

Executive Summary
Safeguarding Adults Review
Learning from the circumstances of the life changing injury to Z

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January 2019

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1. Introduction

1.1 Z began living at Alstone House in Cheltenham on the 4th January 2017. Z is a white woman who was thirty-six years old at the time of the events described in this Report. Z had sustained a brain injury and had been receiving intensive rehabilitation at a specialist hospital. She had regained some basic abilities but there were concerns that she would “plateau” in her rehabilitation. A placement was sought at a specialist unit who could focus on her communication skills using Makaton. Z also had Type 2 diabetes. She had previously lived in an area 120 miles away from the Home.

Alstone House was registered in 2011 as a residential care home providing accommodation and personal care for up to four people with learning and physical disabilities and acquired brain injuries. Alstone House was owned and managed by Lifeways Community Care. It was described as a “*residential care home which provides accommodation and personal care for up to four people with learning and physical disabilities and acquired brain injuries*” (CQC 2017).

Just after midnight on 9th March 2017 Z was attacked by another adult who lived at Alston House. Z sustained serious injuries, losing the vision in her right eye as a result of the attack. Z is still experiencing the symptoms of the trauma following the attack.

Z’s assailant, X, is also an adult at risk. She was twenty- six years old at the time of the assault on Z. She had been living in Alstone House since February 2012. X was born with an aneurysm which haemorrhaged when she was six years old after she hit her head on a sofa at home. She had extensive brain surgery to try to control the bleeding on her brain. After this injury X’s behaviour became very challenging, she was impulsive and unpredictable. Sometimes she behaved violently toward others. X developed a weakness on her left side as a result of the injury to her brain. As a result of her assault on Z she received a custodial sentence of nine and a half years in December 2017 after being convicted of wounding with intent to cause grievous bodily harm.

There had been concerns about the quality of care provided at Alstone House prior to the incident of the 9th March 2017. It was rated as “Inadequate” in all domains by the Care Quality Commission after an inspection in February 2017. Alstone House was closed by the provider, Lifeways, in March 2017.

2. The Safeguarding Adults Review

A Safeguarding Adults Review (SAR) was commissioned by the Gloucestershire Safeguarding Adults Board (GSAB) in response to the permanent harm of Z. The review was conducted in accordance with the GSAB Safeguarding Adults Review Protocol (May 2017), i.e. there was reasonable cause for concern about how organisations worked together to safeguard Z; Z is defined as an adult at risk and has experienced a reduced capacity or quality of life (whether because of physical or psychological effects) as a result of abuse or neglect.

2.1 The Review Report considered how agencies worked together to safeguard Z, to support X, and how agencies addressed emerging concerns about how Lifeways was managing Alstone House with an emphasis on how the protection of the people living there was considered. The Review report also considered what was known about the events of the 9th March and gave a summary of the actions taken after the life changing assault on Z.

The **specific areas of focus** within the Review Report were:

- how the agencies commissioning the placements for both Z and X established, reviewed and monitored the quality of the provider. The specific agencies are Essex County Council (for X) and Eastern Cheshire Clinical Commissioning Group (for Z)
- how the agencies, including the care provider, who were supporting Z and X in the placement, were made aware of their needs, and how those identified needs were responded to.
- how agencies worked together in identifying risks to Z and to others, including X, living at Alstone House, and how they responded to these;
- how agencies and staff were supported to follow agreed policies and protocols.

The consideration of the circumstances affecting Z began six months before her placement at Alstone House and covered the period **1st August 2016 to 1st April 2017**. The consideration of the circumstances affecting X began on the **1st October 2015 and ended on 1st April 2017**.

2.3 Activities undertaken during the Review process included: collation of chronologies, individual agency reports, and conversations with key staff as appropriate, examination of documentation as appropriate, identification of key episodes, and an exploration of these episodes together with the lead reviewers' findings through a learning workshop event attended by nine of the agencies below.

The following agencies have participated within the Review:

2gether NHS Foundation Trust

Cheshire East Borough Council

Eastern Cheshire Clinical Commissioning Group

Essex County Council

Gloucestershire County Council: Adult Safeguarding Team and Learning Disabilities Quality team

Gloucestershire Constabulary

Gloucestershire Hospitals NHS Foundation Trust

Gloucestershire Care Services NHS Trust

Lifeways Group

Royal Well Surgery

South Western Ambulance Service NHS Foundation Trust

Worcestershire County Council were not involved during the time in the SAR scope but held a great deal of information about X as the authority who originally placed her in Alstone House. Worcestershire have been able to answer specific questions related to the review and participate in the review learning workshop.

