Barking and Dagenham Safeguarding Adults Board

Safeguarding Adults Review RC

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1. Introduction

1.1 Safeguarding Adult Reviews (SARs) were established by the Care Act 2014 to respond to situations where serious harm has been experienced by a vulnerable adult. A vulnerable adult is someone who

a) has needs for care and support (whether or not the authority is meeting any of those needs),
(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.

1.2 This review concerns the death of RC (born 21 February 1954). RC was at that time living in supported accommodation at the Accommodation, Barking. At around 6.30am on the morning of 30th May 2015 it is believed that RC took some scones from the fridge in the kitchen area and choked on them. It is the circumstances of this event that is central to this review.

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

1.4 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.

2. Safeguarding Adult Reviews (SAR)

National Requirements

The Care Act 2014 came into effect from 1st April 2015. Under section 44:

"(*1) A Safeguarding Adults Board must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—*

(a) there is reasonable cause for concern about how the Safeguarding Adults Board , members of it or other persons with relevant functions worked together to safeguard the adult, and
(b) condition 1 or 2 is met.

(2) Condition 1 is met if—

(a) the adult has died, and
(b) the Safeguarding Adults Board knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

(3) Condition 2 is met if—

(a) the adult is still alive, and
(b) the Safeguarding Adults Board knows or suspects that the adult has experienced serious abuse or neglect.

(4) A Safeguarding Adults Board may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

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(5) Each member of the Safeguarding Adults Board must co-operate in and contribute to the carrying out of a review under this section with a view to—

(a) identifying the lessons to be learnt from the adult's case, and
(b) applying those lessons to future cases."

3. About this Safeguarding Adult Review (SAR)

3.1 The SAR was commissioned by Barking and Dagenham Safeguarding Adults Board (SAB) and managed by the Safeguarding Adult Review Sub Group (see Appendix A for membership)

3.2 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
- London Borough Barking and Dagenham Adult Social Care – CLDT (Community Learning Disability Team)
- North East London Foundation Trust (NELFT) – mental health and dietician services
- The Service Provider 1 – current managers and providers of services at the Accommodation, supported living where RC lived
- Speech and Language Therapy Service (SALT) – an integrated part of CLDT

3.3 The purpose of this review is to:

i. Consider whether or not RC's death in the circumstances described could have been predicted or prevented.

ii. Develop learning that enables the safeguarding adults' partnership in Barking and Dagenham to improve its services and prevent abuse and neglect in the future.

iii. Ensure that lessons are learnt, rather than to apportion blame. Lessons are to be applied to future cases to improve local practice, procedures and services together with partnership working in Barking and Dagenham to minimise the possibility of it happening again.

iv. The purpose of the review is not to apportion blame or hold any individual or organisation to account. Other processes exist for that, including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation, such as the Care Quality Commission, the Nursing and Midwifery Council, the Health and Care Professions Council, and the General Medical Council.

3.4 Barking and Dagenham Safeguarding Adults Board will ensure recommendations and actions from Safeguarding Adults Reviews are implemented to ensure that learning from these are not lost but used to improve services and prevent further harm, abuse or neglect.

3.5 The following principles apply to all reviews:

- there must be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice;
- the approach taken to reviews must be proportionate according to the scale and level of complexity of the issues being examined;
- the individual (where able) and their families will be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively;
- the Barking and Dagenham Safeguarding Adults Board is responsible for the review and must assure themselves that it takes place in a timely manner and appropriate action is taken to secure improvement in practices;
- reviews of serious cases will be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed and
- professionals/practitioners will be involved fully in reviews and invited to contribute their perspectives.

3.6 Throughout this review all staff have co-operated fully in interviews, finding and providing information, and made time for involvement. Thanks for this openness and candour is expressed to all.

4. **The Scope**

4.1 The scope of this SAR, set by the Safeguarding Adult Review Sub Group, is 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 the Service Provider 1, were sufficient to meet RC's assessed needs

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 particularly Primary Care and the Acute Trust, was able to meet RC's needs for care and treatment in the context of his disability

5. The Methodology

5.1 The way in which the local Safeguarding Adults Board choses to conduct an SAR is not prescribed and it is recognised that the circumstances of each case may require a different approach, however the Social Care Institute for Excellence has issued guidance on options for London Boroughs[1] . Their model has 3 methodology options for conducting Safeguarding Adults Reviews:

(i) Option One – a traditional Serious Case Review approach:

- Appointment of SAR panel, including chair (usually independent) and core membership-which determines terms of reference and oversees process
- Independent report author (overview report, summary report)
- Involved agencies produce Individual Management Reports(IMRs), outlining involvement and key issues
- Chronologies of events
- Overview report with analysis, lessons learnt and recommendations
- Relevant agencies produce action plans in response to the lessons learnt
- Formal reporting to the Safeguarding Adults Board and monitoring implementation across partnerships

(ii) Option Two – Action learning approach. This option is characterised by reflective/action learning approaches, which do not seek to apportion blame, but identify both areas of good practice and those for improvement. This is achieved via close collaborative partnership working, including those involved at the time, in the joint identification and deconstruction of the serious incident(s), its context and recommended developments.

(iii) Option Three – Peer review approach. This option is characterised by peer reviews and accords with increasing sector led reviews of practice. In this option peers can constitute professionals/agencies from within the same safeguarding partnership, (for instance a Safeguarding Adults Board members), or other agencies within the London region.

5.2 The Barking and Dagenham Safeguarding Adults Board has already responded to the implications of the Care Act 2014, which came into force on 1st Aril 2015, by looking at its structural arrangements and developing a revised strategic plan. However, in view of the timing of this SAR the Board has not yet set out its approach to reviews. This needs to be done as soon as possible to ensure a standardised approach which enables learning, consistency and good engagement.

[1] http://www.scie.org.uk/adults/safeguarding/files/SCR_Options_London.pdf?res=true

Learning and Development Point 1

a) The SAB should look to develop an agreed approach to carrying out Safeguarding Adult Reviews

5.3 The method used in this instance therefore was drawn from Option One and Option Two, but also allowing learning and development to be developed by the key participants guided by the issues raised by the circumstances of this SAR. The process included:

i) Review of case records, correspondence in both the local authority, health services, the provider and CQC
ii) Contact with RC's brother
iii) Focused interviews with key participants drawn from the organisations referred to at para 3.2
iv) Written reports or assembled material from the agencies represented
v) Correspondence to follow up on questions and points of clarification from the key professionals involved
vi) Meetings with the appointed SAR Review Panel to assess progress

5.4 Throughout the text and particularly at the end of key section leaning and development points are noted. These are then grouped and set out at the end of the report. These must form the basis of a prioritised action plan endorsed by the SAB. However it is preferable that these learning points are developed further with key staff responsible for both managing or providing services to promote engagement ad ownership. A learning event should be prioritised involving the key agencies and participation if possible.

6. RC

6.1 RC was a 61 year old man who was born in Dagenham and had attended school in the area. He was the youngest of four children and remained close to his brother TC and sister A. He moved to the Accommodation in 2009 having moved there from a different residential home. RC had a moderate learning difficulty and bi-polar disorder.

6.2 RC was supported by staff every day with his personal care, this would include brushing his teeth, scrubbing his back in the bath and washing his hair, however he did not like to stay in the bath for long. As soon as the bath was filled RC would jump in and say to staff '*get out'* then make his way out, staff would say to him '*you're not finished yet*' but still assist him in getting out. Once out he needed staff to support him to apply cream on his legs and especially the heels of his feet.

6.3 RC needed staff support with his medication, which he took three times daily, he relied on staff to order, receive and administer this to him. RC relied on staff to accompany him to all his health care appointments. Staff would record such appointments and carry out any instructions given by health professionals. RC relied on staff to discuss any issues that were raised by health professionals. Throughout the day when RC was happy he would like to sing in a very low tone, if you listened carefully you would hear him sing '*I love you, yeah, yeah'*.

6.4 RC relied on staff to prepare all his meals and drinks. After finishing his meals RC would say to staff '*take it out'* he would then bring his plate and cup out to the sink. RC would like to choose his own cereal and get his bowl out, but any help had to be

said to him in slow short sentences. Throughout the day RC was known to say in a low tone '*behave yourself*' and also tap his forehead.

6.5 Throughout the day RC was encouraged by staff to pull his trousers up, he would end up saying the same thing '*pull my trousers up'*.

6.6 At home he needed staff to complete all the household chores. He liked his clothes ironed and put away in his cupboard nicely.

6.7 RC enjoyed going out in the community and going for long walks around the park. He enjoyed bus rides but staff needed to always try taking him out at off peak times because he did not like crowds and noise. Staff needed to sit with him or stand next to him observing him at all times. While out in the shops, staff need to keep a close eye on him because he might wander off. RC also enjoyed going to the cinema and liked many different kinds of films.

6.8 RC had no concept of money or how to use it. When out he never carried his wallet or used money.

6.9 RC was not able to make choices for himself but had a family who could make decisions on his behalf.

6.10 **Things that were important for RC.**

- To have his meals on time.
- To have his medication on time.
- Family outings with his brother TC every other Saturday.
- To visit the pub and have a shandy.
- Brother TC's birthday.
- Staff to follow his food guidelines. To have thickeners in all his fluids.
- To be weighed every weekend and record findings.
- To look smart at all times.
- Support to access the community with staff who know him.
- To have his own space.
- To maintain his own independence.
- To visit the Chiropodist every month to have his feet looking good.
- To have his trousers pulled up at all times.

6.11 **What people who know him, liked and admired about him.**

6.12 RC had a nice smile, a good sense of humour, if he was happy he would just start to sing in a low pitch voice. He enjoyed spending time listening to the radio in his room and just chilling.

6.13 This information was provided by staff at the Service Provider 1 in response to a request from the independent SAR author.

7. Family Involvement

7.1 RC's brother, TC, lived locally and had frequent and close contact with RC. They went out together in the locality and TC kept in close contact with the staff responsible for RC's care. RC also had a sister, A, who lives in Canada. She also visited RC when able.

7.2 This family contact was valued by staff and very important to RC.

7.3 RC's brother TC was contacted by the local authority and then by the author of this review in July 2015. The purpose of the review was outlined and he was offered the opportunity of discussion. In the circumstances he took the view that he would prefer to leave all these matters to be dealt with by the Coroner who would review all the important details. That view was respected.

8. Key Events

8.1 As a part of understanding RC's needs and how these were being met a full chronology was drawn up as part of the preparation for this SAR and is attached at Appendix.

