Safeguarding Adult Review

About

JOHN[1]

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Independent Author

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[1] Name has been anonymised

Contents

1. INTRODUCTION

Why is this Safeguarding Adult Review (SAR) being undertaken?

1.1 This SAR was commissioned by Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board (SSASPB) because of the death of John in March 2016; he was aged 66. He died as a result of choking on food and packaging which he had ingested at some time during the night in his care home; he was found unresponsive by care staff in the morning; they called an ambulance and he was pronounced dead. There had been long term concerns about John's binge eating and this was found to be a contributory factor in the cause of death along with cerebrovascular disease/stroke[2].

1.2 Section 44 of the Care Act 2014[i] requires a Safeguarding Adults Board (SAB) to undertake a Safeguarding Adult Review (SAR) if:

- A*n adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) has died,*

And

- T*here is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult.'*

About John

1.3 John was previously a resident of Stoke on Trent and had received care and support from Stoke on Trent Adult Services; they funded his care under Section 117 entitlement[3]. The care home where he had lived for 15 years was in Staffordshire. He had a mild learning disability and a diagnosis of schizophrenia. He is White/British. He has one surviving sister. John said he liked living in the care home. He was very close to the two other residents and often went out to lunch and the pub with them. He was sometimes sad when he thought about his mother and father and he reported missing them. He also had two friends at the home who had died and he talked also of missing them and talked to staff regularly about these losses. He liked music, particularly songs of the 60's[4]. He was visited and contacted by his sister, which he said he enjoyed.

The Care Home where John lived

1.4 John lived in a care home which is registered to provide accommodation and personal care for up to 7 people with learning disabilities. During the period of time being

[2] This was the conclusion of the post-mortem as part of the inquest

[3] Section 117 Mental Health Act 1983 (MHA 1983) imposes duties on NHS Clinical Commissioning Groups (CCGs) and Local Social Services Authorities (LSSAs) to provide after-care for patients who have been detained under section 3, 37, 45A, 47 and 48 of the MHA 1983 once they leave hospital.

[4] This information is taken from the profile of John held in the care home records, the person-centred planning tools on file and the detailed daily logs.

reviewed there were only three residents. The Care Quality Commission (CQC[5]) carried out an unannounced inspection in April 2015. The overall rating for the home was "Required improvement". The provider did not act at all times in accordance with the Mental Capacity Act (MCA) 2005 Deprivation of Liberty Safeguards (DoLS) to ensure decisions were made in people's best interests when they were unable to do this for themselves in breach of Regulation 11 HSCA (RA) Regulations 2014[6] the need for consent and there were not always sufficient numbers of staff on duty to meet the needs of people who used the service in breach of Regulation18 HSCA (RA) Regulations 2014 Staffing[7]. The feedback during this inspection from the three residents (including John) was that the staff were kind and treated them with dignity. Relatives praised the open culture and leadership from the care home manager. The Inspectors considered that residents were facilitated to attend appointments, there was appropriate liaison with other professionals and that residents had access to and were supported to eat adequate amounts of food and drink. The home was asked to address the areas that needed improvement through an action plan which was reviewed at the next inspection. There was no further inspection until after John died. The most recent unannounced inspection highlighted improvements in a number of areas.

1.5 Action was taken to ensure the wellbeing of the two remaining residents after John's death; they were found to be provided with effective care and support and they remain living in the care home.

Process of the Review

1.6 The SSASPB Safeguarding Review Panel considered the circumstances of John's death on the 15th July 2016 and proposed that a SAR be conducted; this was agreed by the Independent Chair of the SSASPB. The SAR was halted because of a police investigation which subsequently concluded that no criminal act had been committed and the SAR process recommenced in May 2017.

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[5] The CQC is the independent regulator of health and adult social care in England. They make sure health and social care services provide people with safe, effective, compassionate, high-quality care and we encourage care services to improve. www.cqc.org.uk

[6] Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 11. The intention of this regulation is to make sure that all people using the service, and those lawfully acting on their behalf, have given consent before any care or treatment is provided. Providers must make sure that they obtain the consent lawfully and that the person who obtains the consent has the necessary knowledge and understanding of the care and/or treatment that they are asking consent for.

[7] Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 18
The intention of this regulation is to make sure that providers deploy enough suitably qualified, competent and experienced staff to enable them to meet all other regulatory requirements described in this part of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

1.7 It was agreed that the SAR would review the period from May 2015 when John's care needs were reviewed to March 2016 when he died. Each agency involved with John was asked to complete a chronology and appraisal template (see appendix 1 for a list of agencies). The care home records were also reviewed including daily logs, care plans for John, staff meeting notes and residents meeting notes.

1.8 A panel of senior managers (see appendix 1) was convened and oversaw the review process, received draft reports and provided feedback to the overview author. Interviews were held with all the professionals who had contact with John during the review period. The overview author visited the care home, met the two residents and interviewed the Manager; but the staff could not be interviewed as they had all left their posts. These were the people who knew John well and their perspectives have been included through the use of their police statements completed as part of the criminal investigation.

1.9 All the professionals involved with John were invited to a practitioner's event to discuss emerging themes and to reflect upon the chronology of events. We are very grateful to all who attended, and for providing helpful and thoughtful feedback. This was not easy for them as many had built up a relationship with John and were affected by his death.

1.10 John's sister was invited to participate in the review process, but felt she was unable to because of poor health.

1.11 This overview author for this SAR is Jane Wiffin. She is an experienced safeguarding professional and social worker with extensive experience in safeguarding practice and over 15 years' experience of undertaking Serious Case Reviews and more recently Safeguarding Adult Reviews. She has authored over 75 reviews, most of which have been published. She is completely independent of all agencies involved in this review.

2. CHRONOLOGY OF PROFESSIONAL INVOLVEMENT: MAY 2015 TO MARCH 2016

2.1 On the 22 May 2015 John had his learning disability register review[8] at the GP's. John was brought by the care home manager (CHM) who reported that there had been a deterioration in John's wellbeing; he was unsteady on his feet, his speech was slurred, he had lost weight, he was sleeping a lot and seemed tired, at times he was also described as agitated and argumentative. The GP referred him to the TIA[9] clinic and he was seen on 28th May 2015. The clinic assessed that John had suffered a minor stroke with some face weakness and dysarthria[10] (difficulties in speaking and swallowing). Medication was prescribed and no follow up treatment was required.

2.2 On 17 June 2015 Social Worker 1 (SW1[11]) started the review of John's care and support needs. This review should have been undertaken annually[12ii] but was delayed and the delay meant there was no up-to-date Local Authority Care and support plan[13]. The CHM reported a deterioration in John's wellbeing and asked for there to be a reassessment of his care and support needs, including a consideration of funding arrangements with the aim of increasing the support provided. The CHM reported that John had had a TIA, was doubly incontinent and his behaviour had become more challenging, including an escalation in binge eating behaviour and getting up in the night to access food. SW1 agreed that a full Living Well Assessment[14] was required. A referral was made to the Community Learning Disability Team for:

- Occupational Therapy assessment because of the reported mobility issues
- Speech and Language assessment because of the reported swallowing difficulties;
- Continence assessment;
- Physiotherapy;
- Falls assessment;

[8] Adults who have a learning disability can join the learning disability register which means they get extra support form their GP and an annual health check. https://www.mencap.org.uk/advice-and-support/health/dont-miss-out/dont-miss-out-guides

[9] Transient Ischemic Attack (TIA) is a "mini stroke" that occurs when a blood clot blocks an artery for a short time. The only difference between a stroke and TIA is that with TIA, the blockage is transient (temporary). Unlike a stroke, when a TIA is over, there is no permanent injury to the brain.

