Ms A

1. Introduction

This summary report was presented to the Redbridge Safeguarding Adults Board on 26th June 2018. The Board agreed all the recommendations.

This Safeguarding Adults Review was commissioned by the then Chair of the Redbridge Safeguarding Adults Board (SAB) in June 2016, following the events outlined in Section 2 below. Pauline Brown, a former Principal Officer and Head of Adult Safeguarding in LB Redbridge Adult Social Services, was commissioned to produce an independent report on the case.

Ms Brown submitted her report in November 2017. Agencies involved in the case were then given an opportunity to identify what they believed to be any factual inaccuracies in the report. In this process, a number of discrepancies were identified between the information that the independent reviewer found in the records to which she had access and the information reported by NELFT following their subsequent scrutiny of the records. Ms Brown declined to reconsider her report on the basis of the corrections suggested, which has meant unfortunately that it has not proved possible to arrive at a fully agreed statement of the facts. However, the key themes are clear and not substantively affected by the detail of the NELFT comments. There is little prospect, without substantial further delay, of arriving at a final report which could be accepted as providing a fully accurate account of the events of 2008 – 2014. The events are too far in the past, too many of the individuals directly involved are no longer available to contribute, too many records are not available, and too many organisational changes have happened since to make this possible. There have also been legislative changes. The really important thing now, and without further delay, is to identify the key lessons to be learned, and to act on them.

A SAR Panel, with representatives from NELFT, the CCG, and the voluntary sector, and chaired by the independent chair of the Safeguarding Adults Board, met on 23rd April 2018 to consider Pauline Brown's report and the suggested corrections from NELFT. Ms Brown was unable to attend. The Panel agreed this report as a summary of the findings and conclusions of the review to be presented to the Safeguarding Adults Board.

2. Circumstances giving rise to this Safeguarding Adult Review (SAR)

An ambulance was called to a Supported Housing Unit in Ilford on 7th January 2014, after what was described as an accident involving Ms A who was found to be in a state of undress, unconscious and had stopped breathing. In attendance when the ambulance and paramedics arrived were two care workers ('D' and 'C') who reported that Ms A had fallen in the bath whilst alone and had been found with her head in the water by 'C' who was alone on duty at that time.

When they arrived the paramedics called the police. When the police arrived, they arrested 'C' who was taken into police custody on suspicion of working under the influence of alcohol and drugs.

According to her statements, 'C' was alone caring for Ms A, who she had left in the bathroom whilst she went to collect her bedclothes. She stated that she heard a thump and went back

in to the bathroom and found Ms A face down unconscious in the bath. 'C' had tried to revive her, and when she was not successful called her back up care worker 'D'. She later admitted taking cannabis earlier that evening.

The incident happened at 9.15 pm. 'C' called 'D' at 9.38 pm. The call lasted over five minutes. An ambulance was then called by 'D' at 10.06pm.

'C' told police she thought Ms A was unconscious but that she tried to revive her in a number of ways for example by slapping her face, and then started a series of chest compressions before calling 'D' for help. She continued to try and revive Ms A until 'D' arrived who, it appears, took over and continued to do the same. It was then that the ambulance was called at 10.06pm.

There was a lengthy investigation into Ms A's death and a number of pathology reports were produced. However, pathologists were unable to determine the cause of death or to attribute it to any actions on the part of 'C'. At the inquest the Coroner therefore recorded a verdict of death from uncertain causes.

However, the Crown Prosecution Service concluded that: -

"the deliberate failure of 'C' to call an ambulance between the last loss of consciousness until 'D' called one at 10.06pm is evidence of wilful neglect in that it was a decision made deliberately knowing that there was some risk to Ms A's health who would suffer unless she received emergency treatment or made with reckless indifference to the risk…Consequently a charge under s44 Mental Capacity Act 2005 should be laid."

'C' was charged under Section 44 (1) and (2) of the Mental Capacity Act with wilfully neglecting a person lacking or believed to be lacking capacity. On 8th February 2016 she pleaded guilty to the charge and was sentenced to a 19-week term of imprisonment. According to the independent reviewer, it was stated in court that that she had a history of shop lifting and abuse of cannabis and alcohol.

3. Analysis and Findings

3.1 Ms A was a woman with severe learning disabilities, aged 54 at the time of her death in January 2014. From November 2011 until her death she lived in a Supported Living flat. However, her care and support needs were met, not by the Supported Living provider, but through a Direct Payment which funded a 24 hour package of live-in support. This was fully funded by the Redbridge Clinical Commissioning Group (CCG) under Continuing Health Care arrangements. Ms A had exhibited very challenging behaviour from an early age. She also had a number of physical health issues and conditions.

