



Barking and Dagenham  
Safeguarding Adults Board

Safeguarding Adults Review

Executive Summary

RC

January 2016

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This Executive Summary and the full Safeguarding Adults Review (SAR) was prepared and written by Ian Winter CBE on behalf of Barking and Dagenham Safeguarding Adults Board. The Board received and endorsed the full SAR Report in December 2015.

Throughout the review all staff fully co-operated and readily provided information and reflection.

## **1. About this safeguarding adults review (SAR)**

1.1 This review was commissioned by Barking and Dagenham Safeguarding Adults Board to investigate the death of 61-year old RC.

1.2 Its purpose was to:

- Consider whether or not RC's death in the circumstances described could have been predicted or prevented.
- Develop learning that enables the safeguarding adults' partnership in Barking and Dagenham to improve its services and prevent abuse and neglect in the future.
- Ensure that lessons are learnt, rather than to apportion blame.

## **2. About RC**

2.1 RC was born on 21 February 1954 in Dagenham, the youngest of four children and had a close relationship with his brother TC and sister A. He moved to the Accommodation, Barking, in 2009 from a different residential home. He had a moderate learning difficulty and bi-polar disorder.

2.2 RC was supported by staff with daily bathing, personal care, food preparation and nutrition, and household chores. He also needed to be accompanied to health care appointments.

2.3 RC enjoyed going out in the community, long walks around the park and bus rides. Staff aimed to take him out during off peak times as he disliked crowds and noise. In shops, staff needed to keep a close eye on him in case he wandered off. He also enjoyed going to the cinema.

2.4 RC had no concept of money or how to use it. He was not able to make choices for himself but had a family who could make decisions on his behalf.

## **3. The circumstances of RC's death**

3.1 On 30 May 2015 at around 6.30am, it is believed that RC took some scones from the fridge in the kitchen area and choked on them. The circumstances of this event are central to this review.

3.2 Following an emergency admission to hospital at 7.49am on 30 May 2015 and despite extensive efforts to save him, the decision was taken on 4 June 2015 to end the life sustaining medical interventions and RC died at 4.48am.

3.3 Prior to this there had been a choking incident in 2013 which hospitalised RC for several days. Following this, the Speech and Language Therapy Team (SALT) recommended a pureed diet only, with thickened fluids.

## **4. How this review was conducted**

4.1 The SAR was commissioned by Barking and Dagenham Safeguarding Adults Board (SAB) and managed by the Safeguarding Adult Review Sub Group

4.2 An independent reviewer was asked to carry out a review of the actions by partner agencies and prepared this report based on information provided from:

- Barking, Havering and Redbridge University Trust (BHRUT) - acute care
- Clinical Commissioning Group (CCG) – particularly the GP service
- London Borough of Barking and Dagenham (LBBD) Commissioning Services
- Community Learning Disability Team (CLDT), London Borough Barking and Dagenham Adult Social Care
- North East London Foundation Trust (NELFT) – Mental Health and Dietician Services
- Service Provider 1 – current managers and providers of services at the Accommodation, providing supported living where RC lived
- Speech and Language Therapy Service (SALT) – an integrated part of CLDT

## 5. Scope

5.1 The scope of this SAR, set by the Safeguarding Adult Review Sub Group, was to consider:

- i. The extent to which the assessment of RC's health and social care needs was comprehensive and of sufficient depth
- ii. The extent to which any specialist assessments were of sufficient depth, and contributed to the overall assessment
- iii. Whether the assessments had been reviewed and updated in a timely fashion
- iv. Whether assessments and reviews had considered issues of capacity in any areas of RC's life, and whether the steps taken as a result of any judgements were sufficient
- v. The extent to which the care plan in place at the time of RC's death reflected the outcomes of assessments about RC's health and social care needs
- vi. The extent to which the services commissioned by the local authority, provided by Service Provider 1 were sufficient to meet RC's assessed ne
- vii. Whether the transfer of provider in 2015 had ensured continuity of care for RC
- viii. The extent to which any services delivered by the CLDT, whether by local authority staff or NELFT staff, were sufficient to comprehensively assess RC's needs, and arrange and oversee appropriate care and treatment
- ix. The extent to which the Primary Care and Acute Trusts were able to meet RC's needs for care and treatment in the context of his disability

## 6. Summary of findings in key areas of scope

**Q1. The extent to which the assessment of RC's health and social care needs was comprehensive and of sufficient depth**

6.1 Throughout the key period RC was living at the Accommodation (since October 2009) under the ownership and management of the Service Provider 1, Provider 2 and then

the Service Provider 1 again. There are comprehensive care records that chronicle his needs, activities and significant incidents on a day to day basis.

