to manage, additional supervision and 1 to 1 meetings took place, and management presence increased.

5.4.2 Social Work staff within Adult Social Care accessed consistent line management support from their Team Manager and Advanced Practitioners within the Learning Disabilities and Transitions Team. This included the provision of regular professional supervision sessions delivered in line with the directorate's supervision policy requirements in terms of frequency. This support continued during the time period in question.

5.4.3 Managerial oversight within health services is not well evidenced. Safeguarding professionals within acute and community settings were not approached for additional support and supervision in relation to Ronald.

5.4.4 It is clear that at points of transition involvement of managers in Blue Light CTR meetings led to swift placement decisions that had, at least initially, a positive impact on Ronald.

5.4.5 Managers involvement in CHC meetings initially led to a more cohesive health approach. At the point Ronald's care transferred from care provider 2 to hospital the CHC nursing service was of the opinion that reasonable adjustments had been arranged to support Ronald in hospital with 1:1 care from his community support arranged to assist on the ward. However there was insufficient managerial oversight as to whether this shared care arrangement was working for Ronald (see section 5.6.4).

5.4.6 **Learning point 5:** There is a need for greater managerial oversight when a person in care provision is admitted to hospital and a shared care arrangement is made. It is essential that a comprehensive and reasonable plan of care ,with clear lines of accountability and responsibility for both agencies, is established. Currently there is no shared care protocol in place. Walsall Healthcare NHS Trust has done work on

clarifying the roles when carers are going into hospital to support a person who is an inpatient.

Recommendation 6: Walsall Healthcare NHS Trust to produce a shared care protocol and plan an audit to ensure this, coupled with the recent clarification of roles, is meeting patients care needs fully.

5.5 Family and adult involvement

5.5.1 Whilst Ronald lived in residential settings he remained a key member of a very loving and tight knit family, who were in regular contact. Ronald was involved in all significant family events and gatherings, such as weddings and Christmas. Ronald also spent quality time with his sister, within her home, every week.

5.5.2 Contact between practitioners and the family was not always consistent. Family members were involved in some MDT meetings but not always involved in assessments. They were informed on all but one occasion when safeguarding referrals were made, but were not integral to the enquiry. They did not always get opportunities to discuss Ronald outside of meetings, and they did not receive sufficient feedback at the conclusion of assessments and enquiries.

5.5.3 The family reported to the reviewer that they had raised concerns about Ronald's care and carer to a number of practitioners over the review period, but did not get feedback regarding any actions taken to address their concerns. This was sometimes done following MDT meetings. It is not clear whether those practitioners approached by the family understood that the family had an expectation that the practitioner would take action. In some circumstances there can be a lack of clarity as to whether family members are sharing information and raising a concern. Practitioners need to be frequently asking 'do you need me to act on this or has this been resolved?'. The Ask, Listen, Do[15] initiative is a source of information for people with a learning disability, autistic people, families and carers, that supports organisations to learn from and improve the experiences of people when families raise a concern. Signposting to this initiative might have given the family an alternative way of raising their concerns. As a result of some aspects of the care Ronald received in hospital, the family contacted the Patients Advice and Liaison Service (PALS) within the hospital but report they are yet to receive resolution to their complaint. Covid-19 has reportedly delayed the conclusion of the investigation. Within the LeDeR annual report[16] it was felt families should routinely be invited to provide feedback after the death of a relative in a proactive way. This subsequently took place as part of Ronald's LeDeR review. The family raised their concerns which were given full consideration and resulted in the subsequent MAR and SAR application.

Learning point 6: Ronald's family were an integral part of Ronald's care and support network. The agencies who were represented as part of this review have been unable to identify where there was a breakdown in communication. However, good practice would always be for Practitioners to afford families the time and space to

[15] https://www.england.nhs.uk/learning-disabilities/about/ask-listen-do/

[16] https://www.bristol.ac.uk/media-library/sites/sps/leder/LeDeR_Annual_Report_2018%20published%20May%202019.pdf

speak with them individually not only in meetings. Any query raised should have led to a response.

Recommendation 7: WSP and its partners to promote

- the proactive inclusion of all family members, who are actively involved in the care and support of clients, unless there is clear rationale not to so, and
- feedback to families post assessment or safeguarding enquiry
- families being provided with clarity on who they should report concerns to and where to go to gain support.