8.2 A summary of the key elements is set out below:

October 2009	RC moves to the Accommodation, managed by Provider 2
18 April 2011	Health Action Plan created. Recommends supervision while eating and the cutting up of food into small pieces
July 2012	Health Action Plan reviewed
29 April 2013	Admitted to hospital after choking episode
3 May 2013	Dysphagia risk assessment carried out by SALT. SALT provides new eating and drinking guidelines - moist fork mashed diet.
29 May 2013	Swallowing risk assessment and eating guidelines created by SALT - soft mashed food, meat blended, no sandwiches or rice, and bread only when cut up. All foods to be blended separately, small spoon to be used. Drinks: thicken all fluids to stage 1 (syrup consistency)
29 July 2013	Dysphagia Management Plan Review
December 2013	Health Action Plan updated – states that food should be soft and pureed and that fluids should be thickened
12 December 2013	RC admitted to hospital as day patient to have gall stones removed.

8 April 2014	CLDT support plan
30 May 2014	Risk assessment form by Provider 2 and action plan
21 May 2014	RC sees consultant psychiatrist
26 June 2014	Last Dysphagia review – no changes made to the existing plan
2 September 2014	Care Plan reviewed by CLDT
October 2014	Health Action Plan updated
25 October 2014	Provider 2 Support Plan
1 February 2015	The Service Provider 1 become responsible for the management of the Accommodation
18 February 2015	The Service Provider 1 Support plan agreed referring to SALT guidelines
12 March 2015	GP Check up
March 2015	Psychiatric Review
1 April 2015	The Service Provider 1 risk assessment completed
21 May 2015	Psychiatric Review
30 May 2015	Admitted to hospital after choking at the Accommodation
4 June 2015	RC passes away

9. **Learning Disabilities and Dysphagia**

9.1 RC had a number of health related difficulties which required consistent health and social care support. While many of these conditions interacted, the most significant to his daily living and safety was the risk of choking when eating food. This often occurs with individuals who have a learning difficulty as one in three people with learning difficulties has Dysphagia problems. As part of this SAR the background and incidence of this condition was reviewed.

9.2 Background literature records that people with a diagnosis of learning difficulty are well known to be at higher risk of choking than other people and there is much research evidence to support this, for example, Thacker (2007), Samuels (2006). This is due to several factors including:

- problems with chewing
- difficulty swallowing (dysphagia)
- behaviours such as bolting food or pica (eating inappropriate and non-food items)
- the effects of medication.

9.3 These difficulties can have a significant impact on a person's health, resulting in problems such as aspiration pneumonia and frequent upper respiratory infections, undernutrition and dehydration (Harding, 2010).

9.4 In the most extreme cases, a piece of food (or non-food item) can obstruct the airway and lead to death.

9.5 There has been national concern regarding the care of those with a learning difficulty - the "Death by Indifference" (Mencap 2007) report describes what it calls 'institutionalised discrimination', which results when organisations fail to make changes in the way they deliver services to take account of people's differing needs. In addition, the Six Lives report (PHSO 2009) questioned commissioning and provision of services, stating: "*The findings of our investigations pose serious questions about how well equipped the NHS and councils are to plan for and provide services tailored to the needs of people with learning disabilities*". Since the publication of the Six Lives report in 2009 and 2012, Mencap have identified a further 74 people with a learning difficulty (Mencap 2012) who have died as a result of institutional discrimination. The report cites poor communication, lack of basic care and attention, and a failure of services to meet the different needs of people with learning disabilities as reasons for the high numbers of deaths.

9.6 In managing Dysphagia it is essential to involve patients and their carers in care planning and management. Non-compliance with management strategies for swallowing difficulties, by both patients and their carers, is common. Adults with a learning disability may find it hard to understand the implications of their swallowing difficulties; it is, therefore, important that their carers recognise the need to follow guidance in order to reduce the risk of aspiration. Management /care plans should:

- be individualised and include advice provided by a Speech and Language Therapist and a dietician
- outline the patient's needs, identify plans or goals to address those needs,
- make clear the actions needed to achieve the goals, and evaluate the management process
- be reviewed regularly to ensure they continue to meet the patient's needs

Learning and Development Point 2

a) Some local authorities and health organisations have reviewed and developed their 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 The Leicestershire Partnership Eating and Drinking Difficulties in Adults with a Learning Disability.

10. Responding to the scope of the SAR

The following section focuses on the particular questions set out by the Safeguarding Adult Review Sub-Group for consideration to cover the scope of this SAR. Each question is considered separately although in some areas there is an element of overlap

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

10.1 As will be shown below there were areas of very significant work to assess and support RC's needs covering his specific health and social care situation. For the purpose of this review much of this has been tracked back to September 2011. Throughout the key period RC was living at the Accommodation (since October 2009) under the ownership and management of the Service Provider1, Provider 2 and then the Service Provider 1 again, there are comprehensive care records that chronical his needs, activities and significant incidents, on a day to day basis.

10.2 In common with individuals who may be in touch with various parts of the social care and health system there is no single or co-ordinated recording system that brings together assessment, review or case records, nor is it possible or perhaps feasible that individuals in one part of the system can access records in another part of the system. However, the current system of case recording in adult social care using computerised records is clunky, difficult to follow, cross reference and refresh. This is common in many local authorities. Too much a situation of the system driving case work perhaps. This needs reviewing. (See Learning and Development Point 3)

10.3 This level of complexity and lack of integration requires a robust and regular review mechanism that can draw together the various strands of activity that make up an individual's life to provide not only a comprehensive assessment but consider the interaction of one element with another. As will be seen from Q3 below this did not happen in RC's situation. (See Learning and Development Point 5).

10.4 The commissioning of services, particularly as this relates to the individual's social care, needs examination. The monitoring of contractual arrangements and the letting of new contracts should not be carried out in isolation from the individual's care needs (see Q6 below).

10.5 It is of particular note that 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.

10.6 Having reviewed all the case records, there is a lack of consideration of RC's needs within a context of **risk**. The most notable and commendable exception is the Speech and Language Therapy 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.

Learning and Development Point 3

a) 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.

b) In integrated teams at least, health and social care assessments should be brought together specifically for high risk individuals.

c) Consideration of a comprehensive and jointly agreed risk analysis and ensuring that risk remains paramount with individuals who may be considered very vulnerable

d) Review the use of the Mental Capacity Act for all high risk and complex individuals

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

10.7 Specialist assessments for RC were broadly defined by the input from the:

- General Practitioner
- Consultant Psychiatrist Mental Health
- Consultant Psychiatrist Learning Disabilities
- Dietician Service.
- Speech and Language Therapy (SALT) Service

10.8 The chronology of contact with each of these services is shown at Appendix B. 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.

10.9 When required, advice from the dietician services 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 the parallel services provided in learning difficulty and similarly not seen to be in conjunction with primary care services (GP).

10.10 The specialist area the work of Speech and Language Therapy is the most comprehensive and well documented. In terms of positive learning for this review and other work this input was of a very high standard indeed and 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 to staff regarding RC's needs in the supported living service, liaison with dietary services and contact with hospital services. This particular area of assessment was both comprehensive, conducted to a high standard and of sufficient depth.

10.11 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 to staff on how to blend and thicken fluids.

10.12 Comprehensive guidance was given to staff on how to support and observe RC when he was eating or drinking including advice to help RC 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.

10.13 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 dealt with individually there was insufficient integrated understanding.

10.14 The risk of this is that professionals, even with good intentions, are working in isolation and may not fully recognise the impact of one course of action in relation to another.

10.15 A very relevant example of this for RC was that his prescribed cocktail of medications, as set out in the table below, contained at least 5 elements that may have side effects that impact on swallowing. RC's greatest risk was that he suffered from acute Dysphagia.

Medication	**Possible side effects**
Clonazepam 500mg twice a day	Depresses central nervous system. Can decrease awareness and voluntary muscle control that may affect swallowing
Lithium Carbonate (Liskonum) 450 mg twice at night	Dry mouth Can effect movement disorders that impact muscles of face and tongue involved in swallowing
Procyclidine 500mg once a day	Reduces production of saliva
Risperidone 3mg in total during the day	Produces dry mouth – same as side effects of Lithium
Oxybutynine 2.5 mg three times a day	Improves bladder capacity May affect muscles of the oesophagus that are involved in swallowing and may cause dysphagia

10.16 There is no record of this possible cumulative impact of the medication in any of RC's notes or guidance given.

10.17 The Speech and Language Therapy work included risk management and 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."*

10.18 By the end of May 2013 RC's dietary needs were refined and it was made clear that all food should be blended, no sandwiches or rice, and all fluids thickened. Subsequent follow up shows that his needs were monitored with further staff training on managing Dysphagia in June 2014 and the last Dysphagia review being on 26th June 2014.

10.19 It is clear that in RC's situation specialist assessments were crucial to meeting his needs and providing for his care. In common with many individuals with similar needs the role of local authority social care services may be relatively small in the day to day, and where there are integrated teams (as was the case here) the direct input of

social workers is often limited to annual reviews or intervention at times of change or emergency.

10.20 The role of the statutory social care service then is principally to support comprehensive reviews, respond to changing circumstances and the contract monitoring and reviewing of placements through its commissioning service.

10.21 The role of commissioning will be considered at Q6 and the role of statutory reviewing will be considered at Q3.

Learning and Development Point 4

a) Consider new care co-ordination responsibilities/arrangements between agencies for high risk individuals, ie where, how and who is co-ordinating.

b) Where specialist services are involved co-ordination there should be agreed arrangements including for integrated teams.

c) Case records (access and availability) needs consideration or a simple and consistent recording of high risk messages set out for all individuals who require it.

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

10.22 On an individual basis there were ongoing considerations in most elements of the 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 Speech and Language Therapy. While there had been updates from both Consultant Psychiatry and Consultant Learning Disabilities areas these were not necessarily prioritised nor do they appear entirely co-ordinated. This similarly points to a new co-ordination role and responsibility. The work of commissioning and the review of contract compliance and quality standards will be dealt with in Q6.

10.23 RC had regular reviews of his care carried out by Provider 2 and then by the Service Provider 1 as follows:

- Provider 2 choking risk assessment and action plan on 1st June 2014 sets out the choking risks to RC, the measures taken to reduce the risk and identifies additional actions by staff to further reduce the risk by reminding RC not to rush his food.

- Provider 2 support plan completed on 25th October 2014. There is reference to staff supporting RC in buying foods that SALT recommended and needing to have soft or pureed foods and drinks thickened, but it is on the last page with no particular emphasis placed on it.

- The Service Provider 1 support plan completed in February 2015.

What needs to be done	How will this be done Who will do it Who else needs to be involved
I would like to be supported to make healthy choices around meal times	Staff to follow guidelines in place from SALT team. Staff to ensure my nutritional needs are met and taking into account my likes and dislikes, this can be done when I go shopping, staff need to show me what food is good for me, also I have a weekly menu form 206 so I can ensure I am eating healthily

This February 2015 support plan also refers in the social participation section to RC having a pub lunch. This is absolutely contrary to the SALT guidance and dilutes consideration of risk.