The families of Z and X were involved in drawing up the terms of reference for the Review, gave evidence to the Review and suggested amendments to the final version of the SAR. Z was not able to participate in the SAR due to issues regarding her mental capacity. X has been supported to read the review but was unable to directly participate.

3. Findings and Learning Points

3.1 Findings and Learning Points: Z

a) How the agencies commissioning the placements for both Z and X established, reviewed and monitored the quality of the provider (Z).

There were pressures around establishing Z's placement, she was in hospital for almost a year after a potential placement was identified for her, a delay contributed to by lack of capacity in the mental health complex care team. Z did not have a care coordinator who might know and understand her as an individual. Z needed a placement which could manage the complexity of her needs and support her continued rehabilitation. The agencies who contributed to this Report found such specialist placements hard to identify nationally. In the event Z's family identified the placement and it was progressed based on a positive but two-year-old CQC Report and the commissioner's check with the Gloucestershire CCG and local authority. The service had no "quality mark" or accreditation with any ABI specialist agency, e.g. Headway. A provider can set themselves up as an ABI specialist service and there is no agreed scheme of accreditation that the provider and commissioner/placing authority can use to assure the quality of service.

The commissioner did visit the placement alongside Z's family but was reliant on the verbal assurances of the Home Manager as to how Z's support would be delivered. Z did not visit the service as the long journey would have negatively affected her wellbeing. An opportunity to observe how staff and manager, other residents and Z interacted was lost, and the assurances of the Manager regarding staff training, skills and knowledge untested.

No assessment of the compatibility of Z with the needs of the other people at Alstone was undertaken, Lifeways did not undertake such an assessment and the commissioner did not ask for the information.

Eastern Cheshire CCG have undertaken a number of steps to ensure that there is process in place to rigorously check the quality of placements, including a compatibility tool. Other SABs have commissioned risk compatibility processes which may also be helpful, for example Bristol Safeguarding Adults Board. It is understood that work is underway in the South West region to agree a quality framework for commissioning placements for people with learning difficulties.

It is not known how the commissioner proposed to review Z's placement, but her care and support was reviewed early in the placement in response to concerns about quality identified by the host authority. District nurses identified concerns much earlier in the placement. It appears that because these were not understood as adult safeguarding concerns the mechanism to inform the placement commissioner was not used. Vital information that could have alerted the commissioner earlier to poor quality and harmful care was unwittingly withheld.

The new Managing Authority, Lifeways, did not apply to Cheshire East Borough Council for an authorisation of Deprivation of Liberty for Z. It is not known if Lifeways were given the name of the Supervisory Body in Z's case, but they also did not ask for this information. A DoL authorisation is useful additional scrutiny and assessment. As Z had no one in the area to be her Representative an advocate may also have been considered via the DoLS process.

Learning Point 1: When assessing the suitability of a placement a number of approaches need to be taken to ascertain that the service can address the identified needs of the person. Nationally agreed quality frameworks or accreditation under a recognised scheme are useful as an assurance of quality together with tools to assess compatibility and opportunities to see evidence of the approach that a provider will take with the person. CQC Reports must not be relied upon as an indicator of quality.

Learning Point 2: A monitoring plan must be made prior to placement when placements are commissioned some distance from the commissioner or "placing authority". This will be assisted by clarity about local agencies involved in the person's care and how these agencies can communicate with the commissioner. The views of the agencies involved must be sought out by the commissioner, as part of a Review process or as part of another monitoring pathway.

b) How the agencies, including the care provider, who were supporting Z and X in the placement, were made aware of their needs, and how those identified needs were responded to: (Z)

In February 2017 the provider had begun to develop a support plan for Z which included a plan to manage her risk of choking but was not informed by a referral to speech and language therapy as recommended. There was no risk assessment regarding her medication and no guidelines on managing her diabetes. There was no support plan in place regarding her communication needs and, contrary to what her family and commissioner had been told, no Makaton user on the staff team. Without these vital elements in place the Alstone staff supporting Z on a daily basis had an inadequate guide as to how to care for her. They had no training in diabetes and, after the first two weeks of her placement, no consistent manager or team leader to direct them.