5.6 Partnership working

5.6.1 There is evidence of some good partnership working, with Heath and ASC coming together for MDT meetings and involved in Ronald's plan of care. The GP also notes involvement in MDT meetings however direct attendance is not evidenced.

5.6.2 The accommodation provider had, on occasion, been requested by care provider 1 to assist them in managing Ronald's behaviours, however there is no formal record of the assistance provided within the accommodation provider records.

5.6.3 The move to care establishment 2 was based on, and met, Ronald's needs at that time.

5.6.4 Whilst there is much that was positive there are a number of areas that warrant further exploration.

5.6.5 Whilst it was good practice for familiar carers to continue to be involved in delivery of Ronald's cares, during Ronald's extended admission to hospital towards the end of his life, care provider 2 were unhappy with the lack of support they received in caring for Ronald's additional medical needs. Hospital staff raised their own safeguarding's about care provider 2. Hospital placed security staff outside Ronald's ward/side room door, in response to JP's unpredictable behaviour. The lack of support of care provider staff by ward staff, in delivering Ronald's cares, meant security staff were being called upon to assist.

5.6.6 Carers and hospital staff did not establish a comprehensive plan as to who could and would deliver each aspect of the care Ronald required. Ronald was prescribed medication carers were not trained, qualified or insured to administer; hospital staff assumed carers would do this. The result was Ronald was not being administered his medication as prescribed. Ronald would at times need 2:1 care, as he had in care establishment 2. Hospital staff did not support his carers to deliver this, so security staff, placed to manage his aggression, where called upon to assist. Ronald's carers were left working long shifts with no support from hospital staff. This has been recognised within the hospital's single agency report.

5.6.7 At the practitioners event those present indicated that as soon as someone becomes health funded, ASC would close the case unless any safeguarding concerns were raised. Health practitioners reported no handover or communication from ASC at point of case transfer. This was reported as a regular issue. ASC practitioners reported that as the issues in this case had been mainly related to health they felt health were already fully aware of all of the information. However, whilst this was the perception of practitioners, the reviewer learned that transitional arrangements, both in terms of funding and continuity of care, were assured prior to closure to ASC (health funded from 22.05.2019 but closure to ASC was not actioned until 11.07.2019). This suggests the issue may not be between agencies but within health.

Senior managers within ASC indicated there are close working relationships between ASC and CCG regarding LD clients, which enables further discussion and information sharing as necessary.

5.6.8 Greater consideration of the trauma Ronald had suffered, both prior to and during the review period, and greater consideration of triggers for a deterioration in his behaviours, could have brought about more comprehensive trauma informed practice.

5.6.9 Ronald was referred to Clinical Psychology regarding his verbal and physically aggressive behaviour, because there was a risk of placement breakdown, and assessments took place in December 2018 and January 2019 using the Functional Assessment interview and Contextual Assessment Inventory; carer's were present. The assessment indicated that the main function of the challenging behaviour was escape, most likely of how he was feeling (anxious/angry), rather than an actual place. There was a hypothesis at the time that the behaviour was related to historical trauma, though it wasn't possible to confirm this due to lack of Ronald's engagement with the assessment. The information from the assessment contributed to a personal behavioural support (PBS) plan for Ronald. The last Psychology involvement was to attend the MDT towards the end of February 2019. At that time where a number of physical health needs which were seen as of greater importance thus Ronald's psychological needs were placed secondary.

5.6.10 Whilst it is positive that Ronald's behavioural and psychological care needs were considered, there was a need for equal recognition of the psychological component of Ronald's behaviours, with a clear focus and additional input, that might have been beneficial and assisted Ronald. There is now a Trauma Development Pathway for people with learning disabilities; associated training for practitioners is due to commence.

5.6.11 The reviewer learned that Ronald would historically have removed himself from any situations that he was uncomfortable with. A fall, prior to the review period, had caused a reduction in his mobility which had impacted on his ability to do this. Professionals needed to work with Ronald to find an alternative way of coping with uncomfortable situations. Whilst some work was done with Ronald around eating using a talking mat, and he had an assessment of mood, there was little of a therapeutic nature. Practitioners reflected that it was possible Ronald had regressed and thought he was back in the institutional environment of his younger years, that his previous trauma might have been affecting his life during the review period.