- The Service Provider 1 "one page profile" on RC completed on 18th February 2015. This document does refer to his pureed diet and need for drinks to be thickened, however it is at the 3rd paragraph of a second box on page 2 and therefore not immediately recognisable as the key piece of information that RC depended on to keep him safe every day

- The Service Provider 1 risk assessment completed 1st April 2015 – sets out all staff to follow SALT guidelines, all food to be blended and fluids thickened.

10.24 The local authority social care conducted RC's most recent annual review on 2nd September 2014.

10.25 This is a crucial event and one at which there is an expectation that there would be a comprehensive review of an individuals' care needs drawing on key information of those who might have a role in health or social care support for the individual. The task has professional aspects in terms of looking at issues from a number of perspectives, balancing need and risk, the 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.

10.26 It is also an opportunity to meet with the individual concerned and where possible the family and the respective care staff. From it should flow key actions for any of the key players in the individual's care or support.

10.27 In Barking and Dagenham around 370 such reviews are conducted each year and until recently they had been shared between the 8 designated social workers. Due to the pressures on time and staffing and to even out how these were done throughout the year during the second half of 2014 the reviews were mainly assigned to an individual social worker who could concentrate on them.

10.28 The record of RC's review on 2nd September 2014 is contained at Appendix D.

10.29 The review invitation was issued to RC and the Service Provider 1. There is no evidence that notification of the review was sent to anyone else.

10.30 No written reports were commissioned from any of those involved with RC. There is no evidence of verbal updates being sought beforehand.

10.31 The commissioning section was unaware of the individual case review. The individual conducting the review did not have any pre-prepared material regarding RC

10.32 The review was held on 2nd 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 in a way that might be considered as accessible.

10.33 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.

10.34 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 do a Barbeque
- There are no recorded concerns about RC's safety
- There was no need to consider further mental capacity of deprivation of liberty

10.35 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.

10.36 It is of further concern that none of the specialist assessments referred to in Q2 above appear to have been referred to or referenced before, during or after this review.

10.37 Of particular concern is that Speech and Language Therapy (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.

10.38 Of further concern is that the input from the Accommodation staff made no reference to his Dysphagia, the single, most important issue for RC and his safety and wellbeing.

10.39 While it may be said that, of itself, this review may not have a direct bearing on the events of 30th May 2015, the priority of RC's acute Dysphagia was not referred to or reinforced at this important review. Subsequently, anyone consulting this record would be totally unaware or the daily risk that this represented to RC.

10.40 The report from the review was circulated to RC and the Service Provider 1 as the provider. There is no evidence that it was sent to the RC's brother or anyone else which at the very least would have been a good checking mechanism, and in any event should be standard practice. One set of supervision notes for the worker who

conducted the review dated 20th October 2014 are adequate but make no reference to RC's review.

Learning and Development Point 5

a) **Ways of prioritising more comprehensive reviews of individuals care where there is high risk to them and complexity of services to achieve better interaction.**

b) **Preparatory work required by the reviewing officer**

c) **Information for those being reviewed (and their families) in ways that they can access and understand**

d) **Are social workers the only people who can conduct reviews - does it have to be a social workers task**

e) **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**

f) **Review all current higher risk/Dysphagia individuals in a planned and timetabled way.**

g) **Develop a way for the on-going priority for individuals with Dysphagia**

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

10.41 In relation to RC 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 and there are general capacity questions and comments in the recording from the Service Provider 1 specifically around his personal care, finance and taking medicines.

10.42 Because of this lack of formal MCA the SALT team were not asked to contribute to an assessment.

10.43 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.

10.44 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.

Learning and Development Point 6

a) **Develop ways in which the individuals subject to MCA can be prioritised for review**

b) **Develop methods to ensure information for social workers, other specialist workers, joint approach in mental health etc**

c) **Review of all complex and high risk individuals to ensure full consideration of MCA has been completed**

d) **All reviews to ensure MCA is considered**

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**

10.45 While there was in place:

- Health action plan (dated October 2014),
- Review from the local authority (dated 2nd September 2014)(referred to Q3)
- Review material from the Service Provider 1's internal processes (dated 18th February and 1st April 2015) (referred to at paragraph 10.23)

these were uncoordinated, did not reference each other or align. They were not accessible by each key professional in any way. Key information was not shared.

10.46 Within the Service Provider 1 there was a care plan in place for what might be called the day to day work and task of supporting RC (this is contained in Appendix G). The issue of RC's particular dietary needs, and the reasons underpinning them, are not immediately apparent and the priority of following SALT guidelines are not drawn out.

10.47 The problem here is how these various activities are drawn together, accessed by all and be the basis of a plan and risk assessment of how RC's needs can best be met. Indeed the care plan should be a key element of any review, which it was not. Some of the prepared work from the 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.

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

Leaning and Development Point 7

a) **Explore ways in which a single care plan can be maintained for individuals and accessed by all.**

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

10.49 It is important to look at some of the history of the Accommodation and the ways in which the Commissioning section of the local authority carry out their work.

10.50 The Accommodation was previously a residential unit. A 3 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.

10.51 Following a competitive tender for three contract lots of schemes, the Service Provider 1 was awarded the contracts for Lots 1 and 2. Lot 2 was inclusive of the Accommodation and the contract commenced 1 February 2015

10.52 A risk assessment is carried out on each of the contracts, and these are reviewed yearly. This determines the Quality Assurance (QA) monitoring schedule, with a default of quarterly monitoring with an overall yearly review. However, if performance indicates issues with the provider this is increased dependent upon the seriousness of the concerns. A template is used for each report which includes all the main checks.

10.53 After the award of the contract the provider was advised of the contract performance information to be supplied by them and also of the checks that would be made during a QA visit. At the same time the Service Provider 1 was given the Safeguarding protocol and copies of the relevant document for reporting.

10.54 When carrying out a planned QA visit to a provider the main areas focused on:

- Preparation by looking at previous QA reports, CQC latest inspection report and findings and any recent history of safeguarding alerts, complaints or serious incidents so that there is background information before the visit takes place
- Physical standard of the accommodation (if appropriate) – is it clean and well maintained
- Health and Safety requirements being met (if appropriate) – adequate fire safety, electrical and gas safety measures in place
- Adequate staffing levels for the provision of the care required
- Staff training is up to date and there is a training programme in place
- Policies and procedures are of the required standard
- Administration functions are well organised
- Risk assessments for service users are being regularly reviewed
- Meeting residents (if appropriate) and making sure they are happy (if they can communicate this), they are kept active, they have a programme of activities to keep them occupied, person centred support plans
- Open, communicative and cooperative management that are happy to engage with the contract team
- Generally assess the feel of the place, that it is well run, that the residents are happy and well cared for, that staff are experienced and well trained and equipped to deal with any situation, that the provider is committed to working with the commissioner to provide the best service to customers as possible.

10.55 The last QA visit to the Accommodation was on 24th March 2015. The Service Review Officer and social worker were both in attendance. Additionally, in May 2015

the Learning Disability Joint Commissioner and the Commissioning Manager, Quality Assurance, took the opportunity to visit the Accommodation informally while en route from a scheduled visit to another neighbouring provider. As an informal visit no file note was recorded, but the officers confirm that nothing in the visit alerted them to matters of concern.

10.56 The same monitoring principles are used for all providers including contracts and spot purchasing. During a QA visit a random selection of service users' files would be checked as per the QA process. Each service user has a yearly review by an allocated social worker.

10.57 For learning difficulty, any specialist health or support needs would be included in their Health Action Plan supported by the CLDT.

10.58 There is an overall performance monitoring framework in place. Monthly monitoring includes:

- 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) A dashboard is presented which provides information on residential and homecare providers, including how many safeguarding alerts, serious incidents and Deprivation of Liberty Safeguards (DoLS) applications. This relates the data to capacity and how many London Borough of Barking and Dagenham (LBBD) service users are being provided for. The group takes a view about a status for each institution or agency ranging from Green, through Amber (some concerns), Red (significant concerns) to Black (serious concerns, sufficient to merit LSI, embargo or other co-ordinated action). This information is progressively summarised at later stages of the process.
- Directorate Performance Callover (attended by Corporate Director, Adult and Community Services, relevant Divisional Directors, and supported by the performance team) This process ensures that an overview of performance on social care, including commissioning activity is reviewed by the senior leadership team. The dashboard includes contract performance, complaints, and a 'by exception' extract of the output from the Safeguarding and QA callover.
- Performance Directorate Management Team - A high-level summary of performance is presented for all divisions

10.59 As can be seen there is a comprehensive approach in place to the commissioning of services like the Accommodation for RC. This is inevitably more targeted towards many of the broad contract compliance issues than the individual care situations. There are tried and tested processes for monitoring contract performance.

10.60 While reference has been made in the reporting for this SAR from Commissioning to ongoing contact between the Commissioning service and the provider team (CLDT) there is 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.

10.61 While it is right to keep the 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.

10.62 In summary, the Commissioning Service had some very good records that covered the activity outlined above. From a process point of view it was generally comprehensive and accessible. It perhaps inevitable that in organisations the growth of commissioning seems to have a marked an 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 seems to engender is questionable.

10.63 In short, 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

10.64 As commissioning activities are further separated and perhaps merged with heath or others, safeguards must be put in place to ensure that individual's best interests and safety are not compromised. The SAB has a key role in ensuring that integrated arrangements are not jeopardised.

10.65 On the specific question of whether the commissioned services were sufficient to meet RC's assessed need, there is no evidence to suggest that this was not the case. However, the context was that the assessment of RC's needs (and the consequent care plan) while good in part were by no means comprehensive.

Learning and Development Point 8

a) Consider how contract monitoring, Quality and Assurance and commissioning could be better linked with the individually based assessments

b) Streamline the current process of call over and focus on the priority issues, including use if integration/joint work, record sharing

c) There is a specific role for the SAB as commissioning develops to ensure that the focus on individuals as a part of contracting is not lost

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

10.66 At the end of the expiry of the 3 year contact with Provider 2 that had started on 1st October 2011 the commissioning section undertook a competitive tender exercise and following this the Accommodation scheme was awarded to the Service Provider 1 commencing on 1st February 2015.

10.67 The Service Provider 1 had previously run a service out of the Accommodation, the contract for which had finished in September 2011. The contract was awarded to the Service Provider 1 because of their stronger evidence of experience and commitment to personalisation, the Service Provider 1 were also the highest scoring provider during the service user evaluation process.

10.68 Notwithstanding this change, there is very little evidence that the move to a new service provider caused any significant disruption to the day to day operations at the Accommodation.

10.69 The issues of continuity of staffing were covered in detailed discussions between the commissioner and provider at the Accommodation and reassurances were sought, and appear to have been met with minimal disruption or change.

10.70 Of the 9 staff working in the Accommodation for Provider 2, 8 staff transferred and continued to work there when the Service Provider 1 took over.

10.71 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 is of course 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 hand over 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.

10.72 It is therefore very important that when the commissioning section is managing contractual changes the individual assessed needs and care plans of individuals should be receiving as much attention from professional care staff as part of the overall due diligence obligations. These activities should not be operating in isolation.