3.2 Prior to this placement, Ms A had lived since 1989 in a series of Learning Disability Hospital, care home, and assessment unit placements, funded throughout under NHS Continuing Health Care. From around 2009, Ms A's family were increasingly unhappy with the care she was receiving. In July 2010, a safeguarding alert was raised following an allegation by a member of staff in the care home in which she had lived since 2008 that her money was being misused by her key worker. The investigation was inconclusive and led to no further action. A suffered a severe burn in April 2011, in the same care home, which was the subject of a safeguarding investigation by the police. This did not however establish any liability on the part of the care provider. Following this incident, Ms A's family refused to allow her to return to the placement following hospital treatment. She spent a short time in another care home but this

home was due to close. The Direct Payment arrangement was then put in place at the request of Ms A's family. The independent reviewer felt that this arrangement was made in something of a crisis situation, in response largely to pressure from a family who had been extremely critical of the care Ms A received over an extended period. The reviewer suggests that this may have meant that the arrangement was made without fully considering whether it was an appropriate response to Ms A's very specialist needs. One of the conditions of eligibility for a Direct Payment is that the local authority considers it an appropriate way of meeting the person's eligible needs. The Council's Cabinet agreed a revised Direct Payments policy on 6th March 2018, and this condition is referenced in that policy. However, given the rightful presumption that people should have as much control over their own care as possible, with as limited restriction on that autonomy as possible, it would be helpful for staff and decision makers if the policy included more specific guidance on the limited circumstances in which a Direct Payment might be considered not to be an appropriate way of meeting somebody's needs.

3.3 The events of 2011 need to be understood in a context of a shortage of appropriate care provision for people with the most complex needs and challenging behaviour, able to respond effectively at points of crisis. The Panel was also concerned about the pressure and potential isolation of front line practitioners striving to respond effectively in such circumstances, and emphasised the need for them to be effectively supported in this challenging area of work.

3.4 Ms A's sister, 'J', had Deputyship through the Court of Protection and had the power to make all financial decisions on Ms A's behalf. She was responsible for the management of the Direct Payments budget. The care plan at the point of placement in November 2011 was that care would be provided on a shift basis by five different workers. However, within three months four of the workers had left, and all care at that point was being provided by a single worker, 'D', who had previously been Ms A's key worker in the care home in which she lived from August 2008 to her admission in hospital for treatment of the burns already referred to. 'D' persuaded 'J', 'A's sister, that a colleague from this care home, 'C', should be employed to join her. After a short period of time, they were the only two care workers employed to work with Ms A. By at the latest November 2013, it was clear from the record of a social care review carried out that month that there were only two care workers providing 24 hour, seven day a week care for Ms A, and that they each worked alone. Also, 'J' reported to the independent reviewer that within a short time of this becoming the arrangement, she was convinced by the care workers into signing a blank time sheet which allowed them to photocopy her signature and complete their own time sheets. She also told the independent reviewer that 'D' had suggested she set up a limited company, which she did, through which 'D' could be employed to care for Ms A. However, it appeared to 'J' that when 'D' realised that would not have direct access to any cash payments that she lost interest in this venture.

3.5 The independent reviewer did not see in the records she examined any evidence of a care plan, support plan, personal health plan, or risk assessments for Ms A during the period in which she was supported by Direct Payments. However, NELFT report, following their scrutiny of the records following receipt of Pauline Brown's report in November 2017, that there is a record of a support plan dated 15.9.11, a note that a Health Action Plan was completed in May 2012, and risk assessments documented in care reviews in September 2011, November 2011, and March 2013. However,

there has been no evaluation of the quality of these plans and assessments. The reviewer also found no record of any activity or community engagement as part of any care and support plan or facilitated and supported by her carers. NELFT's scrutiny of the records suggests some limited discussion of social club opportunities in 2012. The independent reviewer reports that it emerged in the police investigation that that much of the care workers' time was spent on the phone, and comments that "this could only mean that Ms A was left, at least for the most part, with very little to do in the way of activities."

3.6 In spite of these discrepancies, there appears little doubt that from the outset of Ms A's placement in her flat, the quality of care was extremely poor; that the substantial risks to her welfare created by the care arrangements were not identified and addressed; or that 'J', even though over time, as she told the independent reviewer, she came to feel blackmailed and threatened by 'D' and 'C' on the issue of allowing them to complete their own time sheets under her photocopied signature, did not feel able to raise her concerns with professionals or resist the demands of the care workers as she feared that this would lead to Ms A's care being jeopardised. It is agreed that annual social care reviews took place throughout the period 2011 to 2013, but the review process does not seem to have identified or addressed any of these issues.