[10] Dysarthria is difficulty speaking caused by brain damage or brain changes later in life. ... slurred, nasal-sounding or breathy speech. ... difficulty swallowing (dysphagia), which may lead to constant drooling.

[11] This was a social worker from Stoke on Trent Adult Care team

[12] Under section 27 of the care Act 2014 it is expected that care and support Plans are reviewed annually, unless there is a need to review earlier than this http://www.legislation.gov.uk/ukpga/2014/23/section/27/enacted

[13] Following the needs and carer's assessment and determination of eligibility a plan must be provided where a local authority is required to meet needs under section 18 or 20(1) of the Care Act, or decides to meet needs under section 19(1) or (2) and 20(6) of the Act

[14] Local authorities must promote wellbeing when carrying out any of their care and support functions in respect of a person. This may sometimes be referred to as 'the wellbeing principle' because it is a guiding principle that puts wellbeing at the heart of care and support. Care Act 2014

- Dementia assessment.

2.3 This was a comprehensive assessment package to address John's complex needs which was instigated by SW1, but over time there was a lack of clarity regarding who was responsible for the development of the care and support plan for John, how this plan would link with the existing care plans within the care home and who would be the Lead professional[15]. This issue of confusion and uncertainty about roles and responsibilities of key professionals is addressed in Finding 1. The reassessment of the number of hour's support John needed was never completed. Funding for waking night staff to support John was agreed in March 2016 and was not instigated by the care home. The drift in this aspect of the agreed review of John's care and support needs was exacerbated by the absence of any recording regarding the assessment process (**see Finding 3**) and any multi-agency processes to coordinate progress of the assessments and finalise a new care and support plan. This importance of a coordinated multi-agency plan which is reviewed over time is addressed in **Finding 2**.

2.4 John was seen in July 2015 by the Community Learning Disability Nurse as a triage process for all the subsequent individual assessments. He was seen again a week later regarding self-harm because of reported concerns regarding picking at his skin. There was no specific plan formulated for this and this aspect of his needs was not addressed; this appears to be because there was no overall multi-agency plan developed bringing together the information about all the current concerns regarding John's wellbeing. Something discussed in **Finding 2.**

2.5 John was seen on 4 August 2015 by a physiotherapist for a mobility assessment; verbal feedback was provided to the staff member on duty about how to improve his mobility. This advice was incorporated into his mobility care plan. The care home had multiple care plans for different aspects of John's life; this was not a helpful approach to care planning in the home, caused confusion for the care staff. This issue is discussed in **Finding 3** regarding poor recording practice across some of the professional network within the period under review.

2.6 On 5 August 2015 the speech and language therapist (SALT) tried to make contact with the home and found this to be very difficult as the phone was not answered and messages were not responded to; it made making appointments very difficult. This was an issue of concern for many professionals over time and poor communication is

[15] Local authorities should work alongside other professionals to establish a 'lead' organisation who undertakes monitoring and assurance of the combined plan (this may also involve appointing a lead professional and detailing this in the plan so the person knows who to contact when plans are combined). Particular consideration should be given to ensuring that processes are aligned, coherent and streamlined, to avoid confusing the person with different systems.

addressed in **Finding 3**. This was never raised directly by any professional with the CHM or staff.

2.7 The SALT did manage to make contact and visited on the 10 August 2015. A full assessment was completed and a "fork mash diet[16]" was recommended because of John's difficulties in chewing and eating large lumps of food. The plan was explained to the member of staff present and a leaflet and plan were provided. This was a clear and appropriate plan. The SALT was concerned because the member of staff on duty could not provide a clear history regarding John's minor stroke or the difficulties with chewing and could not provide written records. It is unclear why this was as John had a care plan for his health needs and a written record of all recent health appointments. This may have been caused by the many different care plans, making accessing information quickly difficult. This is something addressed in **Finding 3**. The SALT was not informed about John's habits of binge eating frozen food and other inappropriate foodstuffs, particularly at night. This meant that the proposed plan of action could not address these concerns or the additional risks these actions posed to John's chewing difficulties and the risk of choking. It remains unclear why this was but is picked up in **Finding 3** regarding poor communication within the care home setting and across the professional network.

2.8 The speech and language therapist sought advice from her manager the next day regarding her overall concerns about the care home and it was agreed that the CHM would be contacted (an attempt was made and a message left), the SW1 (a message was left) and the Community Learning Disability Team were sent an email. This was an appropriate plan of action and was an example of effective communication.

2.9 On the 12 August 2015 SW1 contacted the Local Authority finance team to report concerns that had arisen regarding John's finances during the review that had taken place 8 weeks earlier. It was agreed that SW1 would explore John's finances and carry out a mental capacity assessment of John's ability to manage them. This was an effective plan.

2.10 On the 2 September 2015 the speech and language therapist undertook a follow up visit to the care home. She was immediately concerned because John was sitting at the table with a bulging catheter bag and the member of staff on duty needed prompting to address this. The food diary was reviewed and it was clear that John had been offered food that was not recommended as part of the fork mashable diet. The speech and language therapist went through the recommendations with the staff

[16] Dysphagia Diet Food Texture Descriptors. These descriptors four descriptors detail the types and textures of foods needed by individuals who have swallowing difficulties and who are at risk of choking or aspiration (food or liquid going into their airway); Descriptor 4 is fork mashable Diet. The descriptors provide standard terminology to be used by all health professionals and food providers when communicating about an individual's requirements for a texture modified diet.
www.thenacc.co.uk/assets/downloads/170/Food%20Descriptors%20for%20Industry%20Final%20-%20USE.pdf

member again and left another copy of the report. It was agreed that compliance with the diet would be reviewed in 4 weeks' time.

2.11 The SALT emailed SW1 to express further concern and said that she would make a safeguarding referral to the Staffordshire Local Authority Safeguarding Team[17] if she found her recommendations were not being followed at the next visit. SW1 emailed back to say she would be undertaking an unannounced visit and would also be contacting Staffordshire County Council to make a safeguarding referral.

2.12 On the 3 September 2015 a quality assurance visit was carried out at the care home by Staffordshire County Council. This was not instigated as a result of concerns about John and he was not seen on any of the inspection visits. The Quality Report highlighted a number of areas that needed addressing:

- Ensuring that staff were up-to-date (including being trained) regarding legislation, good practice and particularly safeguarding;
- Correct policies and procedures available;
- Individual supervision sessions to be conducted, notes to be kept and signed by all;
- Ensure that person centred care plans are developed for all areas of support needed for each individual;
- Daily records to be more detailed by providing more information on behaviours exhibited by residents;
- To ensure that resident's mental capacity was assessed and their decision-making capacity recorded.

2.13 The care home was tasked with addressing these issues in preparation for the next monitoring visit. This information did not form part of the subsequent adult safeguarding (Section 42 enquiries[18]) and this is discussed in **Finding 4**.

2.14 On 8 September 2015 SW1 made an adult safeguarding referral regarding John focussed on concerns regarding possible financial abuse and compliance with support and the diet recommended by the SALT. This was assessed by the Staffordshire MASH[19] and it was agreed that an adult safeguarding (section 42) enquiry[20] would be undertaken. Stoke on Trent was the funding authority for John's placement and SW1

[17] This was a different social work team because the care home was in Staffordshire.