Z was left unprotected from risk in the environment (the floor to her feet) and risk from her fellow residents. No food diaries were kept. She had no activities planned. There are accounts of her loss of dignity and neglect by staff at Alstone. She was allegedly harmed over a significant period of time by another resident without any referral to adult safeguarding or information to the responsible commissioner.

District Nurses and Diabetic nurse were aware of Z's needs and responded well to health concerns. The acute trust responded to Z's needs post incident, using the provisions of the mental capacity act 2005 to make proportionate decisions about her care and treatment in her best interests. A Learning Disability nurse supported the plans made for her during her hospital stay.

Learning Point 3: When care and support needs are complex initial support plans must be received and checked by commissioners who will also be able to comment and add to their construction.

c) How agencies worked together in identifying risks to Z and to others, including X, living at Alstone House, and how they responded to these (Z)

The impact of failure to understand and manage Z's diabetes could be fatal or life damaging. This risk was mitigated by visits from district nurses but should still have been understood from the perspective of actual harm (an increasing number of hypoglycaemic episodes) or potential harm (walking around a premises where building work was being conducted in bare feet). Conversations about concerns need to focus on the impact of the concern on the individuals(s) in the situation. Only in this way can we move away from describing poor practice as a "quality" concern instead of appreciating what the implications are for the people involved. If referrers are concerned that action is not being taken escalation routes should be considered.

If a safeguarding concern had been received by the Gloucestershire Adult Safeguarding team in early February 2017 the commissioner would have been alerted earlier to the poor care being given to Z.

The failure to report the ongoing abuse of Z by another resident at Alstone House had a detrimental effect on the quality of her life. Lifeways staff made eight referrals regarding Z but one for X after on-going verbal abuse escalated to physical assault. It is hard to understand why Lifeways staff made eight referrals regarding X but only one for Z. One possible answer is that post the departure of the Home Manager and team leaders in December 2016/January 2017 staff no longer made appropriate contact with the adult safeguarding service.

Learning Point 4: The definitions of what is a concern about quality and what is a safeguarding concern need to be revisited with an emphasis on impact on the individuals concerned. Consideration can also be given as to how conversations take place, a written concern which enables the referrer to reflect and for details to be properly recorded may be more effective than a verbal conversation.

3.2 Findings and learning Points: X

a) How the agencies commissioning the placements for both Z and X established, reviewed and monitored the quality of the provider(X).

X's placement was initiated by a different local authority at a time when the service at Alstone House appears to have been run effectively. Evidence indicates that X had a detailed support plan which the placing authority reviewed frequently and received regular updates about. The local authority was nearby and had a long historical connection with X and her family.

Responsibility for funding the placement changed in November 2014 with the responsibility being passed to a local authority 160 miles away by a Judicial Review. The two local authorities concerned had not discussed how the new placing authority could effectively support this complex individual and unusually restrictive support plan from such a distance. Whilst the new placing authority adhered to their statutory duties regarding review, they were unable to support the placement in the way that the more local authority could and in the way the support plan required.

It is unclear whether the new local authority ever appreciated X's needs and the rationale for the type of support plan that was passed to them. They may not have understood X's history, and there is evidence that they did not understand the impact of her disability. X and her placement costs were passed on to this local authority who may not have completely owned their role in her support as evidenced by the delays in their response to concerns expressed by Lifeways, Gloucestershire and the police.

The placing authority requested and received risk assessments regarding X in March 2016 but must have noticed that these were out of date and bore no relationship to the new arrangements for her support (reduction of 2-1 support discussed in February 2016 and implemented in March 2016). Lifeways, CQC and the Gloucestershire Quality Assurance

Team all noted the absence of plans or risk assessments for X, and we do not know if these were requested or scrutinised by the reviewing social worker in February 2016 or July 2016.