3.7 Although Ms A's care was fully funded by the CCG, professional ownership sat with the Learning Disability Team, a multi-agency service provided through a Section 75 partnership agreement between LB Redbridge and NELFT, and managed by NELFT. (Since April 2016, these services have been provided as part of the integrated health and social services (HASS) partnership between LBR and NELFT, and delivered through the four HASS localities rather than as a single borough-wide service.) A had an allocated social worker within the LD Team from March 2011 to October 2012, but the social worker closed the case on 17th October 2012, informing the family of this in a letter dated 8th February 2013 and advising them that they could access further support if needed by contacting the Learning Disability Team. The independent reviewer described this as meaning Ms A's case was 'effectively closed to the learning disability service'. This is a slight misunderstanding, as a number of professionals within that service continued to engage from time to time with Ms A's care – psychologist, speech and language therapist, community nurse, occupational therapist, physiotherapist, and reviewing officer. NELFT have confirmed that Ms A's case was open to the Learning Disability Team continuously from August 1997 until her death.

3.8 However, it does not appear that these different roles and interventions were co-ordinated as part of an overall plan, or were clear to or understood by 'J'. Crucially, there does not appear to have been any individual whose role was to coordinate the provision and oversight of Ms A's care, or with the primary responsibility for understanding her daily lived experience. As a result, neither the inadequate nature of the care being provided, nor the increasing stress on 'J', who was simultaneously having to cope with a range of serious health and other personal difficulties, were understood or addressed.

3.9 No one individual clearly had the role of Care Co-ordinator. The guidance on direct payments for healthcare (2014, updated in 2017) is very clear that there must be a Care Co-ordinator named by the CCG, and that their responsibilities include:

- managing the assessment of the health needs of the individual as part of the care plan
- ensuring that the individual, or representative and the CCG have agreed the care plan
- undertaking or arranging for the monitoring and review of the direct payment, the care plan and the health of the person
- and liaising between the CCG and the person receiving the direct payment.

These requirements were not met in Ms A's case.

3.10 Although NELFT's comments suggest that there were a number of discussions with 'J' in which it was explicitly stated that the NHS was fully funding Ms A's care, and professionals may have assumed that this was understood by her, it is clear from what 'J' told the independent reviewer that in fact the family assumed throughout that the local authority had full responsibility for Ms A's care. Even between professionals, no record has been identified which sets out clearly the respective roles and responsibilities of the different agencies involved. As the Learning Disability Team was a multi-agency health and social care service, delivered under a Section 75 agreement, this may have seemed unnecessary to the professionals involved. However it has been confusing for the family and made the failures in Ms A's care even more difficult to understand or to attribute responsibility for. Assurance is needed that there is greater clarity about responsibilities under the current and broader health and social care partnership arrangements now in place.

3.11 It follows from the agreement of NHS Continuing Care funding in 2008 that Ms A was assessed as having a 'primary health need'. However, as stated by the independent reviewer:

> What does not appear to have been considered by professional agencies with the family, or indeed by the family themselves, was the fact that Ms A's level and type of needs were highly complex and unpredictable. This required highly skilled input, and anyone with responsibility for her day to day care, who did not have these skills, would need significant support from people with the appropriate expertise available to support them. The family required this as they had not had the full responsibility for Ms A's general care for twenty years, and the person taking responsibility was now the younger sister. It was also clear from the outset of their involvement that neither the family nor the employed care workers had the professional medical skills or knowledge to cope with Ms A's complex health needs without the appropriate ongoing supervision.

3.12 There appear to be no records available of the support provided to 'J' by the Direct Payments Support Service which at the time of these events was outsourced to an independent provider. It is not clear if DBS checks were ever completed on 'C' or 'D'. The revised Direct Payments Policy agreed by the Council's Cabinet on 6th March 2018 is slightly ambiguous on this issue. The policy itself refers to DBS checks as mandatory:

> 'The DBS check must be undertaken if the PA has unsupervised access to the person they are caring for. PAs who have unsupervised access to recipients must have and be able to disclose on request a current enhanced DBS check….The recipient or their authorised/nominated must ensure that an

enhanced DBS check is undertaken when employing a person who will have unsupervised access to children, young people or adults in the course of their work.'

The Direct Payments agreement template however expresses this requirement as a recommendation:

> Redbridge Council recommends that all prospective employees undertake an enhanced Disclosure and Barring Service (DBS) check, before you employ them.

It does not appear to be a condition of the payment.

3.13 The independent reviewer takes the view that:

> There is always the possibility Ms A's death could not have been prevented as the cause of death was never ascertained even though real efforts were made to do so. None-the-less, the guilty outcome of the prosecution of 'C' as the care worker present at the time of Ms A's passing and the very strong suspicion on the part of the police and the family that the circumstances around her death clearly indicated at the very least a serious level of foul play contributed to her demise.