- 6.2 In common with individuals who may be in touch with various parts of the social care and health system there is no single or coordinated recording system that brings together assessment, review or case records. Nor is it possible that individuals in one part of the system can access records in another part of the system.
- 6.3 The current system of case recording in the local authority adult social care directorate is computerised. It is clunky, difficult to follow, cross reference and refresh. This is common in many local authorities.
- 6.4 This level of complexity and lack of integration requires a robust and regular review mechanism. This needs to draw together the various strands of activity that make up an individual's life to provide not only a comprehensive assessment but also to consider the interaction of one element with another.
- 6.5 The commissioning of services, particularly as this relates to the individual's social care, also needs examination. The monitoring of contractual arrangements and the letting of new contracts should not be carried out in isolation from an individual's care needs.
- 6.6 The Mental Capacity Act (MCA) was never fully considered for RC. The MCA could have provided a standardised and comprehensive framework in which RC's needs could have been understood, recognised and then worked with by all. Too often there were assumptions about his capacity (or lack of it) but this was never properly assessed.
- 6.7 Having reviewed all the case records, there was a lack of consideration of RC's needs within a context of **risk**. The most notable and commendable exception is the SALT Service dating back before September 2011 through to RC's untimely death. It is regrettable that this clear and strong analysis was not always apparent or referenced in other assessments or reviews.

**Q2. The extent to which any specialist assessments were of sufficient depth, and contributed to the overall assessment**

- 6.8 Specialist assessments for RC were broadly defined by input from the:
  - General Practitioner
  - Consultant Psychiatrist, Mental Health
  - Consultant Psychiatrist, Learning Disabilities
  - Dietician Service
  - Speech and Language Therapy (SALT) Service
- 6.9 The chronology of contact with each of these services is set out in the full SAR report. There is good evidence that RC's physical care needs, and particularly those that are often lacking for people who may have a learning difficulty, were sensitively considered by the care providers and the health care professionals.
- 6.10 When required, advice from Dietician Service was also available. RC's medication was appropriately reviewed in its own right within Mental Health Services, but there is less evidence that this was done in conjunction with other services.

- 6.11 The specialist work of SALT is comprehensive and well documented. In terms of positive learning for this review and other work, this input was of a very high standard; the chronology shows that throughout there was a consistent approach that reacted and responded to RC's needs. This extended to positive support and direct training for staff regarding RC's needs in the supported living service, liaison with dietary services and contact with hospital services.
- 6.12 Following RC's admission to hospital as a result of a choking incident in April 2013, the Speech and Language Therapist revised the assessment for meeting RC's needs. There followed a comprehensive Dysphagia assessment, training sessions for the then staff at the Accommodation and follow up visits. This also included provision of a written practical chart as a reminder to all staff of RC's dietary needs and practical assistance on how to blend and thicken fluids.
- 6.13 Comprehensive guidance was given to staff on how to support and observe RC when he was eating or drinking including advice to help him sit upright while eating and for up to 30 minutes afterwards. RC's dietary needs were kept on a small poster in the kitchen as a reminder.
- 6.14 However, there is an overall conclusion that RC's complex physical health care needs, his enduring mental health needs and his learning difficulty and their interaction with each other both medically or in terms of his care needs were never really put together. It is concluded that while these were dealt with individually, there was insufficient integrated understanding.
- 6.15 There is no record of this possible cumulative impact of the medication in any of RC's notes or of any guidance given regarding any adverse impact.
- 6.16 The SALT work included risk management. It was recorded in May 2013 that "*RC's risk of choking is high and the likelihood of harm occurring is high. Key action was that staff must follow existing guidelines and receive first aid training including choking.*" But there was no comprehensive or shared risk statement.