Learning and Development Point 9

a) To ensure due diligence, care plans assessment for individuals should be given the same consideration as contractual arrangements, particularly at a time of re-tendering. This will require closer work between commissioning and front line services

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

10.73 The London Borough of Barking and Dagenham (LBBD) and NHS elements of the learning disability services were brought together in an integrated structure of a Community Learning Disability Team (CLDT) in April 2011. This brought together social workers and nursing staff in 3 mixed clusters with psychiatry, psychology and therapists working separately but as part of the overall team. Integrated work practices were agreed and set out in an agreed operation policy. The team is co-located with LBBD taking the day to day lead responsibility. Appropriate professional supervision is provided to each individual discipline.

10.74 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 speech and language therapy were located but 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.

10.75 Crucially, as noted previously, the SALT team member was not 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.

10.76 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.

10.77 Services in various parts of the system were sufficient, and there were not elements of RC's care either through mental health services, learning disability services, social care, accommodation in which there were huge gaps in provision, but what was lacking was:

- co-ordination of those 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

Learning and Development Point 10

a) 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.

Q9. The extent to which particularly Primary Care and the Acute Trust, was able to meet RC's needs for care and treatment in the context of his disability

10.78 The chronology shows that there was some reasonable contact focused on RC's primary care needs and in turn from time to time acute care requirements.

10.79 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 of acute Dysphagia.

10.80 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.

10.81 Throughout all the records across the agencies – with the exception of SALT – there was insufficient consideration of risk and risk management for RC. There is no specific mechanism for doing this; no recognised indicator or even collective form that was universally understood. While it is true that more forms or bureaucracy do not of themselves safeguard people a more standardised approach in an individual's records for those who have high risk needs could go a long way to supporting staff members and managers who from time to time need to pick things up quickly.

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

Learning and Development Point 11

a) **Further consideration of how integrated services at an organisational level can better provide personalised, focused for individuals that are responsive to needs and risks.**

b) **Bring Health Action Plans and Local Authority reviews together so that they play a more central and significant part of planning and co-ordination.**

c) **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.**

10.83 Regarding the specific events on the morning of 30th May, these have been discussed with the individual worker who was on waking night duty who dealt with RC between around 6.30am and his admission to hospital at 7.49am. It also involved interviews with the regional manager of the Service Provider 1 and a review of all documentation including their own internal review and various statements. Throughout there has been full co-operation from all those involved and it should be recognised that this too has had an impact on them.

Learning and Development Point 12

a) **Consider ways of ensuring that key information about individuals is constantly and renewed and that basic assumptions are challenged**

Summary of Events on 30th May 2015

10.84 On the 30th 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 their training in management and development.

10.85 CW1 had been employed at the Accommodation as a night support worker commencing November 2013 until July 2014. During this time CW1 worked 7 day time shifts. This was when the Accommodation was managed by Provider 2.

10.86 CW1 then transferred on secondment to another establishment in the group where the worker continued to provide waking night support. In March 2015 that secondment ended and the CW1 returned to the Accommodation. There is no doubt that CW1 is a conscientious, dedicated worker who took the role very seriously.

10.87 The sequence of events on 30th May is recorded in the Safeguarding Alert on 2nd June 2015. This is taken from the initial statement made by the worker on 30th May 2015 to the On-call Manager.

10.88 The following sequence starts from around 06.30 on 30th May 2015 outlined in the account of the night staff on duty at the time (CW1):

- *I was washing another resident and then I wanted to change my gloves, so I went into the Laundry room, It was then that I had seen that RC had gone into the fridge and taken the ketchup out, as it was on the kitchen floor leading to the lounge.*
- *I went to clean up the ketchup as I did not want anyone to slip over and get hurt.*
- *Due to RC taking the ketchup out of the fridge, I thought that he must be hungry so I gave him a banana. When I left RC, he was relaxing in the lounge and eating his banana so I went to finish supporting the previous resident with his Personal Care.*
- *When I had finished supporting the other resident, I came down the corridor and I could see crumbs on the floor, I could see RC in the corridor.*
- *So I asked RC to go upstairs because he had soiled his cloths with ketchup and I could see that he had been eating (cake) scones*
- *I went into the kitchen and saw scones all over the kitchen floor (they were all over the place) so I shut the kitchen door.*
- *I came upstairs to change RC and found him on the floor by his bedroom door,*
- *I could see that he was unconscious; I tried to remove the food out of his mouth to clear his airways. I slapped him on the back, and then tried to check his pulse. I could not feel anything.*
- *Before I left RC, I put him into the recovery position and went downstairs to get the phone I called the emergency service's straight away and rushed back upstairs to carry out their instructions until they arrived.*
- *They told me to tilt his head back and to breath into his mouth (resuscitation) they asked me if I could feel any air, I replied NO, I also did a couple of compressions, they told me to lay him flat; while they were speaking to me, they told me that the ambulance was on its way.*
- *Then they called me back to ask for the number of the house, buy the time I had said the number, they were outside.*
- *I let the paramedics in and left them supporting RC while I contacted his brother and the On Call service…..*

10.89 Quite understandably as this record was made on 30th May only a short time after RC's hospitalisation it was at a time of significant distress and upset for the individual concerned and indeed the whole staff team.

10.90 Support was offered for CW1 by the organisation and CW1 was supported to have time and space, the worker was absent from work for about two months.

10.91 CW1 made a subsequent statement on 3rd July 2015 as a part of the Service Provider 1 internal investigation. This is included at Appendix E. The most important feature of this statement is the following:

"So I asked RC to go upstairs so I could support him to change his clothes. I didn't see that he was eating at that point and don't recall if he had anything in his hands

but I do recall that he did have puffy checks but I didn't go so near as to check his mouth".

10.92 The worker also reports at the end of that statement *"I have never read any of RC's risk assessments, support plans or guidelines before. I haven't seen them before*." This statement was made to the Regional manager and another manager

10.93 There was then a structured interview with the Regional Manager on 10th July 2015 where CW1 was questioned, the relevant passages of which are included at Appendix F. However, key passages are set out here.

Question: In your statement you made last week you state that you haven't seen support plan and risk assessments. Was that inaccurate.

Answer: Yes

Question: Why did you say that

Answer: I wasn't thinking and I thought you meant by the question that I should have read it every time I went on shift

Question: From all those questions and documents I've shown you, you have agreed that you have seen the support plans, risk assessments and guidelines

Answer: Yes

Question: Are you aware of the things written on here that it tells you

Answer: Yes I am…

10.94 Regrettably this structured interview 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.

10.95 The key discrepancy from the initial statement (made on 30th May) and the statement made on 3rd July was not addressed and in light of its singular importance this should have been carefully followed up. It is suggested that the use of leading question interviews should be reviewed.

10.96 Perhaps it is reasonable to conclude that the first statement (30th May) should be relied on as to what happened that day.

10.97 While it is understandable that there might be some variance between statements made at different times it is of concern that in the key areas relating directly to RC's situation there is a contradiction directly relating to the issue of food.

10.98 While it is not the purpose of the SAR to make definitive judgements about any individual's actions there are some learning points that need to be carefully followed up.

Learning and Development Point 13

a) The issue of taking statements, supporting staff collecting information and collating it should be thoroughly reviewed under the auspices of the SAB with clear guidance given to all agencies and providers

11. Predictability and Preventability

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

11.2 It is important to remember that the purpose of the SAR is to ensure that lessons are learnt, rather than to apportion blame, and applied to future situations to improve local practice, procedures and services to minimise the possibility of a similar situation happening again.

11.3 Predictability cannot be defined as an exact science, rather, it is the balance of bringing together a number of known factors and circumstances. For RC these factors are:

- RC suffered from acute Dysphagia (see section 9)
- 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 (see paragraph 10.15)
- 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 appetites
- 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, at that time.

11.4 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.

Learning and Development Point 14

a) 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

Preventability

11.5 In considering preventability it is again important to remember the purpose of the SAR and its responsibility. However it is also important to review as a part of this section the events on the 30th May 2015 as set out from paragraph 10.84.

11.6 Prevention and risk were inevitably intertwined for RC, and some of the elements outlined above in relation to predictability point to high risk areas that required practical and consistent preventative practices

11.7 This was made clear throughout the SALT work and reinforced at the Dysphagia review at the home in June 2014.

- The Service Provider 1 support plan completed in February 2015.

What needs to be done	How will this be done Who will do it Who else needs to be involved
I would like to be supported to make healthy choices around meal times	Staff to follow guidelines in place from SALT team. Staff to ensure my nutritional needs are met and taking into account my likes and dislikes, this can be done when I go shopping, staff need to show me what food is good for me, also I have a weekly menu form 206 so I can ensure I am eating healthily

In this February 2015 support plan there is also reference in the social participation section to having a pub lunch. This reference is concerning, and reinforces the impression that the high priority emphasis on the risks to RC resulting from his Dysphagia was becoming diluted.

- The chocking risk for RC was given a low profile in the Service Provider 1 "one page profile" on RC completed on 18th February 2015. This document does refer to his pureed diet and need for drinks to be thickened, however it is shown at the 3rd paragraph of a second box on page 2 and therefore not immediately recognisable as the priority piece of information that RC depended on to keep him safe every day

- However, the Service Provider 1 risk assessment completed 1st April 2015 – sets out all staff to follow SALT guidelines, all food to be blended and fluids thickened.

11.8 It is extremely unfortunately the primary issue of RC's needs 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.

11.9 There was another unfortunate basic assumption where it has often been recorded or said that RC did not steal (take) food.

11.10 This assumption given his situation where he was doubtless often hungry, and where he had been known previously to enjoy his food and devour it in what might be termed a "greedy way", was unfortunate. It would have been more accurate to say that RC had not been seen to take food.

11.11 Added to this 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 case.

11.12 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.

11.13 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, on occasion, for him. A determination of his Mental Capacity should have been completed. It is also why each and every key professional interaction with him should have had these risks as the highest priority in discussion and in the minds and actions of all staff. His statutory review failed to do this.

11.14 Some may argue that in view of all his 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.

11.15 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.

Learning and Development Point 15

a) How to ensure all care staff are fully appraised of care plans and risk analysis

b) Where training has taken place dealing with areas of special concern how can night support staff or part-time staff be engaged.

c) How can the pattern of early morning waking and support be best handled by a single person or should day staff rotas be amended to ease workload.

d) 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

11.16 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 Therapists
- 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 30th May RC should have been supported with the full cognisance of his risks and needs and following SALT guidelines.

