Luton
Safeguarding Adults Board

Safeguarding Adults Review
Mr B

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1. Introduction

In March 2018 the East of England Ambulance Service conveyed an 87 year old (white British male) Mr B from a local care home to hospital. As a result of what they saw and heard they made a safeguarding referral to Adult Social Care.

1.1 This led to a Care Act 2014 section 42[1] enquiry being undertaken. This section 42 enquiry concluded in September 2018 that Mr B suffered neglect and acts of omission whilst in the Care Home. On review, an additional, bespoke section 42 enquiry, was commenced in March 2019. This was not in replacement of the original enquiry but to consider additional lines of enquiry and information and the two are identified for consideration in tandem.

1.2 Mr B was a vulnerable adult who had been in receipt of rvices from a number of agencies. The Luton feguarding Adults Board independent chair agreed that ese circumstances reached the requirements for a Safeguarding Adults Review as set out in the Care Act 2014.

2. The Review Process

The author of this report was commissioned to undertake the review in line with guidance set out in the Care Act 2014. The independent reviewer is Brian Boxall, a retired Detective Superintendent who served in Surrey Police for 30 years. Since his retirement, he has been an independent safeguarding consultant who has undertaken a number of serious case reviews, in relation to both adults and children. He is currently the independent chair of a couple of Safeguarding Adults Boards.

2.1 Methodology

Terms of Reference were produced and agreed (Appendix A). The following agencies were identified as having a significant involvement with Mr B and the Care Home and produced Individual Management Reviews (IMR's)

- Luton Adult Social Care
- Cambridgeshire Community Services
- General Practice (GP)
- Bedfordshire Police
- Ambulance Service

2.2 The Clinical Commissioning Group commissioned a review of the palliative care provided to Mr B. This was made available to the author.

[1] The **Care Act** 2014 (**Section 42**) requires that each local authority must make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect. ... When an allegation about abuse or neglect has been made, an enquiry is undertaken to find out what, if anything, has happened

2.3 The Care Quality Commission provided information to the author.

A Safeguarding Adults Review Panel was appointed to work with the author. This panel consisted of the following individuals:

- Luton Clinical Commissioning Group: Head of Adult Safeguarding Lead and Designated Nurse
- NHS Luton & Dunstable Hospital: Adult Safeguarding and Designated Nurse
- Cambridgeshire Community Service: Adult Safeguarding Lead
- Bedfordshire Police
- Luton Borough Council
- Quality Assurance & Care Placement Manager
- Head of Adult Social Care
- Service Manager Strategic Safeguarding
- Legal Advisor
- Commissioning Manager

2.4 **Review Period**

The review will examine three areas:

a) The care and support provided to Mr B and Mrs B whilst in the community.
b) The response to care provided to Mr B whilst he was resident at the Care Home.
c) The Local Authority and Care Quality Commission quality assurance process.

It was agreed that the periods to be considered for:

- part (a) to run from March 2017 to March 2018.
- part (b) to run from February 2018 to March 2018.
- part (c) to run from May 2016 to July 2018.

Additional information outside these parameters has been considered where relevant.

2.5 **Parallel Process**

A number of parallel processes have also considered aspects of this case.

- Adult Social Services referred the findings of the section 42 safeguarding enquiry (completed May 2019) to police. Police concluded that they had insufficient evidence to support a criminal investigation.
- The Care Quality Commission [2] undertook a review of the home in May 2018 and found its services to be inadequate.

2.6 **Family Involvement**

Mr B's wife, supported by an advocate from Age Concern and a friend, met with the author and the Chair of the Luton Safeguarding Adults Board at the

[2] The Care Quality Commission is an executive non-departmental public body of the Department of Health and Social Care of the United Kingdom. It was established in 2009 to regulate and inspect health and social care services in England

commencement of the review. A follow up meeting was delayed due to COVID 19 but when arranged was undertaken in COVID safe conditions in September 2020.

2.7 Report Structure

This report has been written with a view to it being published, so aspects have been anonymised. The review sets out a brief overview of the case history, followed by an analysis of the agency responses and a conclusion.

3. Case Summary

Each agency who processed relevant information, provided the author with a detailed chronology of their involvement with Mr and Mrs B or the Care Home. The following is a summary of the significant contacts extracted from these chronologies.

3.1 Events Prior to November 2016

Mr B had been known to Luton Adult Social Care since 2014. In March 2016 Mrs B had in place a Lasting Power of Attorney [3] for property and affairs. Personal welfare was added in June 2017. In 2016 Mr B was on the Cambridgeshire Community Services NHS Trust's District Nursing Service caseload for catheter care.

In June 2016 Mr B and Mr's B attended the Hospital renal clinic and saw a Consultant Nephrologist. Conservative management[4] was discussed. It was reported that the catheter had helped improve his kidney function and that Mr B was keen to keep it. The Consultant made a suggestion to Mr B's GP to consider him for inclusion on the GP's Gold Standard Framework register to ensure appropriate ongoing support in the community.

3.2 Post March 2017

In May 2017 Mr B received a diagnosis of end stage kidney disease[5]. The District Nurses made a referral to the Macmillan Specialist Palliative Care Nurses. A visit was arranged by the Macmillan Specialist Palliative Care Nurse for the 22nd May 2017. Mrs B forgot that the visit was due, so a new date 1st June 2017 was arranged. Mrs B requested that date as Mr B would be away from the home attending a day centre, and she could have the discussion issues separately to her husband.

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[3] A power of attorney is a legal document that allows someone to make decisions for you, or act on your behalf, if you're no longer able to or if you no longer want to make your own decisions.

[4] The aims of conservative kidney management:

- To protect and maintain remaining kidney function.
- To prevent or treat symptoms of advanced kidney disease.
- To maintain an acceptable quality of life.
- To ensure appropriate arrangements are made for care if patients are increasingly unwell; this includes end of life care.

[5] End-stage renal disease, also called end-stage kidney disease, occurs when chronic kidney disease — the gradual loss of kidney function — reaches an advanced state. In end-stage renal disease, your kidneys are no longer able to work as they should to meet your body's needs.

3.3 A referral was made to Luton Adult Social Care from the District Nurse. On the 29th May 2017 the allocated Social Worker contacted the Macmillan Specialist Palliative Care Nurse. They stated that Mr B was terminally ill (between 3 months to a year to live) but that he did not meet the criteria for Continuing Health Care Fast Track[6]. A reassessment plus a carer's assessment was undertaken, and it was agreed to increase Mr B's attendance at the day centre to four days with transport support from July 2017. It is recorded within the assessment that '*Mr B is able to verbally express his wishes, but he is forgetful'.* His voice/views are not captured in any part of the assessment.

3.4 On the 31st May 2017 the Social Worker attended the home to review Mr B's needs. The main issue identified was in relation to Mrs B's ability to cope with her husband's deteriorating condition.

3.5 On the same day the GP contacted Mrs B. Mrs B asked if anything was in place for Mr B. They discussed the preferred place of death which was home. They also agreed to a Do not attempt Cardiopulmonary Resuscitation.[7]

3.6 On the 1st June 2017 the Macmillan Specialist Palliative Care Nurse visited Mrs B at home. Mr B was not present, he was at the day care centre. The Gold Standard Framework[8] was explained. Mrs B agreed to a referral to the Keech Hospice[9]. Mrs B signed the consent form. She expressed concern about her own health and how that might impact on Mr B.

3.7 On the 12th June 2017 the GP went to visit Mr & Mrs B. The discussion was principally with Mrs B. Mrs B wanted to know what would happen to her husband. The GP explained that it "*would likely to be a slow deterioration leading to a coma and hopefully a peaceful end"*. Mr B only responded when he showed surprise when his elderly dog went and sat at the feet of the GP. The dog did not normally like strangers.

3.8 On the 14th June 2017 the District Nurse created a palliative care plan. A referral was made to the My Care Coordination Team. The District Nurse visited the following day and recorded that Mr B was in high spirits, chatty and did not appear unwell. Mrs B stated that he was having a lot of difficulties with breathing. The GP had visited and advised that the life prognosis was two months to one year.

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[6] **Fast track funding** is intended as a swift form of **funding** to be put into place where an individual's **health** is rapidly deteriorating to ensure that they are not left in a **funding** position that requires **care** fees to be met where it MAY be the case that they are in a palliative, end of life stage.

[7] The purpose of a DNACPR decision is to provide immediate guidance to those present (mostly healthcare professionals) on the best action to take (or not take) should the person suffer cardiac arrest or die suddenly.

[8] GSF is a practical systematic, evidence-based approach to optimizing care for all people nearing the end of life, given by generalist front-line care providers. GSF is all about quality care - *quality improvement* with training, *quality assurance* with standards of care and *quality recognition* with recognised accreditation.

[9] The My Care Coordination Team is a service for people registered with a Luton GP who are thought to be in the last two years of life. It is hosted by Keech Hospice and provides advice and support for patients 24hrs/day 365 days.

3.9 On the 15th July 2017 the Social Worker received a telephone call from Mrs B. She informed them Mr B had stage 5 kidney failure. She stated that she wanted her husband to stay at home as long as possible.

3.10 On the 27th September 2017 Mr B's case was discussed at a Multi-Disciplinary Team meeting (MDT). This involved his GP and District Nurses. The District Nurse stated that Mr B was well but becoming more confused, demanding and unsteady on his feet. The District Nurse stated that Mr B lacked capacity to make a decision due to lack of insight into his own condition and impact on his wife. There is no evidence of any recorded Mental Capacity Act assessment or any advocacy option.

3.11 The Social Worker was contacted and stated that they planned to visit the family with a view to getting urgent respite. It was stated that Mr B's capacity was questionable but that when he had capacity, he did not want respite and Keech Hospice may take Mr B temporarily, but it may need to be a nursing home or residential home placement.

3.12 On the 2nd October 2017 the Social Worker visited Mr & Mrs B at their home address. It is not recorded if Mr B was present or if he was spoken to alone. Mrs B wanted some respite but was aware Mr B was reluctant, and he could not cope on his own at home. The Social Worker supplied a list of four care homes located near to their home address as Mrs B wanted to be able to visit him easily. It was suggested that Mr & Mrs B visit the care homes.

3.13 On the 13th October 2017 the District Nurse had a discussion with Mrs B regarding respite, as she had identified the care home that she felt would be good for Mr B. Funding was discussed and the District Nurse completed a Fast Track Continuing Health Care[10] referral.

3.14 On the 24th November 2017, the District Nurse team informed the Social Worker that the Continuing Health Care fast track had been rejected because Mr B's functioning needs at that stage did not meet the criteria.

3.15 On the 27th November 2017 the Social Worker visited the home. Recorded in the signed assessment it states that Mr B can make some decisions, but there is no evidence that his views were captured.

