Trafford Strategic Safeguarding Partnership

Male R

Safeguarding Adults Review

May 2024

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1. Introduction

Scope and Methodology

1.1 This review is in relation to an adult male R aged 22 years who has complex care and support needs. He has a diagnosis of Autistic Spectrum Condition (ASC), no functional language and difficulties in communication due to the severity of his learning disability. R has a propensity for consuming inedible non-food items and is not aware of the risk that this behaviour poses. R has not been diagnosed with Pica or a related condition such as *Prada Willi* Syndrome but requires continuous supervision to ensure his safety and well being.

1.2 R has been described as a *'great character'* having a *'lovely personality'* and whilst at school needed to be subject to close supervision with a high staffing ratio to ensure appropriate support and behaviour management. Whilst R does not have functional language he can communicate when he is feeling, happy, angry or frustrated. He needs familiarity, consistency of approach and enjoys activities related to movement such as swimming and walking.

1.3 R attends a specialist college in Greater Manchester and has an Education Health Care Plan (EHCP). He is one of four children to his parents and has a twin brother M, who also has care and support requirements due to the complexity of his needs. During 2021 both R and M were planning to transition to supported living as part of a bespoke package of care which had been commissioned by NHS Greater Manchester Integrated Care *(Trafford)* and provided by an independent provider agency, Provider 1.

1.4 This review was commissioned following R becoming unwell which resulted in him being admitted to hospital during April 2021 and requiring emergency surgery. It was subsequently discovered that R had ingested a surgical glove which raised concerns regarding the quality and level of supervision which he had been receiving. It must also be noted that the review was discretionary and not a mandatory safeguarding review.

1.5 This followed an earlier admission to hospital in December 2020 which required surgery and a number of non-food items were recovered from his bowel. This was the second hospital admission within a 6-month period. Both of these events were subject to Section 42 Safeguarding Enquiries.

1.6 Following the second admission to hospital a referral was made to the Trafford Strategic Safeguarding Partnership on the 8/4/21. As R was an adult with care and support needs who may have suffered abuse or neglect and there were concerns that agencies may have worked together more effectively, the partnership recommended that a review be undertaken.

1.7 This review examines R's journey through services and considers key themes in respect of the effectiveness of any risk mitigation strategies, the transparency of partnership working between the commissioners and the Care Providers, and the quality of care provided for R. The review also considers the quality, thoroughness and independence of the Section 42 Enquires which were undertaken during December 2020 and April 2021 and considers the transition arrangements, particularly in respect of combining packages of care for two brothers with very different needs.

1.8 The review draws on individual reports provided by service leads and the contributions of practitioners, managers, health professionals and senior leaders who attended a practice event during May 2022. Regular Panel meetings, which have taken place on the 24/1/22, 1/4/22 and 23/5/22, have provided monitoring and oversight regarding due process. In addition, key individuals have been interviewed in order to seek clarity and confirm any actions taken to improve service delivery.

1.9 The review has consisted of senior representatives from the Local Authority, NHS Greater Manchester Integrated Care (Trafford), Continuing Health Care Partnerships and the Provider agencies.

1.10 The review has had due regard to the Mental Capacity Act 2005 and Best Interest Decision protocols and has recognised the statutory requirement for organisations to share relevant information with the Strategic Safeguarding Partnership, in accordance with Section 45 of the Care Act 2014.

1.11 The review has also involved R's parents, Mr and Mrs H. This has been a significant element in the process regarding their views of the quality of care and supervision that had been provided for their son. Both parents had also raised concerns regarding professional boundaries and what parents believed was *'over familiarity'* from a number of carers which then posed a risk in terms of learned behaviours.

2. Background

2.1 During early December 2020 R was admitted to hospital due to presenting as unwell. Diagnostic tests revealed a blockage in his bowel caused from a number of non-food objects. Emergency surgery was undertaken which revealed a bowel obstruction caused by the ingestion of a number of inedible items. These consisted of *'bits of plastic, metal, metal balls, bits and bobs' also- a magnet, nail, screws, earphones and ball bearings.* R's mother reported that this *'pica type'* behaviour had been evident for many years and had been a long-standing issue which had not significantly changed over time. It was also confirmed that the behaviours were consistent with a desire for oral stimulation and consistent with behaviours in very young children.

2.2 R was discharged during early January having spent almost a month in hospital during which he had been placed in an induced coma due to his complex needs. The Section 42 Enquiry concluded that it was unclear where or when the ingestion of these non-food items had taken place. As R was attending college on a daily basis, including the provision of short breaks and outreach from a private provider *Provider 1*, the enquiry concluded that ingestion could have occurred at any of these locations or possibly whilst at home. However, R's mother believed that the most likely location was the college setting.

2.3 Following R's discharge from hospital, ongoing supervision and support was provided at the family home by two providers; *Provider 1* and *Provider 2*. This consisted of 24-hour supervision provided on a 2:1 staffing ratio during the day between 8am and 10pm by Provider 1. Night-time supervision was provided by Provider 2 on a 1:1 ratio during 10pm and 8am.