11.17 There is throughout this review a heightened feeling that the clear guidance and identification of risk set out by SALT and the reinforcement training in 2013 had

dissipated somewhat in more recent times. This is perhaps evidenced by the Service Provider 1 risk assessment for RC completed on 1st April 2015 where the risk regarding choking is set out as follows:

What is the risk	Risk Factor H:M:L	How will we reduce the risk	My Views	Views of other people
PHYSICAL HEALTH Choking/Asoerating RC has difficulty with swallowing food and drink	H	All staff to follow SALT guidelines. All food to be blended, thick and easy will be added to all drinks	Any incidents of prolonged coughing/choking needs to be checked and reported to SALT	SALT has put guidelines in place for staff to follow

11.19 Given the high risk to RC this issue should have been prominently highlighted at the top of the risks reporting his acute Dysphagia whereas it was placed after RC's risk of absconding or wandering off and before concerns about pressure sores.

11.20 A single point of co-ordination of his needs would have assisted.

11.21 Given a priority to his statutory review and planning, analysing and coordinating input should have been done.

Learning and Development Point 16

a) Risk assessment clearly setting out hierarchy of risks that are reinforced at each review point.

12. Conclusions: Action Points and Learning and Development Opportunities

12.1 Set out below are all the learning points identified in the report. These points have not been fully developed as better ownership ad engagement would be achieved by working through the points with professionals and practitioners.

Mental Capacity Act

Review the use of the Mental Capacity Act for all high risk and complex individuals (3d)

Develop ways in which the individuals subject to MCA can be prioritised for review (6a)

All reviews to ensure MCA is considered (6d)

Develop methods to ensure information for social workers, other specialist workers, joint approach in mental health etc (6b)

Review of all complex and high risk individuals to ensure full consideration of MCA has been completed (6c)

Responding to Dysphagia

Review all current higher risk/Dysphagia individuals in a planned and timetabled way. (point 5f)

Develop a way for the on-going priority for individuals with Dysphagia (5g)

Commissioning

Consider how contract monitoring, Quality and Assurance and commissioning could be better linked with the individually based assessments (8a)

Streamline the current process of call over and focus on the priority issues, including use if integration/joint work, record sharing (8b)

To ensure due diligence, care plans assessment for individuals should be given the same consideration as contractual arrangements, particularly at a time of re-tendering. This will require closer work between commissioning and front line services (9a)

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. (5a)

Preparatory work required by the reviewing officer (5b)

Information for those being reviewed (and their families) in ways that they can access and understand (5c)

Are social workers the only people who can conduct reviews - does it have to be a social workers task (5d)

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 (5e)

Consideration of a comprehensive and jointly agreed risk analysis and ensuring that risk remains paramount with individuals who may be considered very vulnerable (3c)

Consider ways of ensuring that key information about individuals is constantly refreshed and renewed and that basic assumptions are challenged (12a)

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 (14a)

Risk assessments clearly setting out hierarchy of risks that are reinforced at each review point (16a)

Ensuring Full Value for Integrated Working

Explore ways in which a single care plan can be maintained for individuals and accessed by all (7a)

In integrated teams at least, health and social care assessments should be brought together specifically for high risk individuals (3b)

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 (10a)

Further consideration of how integrated services at an organisational level can better provide personalised, focused for individuals that are responsive to needs and risks (11a)

Bring Health Action Plans and Local Authority reviews together so that they play a more central and significant part of planning and co-ordination (11b)

Working with Specialist Services

Where specialist services are involved co-ordination there should be agreed arrangements including for integrated teams.(4b)

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 (3a)

In integrated teams at least, health and social care assessments should be brought together specifically for high risk individuals (3b)

Case records (access and availability) needs consideration or a simple and consistent recording of high risk messages set out for all individuals who require it. (4c)

Case Management and Co-ordination

Consider new care co-ordination responsibilities/arrangements between agencies for high risk individuals, ie where, how and who is co-ordinating. (4a)

Where specialist services are involved co-ordination needs clarifying.(4b)

Development for Providers

How to ensure all care staff are fully appraised of care plans and risk analysis (15a)

Where training has taken place dealing with areas of special concern how can night support staff or part-time staff be engaged. (15b)

How can the pattern of early morning waking and support be best handled by a single person or should day staff rotas be amended to ease workload. (15c)

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 (15d)

General/SAB

The SAB should look to develop an agreed approach to carrying out Safeguarding Adult Reviews (1a)

Some local authorities and health organisations have reviewed and developed their 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 The Leicestershire Partnership Eating and Drinking Difficulties in Adults with a Learning Disability (2a)

There is a specific role for the SAB as commissioning develops to ensure that the focus on individuals as a part of contracting is not lost (8c)

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 (11c)

The issue of taking statements, supporting staff collecting information and collating it should be thoroughly reviewed under the auspices of the SAB with clear guidance given to all agencies and providers (13a)

APPENDIX A

Membership of the Safeguarding Adults Review Sub Group

Tudur Williams	London Borough of Barking and Dagenham	Divisional Director Adult Social Care
Mark Tyson	London Borough of Barking and Dagenham	Group Manager, Integration and Commissioning
Andrea Crisp	Barking, Havering and Redbridge University Hospital Trust	Safeguarding Named Nurse
Tony Kirk	Barking and Dagenham Metropolitan Police Service	DCI
Chelle Farnham	North East London Foundation Trust	Clinical Lead (Prevent, MCA and DoLS)
Sue Elliott	Clinical Commissioning Group	Interim Head of Safeguarding

APPENDIX B: Summarised Chronology of Events

Date	Description
1992	RC moves to a Residential Home (which is managed by the Service Provider1) from South Ockendon Hospital Care package funded by LBBD under the care of a consultant psychiatrist at CLTD
October 2009	The Residential Home is closed and RC is moved to the Accommodation, managed by Provider 2. RC registered with an opticians, dentist, podiatrist, dietician and Community Learning Disability Nurse. Annual Health Reviews
18th April 2011	Health Action Plan created by Community Learning Disability Nurse. Recommends supervision while eating and the cutting up of food into small pieces
28th September 2011	1st referral to Speech and Language Therapy (SALT) requested by home due to concerns of risk of choking (because of over filing of mouth) – there have been minor choking episodes in the past. Normally RC would have his food cut into small pieces. A risk assessment had been done and a softer diet implemented until SALT assessment
3rd October 2011	SALT assessment of RC – recommends a soft diet and trying smaller amounts of food on the plate
11th October 2011	Letter from the locum SALT to the GP which recommended soft and thin fluids, meat to be chopped up and moistened if possible and to try placing small amounts of food on the plate and waiting for RC to finish that food before giving more.
4th December 2011	SALT sees RC at mealtime at home. Advises soft diet, any hard meats to be cut up small and moist with sauces, no high risk foods. Information given to home on dysphagia warning signs, high risk foods and a monitoring form for coughing episodes
April 2012	SALT worker allocated to RC
15th June 2012	SALT worker sees RC at home. RC losing weight so review required before updating guidelines. Seen eating ham sandwich and juice – no problems. Home and GP advised if further weight loss to refer RC to the dietician
July 2012	Health Action Plan reviewed
21st January 2013 4th February 2013	SALT sees RC at home. RC on normal diet cut small with normal fluids. Noted that blood tests done due to continuing weight loss + chest x-ray. Fast rate of eating and throat clearing when drinking. Interim meal plan left with home – soft moist cut small diet, no high risk foods (list provided + prompting of RC to slow down), no sandwiches, bread only if cut small with no crusts and put into soup, keep RC upright while eating and for 30 minutes afterwards. Agreed to review in 1 week. Also consider referral to dietician after review in weeks time and blood test results. Discussed with Community Learning Disability Nurse Blood tests show iron deficiency – medication prescribed. Also referred to cardiology. Agreed monitoring forms need to be considered
7th February 2013	SALT meet with staff at home. No coughing and had good appetite but still losing weight. Staff to continue current eating and drinking guidance and monitor coughing. Agree to refer RC to dietician. Community Learning Disability Nurse informed.
28th February	GP refers RC to dietician due to weight loss and dysphagia

2013	
20th March 2013	re-referred to Dietician after original referral lost
29th April 2013	RC admitted to Queen's Hospital after choking episode – rice and chicken
1st May 2013	SALT worker informed of RC's hospitalisation. SALT worker checks staff at home are following eating guidelines – confirm that they are. Hospital informed and advised that he hospital SALT should review
3rd May 2013	RC discharged from hospital
3rd May 2013	SALT provides new eating and drinking guidelines. Says moist fork mashed diet. No high risk foods. Any hard meats to be blended. No sandwiches, no rice. Bread only if cut into small pieces without crusts and moist in soup. Small spoon to be used for food. Drinks: normal - encourage to have small sips.
3rd May 2013	Dysphagia risk assessment done by SALT - refers to risk of choking, risk of chest infections and being underweight. The risk management part of the form identifies that the risk of choking is high and the likelihood of harm occurring is high. The action point is that staff to follow existing guidelines and all staff to be first aid (including choking) training by 30th May
8th May 2013	SALT training session (eating and drinking) at the home - managers also present. Ideas for soft mashed diet left at home. Presentation emailed to manager
10th May 213	SALT worker visits RC at lunch time. No coughing Referral to dietician chased
13th May 2013	Home emails SALT worker. RC's sister had brought in foods for RC and home wanted to check that they were suitable
14th May 2013	Home emails and phones SALT worker for advice after several coughing incidents when eating food on list provided
15th May 2013	SALT worker visits RC at home
16th May 2013	Home emails SALT worker to confirm all staff are aware of new recommendations regarding RC's food
22nd May 2013	RC admitted to Queens Hospital for abdominal distention
29th May 2013	Swallowing risk assessment following the 29th April hospital admission leads to eating guidelines being created by SALT - soft mashed food, meat blended, no sandwiches or rice, and bread only when cut up. Referral made to dietician about concerns of weight loss. SALT worker sees RC at home. Demonstrates how to thicken drink to staff and provided revised eating and drinking guidelines after seeing Hospital SALT recommendations. All foods to be blended separately, small spoon to be used. Drinks: thicken all fluids to stage 1 (syrup consistency), encourage small sips Hospital discharge report discussed with social worker and agreed to make referral to nursing so they can facilitate further referrals to the GP.
30th May 2013	SALT worker makes referral to nursing.