3.16 On the 5th December 2017 the Social Worker received an email from the District Nurse stating that Mrs B and her daughter had requested urgent respite for Mr B. The Social Worker spoke with the District Nurse. Mr B's daughter was concerned that her mother could not cope. She was requesting that the Adult Social Care

[10] **Fast track funding** is intended as a swift form of **funding** to be put into place where an individual's health is rapidly deteriorating to ensure that they are not left in a **funding** position that requires care fees to be met where it MAY be the case that they are in a palliative, end of life stage

organise a Keech placement as had previously been discussed. The Social Worker stated that only the Macmillan Specialist Palliative Care Nurse team could offer this placement. The Social Worker said that they had declined respite, but the District Nurse confirmed that they would go to Keech not a care home. Both acknowledged that it was hard to establish what the family actually wanted. The Social Worker spoke to Mrs B on the same day. Mrs B was unaware of her daughter's request for respite. She stated that she had had a bad morning and that she was at the end of her tether.

3.17 Between the 15th and 17th January 2018, the Care Home was subject to a review visit by the Local Authority Quality Assurance & Care Placement Team.

3.18 The case was allocated to a new Luton Adult Social Care Social Worker on the 17th January 2018. On the 18th January 2018, the Social Worker spoke to Mrs B. A visit was arranged for the following day. The Social Worker contacted Mrs B to change the date of the visit as Mr B would not be there, and the Social Worker wanted to speak with both of them.

3.19 On the 21st January 2018 there was a surgery consultation. Mrs B noted that in the last few weeks Mr B had been feeling stiff, having increasing falls and shaking. GP recorded that Mr B could be developing Parkinson's disease.

3.20 On the 24th January 2018 the Social Worker made a home visit. A needs assessment (FACE) was completed to request local authority funding, and it is recorded that Mr B was supported by Mrs B during the assessment. There was no Mental Capacity Act assessment. It was recorded that '*Mr B is able to verbally express his wishes and feelings'.*

3.21 The needs assessment was completed and sent for authorisation. Needs were identified but there was a lack of information about Mr B from other agencies. Respite at the Care Home requested by Mrs B was agreed for the 19th February to 5th March 2018. The dates were changed to 23rd February to 9th March 2018 when Mrs B's procedure dates changed.

3.22 On the 6th February 2018 Care Home staff recorded undertaking a pre-admission visit with Mr B at his home. A pre-admission assessment was completed. The box marked '*will they give consent to care*' is ticked yes, the box for signature to give consent to care is blank.

3.23 On the 23rd February 2018 Mr B commenced respite at the authorised Care Home. The following day he was found to have fallen on the floor at about 4am. The fall had not been witnessed. The Care Home requested that the District Nurse and paramedic attend.

3.24 On the 24th February 2018 the District Nurse visited Mr B in order to examine an eyebrow wound. There is no record of how the eye injury had occurred or the circumstance surrounding the fall. There is no record of Mr B's voice. The same

day Mrs B contacted the District Nurse to express concerns about a number of issues:

- Full catheter bag and no night bag attached
- Tablets left on the bedside table
- Reported that he had had a fall
- Was still in bed at lunch time
- Had 2 x medication patches.

3.25 As a result of Mrs B's concerns the District Nurse made an unplanned visit to the Care Home. They noted that they had a stock of night bags and the carers knew how to fit them. They advised carers how to empty the leg bag and change it.

3.26 On the 25th February 2018 the District Nurse visited the Care Home. They carried out a holistic assessment. Bruising was noticed but no action recorded. The GP received a fax from the Care Home seeking advice about medication.

3.27 On the 26th February 2018 the Care Home received a letter from the GP giving advice on medication. A Mental Capacity Act 2005 assessment was undertaken by the Care Home on the 27th February 2018. This was in relation to the following recorded questions.

- *Do you understand the possible risks of known (sic)to you if you were to leave the building unescorted e.g. road traffic accident, self-neglect, theft.*
- *Do you understand the importance to you for regular care reviews and consent to care?*

It concluded that Mr B did have the capacity to make informed decisions.

3.28 During the morning of the 26th February 2018 Mrs B contacted the Adult Social Care contact centre asking for the allocated Social Worker. She wished to raise concerns about the Care Home. The Social Worker was not available, and Mrs B was advised to raise her concerns with the Care Home manager.

3.29 On the 27th February 2018 Care Home staff contacted the District Nurse stating that Mr B's catheter was not draining. The same day a GP visited him. Present were Mrs B and their daughter. The GP noted that Mr B was displaying signs of restlessness and agitation. The plan was to change his catheter, start antibiotics and continue TLC (Tender Loving Care). They checked that the Do not attempt Cardiopulmonary Resuscitation care order was in place, advising that if Mr B refused medication, they should not force him.

3.30 On the 1st March 2018 Mrs B contacted the allocated Social Care Manager, expressing concerns about Mr B's condition. The allocated Social Worker contacted Mrs B.

Mrs B stated the following:

- Mr B had had a fall on the 23rd and cut his head.
- His catheter was not draining and on the 25th he had got an infection. GP had been called.
- On the 26th Mr B had pulled out his catheter. The District Nurse was called

out.

- Mr B was not eating properly
- He was challenging towards staff during personal care.

Mrs B questioned if Mr B should be in nursing home. The Macmillan Specialist Palliative Care Nurse stated that she felt that Mrs B was not coping. The Social Worker requested an oversight of the case sending an email to her manager expressing her concerns.

3.31 The Social Worker contacted the Care Home manager. She was informed that they had spoken to Mrs B to discuss the concerns she had raised. Mr B was r refusing medication and not eating and drinking. The GP was contacted and had informed them not to force medication or personal care, and If Mr B becomes upset or refuses, they should respect his wishes. They confirmed that the District Nurse had changed the Catheter. They felt he was becoming more settled. They were happy for Mrs B to contact them daily. The Social Worker updated Mrs B of the conversation with the Care Home Manager.

3.32 On the 5th March 2018 Mr B was seen by the District Nurse. On the 6th March 2018 Mr B was found to have fallen out of bed onto a crash mat. This was another unwitnessed fall. On the same day the Macmillan Specialist Palliative Care Nurse visited Mr B at Mrs B's request.

3.33 On the 7th March 2018 Mr B was found to have slipped off the edge of his bed. Mrs B contacted Adult Social Care expressing concern about the falls. The same day the Social Worker visited Mrs B at the family home address to assess Mr B's additional needs upon his return home. Mrs B's daughter was at the meeting. They expressed concern that Mr B was deteriorating. Mrs B had been informed that his condition was progressing, and he could be looking at end of life care. Mrs B was very upset and blamed herself for his condition. Her daughter felt that given the current situation, her mother would not be able to cope with Mr B at home. Mrs B agreed to an extension to respite and for a reassessment.

3.34 On the same day the Social Worker contacted the Care Home manager by phone. The manager stated that they had seen a sudden decline in Mr B. He was walking on arrival but was now using a frame. He had become weak. They were concerned and he was on 30 minute observations. The manager confirmed that they were still able to meet Mr B's needs if extension was requested. They had spoken to the Community Matron, who said that she felt he was at end stage kidney failure and required palliative care, which the Care Home could manage.

3.35 An assessment was completed and a request for an extension was agreed. This was to allow the Social Worker time to reassess Mr B and arrange a multi professionals meeting to consider Mr B's health and social care needs. The Social Worker was then on leave. She arranged a contingency plan, but the meeting did not take place.

3.36 On the 8th March 2018 the Care Home contacted the Cambridgeshire Community Service Rapid Response team. Mr B was complaining about pain between his legs. They were advised to give additional fluids and that a District Nurse would visit. The District Nurse visited the following day.

3.37 On the 12th March 2018 the District Nurse visited and noted a new wound to the left lower arm which the carers reported was said to have been sustained whilst getting dressed that morning. There is no indication if he was being helped to get dressed. The District Nurse took photographs. They completed a care plan, documenting dressings as primary dressing with Steristrips.

3.38 On the 14th March 2018 the GP contacted the Care Home following a fax from the home. Falls were discussed with Mrs B. She indicated that he had not fallen when being watched by the carer but, he had been found on the floor a few times.

3.39 Mrs B contacted the Social Worker and expressed a view that the Care Home was struggling to care for her husband and that he should be in a nursing home. The Social Worker informed her that she had spoken with the Macmillan Specialist Palliative Care Nurse, and that Mr B did not currently meet the criteria for a nursing home.

3.40 On the 15th March 2018 the GP made a visit to the Care Home due to a reported shortness of breath, falls and bruising. Examination of Mr B determined that he was frail. The GP concluded that he had a severe chest infection. Palliative care was discussed, but Mrs B became distraught and said no one had spoken to her or the family about this and she still wanted active treatment and admission. GP arranged emergency hospital admission. Mr B arrived by ambulance at the hospital at 6.21pm.

3.41 On the 15th March 2018 a safeguarding concern was received by the Multi agency Safeguarding Hub (MASH) Adults from the ambulance service. It was following their transporting of Mr B to hospital. They noted:

- Tear to the skin.
- Multi bruising, different colours indicating injuries at different times.
- Mrs B had told them he had fallen out of bed, none of the incidents had been witnessed or reported to health or safeguarding.

Ambulance staff brought these concerns to the attention of hospital staff at handover. They were also made aware that a safeguarding referral would be made. This information was forwarded to the Trust Safeguarding Team to monitor and confirm.

3.42 A Do not attempt Cardiopulmonary Resuscitation and treatment escalation plan was discussed with Mrs B. It was agreed that they would treat for 48 hours and if he did not improve, a further discussion regarding Palliative care would be considered.

3.43 On the 16th March 2018 Mr B died.

4. Family Views

The author spoke to Mrs B at the commencement of the review and then later on during the review to ascertain her thoughts and views. She has been supported by a friend and a local Age Concern officer who had been acting as her advocate for the process.

4.1 Mrs B explained that Mr B was a kind man who loved his animals, dogs and fish. He was a keen gardener. Before he retired, he had been employed as a chauffeur. They had been married for 27 years it was the second marriage for both of them. He was a loving and supportive husband. Unfortunately, he started to suffer from dementia and Mrs B looked after him as his carer for 7 years.

4.2 Mrs B repeated the concerns that she had previously set out during the Section 42 enquiry. In summary she questioned the use of a residential care home for Mr B, she believed that his condition would have been better supported in a nursing home. She also expressed concerns about the lack of response to the issues she raised whilst Mr B was at the Care Home, this included the increased number of unwitnessed falls, general lack of care in respect of food and clothing, his catheter care and dressing of injuries.

4.3 Cambridge Community Services did investigate the concerns around the catheter care but Mrs B was unhappy with the response from that service. (The author understands that the Cambridge Community Services have invited Mrs B to meet with them to discuss her unresolved concerns).

4.4 Mrs B's specific care concerns will be referred to further in this report.

5 Analysis of Events

This analysis section has been separated into two parts. Part one will examine:

- The care provided whilst at home.
- Mr B's transfer to the Care Home.
- Agency response to concerns raised whilst a care home resident.

Part One

5.1 A Section 42 Safeguarding Enquiry into the care of Mr B was commenced following a referral from the ambulance service in March 2018. It was concluded in May 2019. The enquiry examined in detail the safeguarding concerns expressed by Mrs B, specifically in respect of the care provided whilst Mr B was a resident of the Care Home. The enquiry conclusion was that it had been substantiated that Mr B suffered from Neglect and Acts of Omission by the Care Home.