2.4 Care plans and assessments were updated to reflect ongoing risk and to ensure as far as possible that any non-food items which posed a risk were removed from living areas. However, even with these arrangements in place there were occasions when R ingested a number of items such as a *'sticking plaster*, *a sweet wrapper*, *a sticker from a pepper and a wrapper from a cake.'* Provider 1 has confirmed that incidents took place when, for example, his mother was unloading shopping. In addition R has also been described as having *'lightening fast'* responses, although the provision of 24 hr care will have provided a consistent and continuous oversight. Regarding these issues, Provider 1 has confirmed that all these incidents took place in the family home and were reported to the then Clinical Commissioning Group (CCG), now the Integrated Care Board (ICB). Provider 1 and Provider 2 also reported to the review that they had both raised concerns regarding the home environment and R's ability to access non-edible items. In addition R's twin brother would provide items for R.

2.5 R's first overnight introductory stays at the supported living accommodation took place on Wednesday 31/3/21 and Friday 2/4/21. However, when he returned home on Saturday 3/4/21 he presented as unwell and on the 8/4/21 he was taken to hospital by his parents.

2.6 A subsequent scan suggested that he was suffering with a possible twisted bowel, adhesions and scar tissue at the site of the earlier surgery. However, when surgery was undertaken on the 9/4/21 a surgical glove was removed and there was no evidence of a twisted bowel or adhesions which may have been causing discomfort. This was the second emergency surgical procedure which had taken place within a four-month period, and which resulted in R being placed in an induced coma. Both procedures involved the removal of non-food items from his bowel which constituted a threat to life.

2.7 A second Section 42 Enquiry was undertaken, although neither provider could identify a time when surgical gloves were accessible to R and no carer had observed him ingesting the glove, despite continuous supervision. However, Mr

and Mrs H have provided a timeline of events which suggest that R had been significantly unwell on each day following his return from supported living on Saturday 3/4/21 up to his admission to hospital on Thursday 8/4/21.

2.8 The Section 42 Enquiry concluded that whilst it was not possible to identify the precise time when R had ingested the glove it was likely to have occurred within the timeline provided by Mr and Mrs H, that it had taken place when receiving paid and formal support and therefore constituted an act of omission. This resulted in services provided by Provider 1 being suspended although given the lack of certainty regarding precisely *when* the ingestion had occurred, it was not possible to identify which carers had been responsible for R's supervision at the time.

2.9 I have met with Mr and Mrs H on two occasions, once on a virtual basis and once at their home. Both parents have informed me that they remain disappointed with the progress made by commissioners to identify long term support for their sons.

3. Terms of Reference

3.1 The Key Lines of enquiry and Terms of Reference were agreed by the Safeguarding Review Panel and consisted of four key themes. These are:

- The effectiveness of any risk mitigation strategies for R
- The quality and thoroughness of the two Section 42 Safeguarding Enquiries which were undertaken.
- The transparency of the relationship between the NHS Integrated Care Team and the care providers, namely *Provider 1 and 2*.
- The suitability of the proposed supported living arrangements will also be considered as it was a bespoke package of care for R and his brother.
- The appropriateness of the behaviour and interactions of the caring staff from Provider 1.

3.2 It was agreed that the timescale for the review would be from December 2020 to May 2021 which was essentially the period between R's first and second admission to hospital for surgery.

3.3 It was also agreed that consideration would be given to the extent to which any previous learning from similar incidents had been successfully embedded in practice.

4. The Risk Mitigation Strategies

4.1 Following R's first admission to hospital during December 2020 and the subsequent Section 42 Enquiry, specific recommendations were made regarding

risk mitigation. These included continued supervision on a 2:1 basis during the day provided by Provider 1 and 1:1 supervision at night provided by Provider 2.

4.2 Care plans and risk assessments were updated to ensure that as far as possible, any living areas at home, college and the supported living accommodation would be sanitised, not only in terms of infection control, but in respect of the removal of any non-food items which posed a risk. It is clearly documented that risk assessments and care plans were updated and available on site for carers to reference. Records note that *'parents and staff have been advised to be highly vigilant at all times and care plans/risk assessments have been reviewed' (19/1/21 CWP)*

4.3 It is clear from the records that despite these arrangements R ingested a number of items during this period and his parents have described these incidents as *'red flags'* that occurred after discharge from hospital. Case records note that these included a sticking plaster, which had been ingested during January 2021, a sticker from a bag of sweets which R had found during February 2021, a sticker from a red pepper which had been ingested during April 2021 and the paper from a cake during May 2021.

4.4 Provider 1 carers also reported that there were a number of items in the home which were not always visible to caring staff and that a number of requests had been made to Mr and Mrs H to ensure that the home conditions were as risk free as possible. There is also a concern recorded during April 2021 by Provider 2, that R had been observed to be chewing polystyrene whilst watching television with his parents.

4.5 Provider 1 carers had also observed R's twin brother M giving him non-food items and that combined with his quick responses posed a further difficulty in ensuring that risks were minimised. This was a feature of their relationship that had been reported by R's previous school.