5.6.12 The reviewer learned that historical changes within the CCG resulting in the disbanding of the integrated team were felt by practitioners to have reduced clarity on who to contact and relationships between agencies were lost. Practitioners reported that the way things worked previously was better than the way things work now, that communication isn't as easy or as swift now that there isn't an integrated team.

Learning point 7: Whilst there is significant evidence of partnership working there are some exceptions. A number of disciplines were not well integrated in the partnership approach. The GP was not an integral part of MDTs, the police were not part of safeguarding enquiries and the accommodation provider did not see themselves as playing any part in Ronald's care and as such did not keeping record of

their actions when called upon by the care provider to assist. Some areas have introduced Adult Multi-Agency Safeguarding Hubs to address the safeguarding enquiry issues at point of referral whilst others have opted for a single front door approach.

Recommendation 8: WSP and its partners to seek assurance from the accommodation provider and via ASC commissioners, that accommodation providers are adhering to the CQC standard for record keeping and sharing of safeguarding information pertaining to residents.

6. Good Practice

Black Country and West Birmingham CCG

- A wide range of professionals were involved, frequent communication noted
- GP appears to have been responsive and proactive in working with other agencies to provide care.

West Midlands Police

- The triage car containing multi-agency employees were involved in two incidents. This enabled officers and other agencies to have access to a wider range of information about Ronald.
- The triage car attending incidents or offering advice via the phone was good practice.

Adult Social Care

- Safeguarding enquiries undertaken were all completed in adherence to suggested timeframes enshrined within West Midlands Adult Safeguarding Policy and Procedures.
- In response to all received reported concerns, the decision making to proceed to S42(2) enquiry completion was felt to be entirely appropriate and adherent to Care Act (2014) legal duties.
- Good liaison between Adult Social Care Access and Learning Disabilities and Transitions teams demonstrated to inform S42(2) decision making, as well as to ensure that any immediate risks to Ronald's safety and well-being were managed appropriately, pending enquiry commencement.
- Management oversight evidenced at the time of allocation to Enquiry Officers and at enquiry completion in relation to all safeguarding enquiries completed
- A good standard of case recording was evidenced in the main, to identify actions taken from both a single and multi-agency perspective
- Adult safeguarding concerns identified and reported appropriately where concerns arose.
- Interface between actions required from both a safeguarding and care management perspective were identified consistently; to ensure that multi-agency support for Ronald was provided in a holistic manner.
- Appropriate use of the caused enquiry process utilised, most notably in relation to concern/enquiry 1

- Regular multi-agency meetings to explore concerns and to ensure that appropriate professional support was provided to Ronald to explore and respond to concerns regarding his dietary and fluid intake.
- Ronald's relatives were consistently involved in discussions, reviews and MDT meetings convened to discuss and explore general concerns (including those relating to his nutritional intake) to ensure that responses were holistic and appropriately informed.
- Despite not being the lead professional exploring concerns regarding Ronald's nutrition, his allocated Social Worker escalated where there were concerns regarding Ronald's weight loss and nutritional intake, to ensure that all appropriate escalation actions were undertaken to ensure that concerns were investigated and responded to clinically as required.
- Ronald's support providers were engaged in discussions and assessments regarding his nutrition to ensure that all relevant actions were taken on a day to day basis to maximise his dietary and fluid intake. They also engaged well with the MDT to feedback how Ronald was responding on a regular basis.
- Mental Health Act Assessment provision requested by allocated Social Worker when nutritional (alongside other) risks were felt to be significant, posing a risk to Ronald. This ensured that specialist assessment was completed to explore whether concerns were being caused by mental illness or disorder and whether hospital treatment in relation to such as required.
- The perspective of all relevant parties were considered when exploring Ronald's mental capacity in a multi-agency forum, to ensure that actions were informed by all relevant persons, including Ronald's relatives.
- Where it was determined that Ronald was able to make decisions pertaining to the statutory safeguarding response, principal 1 of the act was considered and adhered to, in order to promote Ronald's ability to remain central to the response; avoiding the completion to two stage assessments of mental capacity where this was deemed as inappropriate for completion. Recording relating to this evidenced the rationale for professional decision making.
- From a multi-agency perspective, assessments of Ronald's mental capacity in terms of pertinent areas of his support were undertaken by the most appropriate involved professional (i.e. SLT staff in relation to Ronald's ability to make decisions regarding his nutritional intake).
- Ronald's relatives were involved in all aspects of decision-making pertaining to Ronald's support and medical treatment.