5.2 It was agreed by the panel that this review would not re-examine in detail

the individual care concerns highlighted by Mrs B, these issues were fully examined by the Section 42 enquiry. It would focus on how agencies responded to Mrs B's concerns when she raised them prior to Mr B's death.

Recommendation

Luton Safeguarding Adults Board: To be assured that the agency recommendations as set out in the Section 42 Safeguarding Enquiry have been actioned.

Palliative/End of Life Care.

5.3 In May 2017 Mr B was diagnosed with end stage Kidney Disease. He had a life expectancy at the time of between 3 and 12 months. From this time onwards the care provided to Mr B was Palliative, End of Life Care.

5.4 In response to the original Section 42 Safeguarding Enquiry, Luton Clinical Commissioning Group commissioned a report that examined the issue of Palliative and End of life care as it related to Mr B's case. It is a comprehensive report authored by a care expert, Jayne Dingemans RGN DN Cert. The report sets out a number of recommendations. This section will reference the report, but not replicate its detailed analysis.

Recommendation

Luton Clinical Commissioning Group: To oversee the implementation of Clinical Commissioning Group palliative care review recommendations.

Luton Safeguarding Adults Board: To be assured that the Clinical Commissioning Group palliative care review recommendations have been implemented.

5.5 The following is the World Health Organisation (WHO) Definition of Palliative Care:

'Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.'

5.6 Whilst Palliative care was being provided to Mr B, it is questionable if it improved the quality of life for Mr and Mrs B.

5.7 NICE guidelines[11] for providing end of life care coordination identifies a number of desired outcomes in respect of care coordination to ensure good

[11] NICE guideline 2019 End of life care for adults: service delivery www.nice.org.uk/guidance/ng142

end of life care.

5.8 The following will explore each of the desired outcomes to establish what took place in this case and its impact.

1) Offer information to the person approaching the end of their life, their carers and others important to them, about who the multi-practitioner team members are (including the lead healthcare professionals in each setting responsible for their care), the roles of the team members and how services are accessed.

5.9 As from June 2017 until Mr B's death in March 2018 the family were being supported by a number of professionals. They included:

- GP.
- Cambridgeshire Community Services NHS Trust.
- Macmillan Specialist Palliative Care Team.
- Integrated Nursing service including District Nursing.
- Keech Hospice: My Care Coordinator.
- Adult Social Care: Social Worker.

5.10 The nursing care was provided by the District Nursing Team and Specialist Palliative Care Team who worked together with the Rapid Response Team as part of the Trust's Integrated Community Nursing Service. The level of support was appropriate given the needs of Mr and Mrs B. They had regular contact with professionals and their commitment is not in question.

5.11 It is evidenced very early on that Mrs B was struggling to fully understand what was being offered and by whom.

The GP IMR highlights
'It is unclear from the entries whether Mr B's wife had a clear understanding of what palliative care means or what the DNAR (Do Not Attempt Resuscitation) form meant in practice.'

The Clinical Commissioning Group Palliative Care report states that Mrs B found it confusing, "*Too many cooks involved*".

A further example of confusion is in regard to Mrs B's understanding of the Gold Standard[12] framework. The palliative care reports highlights:
'Mrs B was left feeling "bitter about the so called Gold Standard which was not explained to her". She felt that "there was a lot of over promising yet the delivery of care was poor".

5.12 Whilst the Gold Standard Framework identified Mr B as an individual in need of palliative care, the Advanced Care Planning was not progressed

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(Advanced Care Planning will be examined later in this report).

5.13 Mrs B's confusion is understandable, one can only image how upsetting receiving the news that her husband was facing end of life in the coming year must have been. Mrs B had been his main carer for many years. This was life changing and there needed to be in place a good level of communication and support so that both Mr and Mrs B fully understood what would happen, who was going to support Mr B and her needs and who she should contact even out of hours.

5.14 When interviewed Mrs B confirmed that she understood that Mr B was dying and was being supported for end of life/palliative care, she was not clear on what each of the agency staff roles were. She stated that they had a brilliant GP, but she was not fully aware of what was meant by the Gold Standard or aware of Advanced Care Planning.

5.15 The Clinical Commissioning Group palliative care review highlights that good communication ensures:

- *Both people receiving and delivering care can understand what's important to the other person.*
- *People feel supported and empowered to make informed choices and reach a shared decision about care.*
- *Health and social care professionals can tailor the care or treatment to the needs of the individual.*

5.16 The initial communication following the diagnosis, appears to have been confusing or lacking.

5.17 The introduction of the Macmillan Specialist Palliative Care Team nurse was a good support option and referral to the My Care Coordination Team[13]. The role of the team however, was not clearly explained to Mr & Mrs B and led to confusion when they stepped down from the case just prior to Mr B entering the Care Home. The Safeguarding enquiry posed the question: *"who the palliative support was for, Mr B or emotional support for Mrs ".*

5.18 It is also recorded that the GP tried to explain to Mrs B what would happen to Mr B over time. This was at the request of Mrs B. What is not is clear is how much Mrs B took in or fully understood what she was being told.

5.19 Whilst the District Nurse, Macmillan Specialist Palliative Care Nurse and the GP updated each other, the staff were visiting separately. This led to confusion and duplication of information. More coordinated joint visits, especially in the initial stages, might have improved the understanding of both Mr and Mrs B 's needs, and might have helped professionals' to understand the individual roles in supporting Mr B.

[13] MCCT: a service for people registered with a Luton GP who are thought to be in the last two years of their life that provides access for patients with palliative conditions.

5.20 An information pack is supplied by Macmillan Specialist Palliative Care Nurse on the first assessment. The Clinical Commissioning Group palliative review identified that the same information is given with no arrangements to review. It states:
'Mrs B's information needs changed over time and she stated that she resented the "verbal drip feed" of information which alternated with onslaughts of written material that she would not find time to read'.

5.21 The Clinical Commissioning Group palliative review identified that the use of language in the case of Mrs B resulted in:

- *Miscommunication among clinicians who relied heavily on SystemOne method of communication*
- *A lack of clarity in verbal communication with Mrs B*
- *Mrs B losing confidence and trust in the Nurses and Social Workers caring for her husband.*

5.22 It is of note that at no time do the words 'dying' or 'die' appear on the health SystemOne (S1) electronic recording system. The word death only appears once in May 2017 and that was in relation to Mrs B's comments about preferred location of death. This would indicate a lack of openness which probably came about due to the desire of some professionals not to upset Mrs B.

5.23 The Cambridgeshire Community Services IMR concludes:
'Instead terms such as prognosis, deterioration and "poorly" were used throughout Mr B's deterioration and healthcare professionals'' interaction with Mr B's wife. One of the implications was that Mrs B might have taken different decisions e.g. about the place of care or transfer to hospital from the RH had Mr B's wife known that there was a strong possibility that Mr B would die at the RH or hospital.'

5.24 Mrs B confirmed this view to the author. Whilst she was aware that Mr B was dying, what she was not prepared for was his rapid deterioration in health and subsequent death once he became a resident at the Care Home. Had she known that this was likely to happen then she would have wanted him to return home to die.

5.25 It is evidenced that some of the supporting workers did not have a good understanding of processes such as Gold Standard Framework, NHS Continuing Health Care fast track funding or even the wording used in end-of-life care cases. It is therefore not surprising that Mrs B might not have fully understood what she was being told during a traumatic period of time. There was a need for professionals to continually test Mrs B's and Mr B's understanding.

2) Ensure that holistic needs assessments are offered, and the person's wishes

and needs are discussed and acted on whenever possible.

Mr B's Voice

What is evident when examining the interaction between agency staff and the family, is the limited recorded evidence of Mr B's voice. There are descriptions of his condition. It is of note that the Social Worker, early on, recorded that Mr B was happy with the care package. What is not clearly recorded is how this conclusion was reached.

5.26 The Adult Social Care IMR does conclude that having spoken to the practitioner, they felt that they did seek and obtain Mr B's views but failed to record them. Practitioners must accurately record interactions.

5.27 The source of information in respect of specific decisions and Mr B's wishes was almost always Mrs B. At times, the location and method of communication with the family normalised this situation and limited Mr B's involvement.

5.28 There were occasions when visits were being arranged for when Mr B was not present. Examples include the initial Macmillan Specialist Palliative Care Nurse visit in June 2017. This should have been the initial assessment of care needs but was arranged for a time when Mr B would not be at home, (he attended a day centre). This could have provided the nurse the opportunity to have explained to Mrs B that the visit needed to be made when Mr B was present. He was the patient, so it was important for the nurse to hear the views of both of them.

5.29 There was only one occasion when Mrs B was informed that Mr B had to be present, and that was in January 2018 during the first contact with a new allocated Social Worker. This was good practice, however, recording of his voice was still limited.

5.30 When the GP visited Mr B at home, they recorded that the discussion was principally with Mrs B and some was in the hallway so Mr B could not hear. On other occasions when Mrs B contacted her GP, the GP recorded that she had a discussion with Mrs B and it was agreed that place of death would be home, and they agreed a Do Not Actively Resuscitate form would be appropriate. There is no record of Mr B's views.

5.31 There appears to have been a focus on Mrs B and her understanding of Mr B's wishes and her needs. They were not being treated as individuals with different care needs.

5.32 Mrs B acknowledged that Mr B was often at the day centre when professionals visited, and she did become his voice. She confirmed that had professionals requested to speak with Mr B alone, she would have had no objection, but this request was never made.

5.33 These early interactions set the pattern for almost all future contact with professionals and even continued when Mr B became resident at the Care Home. The allocated Social Worker never visited Mr B at the Care Home. They did speak with family members at the family home whilst Mr B was in the Care Home. This visit related to his future, again his voice was not being heard.

Mental Capacity

The Mental Capacity Act applies to everyone involved in the care, treatment and support of people aged 16 and over who are unable to make all or some decisions for themselves. It would apply to Mr B.

5.34 The Mental Capacity Act 2005 sets out five 'statutory principles':

- *a person must be assumed to have capacity unless it is established that they lack capacity*
- *a person is not to be treated as unable to make a decision unless all practicable steps to help them to do so have been taken without success*
- *a person is not to be treated as unable to make a decision merely because they make an unwise decision*
- *an act done, or decision made, under the Act for or on behalf of a person who lacks capacity must be done, or made, in their best interests*
- *before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person's rights and freedom of action*

5.35 Absent are any recorded Mental Capacity Act assessments by health professionals in line with the Mental Capacity Act 2005. There is recorded a Mental Capacity Act assessment undertaken on the 27th February 2018 by Care Home staff. This assessment concluded that Mr B did have capacity to make informed decisions in regard to the following questions.

- *Do you understand the possible risks of known (sic)to you if you were to leave the building unescorted e.g. road traffic accident, self-neglect, theft?*
- *Do you understand the importance to you for regular care reviews and consent to care?*

These questions appear to be testing general understanding rather than related to specific decisions. There is no evidence that any further assessments were undertaken whilst he was resident at the home.

5.36 When looking at the recorded observations of Mr B, there are conflicting views as to his level of capacity which would indicate that it fluctuated. Given that this is the case it would have been appropriate to test capacity

regularly. This was especially important as his health began to deteriorate.