[18] Section 42 Care Act 2014 Enquiry by local authority: This section applies where a local authority has reasonable cause to suspect that an adult in its area (a)has needs for care and support (b)is experiencing, or is at risk of, abuse or neglect, and (c)as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it. The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case (whether under this Part or otherwise) and, if so, what and by whom.
http://www.legislation.gov.uk/ukpga/2014/23/section/42/enacted

[19] The Multi-Agency Safeguarding Hub (MASH) is the single point of contact for all professionals to report safeguarding concerns.

worked for this authority. John's care home was in Staffordshire and the SSASPB Adult Safeguarding procedures[21] make it clear that it is the responsibility of the local authority where a person lives to coordinate the enquiry process and SW2[22] was allocated to undertake this enquiry on 8 October 2015. The Adult Safeguarding procedures make it clear that where a different authority is funding a placement that the respective roles of the two social workers should be clarified and negotiated during the planning of the enquiries. This did not happen and this caused confusion about roles and responsibilities and this is discussed in **Finding 4**.

2.15 The SALT visited on the 28 September 2015. She reviewed the food diaries and evaluated that there had been increased compliance with the agreed diet and supervision. The member of staff agreed that they would continue to encourage John to eat appropriate food.

2.16 The SALT was concerned that the member of staff on duty was obviously unwell with a sickness bug and at one point left the room to be sick. She explained that there were no staff to cover her and so she could not go home; cover being a concern raised by the most recent CQC inspection. The information from this visit was shared with SW1, but the concerns regarding the member of staff being sick on duty was not shared with the care home manager. This is discussed further in **Finding 3**. The SALT told SW1 that she would be discharging John from the Speech and Language Service because of the progress made; this decision was made without the SALT being aware of the ongoing concerns regarding John's binge eating. The SALT also encouraged a re-referral for further assessment if there were any ongoing concerns. This information was shared with the care home who were encouraged to be in contact if there were any further concerns. This did not happen and no re-referral made.

2.17 SW1 and SW2 agreed to undertake a joint visit, so SW1 could introduce SW2 to John. There is no evidence that they discussed roles and responsibilities or agreed how the adult safeguarding enquiries would be undertaken. From this point on there was a crossover of roles and confusion about tasks to be completed which is discussed in **Finding 1**. The joint visit took place on 8 October 2015 and was unannounced because of problems making contact with the home in order to make an appointment. John was seen and said that he was happy living in the care home and he liked going out into the community for drinks and meals with his friend. He was able to say what he had eaten for dinner, but he could not say if there was any food he could not eat. The food diary kept by the home was reviewed and some food not recommended by the speech and language therapist was included. It is not clear what action was taken regarding this and whether this was discussed with any of the care home staff. There was a need at this point to discuss whether a mental capacity assessment regarding

[21] https://www.ssaspb.org.uk/Guidance/Section-42-Adult-Safeguarding-Enquiry-Procedures.aspx
[22] SW2 was employed by Staffordshire County Council Independent Futures.

food choice and compliance with the "fork mashable" diet was required and who would carry this out. This did not happen and is discussed in **Finding 5**.

2.18 At this visit SW1 met with the care home manager and other members of staff regarding John's finances. They reported that John had been managing his own finances; the home had recently discovered that John was not receiving his pension and this had led to him not having sufficient funds requiring the home to lend him money. The home manager had subsequently sorted out the pension and John had received a large back payment. Appropriately, SW1 completed a mental capacity assessment[23] of John's management of his finances and he was found not to have capacity. SW1 explained to John that Stoke City would become his benefit appointee. SW1 started the process of appointeeship[24] two weeks later and this was completed in a timely way.

2.19 There is no indication that SW1 and SW2 discussed their separate roles and responsibilities at this time and how they would manage these. This is something that is discussed in **Finding 1**. SW1 believed that an arrangement had been made for both of them to revisit the home on the 13 October 2015 but SW2 had not recorded this and therefore did not attend. SW1 concluded from this visit that John did understand what foods he could and could not eat and why he could not eat some. This conclusion was different from the thinking of SW2 who was uncertain about his mental capacity, but they did not discuss this and they then had no contact for the next 6 weeks. This should have prompted the need for a Mental Capacity Assessment (**see Finding 5**).

2.20 On 22 October 2015 John was visited again by the physiotherapist and he was not at home; the physiotherapist had found it difficult to make contact with the care home and had arrived unannounced as a consequence. The home manager reported that John had been carrying out the suggested exercises and was now back to his former level of mobility. He was discharged from the physiotherapy service and advice was given to re-refer if there were further problems. On the same day SW1 sought feedback on the progress of the referral to the OT and the Community Learning Disability Nurse (CLDN).

2.21 On the 26 October the Community Learning Disability Nurse (CLDN) tried to make contact with the home to make a visit to assess John. Her phone calls were either not answered or a member of staff could not organise a visit because the home manager

[23] Having mental capacity means that a person is able to make their own decisions. A professional should always start from the assumption that a person has the capacity to make the decision in question **principle 1** . Under the MCA 2005 professionals are required to make an assessment of capacity before carrying out any care or treatment if they have reasonable belief someone lacks capacity because their mind or brain is affected by illness of disability. http://www.legislation.gov.uk/ukpga/2005/9/contents

[24] An appointee or organisation is allowed to receive and/or oversee someone's benefits when they are unable to manage their own money due to disability, illness or special needs.

was not available. It was agreed that an unannounced visit would be undertaken with the Occupational Therapist (OT) on the 11 November 2015.

2.22 On the 30 October 2015 John was seen by a dietician. The member of care home staff with him reported that the care home had been following the prescribed diet and that there had been improvements in John's ability to chew and swallow safely. John had lost some weight and he was worried about it. The Dietician reported that his weight was in the normal range for him, but because John was worried about his weight, the dietician agreed that he could gain a small amount. The Dietician was happy with John's progress and discharged him from the service. John's binge eating of frozen foods, dried food such as cake mix and other unusual foodstuffs was not shared with the dietician and so remained unaddressed. This issue of enabling all risks to be evaluated in the context of the prevention of choking is discussed in **Finding 6**.

2.23 The OT and CLDN visited as planned on the 11 November 2015. John was assessed as having good communication skills and there were no observed or reported problems with eating, chewing or swallowing. The OT visited on two further occasions and appropriate aids and equipment were provided including a call bell to alert staff.

2.24 In mid-November 2015 the CLDN assessed that John had capacity to engage in dementia screening (DLD)[25]. This was completed on the 30 November and John's score indicated no concerns. The care home staff shared their concerns about John shredding his continence pads, eating them, eating faeces and wandering around at night. John told the CLDN that he was lonely as a result of the death of the person he shared a room with. The CLDN suggested that the care home put a star chart in place to help John change his behaviour through positive rewards. She proposed that he have access to a night light and that he should be encouraged to use the call button, even if it was early in the morning. A radio was recommended to address the loneliness and also to serve as a distraction to shredding the continence pads.

2.25 On 26 November 2015 SW1 contacted SW2 to ask about the progress of the adult safeguarding enquiry. SW2 responded via email and said that she had visited the home earlier that week (the visit was not recorded in the case files) and the care home staff said they had been given contradictory advice by the Dietician who reportedly said that John "*could choose to eat what he liked*". This information is not recorded in the dietician records and she is clear that this advice was not given, but this was not checked with her. SW2 replied by email and told SW1 that a capacity assessment was required regarding understanding of the prescribed diet. SW1 replied to SW2 by email and said that she would contact the speech and language team regarding issues of

25 www.pearsonclinical.co.uk/Psychology/AdultCognitionNeuropsychologyandLanguage/AdultGeneralAbilities/DementiaQuestionnaireforPeoplewithLearningDisabilities(DLD)/DementiaQuestionnaireforPeoplewithLearningDisabilities(DLD).aspx

capacity. SW1 expressed the view that the home were ultimately the decision makers regarding food choice and they needed to make John aware of the risk of eating inappropriate foods, which SW1 said was high. SW1 said she would be happy to attend a Best Interest meeting[26] to discuss this further. This was confusing because the best interest meeting would only take place where mental capacity had been assessed; this had not yet happened for John in relation to food choice and the degree to which staff could make decisions regarding the food he needed to eat. This was not discussed (see **Finding 5**). SW1 also asked that SW2 provide a date for a follow up visit regarding the issues of possible financial abuse. There was no reply to this email and progress was chased twice further during January 2016. This lack of communication on the part of SW2 was not addressed with her (**see Finding 3**).