Information sharing and communication between the placing authority and host authority was not always reliable or clear. The host authority held no details about X with which to contextualise the concerns that they received. The host authority relied on the provider to inform the placing authority of incidents that it was also aware of. The placing authority had to be pursued for four months for the outcome of an agreed adult safeguarding plan. The host authority experienced difficulties in alerting the placing authority about the increasing concerns in the placement. The host authority became frustrated at what it felt was a slow response from the placing authority which it believed was failing to appreciate its responsibilities as the placing authority for X, this was ultimately escalated at Director level. There appears to be some uncertainty in the placing authority about roles and responsibilities, at one point the host authority was asked to arrange a new placement for X. The placing authority also had the responsibility of convening a review of X's need for continuing funding under s117 which may have given an opportunity to consult with mental health services in the area but did not take this step. The placing authority did not initially appear to understand its continual responsibility for X's accommodation and support after she had been arrested in March 2017.

The difficulties inherent in geographical distance between a placing authority and a placement for a person with complex needs are documented in numerous Serious Case Reviews (e.g. Winterbourne View 2011) and SARs (e.g. Mendip House 2018). In this case Essex County Council did not choose to place X so far away but inherited the arrangement.

Learning Point 5: The difficulties and risks in monitoring and reviewing distant placements are well documented, these must be analysed and mitigated as far as possible when either initiating or taking on a distant and complex placement. It may be possible to commission a more local authority to undertake certain tasks or commission an advocate to represent the person.

Learning Point 6: Examination of support plans, risk assessments and plans and other records must form part of a statutory Review and the implications of an absence of plans understood and acted upon.

Learning Point 7: Clear records of who the stakeholders involved in an individual's support are and how to contact them must be kept by providers and passed to funding authorities in order to facilitate multi agency reviews. Multi agency face to face reviews are essential for people with complex needs and should be the default position when reviewing support plans and placements.

b) How the agencies, including the care provider, who were supporting Z and X in the placement, were made aware of their needs, and how those identified needs were responded to (X).

Worcestershire County Council had clearly documented X's needs and passed these documents to the new placing authority and provider in November 2014. It is unknown whether these documents were read and understood by all social workers from the new placing authority. There were no records fully documenting X's disabilities and support needs at Alstone House by January 2017, the support staff, particularly agency staff, would have had no clear idea of what her needs were or how to work with her.

All agencies working with X lacked knowledge and skill in working with her particular needs, i.e. as a person with an ABI and a resultant organic personality disorder. This led to confusion about the value of the restrictions she had consented to, the best course of action to take in enabling her to gain greater independence and achieve more of her potential in life, and continual misidentification of the meaning of her behaviour. She is referred to as "pushing boundaries" or "wanting attention" and the responses to her needs are predicated on these misunderstandings. Equally the degree of risk that she could put herself at, and others, was not fully appreciated and the carefully constructed boundaries which protected both X and the people around her were effectively removed by March 2017. Support plans were agreed to continue to support X to develop independent decision making and respect her self-determination. These would ordinarily be the best practice course to take, but not for a person with X's specific ABI related needs.

It was very difficult to obtain external specialist support to enable X's needs to be correctly understood and responded to. Two referrals were made to the local Neuropsychiatry team but neither resulted in X being seen and assessed. Lifeways had their own ABI specialist who was in post throughout 2016, but this input is not evidenced, and the placing authority does not appear aware of the existence of the specialist. There is no evidence to show that this specialist had a role in enabling the service to understand X's needs. Lifeways did arrange for X to attend a local Headway rehabilitation course, which may have been useful to X and the staff supporting her. However, the placing authority did not fund this, and the provider does not appear to have gone forward with the arrangements.

X was constantly said to "have mental capacity" to make decisions at important points in her life. She is also described as having "fluctuating" capacity but with no documented analysis of what that meant. At the point at which impulse overrode X's ability to make decisions she would have lost that capacity. There is little training for professionals in how to understand and assess the capacity of people with an ABI to make specific decisions or the importance for these people of a consideration of executive impairment, reduced insight, impulsive and disinhibited behaviour, neglect of own interests and the influence of the environment.

Police and health services responded to X's needs as far as they could understand them, and often gave compassionate and proactive responses.

Learning Point 8: People with ABI can fall “between services” and despite having very complex needs can get no specialist service at all. We need to understand what services are available for people with ABI and ensure that the relevance of and referral routes to such services are understood. If a provider has a specialist team or practitioner who can assist, or an accreditation under a recognised quality mark this must be made clear to the placing authority who must take steps to understand what support is on offer.