5.37 The Cambridgeshire Community Services IMR states:
'The chronology shows that through deteriorating health trajectory there appeared to be no attempt from healthcare professionals in any organisation providing care to Mr B to carry out a formal and comprehensive assessment of his mental capacity'.

5.38 The lack of Mr B's voice was significant. Decisions at this stage in his life were essential as it could have informed his palliative care plan, how Mr B wanted to be cared for is not known including his views on respite.

Advocacy

Mrs B had a Lasting Power of Attorney [14]for property and affairs in 2016 and as from June 2017 for personal welfare, so she had the right to make decisions in the best interest of her husband. However as stated in the Office of the Public Guardian Making Decisions[15] document.

5.39 *'A Personal Welfare Attorney has no power to consent to, or refuse treatment, at any time or about any matter when the person has the capacity to make the decision for himself or herself.'*

5.40 The Mental Capacity Act 2005 Code of Practice[16] at paragraph 7.25 states:

'When healthcare or social care staff are involved in preparing a care plan for someone who has appointed a personal welfare attorney, they must first assess whether the donor has capacity to agree to the care plan or to parts of it. If the donor lacks capacity, professionals must then consult the attorney and get their agreement to the care plan. They will also need to consult the attorney when considering what action is in the person's best interests.'

5.41 The Office of Public Guardian booklet states:

'If the person in your care lacks capacity and has created a Personal Welfare LPA, the Attorney is the decision-maker on all matters relating to the person's care and treatment. Unless the LPA specifies limits to the Attorney's authority the Attorney has the authority to make personal

[14] A lasting power of attorney (LPA) is a legal document that lets you (the 'donor') appoint one or more people (known as 'attorneys') to help you make decisions or to make decisions on your behalf.

This gives you more control over what happens to you if you have an accident or an illness and cannot make your own decisions (you 'lack mental capacity

[15] Office of the Public Guardian 2009 Making Decisions A Guide for people who work in health and social care.

[16] Dept for Constitutional Affairs: 2007 Mental Capacity Act 2005 Code of Practice.

welfare decisions and consent to or refuse treatment (except life-sustaining treatment) on the Donor's behalf. The Attorney must make these decisions in the best interests of the person lacking capacity (principle 4) and if there is a dispute that cannot be resolved, for example, between the attorney and a doctor, it may have to be referred to the Court of Protection'.

5.42 If ongoing assessments of Mr B's mental capacity had been undertaken, it would have enabled professionals to establish and record if his wishes were in line with those being expressed by his wife, and to have formally confirmed that she was able to act as his advocate in his best interests. There is no evidence that Mrs B's Lasting Power of Attorney was explored. It appears to have been taken for granted.

5.43 The Clinical Commissioning Group palliative care report highlights: *'There was no challenge around whether Mrs B was acting in her husband's best interest.'*

5.44 It is important that professional have a good legal knowledge of the implications of a Lasting Power of Attorney including how to check its scope and the role of the Court of Protection.

5.45 Given the identified lack of Mr B's voice and the absence of any Mental Capacity Act assessment, it is of no surprise that at no stage was the introduction of advocacy to ensure that decisions are made in Mr B's best interest considered. This seems to support the mindset amongst the professionals that Mrs B represented her husband's views.

5.46 The lack of or poor application of the Mental Capacity Act and the use of advocacy continues to be a recurring theme highlighted in SAR reviews. The Braye, Preston-Shoot 2017 report Learning from SAR's[17] concludes:

'Twenty one of the 27 reports commented on mental capacity, which represents therefore the most frequently represented learning about direct practice. Despite the occasional comment in one case that mental capacity had been well addressed and best interests decisions appropriately implemented, much of the learning in the SARs is about missing or poorly performed capacity assessment, insufficient scepticism and respectful challenge of decision- making and possible consequences, and in some cases about an absence of best interests decision-making.'

5.47 Despite the continued focus that Safeguarding Boards across the country

[17] Braye, Preston Shoot (2017) *Learning from SARs : A report for the London Safeguarding Adults Board*

have had on the application of the Mental Capacity Act its practical application still seems to be lacking in many cases. This would indicate that the current method of training is not totally effective.

Recommendation

Luton Safeguarding Adults Board:

To review the training of Mental Capacity Act and seek to identify the inhibitors to its clear understanding and application.

To ensure that agencies provide staff with a good legal knowledge of Lasting Power of Attorney including the role of the Court of Protection.

3) Ensure that care is coordinated across and between the multi-practitioner teams and between care settings.

4) Ensure that regular discussions and reviews of care, holistic needs and advance care plans are offered.

5) Share information about the person's care between members of the multi practitioner teams.

5.48 As the NICE guidelines highlight, it is important that workers supporting end of life patients and their carers should be coordinated both across and between services. As has been previously identified, the initial information provided to Mr and Mrs B was confusing and led to Mrs B starting to lack confidence in the support being provided. This lack of confidence appears to have impacted on Mrs B's responses and challenges to services even after the death of Mr B.

5.49 Whilst staff were talking to each other one on one, each of the IMRs highlight the lack of effective coordination between services.

5.50 The Adult Social Care (ASC) IMR states:
'The allocated ASC workers demonstrated good multi agency working, with excellent sharing of information with single agencies over the phone in a timely manner. However, what I felt was missing were all agencies views being gathered at the same time and addressed in a forum such as a professionals meeting'.

5.51 Cambridgeshire Community Service IMR states:
'The evidence suggests that practice could have been improved with better joint working between DN and MSPCN's; joint visits would have been appropriate.
….The benefits of joint visits are several and crucial; they can ensure unity of work. They minimise misunderstandings among health care

professionals and between patient, family and health care'.

Joint visits would have improved the coordination of care and helped to identify family concerns and minimise misunderstandings in the early stages.

5.52 Coordination within agencies was also lacking. An example of this was within Cambridgeshire Community Services. During his time at the Care Home Mr B was being supported by community staff nurses and health professionals from the wider integrated community nursing service.

The Cambridgeshire Community Services IMR notes:
'It is acknowledged that because different staff attended to his care on each occasion this did not facilitate a joined up, holistic approach to care.'

5.53 This lack of coordination is further evidenced by the fact that during the period under review, only one recorded Multi-Disciplinary Team meeting (professionals meeting) took place in September 2017 when the option of possible urgent respite was considered.

5.54 This was an opportunity to have ensured that there was in place effective coordination of support across agencies, to ensure that Mr B's requirements were fully understood, and to provide clarity of action including the undertaking of a Mental Capacity Act assessment and the creation of an Advanced Care Planning document.

Advance Care Planning

Advanced Care Planning is an important process in palliative care, the NICE 2019 guideline defines this as follows:

5.55 *Advance care planning is a voluntary process of discussion about future care between an individual and their care providers, irrespective of discipline.*

An advance care planning discussion might include:

- *the individual's concerns and wishes*
- *their important values or personal goals for care*
- *their understanding about their illness and prognosis*
- *their preferences and wishes for types of care or treatment that may be beneficial in the future and the availability of these*

5.56 It is also known as a personalised care plan, anticipatory care or similar but Advance Care Planning is generally the internationally recognised name. This is an important document that should inform future care in line with desired wishes and outcomes. Any health or social care

professional can introduce Advanced Care Planning discussions.

There is no evidence that such a plan was discussed or that Mr B was involved in any decisions as to his future needs.

5.57 The Cambridgeshire Community Services IMR states:
'….. there were missed opportunities for Advanced Care Planning conversations with Mr B, his wife and his daughter. Some of these conversations could have happened as joint visits between DN and MSPCN.'

5.58 The Clinical Commissioning Group palliative care review identified that the Cambridgeshire Community Services nursing team and the Macmillan Specialist Palliative Care Team did not involve Mr B in the assessment of his needs, care planning and decision making. They acknowledged that they should have engaged with Mr B to ensure that a personal care plan included preferences and priorities for his care.

5.59 The Cambridgeshire Community Services IMR highlights the missed opportunities to work with Mr B.

'From the records in 2016 and 2017, at a time when Mr B might have had capacity to engage in Advance Care Planning discussion at least on some level on some aspects, clinic doctors (e.g. 30 June 2016), GP (e.g. on 31 May 2017) and the MSPCN (e.g. on 1 June 2017), made no record of engagement with Mr B around Advance Care Planning'

5.60 The author has been informed that at the time in question there was no locally agreed document for Advanced Care Plan. There was a locally agreed template on SystemOne1(S1) which can be updated by any health professional using the system.

5.61 It had been agreed through both the Luton End of life Implementation Group and Enhanced Care Home Working Group that it would be unreasonable to ask staff from multiple providers to complete additional paperwork as this would lead to duplication. This was identified as a risk and it was during 2016/ 2017 that the new S1 template was developed. The new template is currently in testing phase with a view to rolling it out across all health care settings using S1.

Recommendation

Cambridgeshire Community Services: To roll out the new Advanced Care Planning template and monitor its usage.

Respite Care Option

The option of respite care to support Mrs B was first being considered in September 2017 when it was becoming clear that Mrs B was struggling and needed additional support.

5.62 In October 2017, the Luton Adult Social Care Social Worker supplied Mr B with a list of four residential care homes situated near to the family home. Mrs B wanted to be able to get there quickly from their home. The Social Worker suggested that they visit the homes. Mrs B discussed the options with the District Nurse and stated that she had visited a specific care home and liked it, feeling that she would be able to leave him there for a week. Once again Mr B was not present, so his views are not known.

5.63 At that time the respite option was not progressed. This appears to have been due to Mr B not agreeing. Once again this was not clearly recorded.

5.64 In the months leading up to February 2018, Mr B's health was deteriorating. Mrs B was struggling both in terms of her ability to physically care for Mr B, and her concerns over her ability to fund future care.

5.65 On the 17th January 2018 the Social Worker completed a Needs Assessment application (FACE) and support plan for funding authorisation of respite at the Care Home. This plan did not reflect any evidence of lack of capacity or the voice of Mr B. There appears to be an assumption that either Mr B agreed to the respite, or that he lacked capacity and that his wife was able to make the decision on his behalf.

5.66 When interviewed by the author Mrs B is clear that Mr B was not aware that he was going to the Care Home. She believes that if he had been made aware, he would have refused as he had done so in 2017.

5.67 A Care Home Pre-Assessment document was completed at Mr B's home on the 6th February 2018. Under the section 'Residents Mental Health' it is marked that the resident was able to follow simple instruction and marked yes that they give consent to care however, the box marked 'sign to give consent to care' is blank.

5.68 Mr B's residency at the Care Home raises the question of who made the decision for this intervention. As has previously been set out, it is not clear that he had capacity to consent. Mrs B did have a Lasting Power of Attorney and was able to make the decision on his behalf with the caveats as set out at 5.42, but the decision-making process is not clearly evidenced.

5.69 This lack of documented evidence is of concern as it would appear that Mr B might potentially have been detained in the Care Home against his wishes. This may be supported by a conversation Mrs B recalls having with

Mr B on the first night. He was distressed when she spoke to him on the telephone and he said "*what have you put me in here for*?"