### **Q3. Whether the assessments had been reviewed and updated in a timely fashion**

- 6.17 On an individual basis there were ongoing considerations in most elements of specialist assessments. This was followed up in relation to RC's physical care with the GP, the dietician service and comprehensively so in relation to SALT. While there had been updates from both Consultant Psychiatry and Consultant Learning Disabilities areas, these were not necessarily prioritised nor do they appear entirely coordinated. This similarly points to a need for a revised co-ordination role and responsibility.
- 6.18 Provider 2 and Service Provider 1 carried out regular reviews of RC's care. A detailed chronology is set out in the full SAR.
- 6.19 By the end of May 2013 RC's dietary needs were refined and it was made clear that all food should be blended and all fluids thickened. Subsequent follow up shows that his needs were monitored with further staff training on managing Dysphagia in June 2014, with the last Dysphagia review on 26 June 2014.
- 6.20 The local authority adult social care service conducted RC's most recent annual review on 2 September 2014. This is a crucial event which should provide a comprehensive review of an individual's care needs. It should draw on key information from those who might have a role in the individual's health or social care support. Its aim is to look at issues from a number of professional perspectives, balancing need and risk,

psychological wellbeing and care on a personalised basis for that individual. It should also consider the nature of the care arrangements that are in place and whether they are appropriate and adequate. A careful consideration of wider social networks for the individual and any adjustment to plans and priorities in the coming period should also be a feature.

- 6.21 It should provide an opportunity to meet with the individual concerned and, where possible, the family and the relevant care staff.
- 6.22 The review invitation was issued to RC and the then Service Provider. There is no evidence that notification of the review was sent to anyone else. It should be noted that this refers to the service provider that held the service contract up until February 2015.
- 6.23 No written reports were commissioned from any of those involved with RC. There is no evidence of verbal updates being sought beforehand.
- 6.24 The commissioning section was unaware of the individual case review. The individual conducting the review did not have any pre-prepared material regarding RC.
- 6.25 The review was held on 2 September 2014 at RC's home at the Accommodation. RC's brother was unable to attend because of work commitments. Apart from RC and the social worker conducting the review, the only other person present was a senior support worker from the care provider. There was no apparent work done with RC in preparation for this review nor does there appear to be any kind of appropriate material available to him (or others) to outline the role and purpose of the review meeting that may be considered as accessible.
- 6.26 While it is not uncommon that social workers conducting reviews like the one for RC might not know or even have met the individual, there is a primary role for care providers in supporting the activity. The lack of any preparation material or reports is unacceptable.
- 6.27 The review conclusions are summarised below:
- RC is independent with eating and drinking. He has a good appetite and he is on a normal diet
  - The home is providing support with meals and drinks
  - His brother takes him out for a meal at a local pub
  - RC enjoys when the home has a barbeque
  - There are no recorded concerns about RC's safety
  - There is no need to consider further mental capacity or deprivation of liberty
- 6.28 The statement that RC has a good appetite and he is on a normal diet is very regrettable. It is wrong and misleading and RC did not have the ability to challenge it.
- 6.29 Of particular concern is that SALT (which is considered to be part of the integrated CLDT) was not informed about the review. More so as it is quite clear that, apart from the staff at the Accommodation, the Speech and Language Therapist had the longest and most comprehensive knowledge of RC's particular needs and of RC's diet which was the single greatest risk factor in RC's life.

- 6.30 Of further concern is that the input from Accommodation staff made no reference to his Dysphagia: the single most important issue for RC and his safety and wellbeing.
- 6.31 Subsequently, anyone consulting this record would be totally unaware of the daily risk that this represented to RC.
- 6.32 The comment about Mental Capacity is thoroughly inaccurate.
- 6.33 The report from the review was circulated to RC and Service Provider 1. There is no evidence that it was sent to the RC's brother or anyone else. At the very least this would have been a good checking mechanism, and should be standard practice.

**Q4 Whether assessments and reviews had considered issues of capacity, in any areas of RC's life, and whether the steps taken as a result of any judgements were sufficient**

- 6.34 There is no record of a formal Mental Capacity Act (MCA) assessment having been done with regard to RC's needs. There are references in case recording to RC not being able to make decisions regarding administering his own medication. There are general capacity questions and comments in the recording from Service Provider 1 specifically around his personal care, finance and taking medicines.
- 6.35 Because of the lack of formal MCA, the SALT team were not asked to contribute to an assessment.
- 6.36 It seems clear that there was a tacit understanding that RC lacked capacity to make safe choices about eating. This should have been pursued by a formal assessment of his capacity to make those decisions and should have been recorded. Had the crucial tests of both diagnostic and functional elements been carried out then, whatever the outcome, this would have placed on record a conclusion that might have helped to prioritise responses to RC's needs and future work with him.
- 6.37 This formal assessment would have focused people's minds on the priority of RC's needs and given a greater emphasis to those working with him directly about how to manage those needs, especially in an open environment where there was an inevitable risk of RC accessing foodstuffs that were dangerous to him.
- 6.38 Consideration of RC's Mental Capacity at the review on 2 September was tardy.