4.6 Records indicate that during April 2021 Provider 2 carers had observed surgical gloves on a table near the bathroom door which R may have had access to. R's parents confirmed that gloves were found in the bathroom and were left by carers, not themselves. This was an issue that was explored at the Practice Learning Event which confirmed that it was not possible to identify which caring agency they belonged to. R's father reported that there are still items of Personal Protective Equipment (PPE) at the house and whilst Provider 1 have reported that PPE has been *'counted in and counted out'* Mr H has alleged that this is not true.

4.7 Both Provider 1 and Provider 2 have reported that whilst parents had hidden items, R knew where to find them. Carers reported that were also occasions when R's mother had given him food items such as doughnuts and which had stickers on, which were wrapped in cellophane. However, this is disputed by R's parents who have reported that R does not like or eat doughnuts. Despite clarity being provided as to risk mitigation and the importance of continual observation

and sanitisation, these additional variables added a further layer of complexity which was on occasion difficult to manage.

4.8 In addition, records from February 2021 note that *'shifts may have finished early to ensure private/family time'* and there were requests from parents for carers to leave early *(pg 257-259 CHC notes, 2nd S42 pg 14)* This was a concern raised by a number of professionals at the time as it suggested that parents wanted to reduce the level of support for R. During April 2021 R's parents had indicated that they did not require a full day from Provider 1 and that his mother *'would be undertaking most of the support'*. There was therefore a concern that R would now be having less support than he was prior to the second surgery and there would therefore be times when he would not be in receipt of professional observation *(26/4/21 CWP).*

4.9 A further consideration is that R's *'pica type'* behaviours had been evident for a number of years and the results of the first emergency surgery indicated the presence of a number of various inedible items which may have been ingested over a significant period of time. However, there was agreement that following this admission there had been a concerted focus on the implications and potential risks of R's behaviours which had resulted in the provision of 24-hour care and supervision and the provision of updated risk assessments.

4.10 As referenced earlier following R's second admission to hospital, emergency surgery revealed a glove similar to the type worn by support staff when providing personal care. R's parents believe that this ingestion took place at the supported living accommodation, although whilst the Section 42 Enquiry has concluded that the ingestion took place during the provision of paid and formal support it has not been possible to identify precisely when this took place and therefore which carers were responsible for R at the time.

4.11 However, Mr and Mrs H have confirmed that just prior to the second period of hospitalisation R had spent 2 nights at the accommodation. He was in considerable discomfort on his return, which Mr H initially thought was food poisoning, although it was confirmed that both R and his brother had eaten the same meals during their stays. Mr H reported that R was in significant distress and discomfort *'as soon as he had walked through the door.'* He had then stopped eating and going to the toilet and was subsequently admitted to hospital a few days later. This suggested to Mr and Mrs H that the ingestion had occurred during the time that R had been staying at the supported living accommodation.

4.12 Mr and Mrs H have also expressed concerns regarding the time that it would have taken for R to have put the glove in his mouth and swallowed it. This is because he enjoys the oral sensory stimulation of chewing which meant that the glove would have been in his mouth for some considerable time. Mr and Mrs H have reported that despite his quick responses this would have been evident to anyone providing care and supervision on a full-time basis. In addition, paid care on the basis of 2:1 support was being provided, which should have ensured a continual, consistent observation of R by his carers.

4.13 Mr H also confirmed that he had visited the supported living accommodation a few days after R's admission to hospital and had seen *'multiple open boxes of surgical gloves in the kitchen and on the microwave, only a few feet away from where R had eaten his evening meal on the 2/4/21'*. However, when this issue was raised, Provider 1 managers had reported that the gloves were not present when R was there as they were kept securely upstairs and were only in the kitchen as they were being used to fill *'bum bags.'* Mr H then asked as to why the bags were not taken upstairs to be filled. Photographic evidence does confirm however that the surgical gloves *were* present in the kitchen and left on the microwave. In response to this Provider 1 have reported that when Mr H visited the accommodation, R was not resident and had not attended the property for over a week. Provider 1 also reported to the review that neither R nor his brother had been attending the property for over a week and that had they been, no PPE would have been present in the kitchen.

4.14 It has also been confirmed that an audit had been undertaken at the accommodation following R's second surgery which confirmed that gloves were accessible and left in unsecured draws. This was explored at the Practice Learning Event which confirmed that surgical gloves were present, although kept in unsecured draws in the kitchen area. Again, this contrasts with the photographs that Mr and Mrs H have supplied which confirms that surgical gloves *were* left on the microwave in the kitchen area. Both these sources of information have therefore suggested a significant issue regarding non-compliance regarding the storage of PPE.

4.15 It must also be noted that given the issues due to the *Covid 19* pandemic there was a significant amount of PPE in use. Whilst this does not excuse any failure to provide effective supervision and oversight, this is a salient consideration which will have impacted on caring responsibilities.