5.70 If this was the case this appears to have potentially been a deprivation of Mr B's Liberty. The Alzheimer's society[18] states the following:

'If the person has not freely chosen where they will live in order to receive care, or the type of care that they receive, it is possible that this care will take away some of their freedom. In some cases, this may amount to a 'deprivation of liberty'. This is not always a bad thing, and it is often necessary when caring for someone, but it should only happen if it is in the person's best interests.

5.71 The Mental Capacity Act 2005 includes the Deprivation of Liberty Safeguards (DoLS).
SCIE[19] describes DoLs as follows:

'DoLS ensures people who cannot consent to their care arrangements in a care home or hospital are protected if those arrangements deprive them of their liberty. Arrangements are assessed to check they are necessary and in the person's best interests. Representation and the right to challenge a deprivation are other safeguards that are part of a DoLS.'

5.72 There is no evidence that this was even considered, and again provides evidence that Mr B's voice was not being heard.

5.73 Whist Care Home respite was the option progressed, given that there seems to be evidence that Mr B had not agreed to this placement, other options should have been considered.

5.74 The District Nurse had previously tried to apply for Fast track Continuing Health Care funding but had been informed that Mr B was not eligible at the time. They could have applied for normal time Continuing Health Care Funding[20] application. This could have identified a plan for increased care at home in order to provide more support for Mrs B whilst she was having treatment. This option was never explored. By January 2018 given the deterioration in Mr B's health, there was an option to have re applied for fast-track funding again, but this was never pursued.

5.75 The identified Care Home specialised dementia care. The home confirmed

[18] https://www.alzheimers.org.uk/get-support/legal-financial/deprivation-liberty-safeguards-dols
[19] SCIE: Deprivation of Liberty Safeguards (DoLS) at a glance May 2015, https://www.scie.org.uk/mca/dols/at-a-glance

[20] **Continuing Healthcare Funding**, also known as **CHC Funding**, is free **healthcare** provided by the NHS and it can cover up to 100% of care costs. ... To be eligible for NHS **Continuing Healthcare Funding**, the individual's need for care must be **healthcare** rather than a social care need.

that they would be able to support Mr B's needs, but as will be seen in part two of this review, at this stage (February 2018) concerns about the Care Home were being raised. What was not identified in the needs assessment was any concern about the current ability of the identified care home to care for him. If discussions with the Local Authority Quality Assurance & Care Placement Team had taken place, concerns might have been highlighted to the Social Worker at the time when the application was made, increased observations could have been undertaken or other options explored.

Recommendation

Luton Borough Council: FACE funding application assessments should include any identified ongoing concerns about the Care Home subject to the application.

Transfer of Care

It is evidenced that Mr B's condition was deteriorating before he became resident at the Care Home. His behaviour was also becoming increasingly erratic and challenging to such an extent that the suitability of the chosen care home to have the skills to be able to care for him, should have been reviewed especially in light of the known concerns.

5.76 If there had been effective coordination between services, along with ongoing assessments and person-centred plan such as the Advanced Care Plan as described previously, then both Mr B and Mrs B might have been better prepared for the transfer to the Care Home. It might also have assisted the Care Home to be prepared for Mr B in terms of fully understanding his needs and wishes.

5.82 The Adult Social Care IMR states:
'The lack of family/multi agency professional meeting was very evident; this should have taken place in order to pull everything together in terms of short term and long term planning'.

5.83 Whilst Mrs B cannot recall the Care Home staff visiting their home, there is recorded evidence that Care Home staff did visit the family home and completed a pre-admission assessment. The information on the assessment had medical history, his medication, mobility, skin integrity, falls and nutritional needs.

Care for Mr B whilst a Care Home resident (February to March 2018)

5.84 Mr B's period in the Care Home was the time for which Mrs B has expressed most concern. It should be recognised that having her husband go to a care home when she had cared for him herself for a number of years, must have been deeply disturbing for her. She was no longer in

charge of his care. Part of the support plan was for the District Nursing service to continue to attend the Care Home, to provide support in line with what they were providing in the home environment. What Mrs B was expecting was that the additional loving care that she provided whilst he was at home, would be replicated during his short respite stay.

5.85 As has been previously highlighted Mr B 's voice was silent. There was no evidence of a coordinated hand over between Macmillan Specialist Palliative Care Nurse, District Nurse, My Care Coordinator, or the Social Worker, so there was a failure to consider the equipment needs of Mr B including catheter care equipment.

5.86 There appears to have been a lack of preparation between agencies and the Care Home, which would have ensured that the home fully appreciated the condition that Mr B was in and the support that he would require. Mr B was transferred to the Care Home direct from the day centre without his wife, it is not clear how he would have reacted to the sudden change in environment. Evidence indicates that he was distressed.

5.87 If a fully coordinated handover had been undertaken, there would have been an opportunity to ensure that Mr B's deteriorating condition at the time of transfer was understood by the Care Home and they were able to cope. It is also not clear how prepared Mr B was for the change of accommodation.

Responding to Care Concerns

Mrs B's biggest concern was the quality of care being provided to Mr B whilst resident at the Care Home. Mrs B did not just raise her concerns after her husband's death but highlighted them within days of the respite commencing.

5.88 Mr B entered the Care Home on the 23rd February 2018 and it is evidenced that his condition quickly deteriorated. Mrs B expressed her concerns of his treatment/care on numerous occasions. They included the following serious concerns.

- Falls on a number of occasions all unwitnessed
- Unexplained injuries
- Catheter care
- Dirty personal care
- Poor Care including food issues, inappropriate clothing and Mr B still in bed at lunch time
- Medication errors

5.89 Mrs B had a background of working in a care home environment so had an understanding of what good care looked like. So, when she raised these issues she was doing so with a good level of experience.

5.90 Mrs B made a number of telephone calls to the GP the District Nurse and

Social Worker. Whilst the District Nurse and the GP responded to individual concerns, there was no evidence of the collective concerns leading to reviews as to whether the home was safe. When Mrs B complained about the home to social care, she was told to speak with the home manager.

5.91 The Social Worker did contact the Care Home manager and sought explanations to Mrs B's growing concerns. They appear to have accepted the explanations given by the manager. At no stage did the Social Worker ever physically attend the Care Home to see for themselves the current situation.

The Adult Social Care IMR states
'From the evidence I have seen the worker was asking the right questions of the home but this was over the phone. As a practitioner, we gather evidence through observations and looking at records as well as speaking to Mr B.'

5.92 They did contact Mrs B. It was at that time they arranged to meet with Mrs B and her daughter to assess the needs for when Mr B returned home. They did not consider requesting a professionals' meeting or a joint visit to the home to undertake assessment of the current situation including trying to hear Mr B's voice.

5.93 Given the concerns raised, including unexplained injuries, this was a missed opportunity to have intervened and to have considered a safeguarding referral. The Social Worker might also have considered contacting the Quality Assurance & Care Placement Team**.** Had this taken place they may have highlighted the result of a local inspection that had taken place in January 2018. (subject to comment in part two).

Recommendation

Luton Adult Social Care: When concerns are raised with a social worker about a care provider there should be a notification to the Quality Assurance & Care Placement Team.

5.94 Professionals were trying to manage Mrs B and her concerns but not considering Mr B and his care needs and his deteriorating health condition. By the 7th March 2018 the Care Home manager informed the Social Worker that they had seen a sudden decline in Mr B.

5.95 Whilst the Social Worker failed to visit the home, the District Nursing service made 10 visits in 20 days either as part of a routine or at the request of the Care Home. The home staff made seven direct approaches to the district nursing service requesting help. Mrs B made contact with

the service to set out her concerns. They included the catheter bag not being emptied, the night catheter bag not being fitted, Mr B being in bed at lunch time and medication error in respect of Rivastigmine Patches[21]. This level of involvement should have led to the health care professionals raising the question as to whether the Care Home was able to cope with his needs and deteriorating condition, and whether a different care environment should be considered.

5.96 The health care staff are expected to report clinical incidents in both care homes and patients own homes on the electronic incident reporting system DATIX. This includes skin tears, unexplained falls, pressure damage, unexplained bruising, medication errors and concerns re the quality of care. All recorded incidents are monitored internally to identify any safeguarding issues which would be referred to the local Multi Agency Safeguarding Hub (MASH), or for consideration for a case management environmental issue a notification would be sent to the Quality Assurance & Care Placement Team at the Local Authority

5.97 What is highlighted is that the visits to the Care Home were undertaken by different individuals of the District Nursing team. They appeared to only respond to the immediate health needs and did not take into account the overall standard of care Mr B was receiving. They do not appear to have recorded the reported incidents, falls and skin tears on the Trusts incident recording system (DATIX) so they were not picked up.

The Cambridgeshire Community Services IMR concludes:
'In Mr B's case during admission to RH it was not recognised that the different HCPs did not link up the different incidents that occurred with Mr B. These events were not recorded on the Trust's incident reporting system (DATIX). This resulted in a failure to raise safeguarding concerns at the time'.

5.98 The Cambridgeshire Community Services IMR captures a rationale behind failure to report concerns:
'*There was evidence of a lack of "professional curiosity", e.g. around causes of incidents. The focus was on efficient completion of a series of physical care tasks rather than maintaining an inquisitive mind around incidents and their significance, reporting them through the appropriate formal channels, and acting as Mr B's and Mr B's wife's advocate'.*

5.99 Again, there was a lack of any coordination of support and assessment or action.
The Cambridgeshire Community Services IMR states:
'The incidents after admission to RH should have alerted HCPs to

[21] Rivastigmine transdermal patches are used to treat dementia

recognising Mr B's deterioration, thereby enabling discussion of realistic plans for care, and referral for appropriate care funding. A joint visit with GP and MSPCN/DN would have given Mr B and Mr B's wife consistent messages across all the multi-disciplinary teams around health progression and expectations for the future.'

5.100 This failure to identify and record on the DATIX system was a major inhibitor to the identification of the growing concerns being raised by Mrs B and witnessed by the District Nurses.

5.101 As a result of this case and other concerns about the Care Home, the Trust worked closely with Luton Clinical Commissioning Group Deputy Director Nurse to remind staff of their duty of care around raising concerns/safeguarding. A full review of training has been completed in line with Intercollegiate Adult Safeguarding: Roles and Competencies for Health Care Staff. (August 2018 RCN).

Recommendation

Cambridgeshire Community Services: To be assured that all staff are fully aware of the requirement to record incidents on the DATIX system.

5.102 On the 8th March 2018 the Social Worker requested an extension to respite, the rationale given was to allow the allocated worker time to reassess Mr B, and arrange a professionals' meeting to look at his health and social care needs. This appears to be in preparation of him going home. It totally ignored the immediate concerns being highlighted. Unfortunately, a professionals' meeting never took place as Mr B died a few day later.

5.103 Given the concerns raised by Mrs B, the Social Worker should have visited the Care Home and seen Mr B to seek his views before requesting an extension of respite.

5.104 It would appear that by the 7th March 2018 there were serious concerns about Mr B's health and that he was approaching his final days. This was a point in time which provided an opportunity for a professionals' meeting to consider the options for his final days. Mrs B had always made it clear that she wanted him to have his last days at home. An option for fast-track funding to support that could have been explored. It was not, and as previously stated, Mrs B whilst understanding he was dying, had no thoughts that it would be so soon.