<u>Black Country Healthcare NHS Foundation Trust</u>

- A safeguarding alert and incident form were raised as soon as BCHFT was made aware regarding the choking issue.
- Immediate advice to correct care practice was provided by SLT even though SLT clinical input with Ronald had been closed. This included further information and explanation.
- There was evidence of BCHFT decision-specific capacity assessments and best interest decision meetings in relation to swallowing assessment and intervention involving both carers and family members.

- BCHFT responded quickly to the initial referral with appropriate onward referrals internally and to dietetics with information to reduce risk of choking to GP and all concerned in care including family.
- Swallow assessments were based in familiar settings and including observations (following capacity and best interest decision discussion) in a favourite restaurant.
- Support for Ronald's understanding was provided by SLT using Talking Mats approaches around drinks and food choices due to continued low intake.
- Report of incorrect food textures (grapes) were actioned as a safeguarding alert and incident form and advice given immediately to carers.
- Timely and robust assessments- SLT, Psychiatry Community Nursing, Acute liaison Community Nursing raising the risk of diagnostic overshadowing
- Frequent requests for specialist investigations- e.g. gastro
- Requests for reasonable adjustments for Ronald when accessing specialist assessments, scans etc.
- Escalating need for investigations when repeated visits to A and E for rectal prolapse issue.
- Psychiatry escalating need for GP to admit regarding weight loss
- Issues of concern were highlighted- safeguarding raised, referrals for specialist intervention, requests regarding enhanced and nursing community care, raising need for nursing home discharge care package in community, liaison with GP, specialists and
- Prompt response to referrals and regular reviews.
- Acute liaison and liaison with community LD team whilst Ronald an inpatient.
- Instigating best interest decision meetings including family for areas of input relating to dysphagia.

<u>Care provider1</u>

- All people involved in the care and support of Ronald worked very closely together to try and ensure the appropriate support was offered at the right time. Communication was multi-disciplinary, and all partners wanted to ensure Ronald health and wellbeing was stabilised and maintained. The service worked with all the multidisciplinary teams and family in a proactive way.
- Staff within the service would support Ronald and encourage him to have whatever food he fancied at whatever time he wanted, which meant cooking meals and/or vising places that could tempt him. Staff's creativeness and ability to adapt to the difficult and challenging situations they were placed in was commendable. The staff team rally cared for Ronald and wanted to do their best to support him. The support from health colleagues during the difficult times was very good and more often than not very swift.
- Once we as a service recognised, we were not meeting Ronald needs we instigated an emergency review to ensure Ronald was referred to somewhere that could meet his needs more appropriately.

<u>Continuing Healthcare Nurses</u>

- Recognition of the MCA and Best Interests, MDT's arranged and action plans put in place. Inclusive of up to 9 professionals from various teams on 21.12.19 & 17.01.19, relapse plan 21,01,19. Joint funding agreed with the CCG.

- Best Interest meetings
- Hospital LD Liaison nurses and safeguarding nurse supported when they could to family and other professionals

Care Provider 2

- Placement lead by Registered Manager personally who was then able to not only support Ronald but outline information to the associated professionals with first-hand experience.
- Referrals were made for MCA assessments and where doubted queried with assessors.
- The relationship between the team and Ronald's family has always been a strong one and they are still in touch with the team now .

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- Recognition of the need to engage with the consultant psychologist
- Continued attempts to Contact with the consultant psychiatrist for advice and support
- Mental capacity assessments around the Naso-Gastric tube insertion
- Dietician involvement and involvement of the nutrition clinical Nurse specialist
- Clinical swallow assessments undertaken by the speech and language therapist
- MDT meetings held with internal and external staff and his family to agree a plan
- Learning Disabilities acute liaison Nurse involvement
- Reasonable adjustments made to support care, i.e. carer remained with Ronald, menu options considered
- Completion of mental capacity assessment and best interest proforma
- Involvement of learning disability nurse both from the acute and community team
- Carers stayed with Ronald throughout his hospital admission

Practitioners reflections

- PAMHS relationship with WHT staff has been built up really well and the communication between them is excellent
- Practitioners felt that residential care setting 2 staff not only extended Ronald's life but drastically improved his quality of life and that they worked extremely hard with Ronald and his family
- The relationship between the acute hospital trust staff and the community teams is really strong
- Practitioners felt that all practitioners involved pulled together to support Ronald as best as they could
- Hospital LD Liaison nurses and safeguarding nurse offered support when they could to family and other professionals
- Best Interest meetings were held
- Ronald's placement at care establishment 2 was led by the Registered Manager personally who was then able to not only support Ronald but outline information to the associated professionals with first-hand experience.