2.26 On 17 December 2015 the CLDN visited John again. The care home said they were concerned about John shredding his continence pads and binge eating habits (often referred to as stealing or taking food). It was reported that John was not using the call button; the reward chart had not been implemented and the CLDN expressed concern about this. CLDN proposed visiting fortnightly to monitor the situation. She asked that the reward chart be implemented, and John to be encouraged to use the call button. CLDN was concerned that the current shift patterns did not support John. It was explained that staff did get up in the middle of the night to support John, but that there was currently no funding for waking night staff but this was being reviewed as part of the overall assessment of John's existing care and support needs; this review was significantly delayed and should have been robustly challenged by the care home manager (**see Finding 3**). The CLDN made a referral to the GP for a full dementia screen, a cardiovascular assessment, blood pressure, ECG and urine analysis.

2.27 The CLDN visited again on 31 December 2015 and the recommendations had still not been implemented. The staff on duty were reminded of the plan and the CLDN said she would send a letter as a reminder; this was done and the plan clearly outlined. This was helpful, but the lack of compliance needed addressing with the Care Home manager and this was another area of concern that was not directly tackled. See **Finding 3**.

[26] The Mental Capacity Act defines mental capacity as time and decision specific. It provides a legal framework for assessing mental capacity and then making best interest decisions when a person is assessed not to have capacity. A formal Best Interests meeting may be required when decisions are very complex, significant or risk laden, there are different decisions with differently loaded risks/benefit, there are different views as to what is considered to be in an individual's best interests; and when there are options and issues that require the input of different professionals/people, and which can only be properly covered and addressed through such a face to face a meeting;

2.28 At the beginning of January 2016, the care home discussed being concerned about John's binge eating of inappropriate food, being up through the night and eating faeces. Staff talked to him about the dangers of this for him. From this point onwards, the daily logs show that John smeared faeces over his room, appeared to eat faeces and emptied his catheter almost every day. Staff found the room to be covered in faecal material. This was shared with SW2 when she visited and discussed with the CLDN and SW1 in February.

2.29 In early January 2016 there was a follow up visit by Staffordshire Quality Assurance service. Progress had been made regarding the quality of care plans and recording practices and awareness of mental capacity issues. However, the requirement to ensure that the residents mental capacity was assessed and their decision-making capabilities were recorded had not been completed and it was agreed that this would be done by the end of April. This did not happen for John. There remained concerns about the supervision of staff. There is no evidence that these issues were shared with any other professional (except possibly SW2) despite the findings echoing concerns about the assessment of mental capacity within the home.

2.30 On 6 January 2016 SW1 emailed SW2 to ask for a date to go through the finances at the home. This was not responded to and a follow up was sent on 20 January 2016 where SW1 said that she was concerned about drift with the safeguarding enquiry and that she considered that an Enquiry Review Meeting (ERM) was needed. SW2 replied to the follow up email and said that she had looked at the finances and there were no concerns, the home was following the speech and language plan and when John asked for food that was not on the plan they softened it with gravy or beans. SW2 said that she was planning to visit once she had received the feedback from the Quality Monitoring visit and suggested that SW1 could visit at the same time. SW2 reported that she did not consider that John was at continued risk of harm and was considering closing the safeguarding referral.

2.31 SW1 replied via email saying she remained concerned regarding the financial circumstances, that the records had been unclear and that the family of another resident had made complaints of financial irregularity a number of years ago; no detail was provided and it appears these concerns were many years earlier and unsubstantiated. SW1 asked to receive feedback from the Quality Monitoring visit, but there is no evidence that this happened. SW1 asked SW2 if she had been in touch with the speech and language service regarding a mental capacity assessment. This was a real confusion of roles. SW1 stated that she believed that the home were ultimately the decision makers regarding food and choice but no plan was agreed to take this forward; the ERM would have been a useful way forward to clarify roles and responsibilities across the professional network and to make clear the expectations of the Care Home. SW1 reiterated that she remained concerned and that a joint visit would be helpful. A visit was organised and took place three weeks later.

2.32 On 21 January the OT and CLDN visited John at the care home. They were unaware of the discussion between the two social workers regarding issues of capacity. The CLDN noted that the reward chart was in use and John seemed pleased with his progress. There remained concerns regarding John binge eating of inappropriate foods, including two dry pot noodles and a jar of cranberry sauce. The OT recorded that John had made good progress with his mobility. It was agreed that John would be accompanied into the community by a member of staff because of his lack of road safety awareness and an assessment of this was organised.

2.33 On 4 February 2016 CLDN visited John. She spoke to the care home manager who felt that the current plan was not working and there had been no improvement in John's behaviour. There had been a staff meeting the day before and the staff had said they felt they could no longer cope. John continued to take food from the kitchen, eat his continence pad and eat faeces. The CLDN advised continuing with the plan, she would telephone SW1 to organise a review meeting and organise for John to attend the memory clinic. CLDN agreed to visit in three weeks' time. This was an appropriate and proactive response to the growing concerns about John and his care. CLDN telephoned SW1 on 15 February 2015 and left a voice mail (not sure if this prompted the visit the next day as this message is not recorded in the case notes for SW1). CLDN had no response regarding the request for a review meeting. A review meeting was organised for four weeks' time.

2.34 0n 16 February SW1 made a visit to the home with SW2. SW1 recorded that the financial concerns had been addressed. The care home manager reported that the staff were working well with John to support appropriate choices of food in compliance with the agreed diet. The care home manager said the current main concern was that John was binge eating inappropriate food unsupervised and this had recently included a jar of honey and 3 frozen chicken Kiev's; this behaviour was referred to throughout the records of all agencies as "stealing" and the lack of exploration of this behaviour over time is discussed in **Finding 6**. The care manager reported that John was also smearing and eating faeces and eating his continence pad. SW1 agreed to make a referral to the Intensive Support Team (IST) for increased support due to a "*rapid deterioration in* John*'s behaviour*". This referral was not accepted because the team did not provide services after 8pm and night care was required (again this was recorded after John's death). The manager wrote in the homes daily record that SW1 would organise an early appointment with John's psychiatrist and email over Deprivation of Liberty Forms (DOLS).

2.35 On 16 February the adult safeguarding enquiry was completed and written up; there is a flexible timescale for completing these enquiries because of the need to address all risks and to be person centred in approach. This enquiry did not need to take so long to come to its conclusion, and it is of concern that one of the key issues, that of John's capacity to make decisions about what he ate, both at meal times and during the night

when he was binge eating inappropriate food was not addressed and remained as a recommendation. The financial concerns were said to have been resolved, but the risk of choking remained and a formal mental capacity assessment was recommended. This should have led to the development of a safeguarding Plan[27] which should have outlined how this continued risk of choking would be addressed and who would do the mental capacity assessment and by when. It was noted that when this assessment was completed SW1 would ask the SALT to reassess. This was again a confusion of roles between the care planning and safeguarding enquiry processes. The Section 42 report was sent to the home manager and SW1. The mental capacity assessment risk assessment was never undertaken.