**Q5. The extent to which the care plan in place at the time of RC's death reflected the outcomes of assessments about RC's health and social care needs**

- 6.39 The following were in place:
- Health action plan (dated October 2014),
  - Review from the local authority (dated 2 September 2014)
  - Review material from Service Provider 1's internal processes (dated 18 February and 1 April 2015)

However, these were not cross referenced and did not align. They could not be accessed by each key professional. Key information was not shared. There was no evidence that together they formed the basis of a plan and risk assessment.

- 6.40 The care plan should be a key element of any review, which was not so in this case.



6.41 Some of the prepared work from Service Provider 1 that had been carried out with RC was of a good standard. His care plan in relation to his diet was comprehensive and had last been reviewed in June 2014 by the SALT team.

6.42 A MCA assessment would undoubtedly have contributed to a comprehensive care plan.

**Q6. The extent to which the services commissioned by the local authority and provided by Service Provider 1 were sufficient to meet RC's assessed needs**

6.43 The Accommodation was previously a residential unit. A three-year contract was awarded to Provider 2, commencing 1 October 2011, to remodel the homes into supported living schemes. The scheme was successfully de-registered and the service has been functioning as a supported living scheme since 2012.

6.44 Following a competitive tender, Service Provider 1 was awarded the contract and the contract commenced 1 February 2015.

6.45 A risk assessment is carried out on each of the contracts, reviewed annually. This determines the Quality Assurance (QA) monitoring schedule with a default of quarterly monitoring with an overall yearly review.

6.46 The last scheduled QA visit to the Accommodation was on 24 March 2015. The Service Review Officer and social worker were both in attendance.

6.47 An overall performance monitoring framework was in place. Monthly monitoring included:

- Safeguarding and Quality Assurance Callover (attended by Divisional Director, Adult Social Care, Group Managers for Integrated Care and Integration and Commissioning, Business Unit Manager, Quality Assurance Manager, Performance Officer)
- Directorate Performance Callover (attended by Corporate Director, Adult and Community Services, relevant Divisional Directors, and supported by the performance team)
- Performance Directorate Management Team – a high-level summary of performance is presented for all divisions

6.48 As can be seen there was a comprehensive approach in place for services. This was inevitably more targeted towards many of the broad contract compliance issues than the individual care situations. These are tried and tested processes for monitoring contract performance, however the focus on personalisation and outcomes is less clear.

6.49 The independent reviewer was told that there is ongoing contact between the Commissioning service and the provider team (CLDT). However, there was no record of how this contact draws together the care plans and priorities for individuals and the contract/commissioning requirements. Its value therefore is unclear and should be made explicit.

6.50 While it is right to keep a distinction of roles between providers and commissioning, this lack of join-up, not least at a time of diminishing resources, is regrettable and not a sustainable position.

- 6.51 It is perhaps inevitable that, generally, the growth of commissioning seems to have a marked and inexorable separation from the commissioning of care and the various specialist health and social care tasks that support individuals. While this separation may have made little difference to RC, the apparent industry that it creates and the isolation that it may engender is questionable.
- 6.52 In this instance, commissioning and contracting primarily used a tick box exercise in isolation from the rest of the care and health system. This does not help to promote a personalised service that is truly focused on an individual's needs and outcomes.
- 6.53 The commissioned services were sufficient to meet RC's assessed need. However, the assessment of RC's needs (and the consequent care plan) while good in part were by no means comprehensive.

**Q7. Whether the transfer of provider in 2015 had ensured continuity of care for RC**

- 6.54 At the end of the three-year contract with Provider 2 that had commenced on 1 October 2011, the Commissioning section undertook a competitive tender exercise. The Accommodation scheme was subsequently awarded to Service Provider 1 from 1 February 2015.
- 6.55 There is no evidence that the move to a new service provider caused any significant disruption to the day to day operations at the Accommodation.
- 6.56 Issues of continuity of staffing were covered in detailed discussions between the commissioner and provider at the Accommodation. Reassurances were sought and there was minimal disruption or change.
- 6.57 Of the nine staff working in the Accommodation for Provider 2, eight were transferred and continued to work there when Service Provider 1 took over.
- 6.58 While it is clear that the contractual transfer of the service was well handled, this was primarily about the contractual relationship between the Council and the provider. This was a priority and in this situation it was done well. There does not appear to have been the same level of diligence to cover the handover or transfer of individual care plans. While there was minimal disruption on this occasion because of significant continuity of staffing, this should not be taken for granted.
- 6.59 It is therefore vital that assessed needs and care plans of individuals should receive the same level of attention as the management of contractual change. Together, these form part of more comprehensive due diligence obligations and contracting should not be operating in isolation.