5.105 The 2016 report Serious Case Review Concerning Western Rise

Residential Home also highlighted the issue:

'The key issue is a widespread culture of acceptance; accepting the situation in a home without probing further or challenging. That acceptance occurred within the staff employed within the home and within healthcare staff that visited. Policies, procedures and regulatory systems should identify incompetence, poor practice and poor management; however when the system is under pressure, when staff feel that there is nowhere else to place "difficult" residents, then issues that might in another context trigger an alert, may not do so. When staff of all kinds see others accepting poor standards, then their own willingness to challenge can be blunted. Standards can deteriorate until someone calls a halt'.

Recommendation

Luton Safeguarding Adults Board: To be assured that multi-agency staff who attend care homes are cognisant of what good care looks like and how to report when evidence of failing care is identified.

Organisational Changes

Whilst this report has highlighted shortcomings in the provision of service, it is important to recognise organisational changes that have been introduced as a result of this case.

Adult Social Care

5.106 Luton have introduced a new way of working based on the three-conversation model and is called side by side. A key feature is having in place multi agency, multi-disciplinary huddles with health and other partners. The new approach has included Adult Social Care staff being upskilled to have the difficult conversations required in this case and to be more confident in challenging partners.

5.107 They now have a rolling programme around legal framework for Mental Capacity Act and how to put it into practice, as well as training on what a 'good' assessment looks like.

Cambridgeshire Community Services

5.108 They have:

- Revised Mental Capacity and Adult Safeguarding Training
- Revised wound care guidance specifically around skin tears and links to safeguarding.
- Commenced daily minuted handovers within the district nursing service

5.109 **Luton Clinical Commissioning Group**

The Clinical Commissioning Group have now appointed a Multi-Agency Safeguarding Hub Nurse for Adults. Their role is to work closely with a care home when concerns are raised. If there are any themes and trends, they will work with the Local Quality Assurance and Care Placement Team and the Clinical Commissioning Group safeguarding team to collaboratively support positive changes.

Part One Conclusion

5.110 The report, Ambitions for Palliative and End of Life Care: A national framework for local action 2015-2020[22] sets out six positive ambitions for future local end of care support. Whilst there is significant learning to be extracted from this case for all agencies, two of the six ambitions highlight the biggest learning from this case.

5.111 **Ambition One:** Each person is seen as an individual

'I, and the people important to me, have opportunities to have honest, informed and timely conversations and to know that I might die soon. I am asked what matters most to me. Those who care for me know that and work with me to do what's possible.'

5.112 Mr B's voice was not being heard or if it was it was not being recorded. This was a failure by agencies and is against the NICE guidance and the six principals of the Care Act 2014 Making Safeguarding Personal[23].

5.113 Mrs B was the focal point, but at no stage was it explained to her that it was important to obtain the views of her husband. There is no evidence that advocacy was considered or any recorded undertaking of the Mental Capacity Act assessment. Whilst it is clear that Mr B's condition was deteriorating over time, there are indications that he did have a level of capacity.

5.114 He was clearly distressed whilst resident at the Care Home, but there is no

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[22] National Palliative and End of Life Care Partnership
www.endoflifecareambitions.org.uk

[23] **Making Safeguarding Personal** (MSP) is a sector-led initiative which aims to develop an outcomes focus to **safeguarding** work, and a range of responses to support people to improve or resolve their circumstances.
Six Safeguarding Principles

- **Empowerment**. Ensuring people are supported and confident in making their own decisions and giving informed **consent**. ...
- **Protection**. Providing support and representation for those in greatest need. ...
- **Prevention**. ...
- **Proportionality**. ...
- Partnerships. ...
- **Accountability**.

evidence that there were any attempts to try and identify how he was feeling. What is of greatest concern is the fact that Mr B was in the Care Home against his will.

5.115 **Ambition Four:** Care is coordinated

'I get the right help at the right time from the right people. I have a team around me who know my needs and my plans and work together to help me achieve them. I can always reach someone who will listen and respond at any time of the day or night.'

5.116 There were a group of professionals assigned to him and individually they supported him and his family, but there was little evidence that they were a team who understood Mr B's wishes. His multi-agency support was not co-ordinated, and this lack of coordination possibly caused unnecessary distress to his wife.

Recommendation

Luton Safeguarding Adult Board: To review the National Framework to identify local areas of weakness as set out in the six ambitions.

5.117 Professionals need to be reminded that whilst an individual may be subject to end of life care and their health may deteriorate suddenly, they still deserve to die with dignity and with a high level of care being provided. If there is evidence that the standard of care is failing, or safeguarding concerns are raised, then positive action needs to be taken, including making safeguarding referrals.

5.118 In this case Mrs B raised a number of issues that highlighted that Mr B was in receipt of poor care. Professionals failed to work together to review his care and consider other options including increase supported care at home or hospice care. Had this taken place, whilst it would not have stopped him dying, it might have ensured that he died with dignity, and that Mrs B might have had closure and not continue to blame herself.

Part Two

5.119 Part two of this report will examine if concerns highlighted by Mrs B, evidenced in the Care Quality Commission inspection of May 2018 and in Section 42 safeguarding enquiries, could have been actioned earlier.

5.120 **Care Home Inspections and Reviews**

There are two oversight processes relevant to residential care home settings:

- Care Quality Commission Inspections.
- Local Authority Quality Assurance and Contracts Team Reviews.

5.121 **The Care Quality Commission**

The Care Quality Commission regulates all health and social care services in England. The commission ensures the quality and safety of care in hospitals, dentists, ambulances, and care homes, and the care given in people's own homes. They inspect across 5 criteria:

- Is the service safe?
- Is the service effective?
- Is the service caring?
- Is the service responsive?
- Is the service well led?

5.122 **Local Authority**

The HM Gov 2016 report Cutting Red Tape [24] sets out the role of Local Authorities

'Local authorities do not have a formal regulatory role but as commissioners and funders of 49% of adult social care places, they have significant contact with care homes through ensuring access to an adequate supply of suitable places and their need to procure and manage the contracts for these places. They must also ensure value for money and account for the use of public funds. This means that as part of the contract management processes, local authorities will visit and inspect homes on a regular basis to ensure that the needs of care recipients are still being met; and that the care packages being provided are of the necessary quality and value for money.'

5.123 The Care Quality Commission is the regulator and are responsible for the application of enforcement powers including closure. The Local Authority Quality Assurance & Care Placement Team Services oversee contracts and can only take action relevant to the contracting of a care home. They are restricted to the oversight of individuals being funded by the local authority both in local area and out of area. So as is highlighted in this case whilst the Care Home has 84 places only 10 at the time were being funded by Luton Local Authority.

5.124 Under the Care Act 2014 any safeguarding concerns identified are investigated by the local authority adult social care. The importance of the continued assessment of relevant information from all source is highlighted by SCIE Safeguarding and quality in commissioning care homes[25]:

[24] The HM Gov 2016 report Cutting Red Tape [24]Review of adult social care - residential and nursing home sector

[25] **SCIE** Safeguarding and quality in commissioning care homes: https://www.scie.org.uk/publications/guides/guide45/prevention.asp

*'The local authority has lead responsibility for safeguarding in its area. Safeguarding issues are more likely to arise in services that offer poor quality care. Commissioners should therefore take an active interest in the quality of **all** care service provision in their area, including the integration of health and social care, whether or not it is commissioned by them and whatever the method of funding.*
The Association of Directors of Adult Services (ADASS) assert that 'it is important not to rely only on single means of quality assurance but to be able to triangulate information from different sources to be able to evaluate effectiveness, both of partner organisations as well as the partnerships' (ADASS, 2011)'.

5.125 There should be in place a Safeguarding and Quality Assurance loop which ensures:

- Regular Quality Assurance
- Safeguarding info continually passed to Care Quality Commission, Care and Support and Commissioner
- Safeguarding concern raised, Quality Assurance & Care Placement Team provides background information for investigation
- Outcomes of investigation informs future monitoring and actions with Provider.

5.126 The following section sets out the involvement and interaction between the Care Quality Commission, local authority Quality Assurance & Care Placement Team including section 42 safeguarding enquiries in respect of this Care Home.

5.127 **The Care Quality Commission**
The Care Quality Commission inspected this Care Home in January 2016. It was at that time graded as 'good' across all criteria.

5.128 The Care Home made a statutory notification to the Care Quality Commission on the 28th March 2018 in respect of allegations of abuse in respect of Mr B. The Care Quality Commission had previously been notified on the 19th March that this was an expected death.

5.129 In May 2018 as a result of the Section 42 enquiry in respect of Mr B and other concerns, the Care Home was subject to further inspection (review brought forward from June 2018). The inspection outcome graded the home as 'inadequate' across all criteria except 'is the service responsive' which was graded as 'requiring improvement'.

5.130 It found
'People's experience was poor living at X. There had been substantiated concerns from the local authority about neglect and acts of omission. The

people who we spoke with did not speak very positively about the service. We had concerns that people were not always safe who were at risk of falls, those who were an unhealthy weight, and those who needed certain medicines. Staff did not always respond to safeguarding concerns in a safe way. People's dignity and comfort was not always promoted. Staff did not engage with people in way which demonstrated that they knew the people they were looking after.'

5.131 Issues identified during the Care Quality Commission inspection were similar to areas of concern being expressed by Mrs B in February 2018.

5.132 As a result of this inspection the Care Home was placed under special measures[26].
A further Care Quality Commission inspection undertaken in January 2019 found the home to be 'inadequate' across all criteria.

5.133 Following the January 2019 inspection, Care Quality Commission took urgent enforcement action and imposed additional conditions on the provider's registration relating to the location of this Care Home. The conditions restricted new admissions to the home without Care Quality Commission agreement and required the provider to submit monthly reports on actions taken to address the issues at the home. These conditions took immediate effect. The provider did not appeal this imposition and the information was published and is public information.

An inspection held in July 2019 was rated 'Requires Improvement' in all domains other than 'effective' which was 'good'. The home at this stage was removed from 'special measures.'

5.134 **Local Authority Quality Assurance & Care Placement Team**
The Local Authority Quality Assurance and Care Placement Team undertook a review in January 2017. At this time, they utilised the Association of Directors of Adult Social Services (ADASS) workbook process. The Care Home was graded as 'good'. Two areas failed to reach the required standard these being staffing, workloads and safeguarding.

5.135 Following the January 2017 review a remedial action plan was produced. This was validated by the Local Authority in April 2017. Because the 2017 review provided a 'good' rating it did not initiate their escalation process and place the Care Home on a performance review. They only followed up

[26] The purpose of special measures is to:

- Ensure that providers found to be providing inadequate care significantly improve.
- Provide a framework within which we use our enforcement powers in response to inadequate care and work with, or signpost to, other organisations in the system to ensure improvements are made.
- Provide a clear timeframe within which providers must improve the quality of care they provide or we will seek to take further action, for example to cancel their registration.

on the areas that required improvement by validating their evidence of corrective actions. There was no detailed examination of the action plan having been implemented.

5.136 The Quality Assurance and Care Placement Team undertook a second review of the Care Home between the 15th to 17th of January 2018. It coincided with their planned yearly review as the previous review but appears to have been promoted by a Section 42 enquiry and the concerns raised at that time.