	SALT worker visits RC at lunch time. Agreed with staff to continue to follow eating/drinking guidelines. Asked staff to take paperwork to GP appointment the next day Requested that a nurse also attends GP appointment
1st June 2013	RC sees GP
5th June 2013	Homes asks SALT worker for update on referral to dietician
10th June 2013	SALT worker rings home - RC reported as doing well. Home still haven't heard from dietician
May 2013	RC sees dietician
1st June 2013 12th June 2013	Provider 2 risk assessment and action plan Initial home visit by dietician – food fortification advice given and referred to SALT as there was confusion about what food textures and consistency that RC could tolerate
17th June 2013	SALT worker visits home to discuss dietician input. Noted that dietician provided guidelines for the home and brought another thickener to use
20th June 2013	RC sees consultant psychiatrist at CLTD
24th June 2013	Letter from SALT to GP that refers to RC remaining at high risk of aspiration and therefore to continue with pureed diet and thicken fluids
24th June 2013	SALT worker has phone conversation with Dietician SALT worker visits home to discuss advice from dietician SALT worker writes to GP confirming puree diet and stage 1 fluids and raising queries regarding thickener
10th July 2013	SALT worker phones home – no problems with RC
July 2013	All staff receive in-house training on how to support RC at mealtimes by SALT
15th July 2013	RC had full physical check up including ECG due concerns of the Service Provider 1 staff about weight loss. Results were clear
25th July 2013	Dietician review and advice – complan shake increased and double cream to be added to shakes
29th July 2013	SALT worker phones home – discuss the training provided by SALT. Home reports that all staff trained in first aid including choking.
30th August 2013	Telephone dietician review
14th November 2013	Worker CW1 starts to work at the Accommodation as night support worker
20th November 2013	Dietician home visit — now a pureed diet and stage 1 fluids. 30mls Calogen TDS started. Review set for 2 months time
December	Health Action Plan updated – states that food should be soft and pureed and that

2013	fluids should be thickened
12th December 2013	RC admitted to hospital as day patient to have gall stones removed. Discharged the same day
27th February 2014	GP review of medicines. Bloods requested
8th April 2014	CLDT support plan
6th May 2014	Dietician Service writes asking RC to make contact"
21st May 2014	RC sees consultant psychiatrist
30th May 2014	Risk assessment form by Provider 2 and action plan
June 2014	Staff from the Accommodation attend dysphagia training session
26th June 2014	Last Dysphasia review – no changes made to the existing plan
July 2014	Worker CW1 goes on a secondment at another establishment run by the Service Provider 1
2nd July 2014	Home visit by dietician. 30mls Calogen replaced with double cream and puree meals made with gravy instead of water. Review to be held in 6/12 time
21st August 2014	Social Care Review by CLTD
2nd September 2014	Care Plan reviewed by CLDT Referred to as RAP Plan Annual Review
25th October 2014	Provider 2 Support Plan
October 2014	Health Action Plan update from 24th Sept and 1st October 2013
27th November 2014	GP review of medicines. No changes
2nd December 2014	Date of results of serum Lithium tests - all within normal range
11th December 2014	RC sees specialist doctor in Psychiatry of Intellectual Disability. Bloods requested to consider if a small reduction in Lithium could be made. Weight loss (48kg from 53kg) noted. States that RC does not appear to have capacity to consent to treatment "management will continue in his best interests"
January 2015	The Service Provider 1 wins tender for the management of the Accommodation supported living
1st February 2015	The Accommodation transfers from Provider 2 to the Service Provider 1 Support plan by the Service Provider 1 agreed referring to SALT guidelines
11th February 2015	Dietician review (by phone). Complan shakes stopped and suggested that they be replaced with fortified smoothies/milkshakes. Review to be in 4 months time
12th March 2015	RC goes to opticians
12th March	GP visit for check up

2015	
26th March 2015	New glasses for RC collected
March 2015	Psychiatric review
March 2015	Worker CW1 returns to the Accommodation as night support worker at the end of secondment to another establishment run by the Service Provider 1
1st April 2015	The Service Provider 1 completed: • A risk assessment • An assessment of capacity relating to personal care • An assessment of capacity relating to personal finances • A Best Interests assessment relating to the taking of prescribed medicines
20th April 2015	Request made to GP for purple book for RC;s lithium carbonate
30th April 2015	RC goes to NHS Walk in clinic for bruising to forehead and left knee. No other injuries found. No action other than for staff to monitor in case of any changes in behaviour
21st May 2015	Psychiatrist Review. Meds and support to continue
30th May 2015	Approximately 06.30 RC found unconscious by worker CW1 At 07.49 -admitted to emergency department via ambulance 10.15 – transferred to ICU
1st June 2015	SALT worker informed of incident. Reports to adult social care managers. Serious incident form completed
4th June 2015	04.35 life support withdrawn 04.48 RC dies

Appendix C: Key to Acronyms

BHRUT	Barking, Havering and Redbridge University Trust
CCG	Clinical Commissioning Group
CLDT	Community Learning Disability Team, run by London Borough Barking and Dagenham Adult Social Care
CQC	Care Quality Commission
DoLS	Deprivation of Liberty Safeguards
IMR	Individual Management Report
LBBD	London Borough of Barking and Dagenham
MCA	Mental Capacity Act
NELFT	North East London Foundation Trust
QA	Quality Assurance
SAB	Safeguarding Adults Board
SAR	Safeguarding Adult Review
SALT	Speech and Language Therapy Team

northgate
PUBLIC SERVICES

RAP Plan Review (Annual) - Report

LB BARKING AND DAGENHAM

The information in this report was based on the information available on 01/10/2014

SUBJECT'S DETAILS			
Client ID	8041	**NHS Number**	[redacted]
Surname	[redacted]	**Forename(s)**	[redacted]
Aliases	[redacted]		
Date of Birth	21/02/1954	**Gender**	Male #
Main Language	English	**Ethnic Origin**	White British
Is an interpreter required?	No	**Religion**	Christian
Current Address	[redacted], Dagenham, Essex England, [redacted]	**Primary Contact Number**	[redacted]
Home Address		**Main Telephone**	
Email Address			

REVIEW DETAILS			
Review Type	RAP Plan Review (Annual)	**Location of the Review**	[redacted], Dagenham, Essex England, [redacted]
Date of this Review	02/09/2014	**Date of last Review**	02/09/2014

Plan to be Reviewed	01/05/2000 - Adult Care Plan16/05/2006 - LD - HAP20/02/2008 - LD - PCP17/11/2009 - LD - HAP18/11/2009 - LD - HAP

INVOLVEMENT

Name	[redacted]		
Role or Relationship	Key Worker		
Current Address		**Primary Contact Number**	
Email Address			

Key Worker: No **Key Team:** No **Accepted:** Yes **Parental Responsibility:** **Principal Carer:** **Can Be Contacted:** No

PHYSICAL HEALTH & WELL-BEING

Have your desired outcomes been achieved?

[redacted] is a 60-year old vulnerable adult who is living with learning disability. [redacted] is also living with Bipolar disorder. [redacted] is currently living in a 24-hour supported accommodation run by the [redacted]. [redacted] verbal communication is limited and during the review he did not engage well or replied to any of the queries. He was comfortably and happy sitting at the lounge. [redacted] (Senior Support Worker) assisted [redacted] during the review.

[redacted] brother, [redacted] was out of the country and sent his apology.

[redacted] care needs are being met at the home.

[redacted] presented physically well.

[redacted] is independently mobile and he walks around the building regularly. He eats normal diet and [redacted] relayed that [redacted] has a good appetite. He has a good sleeping pattern and [redacted] reported that he usually sleeps through the night. [redacted] is independent with toileting, however, he wears pad when he goes out to prevent from accident.

[redacted] conveyed that [redacted] is able to follow routine. He indicated that when [redacted] wakes up in the morning he goes to the toilet, followed by bath/shower. [redacted], however, requires assistance with dressing/undressing. He is also being prompted to put his laundry clothes into the basket otherwise he will leave it on the floor.

[redacted] is able to verbally communicate with limitations, he is also able to communicate through facial expressions or change of behaviour if he is not feeling well. [redacted] is also able to identify objects and colours. [redacted]'s visual and hearing are both good.

The home is providing [redacted] with the following support:

Prompting and encouragement with personal care and hygiene
Prompting with medications
Provide support with social activities such as shopping, leisure activities i.e. seaside trips, amongst others
Provide support with appointments i.e. GP/hospital
Provide support with meals and drinks
Provide monitoring and supervision with daily living needs and activities as Robert's verbal communication is limited.

[redacted] reported that [redacted] is compliant with his care needs. No concern was raised.

What Has and has not worked, what might improve things?

The home to continuously provide the support that [redacted] requires to meet his daily living needs and activities.

Are any changes to your plan needed in this area? Please give details No

EMOTIONAL WELL-BEING & MENTAL HEALTH

Have your desired outcomes been achieved?

[redacted]'s emotional well being and mental health are quite stable at the moment. No concern was raised.

The home will continuously provide support in order to maintain [redacted]'s overall well being.

What has and has not worked, what might improve things?

None

Are any changes to your plan needed in this area? Please give details	No

ACTIVITIES OF DAILY LIVING

Have your desired outcomes been achieved

Yes. [redacted] requires 1:1 support in order that he meets his daily living needs and activities.

[redacted] requires prompting and supervision with personal care including washing, shower and dress/undress. [redacted] is able to put his used clothes to the laundry basket when prompted. The home continuously support him to enable his independence.

He requires prompting with medications.

[redacted] is independent with eating and drinking. He has a good appetite and he is on a normal diet.

[redacted] is mobile and he is able to manage the stairs. His room is located on the first floor of the home.

[redacted] is independent with toileting. However, if he eats something that do not settle well in his stomach he may have incident of both. He uses pad when he goes out.

[redacted] goes out shopping on Wednesday [redacted]'s brother, [redacted], come and visit him regularly. [redacted] take him out for a meal at a local pub.

The home also provide group activities with other residents and they go to seaside, and play bowling, amongst others. [redacted] also enjoys when the home do a Barbeque when weather permits.

Are any changes to your plan needed in this area? Please give details	No

SOCIAL WELL-BEING

Have your desired outcomes been achieved?

As discussed above, [redacted] participates well in social activities. Whilst his engagement with others is limited due to verbal communication, [redacted] sits around the common area and does not isolate himself.

What has and has not worked, what might improve things?

No changed to current care needs.

Are any changes to your plan needed in this area? Please give details	No

MEDICATION

Has your medication achieved the desired outcomes? Please detail any difficulties

Yes.

Have you been able to take your medication as prescribed? Please detail any difficulties

Yes.

Do you have any concerns about your medication? (e.g. side effects, effectiveness)	No

SAFETY & RISK

Has your safety & the safety of those around you been maintained? Detail any incidents or near misses	Yes

[redacted]'s living arrangement provide him a 24-hour support. He is independent with some aspects of his care needs, however, he requires prompting, encouragement, supervision and monitoring to ensure that his needs are met whilst enabling his independence in the community.

Safety and risk management is followed by the home and progress note, appointments and other significant activities are recorded.

Do you have any concerns about your safety or the safety of those around you?	No

Are any changes to your plan required to ensure your safety and that of those around you?	No

ANY CHANGES NEEDED IN AREAS LISTED

Summary of your plan

[redacted]'s support plan is being managed and followed by the home to ensure that all his care needs are met. [redacted]'s care needs remains the same and therefore it is recommended that he remain in his current accommodation where his care is being provided and he is supported and monitored on site on a 24-hour basis.

No concern was raised.

Your weekly timetable

Wednesday shopping
Flexible time with walking to the park, bowling, seaside trips and other group outings.
[redacted] also visits Beacontree Leisure Centre
Weekly visits by his brother, [redacted] and take him out to the pub.