The Board should not however accept this conclusion. The conviction of 'C' did not allege any foul play and the reference to 'serious suspicion' and any grounds for it are not evidenced. While it is clear that there were serious issues about the quality of care and the quality of professional oversight, and that there was criminal wilful neglect in 'C's' response to her discovery of Ms A on the night of her death, there is no evidence that the death itself was the result of "at the very least a serious level of foul play".

4. Learning and recommendations for action

The purpose of a Safeguarding Adults Review is "to promote effective learning and improvement action …. not to hold any individual or organisation to account." (Care Act Statutory Guidance).

This case highlights serious failings both in the quality of care and the quality of professional oversight. While these failings cannot now be rectified in the case of Ms A, the critical assurance that the Board needs is that these failings would not be repeated now. The Board are recommended to endorse the following as the key learning arising from this review, with associated recommendations for action:

Learning points	Recommendations for action
1. Most fundamentally, the review highlights the absolute importance of effective co-ordination and review of the care arrangements in place for people with the most complex needs and vulnerabilities. This is true, not only for those receiving self-directed support (although as this case shows there are potentially specific risks	i. NELFT and LBR should jointly review the arrangements in place to identify those service users with the most complex needs and vulnerabilities and to ensure that for each person there is a named professional responsible for the effective co-ordination and review of the care arrangements in place.

and vulnerabilities in such situations), but in all care settings.	
2. Specifically, where care is funded by NHS Continuing Care, it is vital that arrangements for care co-ordination are explicit, recorded, and very clearly communicated to service users and families; and that robust arrangements are in place for meeting the primary health care need(s) which are the basis for Continuing Care eligibility in the first place.	ii. The CCG should review all current cases of Redbridge residents whose care is funded by NHS Continuing Health Care, to ensure that effective and explicit care co-ordination and robust arrangements for meeting primary health needs are in place.
3. Reviews must not become simple checklists. They must concentrate on understanding the lived experience of the service user, and be conducted in a way that facilitates and supports both service users and families to express their concerns and worries.	iii. LB Redbridge should review its guidance and procedures on care reviews to ensure that the review focuses on the lived experience of the service user and is conducted in a way that facilitates and supports both service users and families to express their concerns and worries.
4. Where there are complexities of funding and different professional responsibilities, clarity between professionals, and between professionals and service users and families, is essential. Professionals must not assume that simply informing service users and families is sufficient to ensure understanding. 5. There are risks to making long term care arrangements in a crisis and / or in response to pressure, which must be carefully considered and balanced before decisions are made. The welfare and needs of the service user must be the first consideration at all times.	iv. The HASS Management Team should consider how most effectively to disseminate this learning through all multi-disciplinary teams
6. There was at the time of these events (2011) a shortage of appropriate care provision for people with the most complex needs and challenging behaviour, able to respond effectively at points of crisis, and Panel members reported that this continues to be the case.	v. LBR and the CCG should ensure that they address this issue in the development of joint commissioning strategies, in particular the draft Strategic Commissioning Framework for People 2018-2013 considered by the Council's Cabinet on 6th March 2018.

7. For service users with the most complex needs and vulnerabilities, there are significant risks and challenges as well as substantial benefits in the use of Direct Payments	vi. LB Redbridge should consider whether the completion of enhanced DBS checks on people employed by Direct Payment service users should be a condition of such payment; whether there should be more specific guidance on the limited circumstances in which the local authority might consider that a Direct Payment is not an appropriate way to meet a person's needs; and whether there is sufficient guidance and support available to enable service users with the most complex needs and vulnerabilities (or authorised / nominated persons acting on their behalf) to manage their care effectively.

5. Recommendations to the Safeguarding Adults Board

It is recommended that the Board:

1) Record its appreciation to Pauline Brown for her work on this review.

2) Express its sincerest condolences to Ms A's family for the sad death of Ms A, and in particular records its appreciation of J's willingness to contribute to the review through her engagement with Pauline Brown; and that the Chair should write to her accordingly with a copy of this report and of Pauline Brown's report including the suggested factual accuracy corrections from NELFT.

3) Acknowledges that Ms A suffered from serious failings in both the quality of care and the quality of professional oversight, which are detailed in this report.

4) Agrees that it is not possible however to identify any evidence that these failings contributed to her death on the evening of 7th January 2014, the cause of which remains uncertain.

5) Endorse the recommendations for action (i) to (vi) above, and request the relevant agencies identified to report back to the Board in October 2018 on the outcomes of their considerations and any actions taken