5.137 Some of the areas highlighted in January 2017 were again identified as failing in the January 2018 review. This appears to evidence the failure of the provider to implement and sustain effective changes. This brings into question the issue of how a local authority can be assured that improvements are maintained. There is a need to have clearly evidence sustainable improvement over an extended period of time.

5.138 The Quality Assurance and Care Placement Team IMR highlights:
'*….action plans were produced by the quality team to monitor the concerns highlighted. However, most of them were not fully completed with any outcomes recorded and the filing of evidence was disorganized*.'

Recommendation

Quality Assurance & Care Placement Team: To consider monitoring actions plans to rectify failings over a longer period of time.

5.139 The January 2018 review (a month before Mr B became a resident) used a different assessment process the PAMMS system. The Quality Assurance and Care Placement Team reviewing officers identified that the Care Home required improvement in 12 of the 16 standards in the PAMMS[27] system. These 16 standards come under 5 Domains:

1. Involvement and Information
2. Personalised Care and Support
3. Safeguarding and Safety
4. Suitability of Staff
5. Quality of Management

It is of note that they also completed the ADASS system (used in January 2017) alongside the PAMMS and found the home was still graded as 'good' despite the failing in 12 out of 16 areas. This demonstrates the deficiencies in the ADASS assessment or its application. 'Good' did not adequately describe the care provision being provided, when taking into account the recorded weaknesses both in 2017 and 18 and provided a false assurance of the care being provided.

[27] Provider Assessment and Market Management Solution (PAMMS)

5.140 It is of note that the Quality Assurance & Care Placement Team review officers were only able to review residents funded by the local authority. In this case it was 10 residents out of the home capacity of 84. As has been already evidenced they were aware of the concerns identified in the ongoing Section 42 enquiry.

5.141 The following were areas of concern found during the 2018 review. They support the complaints raised by Mrs B.

5.142 Mental Capacity: Failure to comply around consent and adherence to the Mental Capacity Act with incorrect procedures being followed. The IMR author found that whilst the home had been graded good in this area in 2017, examples of similar failing practice had been found but not reflected in the 2017 grading.

5.143 Organisational Culture: Evidence of daily records being written in undignified ways and missing entries for seven days for one user. This had been identified in 2017 and was considered to have been addressed by April 2017 by the provider. Action taken had not been sustained.

5.144 Six of the 12 failing areas came under the safeguarding and safety domain or were related to potential risk including:

5.145 Safeguarding Nutrition: Assessments and care plans evidenced and documented the "potential to cause harm"

5.146 Safeguarding reporting: It was found that staff interviewed stated that if they had safeguarding concerns, they had to report to the manager who would then investigate and report if necessary. This was contrary to the Adult Protection & Prevention Policy which states that staff are responsible for reporting directly to the local authority. This was similar to a finding in January 2017, evidencing that the issue had not been addressed.

5.147 Safeguarding Medication**:** The review found poor infection control practices. Issues around medication were found in the 2017 inspection. Improvements were noted.

5.148 Suitability of Staffing reports that the care home at times was short staffed, which left the residents not effectively supported during those times. This had been identified in 2017.

5.149 Other concerns in the safeguarding domain included ineffective risk management records which were either not completed or not robust.

5.150 The Quality Assurance & Care Placement Team IMR highlighted the

following:
'The quality of officers reported that they had suspicions of further issues within the home but these could not be pursued directly due to lack of evidence. The quality officers also reported that staff were observed to be very defensive during the review and information was not easily presented'

5.151 As a result of this review, the provider was supplied with a copy of the findings on the 12th February 2018 with a two-week deadline for the provider to respond. The provider challenged the report and was given until the 21st March 2018. They were visited by the Clinical Commissioning Group Quality Nurse for Care who undertook training to support improvement.

5.152 Following the January 2018 review and the subsequent action plan, the provider failed to make meaningful changes. This was evidenced by the Care Quality Commission May 2018 inspection which was highly critical in all areas including those identified as early as January 2018.

5.153 The Quality Assurance & Care Placement Team IMR identified weakness in their review process and highlighted the following lessons:

- *To ensure that consistency in approach by officers is reflected in reports*
- *To use new intelligence from the report conducted in 2019 which shows gaps in application of the MCA 2005 not unique to this Care Home.*
- *To ensure officers review previous years reports before conducting their annual review.*
- *On examining staff files, use any information relating to staff to triangulate if it has relevance.*
- *Appropriate and effective filing system put in place to ensure evidence is easily obtained*
- *Work towards developing an open culture of transparency*
- *Officers to remain professional at all times regardless of challenges*
- *Duty of care to be priority which may mean having difficult conversations*
- *Always consider sharing intelligence with other professionals in order for trends to be identified.*
- *To develop more robust action plans and ensure all areas for improvements are detailed and outcomes confirmed.*

The IMR author has produced an action plan to address these lessons.

Recommendation

Quality Assurance & Care Placement Team: To implement their IMR action plan.

5.154 **Section 42 enquiries**

Safeguarding concerns about the home were raised in late December 2017 when an individual suffered from a fractured femur. The Care Quality Commission were informed, and a Section 42 enquiry was commenced. An action agreed at the professionals meeting held on the 12th January 2018 was for the '*LBC Quality & Contracts dept, to monitor the care home records especially the daily logs and staffing levels'.*

5.155 At a second meeting linked to this Section 42 enquiry held 9th March 2018 the following was recorded:

'*I informed the police that because there have been a number of recent safeguarding alerts linked to the care home, our Contracts and Qualities department will be working closely with our Safeguarding team to monitor alerts as well as carrying out announced and unannounced visits to the care home*.'

5.156 This Section 42 enquiry was concluded in June 2018 and found that allegations of neglect and acts of omission of the individual's needs by the Care home were substantiated.

5.157 A second Section 42 enquiry was commenced on the 6th March 2018 following a safeguarding referral from a family member on the 1st March 2018. It raised significant concerns about the Care Home similar in many cases to those raised by Mrs B. The Care Quality Commission were notified of the case and as a result agree to bring forward their planned inspection of the home due in June 2018.

5.158 It was later in March 2018 that the Mr B's Section 42 enquiry was commenced.

5.159 **Response to Care Concerns**

By January 2018 a Section 42 Enquiry had commenced in respect of a serious injury to a resident of the Care Home, the Care Quality Commission were notified. The Quality Assurance & Care Placement Team were actioned to monitor the home situation and responded by undertaking a review in the knowledge that there was a Section 42 in place and that other concerns had been raised.

5.160 The review evidenced concerns and graded the home 'inadequate'. (This was before Mr B entered the home). It was at this point that the ongoing concerns were evidenced. Whilst the Local Authority review was limited to examining records of residents funded by the authority, there is a lack of evidence to indicate that the safety of non-local authority funded residents was being considered at that time.

It is of note that the individual at the centre of the Section 42 was a self-funder.

5.161 Mrs B was raising further concerns as early as the 24th February 2018, but as part one of this review highlighted, safeguarding was not being considered and there is no evidence that despite there being an open Section 42 enquiry and a failed review,
Mr B's concerns about the care of her husband were not being taken into account at this time.

5.162 Had Mr B's Social Worker been aware of the review outcome and the ongoing Section 42, the complaints by Mrs B might have elicited a different response. There is no evidence that Mr B's placement and ongoing concerns where joined up. Each concern was being dealt with individually.

5.163 There was an opportunity as early as late February /early March 2018 for all the findings of the Section 42 the Quality Assurance and Care Placement Team review and the new concerns to have been pulled together and reported to the Care Quality Commission. It was as a result of a further Section 42 enquiry (not Mr B), notified to the Care Quality Commission in March 2018 that triggered them to bring forward their planned inspection.

5.164 It was not until May 2018 after Mr B's death and the commencement of his Section 42 enquiry, that a Multi-Disciplinary Team meeting took place. The findings from May and January 2018 were shared along with issues raised by other professionals. It resulted in the following themes being highlighted:

- Unwitnessed falls, unwitnessed other events resulting in harm to individuals
- Staffing levels and deployment
- Appropriated MCA and DoLS, their understanding and application
- Clique culture" within the home, no empathy, no compassion, defensive
- Dependency tool and skill mix of staff not adequate.

5.165 Following a meeting with the provider, the Care home was placed on "provider performance" status under the council escalation policy. The Care Quality Commission undertook an inspection due in June in May 2018, and as described at the commencement of this section, the inspection found the home to be inadequate and placed it in "special measures[28]".

5.166 What has been highlighted, was a failure to co-ordinate a timely multi agency response to growing concerns about a care provider coming from different sources. The Quality Assurance and Care Placement Team,

[28] Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months.

undertaken partially as a result of the Section 42 in January 2018, should have led to serious questions being raised about the safety of other residents in the care home.

5.167 Instead, there was a prolonged dialogue with the provider. This was despite the knowledge that many of the failings had been identified the previous year and any action taken had not been sustained, so placed into doubt the provider's ability to take remedial action.

5.168 This set of circumstances highlight the unfortunate delays/deficiencies in the Quality Assurance and Care Placement Team review process. It was evidenced that failings identified in 2017 had not been rectified and new areas of concern were identified in January 2018. Despite this, the process of consultation with the home built in a delay. There was an opportunity to have notified the Care Quality Commission of the review findings in January 2018, given the lack of evidence that issues highlighted in 2017 were rectified by the home on a long-term basis.

5.169 This delay in positive action was highlighted in the 2014 Orchid View Serious Case Review [29]

'At some point all services are likely to have safeguarding concerns that need to be investigated. A safeguarding alert does not of itself mean that a service is poor. It is though a serious event and there is an onus on the service provider to treat it as such and to remedy the concern. A sign of a good service is how they rectify things that go wrong. What happened at Orchid View was more an avoidance of positive action to rectify problems, and a series of ineffectual action plans that were not acted on'.

5.170 If concerns had been raised and shared at the time across social care, commissioning the placement of Mr B at that Care Home might have been reconsidered, or at least have led to closer observations of the level of care being provided, and Mrs B's concerns might then have led to consideration of a further Section 42 enquiry prior to his death.

Recommendations

Quality Assurance and Care Placement Team: Should notify Care Quality Commission at the earliest opportunity when a review finds a Care Home to have significant failings.
Luton Borough Council: To have in place an effective intelligence cycle process that identifies and coordinates multiple complaints and safeguarding referrals against a provider and responds in a timely way to assess the level of risk to other residents.

[29] *Orchid View Serious Case Review (June 2014) West Sussex Adults Safeguarding Board*

5.171 **Criminal Investigations**

The police were involved in January 2018 with the section 42 'fractured femur' case. An investigation was undertaken but did not result in evidence of any criminal offences being established. This indicates that when a specific offence such as assault or theft/fraud is suspected, they are recognised early by agencies and receive early police involvement. More complex offences may not receive the same consideration at an early stage of any safeguarding enquiry.

5.172 Examples of complex offences include the Courts and Criminal Justice Act 2015 which introduced an offence of providing for care worker/care provider offences of ill-treatment or wilful neglect and offences in respect of the ill-treatment and wilful neglect of patients receiving treatment for mental disorder (s.127 Mental Health Act 1983) and of those who lack capacity under the Mental Capacity Act 2005 (s.44 Mental Capacity Act).