2.36 The CLDN remained concerned about John and the homes ability to cope with his needs. She tried again to contact SW1 (SW1 worked part time) and replied on her next working day and the Review Meeting was organised for the 3 March 2016.

2.37 On 24 February 2016 SW1 completed the What Matters Review (part of the assessment of care and support needs). This said that the current placement was being assessed to see if it was able to meet John's changing needs.

"*The care home manager reports that John has been displaying unusual behaviours such as eating frozen food and inappropriate foods. His ritualistic behaviour of anal picking and defecation has also increased. The staff report that this is putting* John*'s health at risk as he will at times eat the faeces. He is also scratching and subsequently breaking his skin. This increases his risk of infection. This is also utilising a lot of staff time and a request for more support/care hours has been requested*."

A review of care hours was being undertaken, but no end date was set and this was never concluded. A set of outcomes were agreed including that "John *refusing fork mash diet that increases the risk of choking*" and it was agreed again that a Mental Capacity assessment needed to be undertaken, but there was no agreement about when this would be completed and by whom. The concerns regarding eating of inappropriate foodstuffs and faeces were not included in the agreed outcomes and no plan was made to address them.

2.38 The Review meeting was held as planned on the 3 March 2016. John attended, alongside SW1, the OT, CLDN and the home manager. There were no minutes taken at the meeting, but each professional recorded what was discussed and their own actions. This lack of a multi-agency plan going forward which was agreed by all is discussed further in **Finding 2**. Concerns about John's impaired mobility and waking during the night were discussed. It was agreed that it would be safer for John to move to a room on the ground floor. SW1 agreed to request funding for waking night staff to

[27] A Safeguarding Plan is the document that clarifies all the protective or supportive systems that should be in place, irrespective of who provides these and sets them out as steps towards a defined outcome. https://www.ssaspb.org.uk/Guidance/5.-Chapter-Five-Safeguarding-Plans.pdf

prevent the risk of falls (recorded by some professionals) and the risks posed by choking (recorded by others). It was agreed that staff should consider putting locks on the freezer and removing high risk items from the kitchen; the care home manager said they had been informed by the CQC inspector that they could not do this, and no decision was made regarding this. The way forward was dependant on the capacity assessment and this was not discussed. A memory clinic appointment was to be made and a review by the psychiatrist. At the meeting John seemed unwell, he looked pale and confused and the CLDN advised the home manager to take him to the GP.

2.39 The CLDN and OT spoke to the psychiatrist who agreed to review John, but that this would need to be done through a referral from the GP. It was agreed that John's medication would be reviewed at the forthcoming memory clinic appointment and the need for an assessment discussed.

2.40 John was taken to the Accident and Emergency Department by ambulance the next day and he was admitted to hospital with a chest infection. The hospital admission was not shared with any of the professionals and should have been. John remained in hospital for seven days and was also treated for a urine infection and constipation. He was visited by care home staff and residents on a number of occasions. The CHM reminded the hospital staff that John needed a fork mashable diet. The CHM did not make it clear that she was concerned that John needed a more supportive environment because of his increased care needs, incontinence, smearing of faeces and binge eating.

2.41 On 8 March 2016 SW1 spoke to her managers about funding for waking night staff and this was agreed on a temporary basis until other funding sources could be organised. SW1 phoned the care home and left a message asking them to seek quotes from agencies for waking night staff. She received no reply to this message and it was not followed up.

2.42 On the 15 March 2016 a second review meeting was held. This was attended by John, SW1, OT, CLDN and the home manager. There were no minutes, but professionals recorded their own views of what was discussed and what was agreed in their case records. The focus of this concern differed across the professional network, but this was not known until after John died. Some professionals recalled that the purpose of the waking night staff was to address the risks of John falling, whilst others believed that it was to address his binge eating and the risk this posed of choking. It was agreed an urgent referral would be made to physiotherapy services to address mobility concerns; this happened a week later and a programme of support agreed. John's ongoing binge eating habits and the risks they posed were discussed; CLDN and the OT recommended seeking advice from psychological services, but the first step would be the planned appointment at the memory clinic as this behaviour might be due to the onset of dementia. The care home manager was asked again about seeking quotes for

waking night staff and she said she had not received any information or messages about this. She was asked to do this. Overall, there were concerns that John would need to move care homes because of his increased care needs and the care home manger said she would see what difference the waking night staff made.

2.43 Over the next week the home staff began the process of seeking agency quotes, this needed to be done in a much timelier way. There remained concerns about John's eating of frozen food, mayonnaise, bread and cake mix and he was also often covered in faeces. In the few days before John died the care home staff became aware that he had food in his room, but after his death told the police that they could do nothing about this because John could make his own choice about what he ate and when. On the 24 March 2016 the home manager phoned SW1 to inform her that John had been found dead, having choked on a hot cross bun and its packaging in the night.

2.44 A safeguarding referral was made by SW1 to Staffordshire MASH because of a suspicious death, a recent safeguarding concern and worries regarding the two remaining residents. It was agreed that the police would take this forward as a single agency enquiry. Charges of gross negligence and manslaughter were considered because of the reported delays in the care home seeking waking night staff. Charges of wilful neglect were also sought. An investigation was undertaken but there was no evidence of neglect of John's care found.

3. THE FINDINGS

It is the purpose of any Safeguarding Adult Review to identify the lessons to be learnt from the adult's case and apply those lessons to future cases (Care Act 2014). The review of the circumstances leading up to John's death have identified 6 Findings.

Finding	Title
1.	There was poor verbal and written communication which needs addressing for person centred care to be effective
2.	There was a lack of a holistic and coordinated approach to the complex needs of adults with care and support needs
3.	There is a potential disconnect between the information from quality inspections of care homes, individual safeguarding enquiries and wellbeing assessments meaning that all information needed to address the circumstances of adults with care and support needs is not available and not addressed
4.	The confusion about roles and responsibilities undermined care planning and safeguarding planning
5.	The Lack of clarity regarding who should carry out a mental capacity assessment with John regarding food choices and actions left him at risk
6.	There was a lack of recognition, assessment and action to address the risk of choking in adults with learning disabilities

Finding 1: There was poor verbal and written communication which needs addressing for person centred care to be effective

3.1 There was considerable evidence across the time under review of concerns about the quality of verbal and written communication and the extent to which concerns about the quality of care John was provided with or actions of other professionals were communicated.

Sharing concerns with professionals

3.2 The Care Home did not consistently share concerns with the professionals involved with his care. The SALT and dietician were not told about John's binge eating and could therefore not incorporate this crucial knowledge into their assessments or plans.

3.3 All professionals were concerned that they found it difficult to make contact with the care home, often getting no response to phone calls or leaving messages that were not responded to. Although these were discussed individually, they were never formally shared with the care home manager and she was never asked to take action to address the concerns. This had consequences for John. Professionals made

unannounced visits because they could not make an appointment, and he was out of the home.

3.4 There were concerns about members of staff being unwell, or lacking knowledge of John's care plan and history. These were important to his well-being, but again were discussed, formed part of the adult safeguarding enquiry, but not addressed directly with the manager and no action agreed to address these concerns.

3.5 In the Review meeting in March 2016 it was agreed that funding for waking night staff would be sought, this was sought and agreed. SW1 could not make contact with the care home and so left a message about the agreement for waking nights on the answer machine. The care home manger reported that she did not receive the message. This issue of messages not being received was an existing problem which had not been addressed; the care home manager was never asked to take any action and not held responsible for the poor communication and poor access to a service user. This caused delay.