Your budget

346.92 per week.
ILA is managing [redacted]'s finances.

Were any other issues identified None	
Does mental capacity or deprivation of liberty require further consideration?	No
Does eligibility for continuing care require further consideration?	No
How frequently your plan will be reviewed & date of next review	02/09/2015

FAMILY VIEWS

The views of your family and others around you

[redacted] was not present during the review.
No concern was raised by the family.

Are your informal carersable to continue providing the current level of support? [redacted] regularly visits [redacted].	Yes

IMPORTANT OUTCOMES FOR THE COMING YEAR

Have your most important outcomes for the coming year changed? If yes please give details	No

AGREEMENT TO SHARE REVIEW	
I agree that this review may be shared as needed to support my plan	Yes

OUTCOMES	
Outcome	**Involvement**
SALT No Change in Long Term Support	[redacted]

End of Report

Statement from [redacted] on the events of the 29th - 30th May 2015

I currently work as a support worker at [redacted] in Dagenham. I started here on 14/11/13 and then in July 14 I went on secondment to [redacted]. I retuned back to [redacted] in March 2015. I work as a night support worker and have always had this role.

From my experience as a night worker at [redacted] service, first there were 7 tenants and then down to 5. There were two people downstairs who have epileptic seizures and so our role is to monitor them through the night and deliver personal care in the morning. For the customers living upstairs we would listen for any movement and then support when required. The people upstairs are more independent. They need support but are of a lower risk. The people supported downstairs are at a higher risk and so are downstairs.

People are usually in bed when we arrive. We check everybody every 2 hours, but would also check at any time we hear movement.

If you are in the lounge or dining room you are able to hear any movement upstairs, however if you are in the peoples' bedroom or bathrooms or the kitchen it is hard to hear upstairs. I was never given any instruction where to place myself when not delivering any support. Sometimes I would sit in the lounge and sometimes the dining room. I would normally be able to hear what was going on in both these locations.

If there was any particular need the handover staff would advise us of any needs or concerns. Handovers always take place both with the late staff that I take over from and I always give the morning staff a handover on what the night has been like.

Even though we have recently changed provider I have always known where to record the notes. A record of handover is made. If there was a concern, we would write on handover and we record in the person's record of support. About 2 months ago, I attended Values training and I was shown how we record our notes and outcomes.

When I first started at the service I was given a general induction. [redacted] has lived there since I first came to [redacted]. I shadowed staff as part of my induction. At this time I was employed by [redacted].

It was when I came back to the service in March 2015 from [redacted] that I was employed by [redacted]. I have occasionally worked a few day shifts covering other staff. I was aware that [redacted] required a soft diet as one day I saw staff support [redacted] around meal times. I was involved in cooking the food during the day and recall seeing staff mix his food in the blender. If we made him a cup of tea we would add thickner. As I was a permanent night staff I did not need to give [redacted] food.

I came to work for the night shift on 29/5/15 at [redacted]. I received a handover from [redacted]. No concerns were handed over and she verbally told me everything was all right. At the time of the handover everybody was in bed, I usually get there about 9.30pm and start my shift at 9.45pm. On the night of the 29/5/15, I walked all around the house. I did a security check and I went into [redacted] and [redacted]'s rooms to ensure that the alarms were in place – the assisted telecare. I usually go upstairs. If the customers have their door open, I would check. [redacted] would usually have his door open. [redacted] and [redacted] usually had their doors closed but I would often open [redacted]'s to check on him if there were any concerns . On starting the shift on this night I didn't go into [redacted] room to check at the start of the shift as there were no concerns and he was asleep.

[redacted] was restless but showed no signs of distress throughout the night. He came downstairs on numerous occasions. At 3am I gave him a cup of tea and I put his thickener in. I have used thickner before. I put two scoops in which was enough to thicken the tea.

[redacted] drank his tea and went back to bed. I do remember noticing the time when he had his tea. He still continued to get up and come downstairs despite having had his tea. This was more than normal. Previously he has got up in the night, but nothing like that night. This was a new behaviour that I hadn't seen before. There was nothing visual that I could see that was causing his discomfort. The was no sign or concern around his general health at that point in time.

A started delivering personal care with [redacted] at 6 o'clock, and afterwards I started supporting [redacted]. For [redacted] it would take about 30 minutes. I carried this out in the bathroom on the ground floor, which is next to [redacted]'s room. [redacted] was not around when I commenced personal care with [redacted] or when I finished. After we had finished I would leave [redacted] in his room and he would choose whether he wanted to be in the living room or not. He went to the living room. However, would come and go to his room.

I started to then support [redacted] by taking him to the bathroom. He had been incontinent of faeces and I wanted to change my gloves because I wanted to start on the upper part of his body and I noticed that the gloves were damaged with a hole in so I went into the Laundry room. This is situated right at the other end of the hall way directly in front of me and is in between the dining room and the lounge.

As I was walking that way I saw ketchup on the floor of the hall. I looked to my left and went into the kitchen and saw a trail of ketchup on the floor I then looked up and saw ketchup on the floor in the living room too. I went towards the living room and I saw [redacted] sitting down. He had ketchup around his mouth and on his clothes. He was sitting in his usual chair which is a single chair to the left when you enter the lounge. He liked to sit next to [redacted] who sits on the sofa next. [redacted] wasn't there at this point. I did not see the ketchup bottle on the floor but there was sauce on the kitchen floor leading to the lounge.

I went to clean up the ketchup on the kitchen floor as I did not want anyone to slip over and get hurt. I looked in the fridge and saw that the ketchup bottle was back in its place. Whist I was doing this [redacted] remained sitting in the lounge.

Due to [redacted] having ketchup around his mouth and taking the ketchup out of the fridge, I thought that he must be hungry so I gave him a soft banana. I went for the softest one. I did not mash it up but I broke the banana into two and gave him one half. I've never needed to give [redacted] food previously as I am the night staff. I stayed with him while he ate half of the banana and left him eating the other half to tend to [redacted]. Before I left he had already put the other half in his mouth and was finishing it off. [redacted] ate the banana carefully. Sometimes he will go for his food really quickly but he ate it gently and slowly. I gave him the banana as I knew he was on a blended diet and it was very soft. I have observed him eating on occasions though not given it to him personally before. He was sitting down still in his chair in the living room. He was sitting upright.

He ate the banana slowly and was not coughing. I know that I needed to ensure that he wasn't coughing after food and there was no problem. I left [redacted] relaxing in the lounge while finishing off the banana. He still had food in his hand. I hoped that by giving [redacted] the food he was looking for it would settle him down. [redacted] had free movement around the house and he had never previously given anyone any concerns that he would put himself at risk.

I then returned back to finish supporting [redacted] who was waiting for me and was still in the bathroom sitting on the shower chair in the same position that he was when I'd left him, waiting for his shower.

[redacted] would usually takes about 30 minutes to complete. When I had finished supporting [redacted] he walked to the lounge. I walked down the corridor towards the kitchen intending to make tea for them and could see [redacted] standing in the corridor in front of the kitchen door. There were crumbs on the floor of the corridor, on the kitchen and in the lounge as well.

[redacted] had ketchup and crumbs on them. So I asked [redacted] to go upstairs so I could support him to change his clothes. I didn't see that he was eating at that point and don't recall whether he had anything in his hands but I do recall that he did have puffy cheeks, but I didn't go so near as to check his mouth.

He did not show any signs of distress at this point, not coughing and was behaving as he always did.

After I had asked [redacted] to go upstairs I went into the kitchen and saw that the crumbs were from scones with bits of scone on the floor. It was all over the place so I shut the kitchen door so that no one else would go in. The kitchen was a mess. I didn't do any tidying up at this point as I was going upstairs to change [redacted].

I followed [redacted] upstairs straight away to support him to change his clothes and as I walked along the corridor and turned to the area in front of his room I found him on the floor on his side.

I could see that he was unconscious; I checked whether he was breathing and found that he had food in his mouth, which I scooped out of his mouth to clear his airways and slapped him on the back. I then tried to check his pulse and his hand and could not feel anything.

I put [redacted] in the recovery position and went downstairs to get the phone. This was the service cordless phone. However the reception was erratic and after getting through to emergency services I lost the call. Not wanting this to happen again I rushed to get my own phone from which I was able to make the call and rushed back upstairs to carry out their instructions until they arrived. They told me to tilt his head back and to breathe into his mouth (resuscitation).

They asked me if I could feel any air, I replied no, I also did a couple of compressions, they told me to lay him flat; while they were speaking to me and that the ambulance was on its way.

I received a call from the emergency services as I had given them the wrong door number but by the time I had said the number, they were already outside.

I let the paramedics in and left them supporting [redacted] while I contacted his brother [redacted] and then the On Call manager. I called a telephone number and spoke to a man who said he was the OCB on Call. OCB is our bank of staff [redacted] Bank. I was very upset at this time and emotional and he told me he would ring the On Call Manager. He may have given me the number but not long after, I received a call from [redacted], On call manager.

They took [redacted] to Queen's hospital. [redacted], the day staff, arrived at 7.30am and I gave her the handover.

Once I had handed over everything, we decided that Agnes was the best person to follow [redacted] to the hospital, as she knew him the best. [redacted] (Support Worker) left straight away to go to Queens Hospital.

[redacted] arrived at service and I answered the door. I was crying and very upset and [redacted] said she would talk to me after she had introduced herself to [redacted] and [redacted]. [redacted] supported me to complete the incident form. [redacted] listened to me whist explained what happened. She arranged to cancel my shift for that night, the night shift 30/5/15.

I have never read any of [redacted] risk assessments, support plans or guidelines before. I have not seen them before.

Full statement made by [redacted] to [redacted] and [redacted] 3rd July 2015 and Ilford OCB Office.