4.16 Mr H has disputed that the gloves were not left out in easy reach and has provided a photograph of boxes of surgical gloves placed on the microwave in the kitchen. Both parents have also reported that whilst Provider 1 had indicated at the safeguarding meetings that there was a strict protocol regarding the accessibility and storage of surgical gloves, this was not the experience in the family home. A further concern for Mr and Mrs H was that as R had been assigned 2:1 care by Provider 1 during waking hours he should have had *'eyes on him'* constantly, whether at home or at the supported living accommodation. As Provider 2 provided 1:1 supervision at night the *'time at risk'* element for Provider 2 was therefore minimal. In addition, Mr H reported that during the two weeks prior to R's second admission to hospital he had slept through the night.

4.17 Further considerations were the number of risk assessments in play. Given that R and his brother were transitioning to supported living accommodation with two other adults with complex and differing needs, there were a number of risk

assessments which needed to be considered. These settings included college, the supported living arrangements, transport and R's care whilst at home and during short breaks. Risk mitigation for R may also have been unnecessarily restrictive for his brother M which added a further layer of complexity.

4.18 In conclusion, it is clear that whilst risk mitigation strategies were in place, there were a number of variables which impacted on their successful implementation. Whilst case records suggest that there were occasions when R was provided with food items by his parents and which had non-edible wrapping or stickers which R then ingested, this is refuted by Mr and Mrs H. Both parents have confirmed that R sought these items himself. Case records also indicate that R's brother also gave him items which he chewed and combined with R's quick and opportunistic responses, this required elevated levels of vigilance and responsiveness for safe risk management. As R and his brother did spend time together, risk mitigation on the basis of a principle of least restriction would have required sensitive and careful management.

4.19 There were also occasions when R would locate items in the house that his parents had hidden, and that Mr and Mrs H had to be reminded to remove non-food items from the family home which posed a potential risk. It was also acknowledged that carers may have found being directive in the family home more difficult.

4.20 However, there were occasions when surgical gloves *were* accessible both in the home and at the supported accommodation. There was an acknowledgement that gloves were stored in unsecured draws in the kitchen area of the accommodation, although timely access will have been important for carers providing personal or intimate care. This is *not* to accept that this was acceptable practice however and the photographs that Mr H has supplied clearly indicates that there were boxes of gloves placed on a microwave in the kitchen, readily accessible and only a few days after R's second admission to hospital. In addition, the issue of easy access could have been solved by storing the gloves in *'bum bags'* which carers can wear and access the gloves relatively easily whilst they were caring for R.

4.21 Whilst Mr and Mrs H have provided a timeline which indicates that R was significantly unwell every day following his stay at the accommodation on the 2/4/21, it is a possibility that the glove may have been ingested prior to this date and it had taken some time to produce symptoms and to begin to cause distress for R. However, this is speculative and Mr and Mrs H's concerns regarding this matter are both proportionate and understandable.

4.22 The Section 42 Enquiry also notes that whilst providers could not identify a precise time when R had ingested the glove, it notes; *'on the balance of probability R has ingested the rubber glove in close proximity to when he showed and displayed signs of discomfort/vomiting/constipation. I recognise that I state this as a non-clinical and non-medical professional, but such is based on no concerns about*

behaviour/presentation or physical health mentioned by all I have spoken with during this process' (pg 33)

4.23 Furthermore, the Section 42 Enquiry concluded that ingestion took place during the provision of paid and formal support, thereby constituting an act of omission. The difficulty has been establishing precisely when this took place and therefore where accountability lay, even if it could be concluded that ingestion took place during the week when R had two introductory overnight visits. This was recognised by the safeguarding partnership and was a central feature of why no criminal enquiries were progressed.

4.24 The central feature of this case relates to the importance of robust risk management where *'pica type'* behaviours are evident, and which pose a risk to the health and safety of adults at risk of ingesting non-edible items. This issue was compounded by the different contexts that R received care and supervision in, namely home, college, supported living, transport and short breaks. All these contexts required not only the effective communication of any risk mitigation plans, but that all carers ensured there were high levels of vigilance, observation and supervision in *all* of these different contexts. In that sense the issue is not just with regard to the presence of any risk assessment, but more importantly effective implementation. Provider 1 have also reported to this review that PPE had not been stored securely whilst R had been in college, which raised the possibility that the ingestion of the glove could have taken place whilst R had been attending his college setting. Both Provider 2 and Provider 1 also reported that they had observed PPE to be visible on a table outside the bathroom at home.

4.25 There were risk assessments in place which were regularly updated and available to carers. Yet, despite this and despite the factors which created further complexity in terms of risk management, there were occasions when R ingested non-food items including a surgical glove which was a threat to life, and which resulted in a second emergency surgical procedure. In addition, this second admission to hospital was likely to have been caused whilst R had been receiving paid or formal support and thereby constituted an act of omission. This is perhaps the most worrying aspect of this case, reflecting concerns identified in a previous case which is discussed later in this report.

4.26 In that sense the primary challenge for the Safeguarding Partnership is ensuring effective communication between different *'caring contexts,'* compliance with professional standards and quality assuring any risk management and safety planning.