**Q8. The extent to which any services delivered by the CLDT, whether by local authority staff, or NELFT staff, were sufficient to comprehensively assess RC's needs, and arrange and oversee appropriate care and treatment**

- 6.60 There is little doubt that there are considerable advantages in having an integrated and co-located team especially where those needing services have complex needs across health and social care. It is worth noting that those providing SALT were located only a few desks away from social workers who would be called upon to provide services or conduct the reviews of individuals. This was the case in RC's situation.
- 6.61 Crucially, as noted previously, the SALT team member was neither made aware of RC's review, nor invited to contribute or attend or sent the outcome report from the

review. This lack of communication in any service is unacceptable, made even worse as it occurred in an integrated structure.

6.62 Notwithstanding an integrated team, what was lacking was:

- co-ordination of services
- good communication and consistent focus on RC's priority needs
- a joined up plan and risk assessment of how best to meet his needs

6.63 The key lesson is that the integration of teams and the co-location of workers may not of itself ensure coordinated and integrated care and care planning for individuals. Managers and workers must continue to focus on joint priorities to ensure integration means more than location or nomenclature.

**Q9. The extent to which the Primary Care and Acute Trusts were able to meet RC's needs for care and treatment in the context of his disability**

6.64 The chronology shows that there was some reasonable contact focused on RC's primary care needs and, as required, acute care needs.

6.65 As a general comment and not related to either primary or acute care, it was difficult to find a co-ordinated thread of how services were wrapped around RC. He had complex physical, mental health and learning difficulty needs and the life threatening condition because of his acute Dysphagia.

6.66 While individual services were generally appropriate, some more than others, it was not possible to discover a co-ordinating or fully personalised focus on RC who was, by any standards, a very vulnerable man.

6.67 Throughout all the records across the agencies – with the exception of SALT – there was insufficient consideration of risk or risk management for RC.

6.68 In short the system did not join things up for RC and no individual or co-ordinated group seemed aware of that lack of focus.

**7. Summary of events on 30 May 2015**

7.1 On 30 May 2015, Care Worker 1 (CW1) was on duty as the sole waking night staff at the Accommodation. CW1 was an experienced worker with over 10 years' experience as a carer and trainer, currently completing training in management and development.

7.2 There is no doubt that CW1 is a conscientious, dedicated worker who took the role very seriously.

7.3 The sequence of events on 30 May is recorded in the Safeguarding Alert on 2 June 2015. The detail is set out in the full SAR report.

7.4 In summary, at around 6.30am on 30 May 2015, CW1 was supporting two residents who needed personal care.

7.5 RC came out of the kitchen and had split ketchup over himself and the floor. CW1 thought he must be hungry and offered him a soft banana and then went to attend to the other two residents.

- 7.6 At the conclusion of this, RC was in the corridor and the worker asked him to go upstairs to change as he had ketchup on his clothes.
- 7.7 Between the original statement (taken on 30 May) and a subsequent interview on 3 July, there is a discrepancy in a very relevant detail. Initially, CW1 states that there were crumbs on the floor and that RC had been eating scones. A later interview on 3 July records CW1 as recalling that RC did not have anything in hands but that he did have puffy cheeks but did not go so near as to check his mouth.
- 7.8 It should be noted that the structured interview on 3 July seemed much more to do with organisational and process matters than to further understanding of what had occurred. It was significantly based on leading questions.
- 7.9 The key discrepancy from the initial statement (made on 30 May) and the statement made on 3 July was not addressed and in light of its singular importance this should have been carefully followed up. The use of leading question interviews should be reviewed.
- 7.10 Perhaps it is reasonable to conclude that the first statement (30 May) could be relied on as to what happened that day.
- 7.11 While it is not the purpose of the SAR to make definitive judgements about any individual's actions there are some learning points to be followed up in the conclusions.