3.6 There was also evidence of a lack of timely communication between professionals who were providing assessments or services to John. SW1 was concerned not to have heard from SW2 about the progress of the adult safeguarding enquiries, and there were mix ups about appointments and the recording of actions none of which was addressed. A similar issue occurred between the Community Learning Disability nurse and SW1 and the CLDN did speak to her manager, but the issue was resolved before the agreed action needed to be taken.

3.7 Across the review period there appeared to be a reluctance to challenge or address inter-professional difficulties and have difficult conversations. This is an emerging theme from other Safeguarding Adult Reviews and the most recent summary of SARS completed across London. Professionals must feel confident to address poor communication, poor care and lack of action and its consequences for their clients.

Written records

3.8 There was also variable recording practice noted across a number of agencies involved with John which impacted on a clear plan of action and clarity about what was agreed and what should happen next. The exceptions were the CLDN, the SALT and the dietician all of who recorded their visits and provide clear plans regarding their area of assessment and next steps.

3.9 The Care Home kept a daily log, produced care plans for each area of John's life (mobility, health, eating, independence and social activities). They also kept records of hospital and health appointments, staff meetings and resident's meetings. Although these were comprehensive, and often person centred (the home used person centred formats for talking to the residents about their lives) the different records made it difficult to form a whole picture of John and it would be more useful if they kept one

care plan which included all these different elements. This quantity of different records may have influenced the care staff not having information about John when other professionals asked for it.

3.10 SW1 did not write up the review of the care and support plan, or the assessment plan and therefore this could not be shared with all the professionals involved, so all could understand the complexity of John's circumstances (see finding 2 and the need for a multi-agency plan). This lack of recorded plans may have been why the assessment of the level of funding got lost and the assessment of the binge eating and behaviours such as eating and smearing faeces. Crucially the care and support plan itself was never written up and this made any discussion of how the different care plans linked together very difficult. It is expected that a copy of the care plan is developed for the service user in an accessible way and this also did not happen for John.

3.11 SW2 did not record many of the visits to see John and there was a lack of discussion and planning about the roles and responsibilities of the two social workers, something addressed in Finding 5.

3.12 There were no minutes kept of the two review meetings held in March and consequently all professionals went away with a different understanding of what the significant issues were for John and also what had been agreed.

3.13 Good quality written records are essential to effective multi-agency working and to ensure that actions and decisions are agreed and followed through. Sharing concerns and the professional analysis of a person circumstances is essential for effective care planning and safeguarding and is the cornerstone of professional curiosity. This was not always evident in the care and support that John received.

Questions to the Board

The Board will need assurance from key partner agencies that:

Managers and staff are appropriately skilled to address and discuss concerns about another professionals' approach to the work; to be prepared to have difficult conversations to ensure the well-being of a person with care and support needs.

That all agencies have made their staff aware of the expected standards around information sharing and recording practice and that these are enforced, and poor recording challenged. This is particularly important regarding decision making meetings, care and support plans and safeguarding plans.

Finding 2: There was a lack of a holistic and coordinated approach to the complex needs of adults with care and support needs

3.14 All adults with care and support needs who are living in residential care are entitled to a full assessment and review of their care and support plan[28] annually (Section 27 Care Act 2014). John did not always have annual reviews, but in response to a deterioration in his circumstances a review was organised in a timely way.

3.15 John was included in this review, and there is evidence that he was facilitated to participate, both by the efforts of the care home manager and his social worker (SW1). A comprehensive assessment plan was developed, necessary because there was no existing care and support plan in place, and because John's needs had changed. This assessment process focused on issues of mobility, his swallowing difficulties, concerns about continence and dementia screening and a review of funding arrangements regarding the level of care support needed. Appropriate referrals were made to different agencies and the process of individual assessment started. When concerns emerged about possible financial abuse and the care homes poor compliance with the prescribed diet a safeguarding referral was made and enquiries started.

3.16 Each agency involved with John carried out its own assessment and action was taken to address individual issues. What was lacking was any sense of a multi-agency approach until the weeks before Johns death when appropriately there were two multi-agency meetings initiated by the CLDN. Professionals worked in silos; they did communicate with each other, but there was no sense of a lead agency or person who was coordinating the plan and reviewing the outcomes for John in a holistic way.

3.17 Crucially, the care and support plan were never developed and written up; therefore, no outcomes were set and the unfilled aspects of John's needs not articulated such as funding arrangements to address care needs, and his binge eating and behaviours such as smearing were not addressed.

3.18 This lack of a joint approach meant that some professionals did not have a full picture of John's circumstances. It is clear that there was variable knowledge and understanding of John's binge eating habits and so individual assessments were not as fully informed as they could be. The district nurses who saw John regularly to address his continence needs were unaware of the safeguarding referral or any of the other assessment processes in place.

3.19 It also would have been expected that an Enquiry Review Meeting would have been convened as part of the safeguarding enquiries. This is a formal meeting which brings together all relevant agencies and other key individuals to review the progress of the enquiry and consider further actions. This would have been an opportunity to share

[28] https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance point 10.8

information across the multi-agency network and to resolve some of the unanswered questions about John's care.

3.20 A multi-disciplinary meeting was initiated by the Community Learning Disability Nurse as a result of John's deteriorating situation in the weeks before he died. This was good practice. The meeting did discuss the three central issues, which were John's mobility and risk of falling, John's unusual eating habits and the concerns about dementia. The lack of minutes meant that each agency present recorded their own perspective on the most significant risk to John, and this was different across the agencies. A plan of action was agreed, but no interim plan to address the unusual eating habits was put in place. In fact, the plan to address the risk of falls meant that John was moved downstairs next to the kitchen. At the second review it was agreed that the care home would seek funding for waking night staff, but the purpose of this was not agreed. Some professionals understood it was to address the risk of falls, others the risk posed by John's unusual eating habits.

3.21 It is the responsibility of the Local Authority to undertake annual reviews, but this can be shared with other appropriate professionals, the service user themselves or family members, but this requires discussion and planning. SW1 initiated the assessment processes, but the care home and the care home manager were appropriately expected to facilitate the implementation of the different assessment processes. There was no discussion regarding this and there was a lack of a joined-up approach. This made it disjointed. Professionals contributing to the assessment and the care and support plan were unclear who to feedback information to, and all the outcomes of the different agencies were never brought together. The lack of a holistic plan, or care planning meeting also meant there was no allocated lead professional something seen as important in the Care Planning guidance (Section 10.8[iii]). The CLDN did request a multi-disciplinary meeting and this was convened.

3.22 Good multi-agency working is the cornerstone of the person-centred approach as outlined within the Care Act 2014 where adults with complex care and support needs should expect to receive a holistic and coordinated service. Research and Safeguarding Adult Reviews[iv] highlight that many professionals believe that multi-agency working, regular meetings and reviews can add to their already busy work lives. The evidence suggests the contrary. Effective multi-agency working promotes good outcomes for service users, reduces duplication and ensures that all professionals are focussed on the right issues and concerns.

Questions to the Board

The Board will need assurance from key partner agencies that;

They enable their staff time and space to work effectively in a multi-agency way, that this is valued, and that the care and support needs of adults are addressed through multi-agency processes and do not rely solely on email correspondence.