5.173 These type criminal offences should be considered when there is increasing evidence of safeguarding concerns supported by evidence of failure of services.

5.174 Officers investigating these complex offences require a good investigative knowledge. It is important to secure police involvement at an early stage, as significant delays will impact on an investigator's ability to gather the evidence that might be required. Examples include the interviews of staff and securing of physical evidence including files reports etc. These offences should ideally be joint investigations so that the police are supported by expertise in the area of health and care.

5.175 In this case the May 2018 Multi-Disciplinary Team meeting would have been an appropriate time to consider police involvement given the level of concerns being raised. Inclusion of police at that meeting would have been appropriate. Police did not become involved until January 2019. By this time police did not believe that they had been supplied with sufficient evidence to establish that any criminal offences had been committed. There is need for safeguarding professionals to have a level of legal knowledge in order to consider the potential offences that their enquiries might start to identify. Police involvement does not automatically imply that offences have been committed.

Recommendation

Bedfordshire Police and Adult Social Care: To ensure that staff involved in adult safeguarding have a good legal knowledge of potential criminal offences that might be relevant to cases of ill treatment and or neglect.

5.176 **Organisational Changes**

Bedfordshire Police

The management of criminal investigations involving vulnerable adults within Bedfordshire Police is covered across many teams. Since this enquiry, Bedfordshire Police have designated a Detective Chief Inspector as lead for vulnerable adults. Bedfordshire Police provided the following update:

'An Improvement Plan has been created to ensure continued learning and good practice across the force from frontline to specialist units. The Improvement Plan covers the requirement to complete audits of Vulnerable Adult investigations, continued professional development opportunities and improved partnership working.

'We ensure we participate in the Safer Adult Boards from operational to executive level. The Child and Vulnerable Adult Abuse Team (CAVAA) has now been transformed into the Protecting Vulnerable People (PVP) Team. They are a specialist team who manage investigations regarding familial abuse of children and offences regarding Vulnerable Adults within care settings, home care situations or have issues with capacity. This team is experienced in partnership working and are aware of the legal knowledge required for these types of investigation. We continue to liaise with our partners to ensure early engagement to enable assessment of concerns to identify criminal activity and preserve evidence.'

5.177 **Luton Adult Social Care**

The author has been informed that as part of Adult Social Care's on-going commitment to the development and enhancement of an integrated Adult Safeguarding system in Luton there has been continuing work to promote a partnership approach with police. Adult Social Care confirmed the following:

'Work has been undertaken with the practitioners undertaking Adult MASH triage and screening of incoming referrals to further embed the need to also consider any potential criminality and/or input from police colleagues from the outset when undertaking these activities. Making appropriate checks, facilitating liaison and/or reporting to police colleagues appropriately. This has included work and feedback to providers. For example, historically many care home Providers will report a physical assault between residents to safeguarding but not report it to police. Adult Social Care staff have worked with the providers to ensure a clear and consistent message that they must report also report to police, with due reference number expected. There has been push back from Providers with some, in the earlier phase, advising when they made such reports, the response frequently received from front line police teams/call handlers was that such instances do not require reporting to them. However, ASC has striven to maintain consistent messaging to Providers,

ie they must make police reports as required. There was also liaison with our police safeguarding colleagues regarding the information Providers were reporting, which they took forward and positive change is evident, with this ceasing to be a reported issue by Providers.

However, in the course of further work, such as an s.42 enquiry or a review, social care practitioners are clear of the expectation they take any such development and/or concern forward with police or seek further guidance from management if they have query.

Further pan-Bedfordshire partnership work-streams are planned for ASC, Bedfordshire Police and local Crown Prosecution Service (CPS) with the aim of further honing joint working pathways and opportunities to improve outcomes for vulnerable adults.'

Recommendation

Luton Safeguarding Adult Board: To monitor the progress and impact of the planned partnership work streams.

6. Conclusion

This review examined two sets of events that were running parallel with each other and did not join up until after Mr B's death. The level of care and support for Mr B had whilst at home or during respite and the ongoing quality of the Care Home provision.

6.1 Mr B became a resident in the Care Home in February 2018 and was immediately reported to be subject to sub-standard care. These incidents were not being recorded by health care professionals on their DATIX system and so were not being coordinated. The Social Worker failed to respond by visiting Mr B at the Care Home to investigate the listed concerns, including falls.

6.2 The level of concerns being reported should have been subject to a safeguarding referral and potentially a Section 42 enquiry. This would then have led to a multi-agency response and action to help support Mr B. This did not take place and led to an extension of his respite care being granted without taking into account the ongoing alleged failings of the provider.

6.3 At the same time there were other Section 42 enquiries being undertaken related to that Care Home and the level of the failings of care at the Care Home had been evidenced during the January 2018 Quality Assurance and Care Placement Team review, including areas identified the previous year.

6.4 The combination of the evidenced review failings and concerns raised by Mrs B should have led to consideration as to whether other residents in the Care Home were potentially at risk of harm, and immediate action should have been taken including informing the Care Quality Commission of the result of the Quality

Assurance and Care Placement Team review.

6.5 It was not until a further Section 42 enquiry was commenced in March 2018 that the Care Quality Commission took action to bring their inspection forward to May 2018. A Multi-Disciplinary Team meeting was undertaken in May 2018 and placed the provider on "provider performance" and following the Care Quality Commission inspection placed them in "special measures." Even when placed under 'special measures' following the May 2018 inspection, there is limited evidence that demonstrates that the situation changed. This is evidenced by the January 2019 inspection which still found the Care Home 'inadequate' despite being in "special measures".

6.6 This case highlights the challenges faced when a care provider is failing, and the ability of the Local Authority and also the Care Quality Commission to implement significant immediate sustainable change to ensure that all residents are safe, and their wellbeing supported.

6.7 The Dept of Health guide Managing Care home Closures[30] highlights the following:

Continuity of quality care
Providers should do all they can to prevent care homes closing where possible, particularly where remaining open is in the best interests of the residents and where issues effecting the operation of the home can be overcome.

Where remaining open is both in the best interests of the residents and it is possible to overcome issues, partners should do all they can to prevent care homes closing where possible.

***Quality** - There should be a single shared view of quality between organisations that have a role in scrutinising quality. This will give care providers clarity on what they need to do to avoid failures of quality.*

***Success and sustainability** - Care providers should work with partners to access high-quality and consistent support to tackle challenges to quality and sustainability.*

6.8 The care home market is fragile, and a closure of any home has major repercussions for both residents and placing authorities. The guidance is correct, and the potential closure of a care home should be avoided but at what cost if there is limited improvement. Positive timely action must be taken in respect of wellbeing and safety of residents if conditions are not significantly improved over a short period of time.

[30] *Dept of Health guide Managing Care home Closures* NHS England Publications Gateway Reference 05573

6.9 In this case, the taking of initial action was slow and caused a delay in taking positive action for four months, during which time residents continued to suffer as highlighted by the cas of Mr B.

6.10 Lessons Identified

This review has highlighted a number of lessons:

- The need for the coordination of palliative care between supporting agencies to ensure that there is a clear care plan in place, subject to review as circumstances such as deterioration of health or changes in the care provision. This should encourage where possible joint visits.
- The voice of the individual subject of the care provision must be heard. This should be clearly recorded and where necessary there should be in place Mental Capacity Act to evidence capacity.
- Where a lack of capacity is evidenced the use of advocacy should be considered to demonstrate that decisions are being made in their best interest.
- Care professionals should have a good understanding of the impact of Lasting Powers of Attorney including the role of the Court of Protection.
- Serious reported concerns about the level of care being provided in a care facility must be responded to positively by visiting the facility and assessing the concerns and the suitability of the care home. If considered unsafe then a safeguarding referral should be made.
- Evidence from different sources that a care provider is failing (especially in the safeguarding domains) should be responded to in a timely way ensuring the involvement of the Care Quality Commission.
- There is a need for strongly evidenced validation of implementation and sustainability of a provider action plan over a reasonable period of time.
- Early police involvement in enquires is important in order to secure potential evidence.

7. Recommendations

1 *Luton Safeguarding Adults Board: To be assured that the agency recommendations as set out in the Section 42 Safeguarding Enquiry have been actioned.*

2 *Luton Clinical Commissioning Group: To oversee the implementation of Clinical Commissioning Group palliative care review recommendations.*

3 *Luton Safeguarding Adults Board: To be assured that the Clinical Commissioning Group palliative care review recommendations have been implemented.*

4 *Luton Safeguarding Adults Board: To review the training of Mental Capacity Act and seek to identify the inhibitors to its clear understanding and application.*

5 *Luton Safeguarding Adults Board To ensure that agencies provide staff with a good legal knowledge of Lasting Power of Attorney including the role of the Court of Protection.*

6 *Cambridgeshire Community Services: To roll out the new Advanced Care Planning template and monitor its usage.*

7 *Luton Borough Council: FACE funding application assessments should include any identified ongoing concerns about the Care Home subject to the application.*

8 *Luton Adult Social Care: When concerns are raised with a social worker about a care provider there should be a notification to the Quality Assurance & Care Placement Team.*

9 *Cambridgeshire Community Services: To be assured that all staff are fully aware of the requirement to record incidents on the DATIX system.*

10 *Luton Safeguarding Adults Board: To be assured that multi-agency staff who attend care homes are cognisant of what good care looks like and how to report when evidence of failing care is identified.*

11 *Luton Safeguarding Adult Board: To review the National Framework to identify local areas of weakness as set out in the six ambitions.*

12 *Quality Assurance & Care Placement Team: To consider monitoring actions plans to rectify failings over a longer period of time.*

13 *Quality Assurance & Care Placement Team: To implement their IMR action plan.*

14 *Quality Assurance and Care Placement Team: Should notify Care Quality Commission at the earliest opportunity when a review finds a Care Home to have significant failings.*

15 *Luton Borough Council: To have in place an effective intelligence cycle process that identifies and coordinates multiple complaints and safeguarding referrals against a provider and responds in a timely way to assess the level of risk to other residents.*

16 *Bedfordshire Police and Adult Social Care: To ensure that staff involved in adult safeguarding have a good awareness of all potential criminal offences that might be relevant to cases of ill treatment and or neglect.*

17 *Luton Safeguarding Adult Board: To monitor the progress and impact of the planned partnership work streams.*

GLOSSARY OF ACRONYMS

ADASS	Association of Directors of Adult Services
ASC	Adult Social Care
CAVAA	Child and Vulnerable Abuse Team
CPS	Crown Prosecution Service
DN	District Nurses
DNAR	Do not attempt Resuscitation
DoLS	Deprivation of Liberty Safeguards
GP	General Practice
HCP	Health Care Professionals
IMR	Individual Management Reviews
MASH	Multi Agency Sharing Hub
MSPCN	Macmillan Specialist Palliative Care Nurses
MCA	Mental Capacity Act
MCCT	My Care Coordination Team[31]
PAMMS	Provider Assessment and Market Management Solution
PVP	Protecting Vulnerable People
RH	Residential Home