Learning Point 9: Specific training is needed for practitioners about ABI and the best approach to undertaking a mental capacity assessment and in working with specific features of ABI and resultant disabilities.

c) How agencies worked together in identifying risks to Z and to others, including X, living at Alstone House, and how they responded to these; (X)

Lifeways regularly reported concerns about risk to Gloucestershire and allegedly to the placing authority during 2016. The context of these reports was not understood by the host authority. On two occasions X was seen as the source of harm and no action was taken. Advice about risk taking was seen in the context of whether X “*had capacity or not*” and did not factor in the broader context of her disability, changes to her support plan or living situation. Two of X's overdoses were reported by Lifeways, but no reports were received from the other agencies involved. There was no exploration of how X obtained the medication she used to overdose by the agencies who were aware of the overdose, or consideration of what the implications of this were in the context of an escalation in historical self-harming behaviour. Until the VIST system was introduced the police shared no information about X with Gloucestershire adult safeguarding services.

From May 2016 onward X's behaviours were escalating, and over the year she begins to take drug overdoses which damaged her health, assaulted a member of the public and caused criminal damage outside of the property, she placed herself at risk in her relationships, potentially being physically and financially harmed. Around £20,000 had disappeared from her bank account. Despite her statements that she was struggling to cope with a reduction in support her support was not increased by the placing authority or the failure of the existing agreed support explored.

Learning Point 10: Adult Safeguarding services need to look beyond labels, if someone is a source of harm what does this mean about the quality of their support plan? This may not require a safeguarding response but does require formal communication with the placing authority.

Learning Point 11: A person overdosing whilst living in a residential care setting does require further investigation as to how the means to self-harm has been obtained and whether protective actions are needed.

Learning Point 12: Escalation in risk behaviours to self or others must result in a review of the care and support plan by the placing authority.

3.3 Prevention and Monitoring, identifying risk and responding: Alstone House specific

Lifeways did not carry out Quality Audits at Alstone House for two years on the basis that the service had scored well (90%) in an audit undertaken in January 2015. However the service had a new manager shortly afterward, how a service operates will change when the manager changes, and in addition, by October 2016 there were indications of changes within the service (staffing issues) which Lifeways senior management was aware of.

Learning Point 13: Quality Audits should be carried out at an appropriate date within six months of the manager of a service changing. If Lifeways are only to audit on a two-year basis, they need to develop a set of indicators which will alert senior managers to potential changes in the quality of service provision.

The Lifeways response to the concerns identified by their own Quality Audit, by the Gloucestershire Quality team audit and by CQC was extensive and ambitious but did not take account of the structures needed on the premises to enable the service to run safely during the implementation of the Improvement plan. Lifeways have since identified the impact of the absence of defined leadership within the Home during this time. In addition, there was no work undertaken with local staff to understand the impact of the improvement plan on the people living at Alstone House and how they could be supported through this. For example, so many new people on the premises and so much activity would have had a profound effect on X's anxiety.

The Host Authority has a sophisticated and helpful process to identify quality concerns and can target efforts to improve quality. This can include daily monitoring visits, close work with the CQC and meetings with the provider. There is no evidence that a "risk of harm to individuals" assessment was made as part of the improvement work, and the impact of the organisational neglect on individuals was not identified as organisational abuse. An Adult Safeguarding team, in conjunction with commissioners or placing authorities, has the skill and knowledge to undertake such an assessment and for this assessment to inform the decisions and pathway forward.

Learning Point 14: There is a need for an adult safeguarding risk assessment that can be undertaken with placing authorities and providers regarding specific risks to individuals and mitigations in situations of organisational abuse/or need for extensive improvement plans.

4. Recommendations:

The learning points addressed by the recommendations can be seen in brackets after the recommendation. Gloucestershire SAB will seek assurance of action taken as a result of these recommendations by agencies in Gloucestershire. The Essex and Cheshire East Safeguarding Adults Board are respectfully invited to seek assurance that recommendations given to agencies in their respective areas have been taken up and actioned.