## **8. Lessons and areas for development**

### **8.1 Mental Capacity Act**

- Review the use of the Mental Capacity Act (MCA) for all high risk and complex individuals
- Develop ways in which the individuals subject to the MCA can be prioritised for review
- All reviews to ensure the MCA is considered
- Develop methods to ensure information for social workers, other specialist workers, joint approach in mental health, etc
- Review of all complex and high risk individuals to ensure full consideration of the MCA has been completed

### **8.2 Responding to Dysphagia**

- Review all current higher risk/Dysphagia individuals in a planned and timetabled way
- Develop a way for the ongoing priority for individuals with Dysphagia

### **8.3 Commissioning**

- Consider how contract monitoring, quality assurance and commissioning could be better linked with the individually based assessments

- Streamline the current process of call over and focus on the priority issues, including use of integration/joint work, record sharing
- To ensure due diligence, assessments and care plans for individuals should be given the same consideration as contractual arrangements, particularly at a time of retendering. This will require closer work between commissioning and front line services

#### **8.4 Management and Conduct of Reviews and Risk**

- Ways of prioritising more comprehensive reviews of individuals care where there is high risk to them and complexity of services to achieve better interaction
- Preparatory work required by the reviewing officer
- Information for those being reviewed (and their families) in ways that they can access and understand
- Are social workers the only people who can conduct reviews. Does it have to be a social worker task
- Consider ways in which some reviews could be categorised as priority with a need for specialist input possibly based around the risks the individual might face
- Consideration of a comprehensive and jointly agreed risk analysis and ensuring that risk remains paramount with individuals who may be considered very vulnerable
- Consider ways of ensuring that key information about individuals is constantly refreshed and renewed and that basic assumptions are challenged
- How are risks assessed and triangulated within multi-disciplinary teams? Are staff clear where/who does this and how it is communicated and continually reinforced
- Risk assessments clearly setting out hierarchy of risks that are reinforced at each review point

#### **8.5 Ensuring Full Value for Integrated Working**

- Explore ways in which a single care plan can be maintained for individuals and accessed by all
- In integrated teams at least, health and social care assessments should be brought together specifically for high risk individuals
- The operation of the integrated team and its various elements in relation to individuals with complex needs could benefit from a joint refresh giving clarity to priorities, management arrangements and ways of developing these
- Further consideration of how integrated services at an organisational level can better provide personalised, focused for individuals that are responsive to needs and risks
- Bring Health Action Plans and Local Authority reviews together so that they play a more central and significant part of planning and co-ordination

#### **8.6 Working with Specialist Services**

- Where specialist services are involved co-ordination of standardised approaches should be agreed

### **8.7 Case Records and Shared Information**

- Urgent discussion needed with software suppliers to amend current systems to consider ease of use for analysis of casework information rather than being system driven
- In integrated teams at least, health and social care assessments should be brought together specifically for high risk individuals
- Case records (access and availability) need consideration or the development of a simple and consistent recording of high risk messages set out for all individuals who require it

### **8.8 Development for Providers**

- Consider ways to ensure all care staff are fully appraised of care plans and risk analysis
- Where training has taken place dealing with areas of special concern how can night support staff or part-time staff be engaged
- How can the pattern of early morning waking and support be best handled by a single person or could day staff rotas be amended to ease workload
- In any direct care setting how are critical risk elements kept to the very forefront of workers minds (day, night and part time staff) to ensure consistency of response and safety of the individuals

### **8.9 General/SAB**

- The SAB should look to develop an agreed approach to carrying out Safeguarding Adult Reviews (in light of anticipated London-wide procedures not yet published)
- Some local authorities and health organisations have reviewed and developed approaches to reducing the risk of choking for people with a learning difficulty. The SAB should consider commissioning a learning document in this style, eg Leicestershire Partnership Eating and Drinking Difficulties in Adults with a Learning Disability
- There is a specific role for the SAB as commissioning develops to ensure that the focus on individuals as a part of contracting is built into relevant processes
- There should be urgent consideration supported by the SAB on a cross agency agreed risk status and recording, recognised by all and referred to at any key point of intervention
- The issue of taking statements, supporting staff, collecting information and collating reports should be thoroughly reviewed under the auspices of the SAB with clear guidance given to all agencies and providers

## **9. Conclusions**

### **Predictability and Preventability**

9.1 In addition to considering the nine questions set out in the scope, one of the purposes of this SAR was to consider whether or not RC's death, in the circumstances, could have been predicted or prevented.