4.27 These areas have been subject to continuous improvement, and it was confirmed to the review at the Practice Learning Event by the Learning Disability Team that any *'pica type'* incident is now risk assessed and considered as part of comprehensive safety planning by the Integrated Care Board and Health Partnership (CWP). This forms part of a reviewed screening process which also considers the needs of adults at risk who also have dementia. Safety

planning for younger adults at risk now ensures that children's services are involved at an earlier stage in transition planning to ensure clarity of communication and more effective joint planning.

5. Section 42 Safeguarding Enquiries

5.1 Records indicate that the first Section 42 Enquiry commenced on the 8/12/20 and was completed by a Senior Practitioner from the Community Learning Disability Team and a Complex Case Manager from the Integrated Care Team. This was entirely appropriate, in accordance with statutory guidance and involved a senior officer who was independent from service delivery and line management responsibilities. The enquiry concluded on the 4/3/21.

5.2 The enquiry also concluded that R had ingested a number of inedible items which had caused a bowel obstruction requiring emergency surgery, but that it was not possible to determine when this had taken place. There were a number of settings where R had attended including college, short break care and outreach provided by Provider1. R had also recently left school prior to attending college.

5.3 The enquiry was subject to multi-agency oversight including senior officers from Police, Learning Disability and Mental Health, Commissioning, Adult Safeguarding and the NHS Integrated Care Team. The documentation is comprehensive and takes into consideration R's specific needs, making a number of recommendations including continuous oversight and supervision, the reviewing and updating of risk assessments and consideration of issues relating to Deprivation of Liberty in a Domestic Setting. Submissions were provided by a number of agencies including School, College, Police, the NHS Integrated Care Team and the Local Authority. *R's parents were also consulted with during the process and who acted as his advocates, consistently representing his best interests.*

5.4 The enquiry concluded that R had ingested non-edible items that compromised his physical and emotional well-being, although it was not possible to identify precisely when this had taken place. This was an appropriate conclusion.

5.5 The second Section 42 Enquiry commenced on the 12/4/21 following the second emergency surgery. This was subject to multi-agency oversight in line with statutory guidance and involved practitioners and senior representatives from the NHS Integrated Care Team, Local Authority, Community Learning Disability Team, Provider 1, Provider 2, R's College Trust and Commissioning Services.

5.6 The enquiry considered the daily logs from the supported accommodation during the week when R had two introductory overnight stays and Provider 1 carers were interviewed. None of the records suggested any concerns regarding R having had access to PPE or attempting to put any item of PPE in his mouth and all confirmed that R was continually supervised during his stays. It was

confirmed that Provider 1 carers were interviewed directly by the Senior Practitioner undertaking the safeguarding enquiry.

5.7 As referenced earlier the enquiry concluded that whilst the ingestion was likely to have occurred within the timeline provided by R's parents, the precise date and time could not be identified. However, the enquiry notes; *'I can state that this will have taken place when receiving paid and formal support and constitutes an act of omission' (pg 17).*

5.8 The enquiry made a number of recommendations including a review of the care and supervision arrangements for R, the submission of an application for *Deprivation of Liberty in a Domestic Setting Authorisation*, a referral to the Safeguarding Adults Board which resulted in the commissioning of this review and; *'a roots cause analysis (RCA) to be completed by the (then) CCG (now ICB) regarding risk mitigation/risk assessment and associated processes' (pg. 19).* In addition, following R's second admission to hospital service provision from Provider 1 was immediately suspended and has not been reinstated.

5.9 Whilst Mr and Mrs H have asserted that the safeguarding enquiries evidence a lack of professional curiosity and were insufficiently independent, this cannot be supported. There is no requirement in statutory guidance for enquiries to be progressed by an entirely independent agency and both processes had been undertaken by the Complex Case Manager *and* a senior officer who had not been involved in the commissioning of any support services and therefore had no line management responsibilities. In that sense the Section 42 Enquiries contained a greater degree of independence than would ordinarily be expected.

5.10 The enquiries considered a significant amount of information, consulted with all the relevant agencies, particularly the care providers, and recognised the concerns that Mr and Mrs H had voiced, particularly where this related to the timeline provided. The process was subject to multi agency oversight with all safeguarding partners agreeing with the outcome. Importantly, the conclusions of the enquiry recognised that; *'on the balance of probability R has ingested the rubber glove in close proximity to when he showed and displayed signs of discomfort/vomiting/constipation,'* although the precise date or time could not be identified.

5.11 Given these findings and a review of the process it cannot be concluded that either enquiry lacked sufficient independence, rigour or demonstrated a lack of professional curiosity. However, information from a number of sources suggested that clarity regarding the process and outcomes may not have been effectively communicated to R's parents. This may have resulted in some uncertainty regarding professionals being unsure of what could be discussed with Mr and Mrs H, who parents felt they could talk to and what they could discuss and clarity regarding the rationale for the conclusions of the enquiries.

6. The transparency of the relationship between the Integrated Care Team and the care providers, namely Provider 1.

6.1 R's parents were of the view that the boundaries between the Integrated Care Team and the care providers had become blurred. In addition, they were of the view that there was little transparency and accountability specifically with regards to the commissioning process. Given these concerns there are a number of factors that merit further exploration.