All local authorities must adhere to the ADASS '*Out of Area Safeguarding Adults Arrangements*' (2016) which specify the roles of placing and host authorities. Whilst the host authority has the duty to enact a s42 enquiry, the placing authority has the responsibility to check that the person is safe, that their needs are still being met, and that the Provider can continue to ensure their safety. It is not a recommendation, but an expectation that all local authorities will follow these agreed arrangements.

It is also an expectation that placing local authorities must adhere to the 2018 ADASS/LGA '*Advice note for Directors of Adult Social Services: Commissioning Out of Area Care and Support Services.*' NHS England have not, at the time of writing, issued advice on this subject. The ADASS/LGA advice addresses six of the learning points identified above, i.e. Learning points 1, 2,3,5,6, and 7.

4.1 Gloucestershire Safeguarding Adults Board (GSAB)

4.1.1 GSAB are recommended to share this Review report, with emphasis on the Findings and Recommendations, with the Chairs of the Safeguarding Adults Boards covering Essex and East Cheshire areas. These SABs will wish to assure themselves that the actions recommended by this report are completed by the relevant agencies within their local area who are named in this Report.

4.1.2 GSAB are recommended to make representation to the Department of Health and Social Care regarding the need for legislation and statutory guidance on the roles and responsibilities of host and placing authorities (and health commissioners). This opportunity was lost in the Care Act 2014 but must now be urgently addressed following the findings of this and other SARs including Mendip House 2018. (Learning Points 1, 2,3,5,6, and 7)

4.1.3 GSAB are recommended to seek assurance that the actions recommended to the agencies in Gloucestershire below are satisfactorily completed and the outcomes of these actions evidenced and understood.

4.2 Individual agency recommendations:

4.2.1 Gloucestershire County Council

i) Adult Safeguarding Service:

The service is recommended to lead on work to clarify:

a) How safeguarding and quality concerns are defined (Learning Points 4 and 10).

What must be considered in arriving at a decision whether a concern is about quality of the service or is a safeguarding matter? Individual impact must be considered within the decision as well as looking beyond any label, e.g. an adult at risk labelled as a source of harm.

b) The routes for reporting concerns about quality or poor practice and the routes for reporting safeguarding concerns (Learning Point 4).

Whilst clarifying routes consideration can also be given as to how reports about concerns are made, a written concern which enables the referrer to reflect and for details to be properly recorded may be more effective than a verbal conversation. Formal and reliable communication pathways with placing authorities and other commissioners must be developed.

c) Development of an organisational abuse adult safeguarding Risk Assessment (Learning Point 14).

This Risk Assessment will analyse specific risks to individuals in situations of organisational abuse or when the need for an extensive improvement plan in a provider service has been identified by CQC or via quality assurance mechanisms. This should be undertaken in conjunction with placing authorities and providers.

It is recommended that the Risk Assessment must be a required part of any improvement action taken by the Gloucestershire Quality Assurance Team. The assessment will follow the adult safeguarding principle of Proportionality, i.e. in situations of minor improvement it will be sufficient to identify that risk of harm is unlikely and would have a mild effect. In extensive improvement programmes the risk assessment will need to be thorough and detailed.

Although not specifically examined by this Review it is recommended that the Gloucestershire Adult Safeguarding Service and Quality Assurance team review arrangements regarding joint working on quality improvement and/or organisational abuse.

ii) Gloucestershire adult care is recommended to undertake work in conjunction with the Gloucestershire CCG to understand what services are available for people with ABI in its area and ensure that the relevance of such services is understood, and referral routes are known by all services working with people who have an ABI. (Learning Point 8).

iii) Gloucestershire adult care is recommended to consider the need for specific training on the best approach to assessing mental capacity in people with an ABI and to consider, in conjunction with the South West regional DoLS network, who can offer this training and

who should attend. These considerations can also be shared with any national DoLS network (Learning Point 9).

4.2.2 Essex County Council

i) The Council is also recommended to follow 4.2.1 (iii) above with local MCA leads (LP9).

The recommendations below are specific to Essex County Council within the context of this review but are of relevance to all out of area placements for people who have complex needs.

ii) Essex County Council is recommended to assure itself:

That when responsibility for an individual's placement is transferred to the local authority all historical information relating to individuals is read and known to be understood.