Organisations need to provide assurance that they have processes in place to manage the undertaking of annual reviews. The Care Act Guidance 2014 stipulates that reviews take place at least annually, that these are proportionate to the need and that the task is shared with other professionals, adults with care and support needs and/or their carers where appropriate, that this is appropriately negotiated and there is appropriate oversight of decisions made and plans to be implemented. There needs to be clarity regarding the role of a Lead professional in the context of both assessments of care and support needs and care and support plans.

Finding 3: There is a potential disconnect between the information from quality inspections of care homes, individual safeguarding enquiries and wellbeing assessments meaning that all information needed to address the circumstances of adults with care and support needs is not available and not addressed

3.23 The inspection of care homes and quality monitoring processes are important to ensure that adults with care and support needs are receiving effective and good quality care. This is a reminder of the core responsibility of care homes to provide that quality care. There were gaps noted for John and the other residents in the care home which were to be addressed through action planning. These action plans did not happen quickly enough and were the responsibility of the care home.

3.24 It is striking the extent to which the concerns raised by both the CQC and the local quality monitoring visit of the care home where John lived, chimed with the issues raised through the various assessment's that took place of John's needs. The CQC and the local monitoring visit expressed concern about the care home staff's understanding of the Mental Capacity Act and best interest decisions and this was a central issue in considering his needs. There was a specific requirement for the care home to ensure that residents mental capacity was assessed and that their decision-making capabilities were recorded. This was a central issue in both the care planning process and the safeguarding enquiry.

3.25 The CQC also highlighted staff capacity and this was also something that professionals were concerned about. Yet the information from these two reviews of the home were not incorporated into the well-being assessment, information being collected for the care and support plan or the Section 42 adult safeguarding enquiry. If they had been a more holistic picture would have emerged and clarity regarding what action the care home needed to take to address John's wellbeing.

3.26 It is essential that all sources of information are used to inform an understanding of the needs of adults with care and support needs and gaps that might need to be

addressed. The two inspection processes had information that was important for the well-being of John and the other residents, but this information was not sufficiently utilised.

Questions to the Board

The Board will need assurance from the relevant partner agencies that information from CQC inspections and where appropriately available information from local inspections of care homes is incorporated into care and support planning and review, and into safeguarding enquiries and safeguarding plans.

Finding 4: The confusion about roles and responsibilities undermined care planning and safeguarding planning

3.27 Ensuring the wellbeing and safety of adults with care and support needs requires professionals to be clear about roles and responsibilities. In this case there were two distinct areas where there was confusion. One was there being two social workers involved. The other was confusion about the responsibilities of the care home and the care home manager regarding care planning and the role of the Local authority-carried out by SW1.

3.28 SW1 made an appropriate safeguarding referral to Staffordshire MASH which focussed on three core areas; concerns about possible financial abuse, worries about possible neglectful care and compliance with the SALT plan and concerns about access to and quality of the food provided. This was whilst a re-assessment of John's care and support needs was underway. Liaison between the two social workers was difficult and the decision to visit together, without clarifying why this was caused delays. SW1 assessed the financial issues and took action by assessing mental capacity. The compliance with the fork mashable diet was addressed by the SALT, but without all the information available about John's circumstances and needs. There were continual debates about who should undertake the assessment of John's mental capacity regarding choice of food and action to prevent access to food items which would increase the risk of choking and these remained unresolved. The lack of clarity about roles and responsibilities led to neither an effective safeguarding process or plan or a care and support plan. John's binge eating and behavioural issues such as smearing faeces and allegations that he ate faeces never got addressed and were not shared with all professionals, notably the SALT, the Dietician or the District Nurses. This was relevant information for all of them.

3.29 The second area of confusion was about how the care and support plan for John that was meant to be developed by the Local authority social worker (SW1) linked with the care planning within the care home environment. The care home was primarily responsible for John's day to day care and ensuring that his care and support needs were met. They had care plans in place, risk assessments and they used appropriate

person-centred tools to ascertain his views and feelings. These were also reviewed. This happened completely separately from the care planning and assessment process. Each agency was responsible for clarifying roles and responsibilities in this regard. The Care Act 2014 makes clear that the Local Authority is responsible for developing care and support plans and reviewing them on a regular basis. They can share this task with other professionals and family members and adults with care and support needs. This can only happen through discussion and dialogue. Care home staff cannot take on this task without a mandate from the Local authority. It remains unclear if this role has been made clear in the commissioning arrangements for care homes.

3.30 These areas of confusion created delay, duplication of work and ultimately no overall care and support plan was developed and no safeguarding plan.

Questions to the Board

The Board will need assurance from key partner agencies that;

Where adult safeguarding enquiries are conducted by a different authority from that which has responsibility for care and support needs, there is clarity about roles and responsibilities and that safeguarding enquiries are planned and coordinated in line with this.

That the care planning responsibilities of care homes is coordinated with the care planning responsibilities of the local authority who develops a care and support plan, reviews it and commissions a re-assessment process

Finding 5: There was a lack of clarity regarding who should carry out a mental capacity assessment with John regarding food choices and actions left him at risk

3.31 There was significant confusion across the period of review both regarding whether John had capacity to make choices regarding the food he ate and whether a mental capacity should be undertaken and by whom. The guidance produced regarding the risk of an adult with learning disabilities choking makes clear that a mental capacity assessment must be undertaken. If the adult is assessed as having the capacity to make unwise choices, they may make a decision to eat food that they enjoy, even though they know it may cause them to choke. In these circumstances a person's choice must be respected and a risk assessment and plan put in place. The staff at the care home believed that John had the capacity and right to make choices about the food that he ate. They believed this view had been reinforced by the dietician in her advice to them.

3.32 Where a person is at risk of choking is suspected or known to lack the mental capacity to make decisions about the type of food they should eat, a formal Mental Capacity Assessment must be undertaken to evidence this. There was recognition on the part of many professionals involved with John that this was required, and it was a

recommendation of the adult safeguarding enquiries. It just did not happen, with professionals confused about who should complete it. Whilst it's recognised that any professional could complete the mental capacity assessment, it needs to be clear who completes it.

3.33 It was the responsibility of the care home staff who were making assumptions about capacity on a daily basis. The quality monitoring visit in September 2015 and January 2016 made clear that the care home needed to ensure that the residents mental capacity was assessed and their decision-making capabilities were recorded. This was part of an action plan that was not completed; this was a known gap, which was the responsibility of the care home to address, the responsibility of the quality assurance process to ensure that the care home complied with their requirements in a timely way and as is discussed in Finding 3 this information should have been available to both the care planning process and safeguarding enquiry.

3.34 There was confusion throughout the adult safeguarding inquiry and the care planning process about who could and who should undertake the mental capacity assessment and this was never completed. Understanding John's capacity in this area was crucial to both his well-being, to the plan to enable him to be safe and to address directly the risk of choking.

Questions to the Board

The Board will need assurance from key partner agencies that they have provided training to all staff whose roles require it; at the appropriate level for their responsibilities regarding the Mental Capacity Act; and to notice drift and delay in these processes when professionals cannot agree responsibilities'.

The Board will need assurance that Quality Monitoring processes follow up on actions to be taken by care homes and require those actions to be completed in a timely way.

The Board will need assurance that the care home where John lived has now completed all tasks outlined with the quality monitoring process.

Finding 6: There was a lack of recognition, assessment and action to address the risk of choking in adults with learning disabilities

3.35 Research suggests that people with a learning disability are at greater risk of choking than the wider population. This is due to several factors including problems with chewing, difficulties swallowing, behaviours such as bolting food or Pica (eating inappropriate or non-food items) and the effects of medication. These difficulties can have an effect on an adult's health, resulting in problems such as upper respiratory problems, weight loss/dehydration/nutritional absorption problems and there is also a significant risk of death.