7. Learning already implemented

WMP identified referrals/ information could have been reported to Ronald's SW to make them aware of incidents and that the care home was struggling. A 'Newsbeat' article has since been published relating to taking out non-crime numbers, making referrals and updating investigation logs, addressing this.

Care provider 1 has reviewed their safeguarding procedure and has now developed a clear audit process to monitor care and support.

BCHFT – The LD community service have begun to develop a multi-agency pathway for people who are palliative/end of life from a specialist health perspective which would link into a nutritional care pathway for people with LD with the appropriate multi-agency support.

The BCHFT LD division PAMHS team have developed a package of easy read information in the form of a publication regarding constipation. This has been developed between 2020 to date in response to the LeDer annual report findings 2020 to increase awareness of constipation among carers and professionals working with people with learning disabilities. This would be a useful package to support the Acute Liaison Nurse and other multi-agency colleagues in the community regarding awareness of constipation in people with learning disabilities.

The Acute Liaison Nursing team has been working on more robust pathways for working between the acute hospital teams and LD community, sharing information via electronic clinical records since its implementation in late 2019.

The LD Community service is developing multi-disciplinary outcomes framework as part of their electronic record which consider the patient's view along the Transforming Care 9 principles.

The LD community service continues to audit clinical records including the frequency and review of physical health assessments, capacity and best interest decision making.

ASC - Enquiry Officer and Enquiry Manager external training commissioned for all Adult Social Care staff who acts as Enquiry Officers and Enquiry Managers. This will support in ensuring that responses are more consistent and informed by best practice principles.

Changes have been made to the ASC Mosaic computer system to ensure that how S68 (Care Act, 2014) legal duties are considered and met within safeguarding enquiry completion are more explicitly recorded from a defendable decision-making perspective.

Safeguarding leads within ASC have produced additional internal resources to support practitioners to ensure that statutory safeguarding responses are robustly legally literate, alongside documentation of such.

Regular workshops delivered to ASC staff by safeguarding leads to support staff to become more confident in application of best practice principles in a "real life" context, using case studies and group discussion to share learning.

- Adult Social Care Legal Services offer regular “legal surgeries” to enable practitioner to discuss complex cases and to seek advice regarding the provision of legal options where appropriate.
- Commissioned adult safeguarding training within Adult Social Care now includes exploration of when to seek specialist legal advice in practice.
- Adult Social Care’s case recording policy has been updated, with workshops being delivered by the directorate’s Principal Social Worker to introduce this. This policy outlines the need for clear case recording, embodying the learning point above.

Practice leads and Legal Services within the directorate have collaborated to produce a series of webinars for practitioners to access to refresh and strength understanding, including application of the Mental Capacity Act (2005) and best interests’ decision making, including when legal advice should be considered and sought.

CCG – Work has been progressed and GP’s are now able to code best interest decisions to make them easily visible to practice staff. Whilst this is good practice they are limited to the following options:

- Best Interest Decision Made on Behalf of Patient (mental Capacity Act 2005)
- Best Interest decision taken for sharing end of life care coordination record
- Best Interest decision to allow covert administration of medicines under mental capacity act 2005

8. Action timeline for implementation of learning and development.

Appendix I – Key to acronyms/ abbreviations

A&E	Accident and Emergency
ASC	Adult Social Care
CCG	Clinical Commissioning Group
CHC	Continuing Health Care
CQC	Care Quality Commission
CTR	Care and Treatment Review
DBS	Disclosure and Barring Service
GP	General Practitioner
LA	Local Authority
LeDeR	Learning Disability Mortality Review
LD	Learning Disability
MAR	Multi-Agency Review
MCA	Mental Capacity Act
MDT	Multi-Disciplinary Team
MHA	Mental Health Act
NMC	Nursing, Midwifery Council
PoT	Position of Trust
SAB	Safeguarding Adult's Board
SAR	Safeguarding Adult Review
SLT	Speech and Language Therapy
SW	Social Worker