9.2 Predictability is not an exact science, rather, it is the balance of bringing together a number of known factors and circumstances. For RC, these factors were:

- RC suffered from acute Dysphagia
- There were numerous examples in the past where he would cram his mouth with food if left unsupervised
- Elements of his medication had the potential to impact on his swallowing reflexes
- He clearly enjoyed food and was now confined to a pureed and liquid regime. All this in a day to day living situation where he shared a house where full meals were prepared and eaten in his presence, while he was on what by any standards would be described as an unappetising and unfulfilling diet.
- There had been previous incidents of choking, most notably April 2013
- He was losing weight
- He lived in an environment with others, some of who might be described as having voracious appetite(s)
- While never fully explored or assessed it seems very unlikely that RC had capacity to understand or retain the understanding that certain foods were high risk for him and that this necessitated the special diet
- The Speech and Language Therapist clearly identified the high level of risk in May 2013 and staff training was held to reinforce this.

9.3 In these circumstances it is right to conclude that it was predictable that RC could suffer very serious harm as a result of his condition, moreover that this was a daily feature of his life.

### **Preventability**

9.4 It is extremely unfortunate that the primary issue of RC's acute Dysphagia was not referred to at his statutory review in September 2014. The absence of a Mental Capacity Act Assessment also meant that a priority was not placed on this. This was RC's most critical area of daily risk.

9.5 There was an unfortunate basic assumption that RC did not steal (take) food. It would have been more accurate to say that RC had not been seen to take food.

9.6 He lived in an environment where food was openly prepared, served and stored and where other individuals may have had various elements of eating disorder. There is no evidence that this was taken into account in RC's living situation.

- 9.7 It is likely that in all these circumstances the risk of RC taking/hiding food was quite high. It is not clear from any of the records that this contextual risk was explored, or there was any consideration of how it might be minimalised.
- 9.8 Risk could never be fully eradicated for RC or anyone, but for him it should have been about consistently managing those risks with him and, where necessary, for him. A determination of his Mental Capacity should have been completed. Each and every key professional interaction with him should have had his specific risks as the highest. His statutory review failed to do this.
- 9.9 While it is clear that there was a strong input to the staff at the Accommodation through May to July 2013 and follow up training in June 2014 specifically around RC's needs, it is less clear how this emphasis was being fully and comprehensively maintained with all staff, including waking night staff.
- 9.10 In summary the key factors are:
- If a full MCA assessment had been completed for RC then decisions about how food was stored and his access to it might have been different.
  - Direct work should have been conducted with RC about the impact of eating the wrong foods in a way appropriate to his ability, and then consistently reinforced. This may have deterred him from taking food. This should have been done using appropriate methods. It is disappointing there is insufficient evidence of this.
  - The giving of a soft banana did not fit with the clear guidelines from the Speech and Language Therapist.
  - If there was any sign of other food (cake) then RC should have been supported urgently and directly in accordance with SALT guidelines.
  - On the 30 May RC should have been supported with the full cognisance of his risks and needs and following SALT guidelines.
- 9.11 There is throughout this review a heightened feeling that the guidance and identification of risk set out by SALT and the reinforcement training in 2013 had perhaps dissipated somewhat in more recent times.
- 9.12 A single point of coordination of his needs would have assisted.
- 9.13 A greater priority to his statutory review and planning should have been done.
- 9.14 Some may argue that in view of all this RC should have been in a different environment in which his potential access to foods that might harm him was restricted and the social environment more restrictive. A key question is whether this was a safe environment for RC. It is, on balance, reasonable to conclude that subject to all necessary safeguards support, training, re-enforcement and good external reviewing that this risk was measured and reasonable.
- 9.15 It is impossible to determine if events of 30 May could have been prevented. The above sets out the facts that could and should have been changed.



## **10. Recommendations**

- 10.1 That a comprehensive action plan be developed to implement the learning and development points.
- 10.2 That a partnership event be arranged for practitioners, professionals and managers to feed into the action plan.
- 10.3 That a specific learning and development session be arranged for staff involved in RC's care.
- 10.4 That MCA training be reviewed to include case studies and links to areas of people's work.
- 10.5 That a Choking Policy be developed (by the SAB).
- 10.6 That this Executive Summary should be published.