3.36 There is little national research around this issue; Hampshire Adult Safeguarding Board reviewed knowledge in this area as a result of a number of local deaths of learning disabled adults as a result of choking. They concluded that it was necessary to raise professional awareness of the increased risk of choking for learning disabled adults, that full assessments were carried out which looked at all likely causes and risk factors, that there was timely and appropriate use of mental capacity assessments and best interest decision making and training for care staff in managing risks and dealing with choking incidents.

3.37 The National Patient Safety Agency (NPSA) produced guidance specifically focussed on swallowing difficulties (Dysphagia) and the risk of choking for learning disabled adults in 2007. This recommended a local policy on dysphagia/swallowing difficulties care. This guidance echoes the findings of the Hampshire review and the recent review of five deaths by choking in Stoke on Trent. That's the importance of good assessment, specific care plans that are regularly reviewed and which focus on all risk factors. They have produced specific risk assessment tools, specialised eating and drinking care plans and a specific consent form for the assessment of eating, drinking and swallowing problems.

3.38 Concerns about John's difficulties with swallowing and bolting of food was shared with SW1 during the review of Johns needs in June 2015. This led to an immediate referral to the speech and language service and a prompt assessment was completed and a plan put in place. This was good practice. The speech and language therapist was not told about the concerns regarding John's habit of eating food such as frozen pizzas and cake mix, often during the night, and so could not include that in the plan of action. This meant that a full assessment of the risks of choking for John was not completed, and in fact was never completed in the seven months before his death. The care home manager should have shared these concerns, both at the review and also with the speech and language therapist. These issues were shared with SW1, SW2 and the community Learning Disability Nurse after the speech and language therapist had stopped working with John.

3.39 John's eating habits were not well understood. Care home staff referred to him "stealing" and gorging food and these phrases were replicated in other agencies records. The use of the words stealing was not appropriate and represented a lack of person centred care. This was John's home and he was entitled to help himself to food in the same way as any of the other residents. The speech and language therapists plan changed this, and John was encouraged to follow a fork mashable diet. There was confusion across the professional network about whether he understood this and had the capacity to make choices and understand the risks posed by eating other foodstuffs. This is discussed further in Finding 5.

3.40 It would have been expected that John's unusual behaviour would have been part of the living well assessment being completed, and that a re-referral should have been made to the speech and language therapy service.

3.41 The lack of an assessment of these behaviours either as part of understanding John's wellbeing, but specifically as posing a risk of choking meant an appropriate plan was not in place. It appears that some professionals did not have a sufficient understanding of either the increased risk of choking for learning disabled adults or the factors that might increase this. Action in this area would have increased John's safety.

Questions to the Board

This review can build on the current work being undertaken across the partnership regarding the heightened risk of choking for learning disabled adults. The Board will need assurance from key partner agencies that this work is making a difference to adults with care and support needs.

4. CONCLUSION

4.1 All those professionals who knew John were shocked and saddened by his death. Sadly, it is clear that there was a significant risk that he might choke and the major risk was his binge eating at night. This binge eating was known to some of the involved agencies, but notably not those with the expertise to offer help; the SALT, the dietician, the psychiatrist and the District nurses. This behaviour was not addressed through the care planning processes or the safeguarding enquiry and the individual care plans held at the care home noted the concern and addressed each crisis as it occurred. Overall, no plan was made to assess and try and understand this behaviour, evaluate the risk or put a strategy in place to address it. The care home had a risk framework in place which was ineffective, which depended on staff understanding whether they could stop John from taking food and to deny him access to the kitchen area; they believed that he had mental capacity and that they could not prevent him. The care home should have been clearer about this, something they had been asked to do in the quality monitoring process, but which they had not yet addressed; they should have completed this task and have been held responsible for doing so in a timelier way. There should have been agreement about who would undertake a mental capacity assessment, rather than being left as a recommendation of a safeguarding enquiry which took 5 months to complete, or a care and support planning process that took 9 months and was never completed. A clear steer was needed regarding his mental capacity in this area. This was the responsibility of a number of professionals, and although it was often discussed, no agreement was made and it did not happen.

4.2 In March 2016 in the weeks before John died it was agreed that funding would be provided for waking night staff at the home. This was delayed by messages not being picked up, a known problem that the care home manager should have addressed and SW1 should have challenged when there was no response to her call. The care manager sought agency staff, but this was not achieved in a timely way. This should have made a difference but was likely to be undermined by the ongoing confusion about exactly what the waking night staff were for, some thought to address concerns about mobility issues and the risk of falls, others that it was to address the concerns about binge eating. In the absence of clarity about this and a lack of clarity about John's mental capacity, the waking night staff were likely to believe that they could not prevent him from helping himself to food.

4.3 The learning from the death of John is the importance of a recognition by all professionals of the heightened risk of choking for Learning Disabled adults; the importance of holistic, multi-agency care and support plans which are aligned with care home plans, clarity about mental capacity, roles and responsibilities and feeling

able to challenge when concerns arise and ensure change takes place. It was the co-existence of all these variables that had an impact for John.

APPENDIX 1

SAR Panel Members	
Agency	**Title**
Staffordshire and Stoke-on-Trent Partnership NHS Trust (SSOTP)	Head of Safeguarding, Adults and Children
Healthwatch. Stoke-on-Trent	Healthwatch Engagement Officer
Stoke-on-Trent City Council (SoTCC)	Safeguarding Manager
University Hospital of North Midlands (UHNM)	Senior Nurse, Adult Safeguarding
Staffordshire County Council (SCC)	Statutory Services Lead and Principal Social Worker
Stoke-on-Trent City Council (SoTCC)	Strategic Manager Safeguarding
Staffordshire and Stoke-on-Trent Partnership NHS Trust (SSOTP)	Professional Lead in Social Work
Independent Futures	Joint Funding Lead, Health and Social Care
North Staffordshire and Stoke-on-Trent Clinical Commissioning Groups (CCGs)	Lead Nurse Head of Adult Safeguarding
South Staffordshire Clinical Commissioning Groups (CCG)	Lead Nurse Adult Safeguarding
South Staffs CCG	Adult Safeguarding Nurse
Staffordshire Police	Detective Sergeant (Crime Review Team)
Staffordshire County Council (SCC)	Adult Safeguarding Team Leader
West Midlands Ambulance Service	Safeguarding Lead
North Staffordshire Combined Healthcare NHS Trust (NSCHCT)	Head of Safeguarding
Management and administration of the SAR process:	
Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership	Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board Manager
Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership	Staffordshire and Stoke-on-Trent Adult Safeguarding Partnership Board Administrator

APPENDIX 2

Agencies that provided chronologies
Independent Futures
North Staffordshire Combined Healthcare NHS Trust (NSCHCT)
North Staffordshire and Stoke-on-Trent Clinical Commissioning Groups (CCGs)
Staffordshire and Stoke-on-Trent Partnership NHS Trust (SSOTP)
Staffordshire County Council (SCC)
Staffordshire Police
South Staffs Clinical Commissioning Groups (CCGs)
Stoke-on-Trent City Council (SoTCC)
University Hospital of North Midlands (UHNM)
West Midlands Ambulance Service

5. REFERENCES

[i] http://www.legislation.gov.uk/ukpga/2014/23/section/44/enacted
[ii] https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance
[iii] https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance
[iv] Shoot, P and Bray, S (2017) Learning from SARs: A report for the London Safeguarding Adults Board http://londonadass.org.uk/wp-content/uploads/2014/12/London-SARs-Report-Final-Version.pdf