That support plans, risk assessments etc. held by a provider are seen and scrutinised as part of a statutory review.

iii) In circumstances where an individual has **complex needs** and the placement is **out of area** it is recommended that:

- a) A multi-agency approach is agreed at the beginning of the placement to ensure that the individuals' care and support needs are understood by all involved, that a supportive network of professionals is identified and that a lead professional is clearly known to all concerned. The individual must be actively involved in this process and their aspirations included in any plans made with them.
- b) The placing authority will ensure that a risk management plan is in place and adequately resourced, with roles and responsibilities and appropriate actions to be taken clearly defined. Indicators of the need for urgent review will be specified. The plan will include a set of contingency plans to address potential "worst case scenarios" and mechanisms for keeping the multi-agency team around the individual updated as to staff and contacts changes.
- c) Consideration should be given to commissioning the host local authority, or an independent professional to undertake monitoring visits or reviews as needed.

(Learning Points covered by 4.2.2 (i-iii) 2, 3, 5, 6, 7, and 12)

4.2.3 NHS Eastern Cheshire CCG

i) NHS Eastern Cheshire CCG has undertaken several remedial actions as a result of the harm to Z. In addition to these actions, the CCG is also recommended to ensure that plans are completed with providers to inform the CCG's knowledge of other agencies attending the individual who may be able to inform the monitoring of the individuals well-being (Learning Points 2, 7)

4.2.4 Lifeways

i) It is recommended that the Provider applies for appropriate accreditation of all its services offering support for people with Acquired Brain Injury. Headway is running a well-established accreditation scheme which should be explored. Lifeways must provide clear and evidenced documentation to commissioners/placing authorities of what the service provides, what expertise is available and how this can be accessed (Learning Points 1, 8)

ii) Lifeways is also recommended to review its internal quality audit policy to redefine when service audits are carried out and to specify what service changes will trigger an audit. Changes in management must a key indicator of the need for audit. Audits should be carried out at an appropriate date within six months of the manager of a service changing. If Lifeways are only to audit on a two-year basis they need to develop a set of indicators which will alert senior managers to potential changes in the quality of service provision (Learning Point 13).

4.2.5 Gloucestershire Hospitals NHS Foundation Trust

The Trust is recommended to ensure that an adult safeguarding concern is referred regarding a person overdosing whilst living in a CQC regulated care setting. Self-harm in a regulated setting does require further investigation under adult safeguarding procedures as to how the means to self-harm has been obtained and whether protective actions are needed. If the Trust is assured that such incidents will be received under adult safeguarding processes it can be confident that the responsible placing/funding local authority or health commissioner is informed. It is understood that the Trust has already begun work regarding the promotion of awareness of the need to make an adult safeguarding referral regarding instances of self-harm in a regulated setting (Learning Point 11).

4.2.6 2gether trust

Mental Health Liaison teams based in hospital settings are also recommended to refer an adult safeguarding concern regarding self-harm in a regulated setting (Learning Point 11).

4.2.7 Gloucestershire Care Services NHS Trust

The Trust is recommended to follow its plan to make adult safeguarding supervision available to staff in order to increase awareness and confidence. Staff need to be able to use an escalation pathway if concerned or unsure about the response given by the local authority to a referral. It will be important for staff to understand roles and responsibilities, a referral can be made to the regulator, CQC, about a service, but this is not the same as making sure that an individual adult safeguarding concern is raised with the local authority (Learning Point 4).

4.2.8 Gloucestershire Constabulary

The VIST system is still being refined in Gloucestershire. Local police vulnerability officers are recommended to automatically receive VISTS relating to adults at risk in their area. This is intended to encourage bespoke service and local engagement from dedicated officers

with Adults at Risk who are either designated as “High” risk or repeat “Medium or low” risk adults.

16. Glossary of terms used

ADASS- Association of Directors of Adult Social Services

ABI – Acquired Brain Injury

AMHP- Approved Mental Health Professional

CCG- Clinical Commissioning Group

CHC- Continuing Health Care

CPA – Care Programme Approach

DoLS- Deprivation of Liberty Safeguards

ED – Emergency Department

ICD -10 The tenth version of the International classification of diseases, published by the World Health Organisation.

PRN – “pro re nata” a medical term meaning medicine taken when needed

VIST – Police Vulnerability Indicator Screening Tool

17 References

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