6.2 Firstly, whilst Provider 1 had originally been providing outreach and day care for R prior to the supported accommodation initiative, this would have been an advantage particularly given that there will have been carers who R would have been familiar with. As consistency familiarity and predictability are key features of appropriate care for R, the commissioning of Provider 1 to provide a more bespoke package of care, involving a transition to supported living, will have carried distinct advantages. This will have ensured that as far as possible R will have had some continuity regarding his care.

6.3 Secondly, the proposals for the supported living arrangements were seen as being person centred, bespoke and designed around the needs of R, his twin brother M and two other siblings with complex care and support needs. It was described as an *'innovative, brave and exciting'* new project which was subject to oversight and scrutiny from the three main sources of funding, namely the Local Authority, Continuing Healthcare and Education. Given that funding was trip-partite, all the key financial stakeholders will have had to have been reassured that the tendering, commissioning and delivery processes were free from any pecuniary or conflict of interests. The commissioning process was subject to a multi-disciplinary resource and Panel process which provided independent scrutiny and oversight.

6.4 Thirdly, as both families knew each other this contributed to a more cohesive and family-oriented approach in the design of the support package. Again, this took into consideration the need for familiarity and predictability for R which would reduce the potential for any distress, discomfort or anxiety. Information provided to this review has indicated that the other siblings have remained at the project. Provider 1 have also reported to this review that their progress has been *'amazing'*

6.5 Fourthly, It was important to consider whether the plan for R and his sibling wasn't sufficiently differentiated enough. This raised a question as to whether specific needs and risks for R had been subsumed into a wider set of assumptions regarding the appropriateness of the package of care for both siblings and whether any *'overarching'* risk assessment for both R and M failed to make more subtle distinctions. This issue has been referenced earlier, in terms of risk mitigation and whether risk assessment for one sibling may have been unnecessarily restrictive for the other twin. There was insufficient evidence however to conclude that the proposals for supported living lacked the necessary distinctions.

6.6 Mr and Mrs H have also raised concerns regarding an *'insular management structure'* at Provider 1. *'They are all friends or siblings/children of friends who have known each other for years…this makes for a too-close management structure of the company, and they would all find it difficult to challenge each other if they had to.'* Whilst it is not within the key lines of enquiry to examine the nature of the relationships between support staff it must be noted that there is nothing within statutory guidance or legislation that precludes support services being commissioned from providers who employ extended family members or acquaintances outside of work. The defining feature must be in respect of the quality of the services provided, a transparent and defensive recruitment policy which is compliant with safer recruitment principles, Care Certificate Standards, NICE guidelines and a person-centred approach. It was also confirmed that no concerns had been raised regarding recruitment or in relation to provider 'safe culture' during the fortnightly review meetings involving the ICB and the CWP.

6.7 Mr and Mrs H have also alleged that there were a number of occasions when caring staff have; *'fallen asleep whilst providing waking night support (Provider 2) arriving late for shifts (Provider 2), providing different carers resulting in inconsistency (Provider 1), a lack of confidence managing R's behaviours (Provider 1) and taking smoking breaks whilst on shift resulting in the smell of tobacco in the house'*. Whilst a number of these issues relate to Provider 2 and not just Provider 1 there is evidence that these matters were raised by parents and addressed by the Complex Case Manager at the time with the relevant provider heads. There are also a considerable number of records from a variety of sources which note that the quality of care and support services, multi disciplinary working and co-ordination of provision was extremely high. A summary notes; *'the quality of practice has demonstrated that care and support has been person centred and of a quality standard which is demonstrated within the clinical documentation' (CWP).* However, Mr and Mrs H have refuted this conclusion and raised a concern that the quality of care has been extremely poor. It has also been confirmed that the concerns raised by parents were responded to in 'real time' by the Complex Case Manager and formed part of the regular reviewing process. There is also evidence, provided by Provider 2, which indicates that all instances where concerns were raised by parents were responded to in a timely manner and, where appropriate, employment was terminated. Both Providers reported that there had been consistency in cover and that the same Provider 2 staff continue to support R

6.8 I cannot conclude therefore that the relationship between the NHS Integrated Care Team and the care providers were characterised by blurred boundaries or that pecuniary interests were present during the commissioning process which had not been declared. Whilst Mr and Mrs H had raised concerns regarding the quality of care provided by Provider 1 and specifically the nature of the relationships *within* the agency, this is a separate issue.

7. The appropriateness of the behaviour and interactions of the caring staff from Provider 1.

7.1 Mr and Mrs H have raised concerns regarding a number of issues relating to the interactions of the caring staff with their son. These have included '*sexually inappropriate behaviours from some of the female middle-aged carers…a very senior person always 'blew kisses'…R was taught to blow them back…another 'senior person' told R 'how attractive he was' and was physically hugging him… during a trial day at supported living a carer reported that R had a wonderful time and that there had been lots of hugs and kisses'*.

7.2 Mr and Mrs H reported that they were concerned that their son would repeat this behaviour with other residents or members of the public and that the issues were *'played down'* and not acted on. Mrs H reported that the Complex Case Manager at the time had advised that; *'a safeguarding alert ought to have been raised but that we had enough on our plates.'* Mr and Mrs H have suggested that this was an attempt to divert attention away from the gravity of the issues.