3/7/15

APPENDIX F: Extract from statement by Worker CW1 on 10th July 2015

- **Question:** You have signed here to say that you've read the procedures
  Answer: yes
- **Question:** This clearly shows that you were given an induction and background information about the clients
  Answer: yes
- **Question:** As part of the induction, you were given all the customers' support plans, risk assessments and guidelines. Do you recall looking through people's support plans etc.?
  Answer: What I was asked to do was to look through the files and folders for different policies and procedures, yes. I did look at all the support plans to give me background information on the people I was supporting and this included RC
- **Question:** When you made your statement you stated that you "chose the softest banana". Why would you choose the softest banana
  Answer: Because I saw staff give him soft food and I was aware he was on a soft diet.
- **Question:** When you worked day shifts, you watched other staff and knew to give him soft food from reading the notes and observing other staff.
  Answer: Yes
- **Question:** So the induction you had gave you the knowledge to support RC
  Answer: Yes
- **Question:** I have a list of dates where you worked day on day shifts. Did this help with your understanding of RC's support needs
  Answer: Yes
- **Question:** You mention in your statement that RC was sitting upright. Why is that important.
  Answer: So his food goes down properly
- **Question:** You also said you were looking out for coughing
  Answer: Because if he was coughing it would mean that he was choking and so I'd have to ask him to cough more so as to get it out.
- **Question:** So you knew what to look for
  Answer: Yes
- **Question:** So by reading his plans, working day shifts, observing other staff you did know how to support him – is that right
  Answer: Yes
- **Question:** Do you recall having knowledge and being aware that there was a folder with guidelines for supporting RC with meal preparation
  Answer: Yes
- **Question:** Did you hear from staff about RC's modified diet and were you aware that there was a folder there to go for guidance
  Answer: Yes, I learnt from staff
- **Question:** In you statement you made last week you state you hadn't seen support plan and risk assessments. Was that inaccurate
  Answer: Yes
- **Question:** Why did you say that
  Answer: I wasn't thinking and I thought you meant by the question that I should have read it every time I went on shift
- **Question:** From all those questions and documents I've shown you, you have agreed that you have seen support plans, risk assessments and guidelines.
  Answer: Yes

- **Question:** And you are aware of the things written on here that it tells you
  Answer: Yes I am
- **Question:** After you had been at the service for about a month, you had a one to one supervision on 10/12/13. I have got a copy of that report and on it is recorded that you were very competent and aware of company policy and procedure in Safeguarding adults at risk. It is also recorded "CW1 was able to say the induction received covered all areas of the role as support worker, the induction prepared CW1 to work as a lone worker which CW1 felt was useful. CW1 also mentioned that the induction helped to fit in with the team and also to meet the customers and identify their individual needs." Is that what you felt after the induction
  Answer: Yes
- **Question:** So you we competent and confident to do your job as a night worker
  Answer: Yes
- **Question:** Before this incident did you identify any training neds for yourself to help you carry out your duties as a night worker
  Answer: No I felt confident. I carry out my job to the best of my ability

Support Plan

Date Support Plan Agreed:	**February 2015**	**Planned Review Date: (Maximum 6 months)**	**August 2015**
Support Plan Agreed By: *([redacted] / [redacted] / Support Worker)*		**Signature:**	

** Frequency of Review = Weekly / Monthly / Quarterly / Bi-Annual / Annual*

PLAN		DO		CHECK	
Area of Support	**What needs to be done?**	**How will this be done? Who will do it? Who else needs to be involved?**	**When and how often will support be delivered?**	**What I want to achieve? (Outcome)**	**Frequency of Review***
Economic Wellbeing **Managing money/ banking** 	I require support from staff to manage my money and also understand the value of money, ILA manages my finances and provides money at my request.	Staff need to request from ILA after supporting me to decide how much money I need to spend for the month. Staff will work with me to decide day to day spending. Staff will support me in keeping all till receipts and record all outgoings and incoming monies on an imprest sheet form 22.	Daily	To learn how to budget my money and keep my finances safe.	
Shopping 	Staff will support me to choose where to shop. I like to shop at different supermarkets.	I need one staff to support me with my shopping each week and when needed, also to help me to write a shopping list of food I want to buy. I need staff to support me to buy new clothes and shoes when my clothing or shoes needs replacing. Staff to inform ILA so they can arrang money for this and complete my property chart accordingly/	Daily	To be independent as possible and feel part of the community. To look smart and tidy.	

** Frequency of Review = Weekly / Monthly / Quarterly / Bi-Annual / Annual*

PLAN		DO		CHECK	
Area of Support	**What needs to be done?**	**How will this be done? Who will do it? Who else needs to be involved?**	**When and how often will support be delivered?**	**What I want to achieve? (Outcome)**	**Frequency of Review***
Being Healthy **Personal care** 	I need staff to support me with all aspect of my personal care, staff to help me dress and undress	I need staff to support and prompt me when having my personal care, I will need support on the appropriate clothing for the weather for example I might choose to go out in winter without a coat.	Daily	To keep clean and healthy	Monthly
Support around using the toilet 	I am able to use the toilet independently but need prompting from staff and also prompting to put my pants/trouser up when finished.	I need staff to support me put my brases back after using the toilet. Staff to prompt me to keep my trousers up after using the toilet especially when I am not wearig my brases.	Daily	I want to be supported with dignity and respect	Monthly
Medication	I take my medication three times daily and need staff to support me to take this on time.	I need my medication locked in a cupboard for safety. Staff to follow risk assessment form 388 & best interest form 309 , MCA form 308. Staff to follow procedure for checking medication.	As prescribed on the prescription	To keep me safe.	Monthly

** Frequency of Review = Weekly / Monthly / Quarterly / Bi-Annual / Annual*

PLAN		DO		CHECK	
Area of Support	**What needs to be done?**	**How will this be done? Who will do it? Who else needs to be involved?**	**When and how often will support be delivered?**	**What I want to achieve? (Outcome)**	**Frequency of Review***
Meal time 	I would like to be supported to make healthy choices around meal times	Staff to follow guidelines in place from SALT team. Staff to ensure my nutritional needs are met and taking into account my likes and dislikes, this can be done when I go shopping, staff needs to show me what foods is good for me, also I have a weekly menu form 206 so I can ensure I am eating healthily.	Daily	To learn what foods is good for me and what foods is not good for me.	
Making GP appointments 	I will need support to make doctors appointments and to attend them.	Staff need to record in my health planner and diary when appointments have been booked. Staff are to follow my health appointments and record this in my health action plan. Staff need to arrange appointments for me when needed.	When needed	To ensure I don't miss health appointments, so I am clear when my next appointment is due.	
Foot and nail care	I need support to cut my nails, I also have issues with my feet.	Staff to follow my risk assessment form 388	When needed	To ensure my nails are kept short.	

** Frequency of Review = Weekly / Monthly / Quarterly / Bi-Annual / Annual*

PLAN		DO		CHECK	
Area of Support	**What needs to be done?**	**How will this be done? Who will do it? Who else needs to be involved?**	**When and how often will support be delivered?**	**What I want to achieve? (Outcome)**	**Frequency of Review***
Health care appointments 	I will need support in making yearly health check up appointments and visit the dentist every six months, attending the psychiatry, optician , psychologist.	Staff need to keep a record of when my checks are due and support me to attend.	When needed	To ensure I don't miss health appointments, so I am clear when my next appointment is due.	When needed.
Communication 	I have limited communication and talk in a low tone, and sometimes use hand gestures,	Staff to speak to me and use short slow sentences so I can understand what is being said to me to find out my likes and dislikes.	Daily		Monthly
Landlord/ paying rent	I receive housing benefit, the contribution that I need to pay towards my rent is managed by ILA who are my appointee.	ILA supports me with this so the staff will not need to do anything.	Monthly	To ensure my rent is paid on time	Monthly

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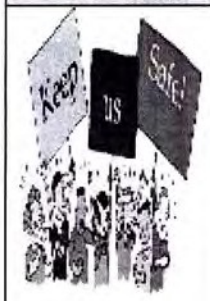
** Frequency of Review = Weekly / Monthly / Quarterly / Bi-Annual / Annual*

PLAN		DO		CHECK	
Area of Support	**What needs to be done?**	**How will this be done? Who will do it? Who else needs to be involved?**	**When and how often will support be delivered?**	**What I want to achieve? (Outcome)**	**Frequency of Review***
Housing repairs	Staff to report all repairs to L&Q especially repairs to my bedroom.	Staff will support me to look around my living environment to identify and report any repairs and H&S that needs attention to L&Q, staff will need to record what repairs have been reported and when it was fixed using form 14.	Weekly	In a safe living environment	Monthly
Property form	Staff need to support me to record all new items I buy so there is a clear audit trail	Staff must complete form 148 each time I buy a new item	When needed	To have a clear audit trail	Monthly
Safety & Security **My personal safety**	I need support from staff at all times and cannot be left in the home without support as it is unsafe for me. [redacted] has been know to wander	Staff to follow all risk assessments form 388 [redacted] needs day and night support to ensure his safety at all times.	Daily	To feel safe and supported from the staff team.	Daily

** Frequency of Review = Weekly / Monthly / Quarterly / Bi-Annual / Annual*

PLAN		DO		CHECK	
Area of Support	**What needs to be done?**	**How will this be done? Who will do it? Who else needs to be involved?**	**When and how often will support be delivered?**	**What I want to achieve? (Outcome)**	**Frequency of Review***
	during the night and go in and out of the bathrooms and toilets. I rely on staff to keep me safe at all times When out in the community I need staff to ensure I am safe when crossing the road.	Staff to ensure my safety at all times. I rely on staff for my safety when out in the community.	Daily Daily		Daily Daily
Social & Civic Participation	I like to go bowling, cinema, walks, shopping, local shops, café, and barbers, theatre and having a pub lunch and shandy. I need support in finding activities that interest	Staff to support me to develop a planned timetable of activities so that I have a routine and structure to my days especially when I am not going to activities.	Daily	To feel a part of the community and to meet new friends.	Monthly

** Frequency of Review = Weekly / Monthly / Quarterly / Bi-Annual / Annual*

PLAN		DO		CHECK	
Area of Support	**What needs to be done?**	**How will this be done? Who will do it? Who else needs to be involved?**	**When and how often will support be delivered?**	**What I want to achieve? (Outcome)**	**Frequency of Review***
	me.				
Enjoy & Achieve Attending my over 60's club	I like to attend the over 60's club and need staff support to attend every week.	I need staff to remind me every week to attend my club and also to go me ready and attend on time.		To meet me friends.	Monthly
Doing my own washing and cleaning my room	I need prompting from staff how to load the washing machine with my clothes and also how to unload, I need staff support to clean my room.	I need staff to support me to clean my room and also prompt me when my wash day due..I should be prompted to take my laundry basket down but it should be a reasonable load, that I can carry,			Monthly

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** Frequency of Review = Weekly / Monthly / Quarterly / Bi-Annual / Annual*

Appendix H: Ian Winter Biographical Details

Ian Winter CBE

Ian has over 40 years experience at local, regional, national and international level in health and social care. He was the Director of Adult and Children's Services in a large shire county, pioneering work on re-ablement, care management and integrating learning disability and mental health services.

Ian led an in-country assignment for the Royal Government of Cambodia, securing substantial World Bank funding over a 10 year period for healthcare.

He served for 6 years as senior civil servant in the Department of Health as regional director for London and other national projects.

Following this he worked on an integrated response to the Winterbourne View abuse scandal and researched and produced the national stocktake of progress which was used as the key bench mark for further action

Ian is the Board Chair at Croydon Care Solutions, a trading company providing innovative approaches in learning disability services and commissioning specialist support to daily living.

He currently is currently supporting a London Borough to implement the Care Act 2014 and a major project to reshape social care services.

He is the independent Chair of a Partnership and Transition Board for learning disability services for an authority in the Home Counties and an adviser to a private sector organisation in the provision of high quality care assessment services for adults.

Ian was awarded a CBE for services to social care in 2012.

October 2015