7.3 Given these concerns there are a number of points which merit further consideration.

7.4 *Firstly*, whilst there are no records in any of the chronologies or individual agency reports which report these concerns, there is evidence of e-mail exchanges from the Complex Case Manager to Mr and Mrs H which followed a meeting with both parents to discuss their concerns. This notes; *'following the meeting this morning and the issues raised, I have written to Provider 1…you were absolutely right to raise this and please don't worry that you are upsetting people… I await a response from Provider 1' (24/3/21).*

7.5 A further e-mail to Provider 1 notes; *'I was somewhat shocked at the meeting with Mrs H this morning regarding her discomfort at how some of the female* Provider 1 *Support Workers are behaving with the twins…I have to insist that you conduct training as soon as possible with all support staff as to what is appropriate when supporting individuals with a Learning Disability/Autism' (24/3/21).*

7.6 This e-mail is comprehensive and addresses a number of concerns relating to professional boundaries and *'boundary violations'* such as *'hugging and kissing'*, a concern that R's twin brother had been asked to *'blew kisses back at a carer'*, the inappropriateness of certain types of contact, such as *'hand and scalp massage'*, especially without clear risk assessment and that caring staff should be able to provide warmth, care and affirmation without resorting to these behaviours. The e-mail make clear suggestions at to what training needs to take place, what elements need to be addressed and advises that this is progressed as soon as possible.

7.7 There is therefore unambiguous evidence of professional challenge to the provider regarding a number of issues that R's parents had raised.

7.8 *Secondly*, there is evidence to suggest that training would be provided by the Cheshire and Wirral Partnership NHS Foundation Trust (CWP). Information to this review from Provider 1 notes; *'as per guidance the training was initially*

supposed to be delivered from the CWP but then we were advised we needed to de-brief and meet with all of the staff… management met with the staff between 18th and 22nd June 2021'. Whilst there is no specific guidance which states that the CWP were statutorily required to deliver this training, it did not take place until 3 months later. Given that the training was required to have taken place *'as soon as possible with all support staff'* as per the e-mail of the 24/3/21, this is too long given the nature of the issues raised and the ongoing nature of the work in supporting vulnerable people. Provider 1 has reported that as soon as it became apparent that CWP were not going to deliver the training, in-house training and professional development took place.

7.9 Mr H reported that he had requested evidence that the training in relation to these issues had been delivered which was not responded to. Whilst the review could not identify any written evidence which supports this, the lack of clarity regarding the training provider may have contributed to a lack of responsiveness. However, this is speculative although clarity needed to have been provided to R's parents regarding the dates of delivery and the training provider.

7.10 The review cannot conclude therefore that the issues that R's parents had raised were not responded to, although given the nature of the concerns professional development and training needed to have taken place much earlier than the 18th June 2021. There is no evidence that the Complex Case Manager had not wanted to raise a safeguarding alert due to his concerns that this would be *'too much'* for the family or that *'they had enough on their plates.'* The e-mails to the provider are comprehensive, challenging and are clear regarding the importance of professional boundaries, *'boundary violations'* and risk assessment. In that sense concerns were responded to in a timely and proportionate manner.

7.11 I also cannot concede that the matters raised by Mr and Mrs H would have required a safeguarding alert. They did require a response which was provided, and internal professional development was delivered, albeit a number of weeks later, which addressed the importance adherence to professional standards. This is not to diminish the importance of these concerns for both R and his parents. It locates the response in a more proportionate and appropriate context, and which delivers a measurable outcome.

8. Learning from a Previous Case

8.1 It was important for the review to consider the learning from a previous case which was in relation to the death of a woman D with a significant learning disability, who was cared for in a residential home and who was in receipt of 1:1 care. Whilst D displayed some *'pica type'* behaviours no formal diagnosis of pica had been confirmed. There was therefore a similarity between this case and that of R as some *'pica type'* behaviour was evident.

8.2 There had also been a previous incident where D had placed a non-food item in her mouth. This incident was not escalated, or risk assessed.

8.3 During January 2020 and following D becoming unwell and rapidly deteriorating she died. A post-mortem examination revealed a plastic glove in her stomach. However, the Coroner concluded that on the balance of probability this did not contribute to her death which was from sub-acute bowel obstruction caused by a hernia and linked to previous surgery.

8.4 As part of a Regulation 28 Report issued to the Local Authority, the Coroner raised three concerns to be responded to. These included i) *'gloves in open and accessible locations throughout the home, including rooms and the kitchen area' ii) an earlier incident which was not risk assessed or escalated and iii) No regular use of sensors to alert staff that a resident is wandering.'* Agencies provided the following responses in relation to these three issues.

8.5 It was agreed that as part of ongoing service improvement that when risk assessments are indicative of a potential concern regarding the ingestion of inedible items a number of safety measures would be adopted. These included the use of locked cabinets and support staff signing in and out the numbers of gloves, which are retained on the carer's person. It also included carers carrying hazardous waste bags as opposed to hazard bins in people's rooms, which would ensure safe and immediate disposal in accordance with infection control measures *(Trafford Council Response 29/11/20).*

8.6 It was also agreed that any reported incident regarding the ingestion of non-edible items is escalated to the registered manager of the service and that risk assessments are duly updated where necessary *(Trafford Council Response 29/11/20).*

8.7 However; *'the prescriptive use of sensors could not be routinely provided, as there may be implications pertaining to a person's right to liberty (Article 5 EHCR) without a bespoke assessment of need and capacity'. (Trafford Council Response 29/11/20).*

8.8 Whilst no further incidents of this nature had been reported, which indicated positive progress in these areas, the review into the circumstances surrounding R's care and supervision has identified a number of learning points which bear some similarity to this case. These have included; i) the importance of safe PPE storage and use and eliminating their accessibility for adults at risk; ii) the importance of responding to any instance of *'pica type'* behaviours which inform risk mitigation plans which are appropriately implemented and monitored and; iii) the importance of timely professional development for caring staff. It is these factors which have informed the recommendations for this review.

8.9 Mr and Mrs H have raised a concern that R was admitted to hospital within days of the publication of the response to this Regulation 28 Report and which made a commitment to the issues identified. They have reported that, had the agency implemented the recommendations contained in the report, there would not have been a second hospital admission involving the ingestion of a surgical glove. However, it is clear that the learning from the Regulation 28 Report was

cascaded to officers, support staff and commissioners across the partnership, as part of ongoing learning and development. In addition, these learning points formed part of *Adult Safeguarding Week*, a professional development initiative to raise awareness and promote learning.

8.10 The differences in relation to this case are that whilst R was in receipt of 24-hour care and supervision, he was cared for in a number of settings. These included home, college, supported living and short break provision. This added a layer of complexity regarding his access to non-edible items and suggested that there were a range of locations which may have provided an opportunity for ingestion. In addition, there were two caring agencies which were providing support. R's responses were also described as *'opportunistic'* and *'lightning fast*,*'* which suggests that even with a momentary lapse in concentration on behalf of his carers he may have availed himself very quickly of any non-edible item.

8.11 It is also clear that concerns were raised by carers that R's brother would give him items and that there were occasions, reported by both caring agencies, when R would be chewing non-edible items and whilst in the presence of his parents. Both caring agencies and parents reported their concerns regarding surgical gloves being left out in the home and this is particularly concerning given the concerns identified in the case of D. However, it is extremely difficult to conclude precisely where responsibility for this lay. Photographs supplied by R's father clearly indicate that boxes of gloves were left out in the kitchen of the supported living accommodation and placed on the microwave. These issues were raised with the Complex Case Manager by parents and informed a decision to undertake an audit of how items were stored. This concluded that items such as surgical gloves were not left on shelves or were visible during the hours when residents were in the property and that when residents were present in the property surgical gloves were stored in draws.

8.12 Whilst risk assessments were updated when events took place and there is clear evidence that carers and staff were regularly reminded to be vigilant and to adhere to relevant safety planning, there were instances when R ingested non-edible items and that this was when paid or formal support was being provided. This would suggest that the concerns identified in the case of D have not been sufficiently embedded into the day-to-day practice of caring agencies.

8.13 The particular serious and life-threatening incident when R ingested a surgical glove raises concerns regarding appropriate supervision and observation. The difficulty has been identifying precisely when this took place and therefore where accountability lay. Whilst the Section 42 enquiry concluded that it was likely that the ingestion occurred within the timeline provided by Mr and Mrs H, there is also the possibility that the ingestion *may* have occurred some time before this with symptoms of discomfort not taking place until days or even weeks later. This has some resonance with the case of D who had died due to an unrelated matter, despite the post-mortem identifying the presence of an ingested surgical glove but which the Coroner concluded had *not* contributed to her death. This is not to diminish the gravity of these matters for R and points

to the continued importance of agencies risk assessing and ensuring the ongoing safety of adults who are at risk from the ingestion on non-edibles.

8.14 It is encouraging to note that screening processes now consider any *'pica type'* incident, regardless of formal diagnosis and this informs risk assessment and safety planning. However, the importance of safety planning for adults who are at risk from *'pica type'* behaviours remain the foundational issue in this case.

9. Recommendations

9.1 That where *'pica type'* behaviours have been identified as a risk, for all involved agencies to ensure that any risk assessments, particularly those which take into consideration PPE storage and accessibility, different *'caring contexts,'* different locations and different sets of carers, are both read understood and implemented.

9.2 That where *'pica type'* behaviours have been identified as a risk, for agencies to regularly communicate to staff and carers the importance of vigilance, continued observation and appropriate supervision.

9.3 That where professional development has been agreed following particular concerns or incidents and which have taken place in a particular setting, that this is delivered in a timely manner by the relevant agency.

9.4 For strategy meetings in relation to Section 42 Enquiries to clarify how families will be communicated with regarding process and outcomes,

9.5 For the learning from this review and the previous case *(D)* to be disseminated across the partnership as part of continuing professional development.