GLOUCESTERSHIRE SAFEGUARDING ADULTS BOARD

ADULT CASE REVIEW LEARNING PROCESS OVERVIEW REPORT

SUBJECT: R

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July 2015

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1. Summary of findings

- P did not fulfil their contractual obligations and failed to provide the amount and quality of care required to meet R's need.
- GCC as the responsible commissioning body did not ensure that the care provided met R's needs.
- The response to difficulties in engaging with R by the GP practice, 2gether Trust, and P was to withdraw or reduce services, rather than seeking alternative, proactive and creative approaches to gain and maintain trust and motivation.
- No formal assessment of R's capacity was undertaken during the review period until he was admitted to hospital, even though such action was agreed on several occasions.
- There was a lack of understanding within GCC as to who was responsible for commissioning care on behalf of R and the attendant responsibilities.
- There were unacceptable delays in following up concerns and raising safeguarding alerts by GCC staff and P.
- Opportunities to address concerns and risks identified through multi-agency working were missed.
- The response to differences of culture, practice and standards between teams and agencies adversely affected effective interagency working. There were also occasions where concerns about risk were somehow lost in communication between agencies
- CQC did not have a formal system in place to ensure information from the relevant agencies was always shared with the appropriate CQC staff

Full details of the findings can be found in Section 7

2. Reason for Review and Terms of Reference

2.1 This review was commissioned by Gloucestershire Safeguarding Adults Board (GSAB). The subject, R, is a vulnerable adult funding his own care, who sustained an injury as a result of self-neglect that could have resulted in the loss of a limb.

2.2 The time period covered by the review is June 2009 to August 2014. The full Terms of Reference are attached at Appendix 1. These detail the agencies who participated in the review and set out the particular issues agency authors were asked to consider in their reports. During the course of this review the original Terms of Reference were slightly amended at the request of the Chair of GSAB. The change relates to identifying any similarities with all previous Serious Case Reviews commissioned by GSAB, rather than just the most recent one.

3. Process

3.1 This overview report has been written by an independent reviewer, Christina Snell, who had no involvement in the case.

3.2 A meeting for designated authors of individual agency reports was held on 26th January 2015, where the review process and expectations of the agency reports were discussed. Following receipt of the agency reports, a further meeting for report writers was held on 27th April 2015. This provided an opportunity for authors to challenge the content of the individual reports and make any subsequent amendments to their own reports in the light of discussions.

3.3 A draft overview report, along with the individual agency reports were then circulated in advance of a learning event on 26th May 2015. This was attended by practitioners involved in the case and their managers from all agencies, as well as others with relevant expertise (such as Trading Standards). This event enabled discussion between those directly involved in the case and provided an opportunity for them to challenge and contribute to the reports and findings. A further draft of the overview report was then circulated for final comment before presentation to the Board in August 2015.

3.4 R declined to meet with the reviewer or the Chair of GSAB, but was informed about the process and given the opportunity to comment and contribute prior to the learning event and before finalisation of the report.

3.5 The review has been written with an expectation that it will be published on the GSAB website, in order to ensure the learning is widely disseminated. The ultimate decision about publication will be taken by GSAB in consultation with R.

4. Background

4.1 The subject of this review is referred to as R. Other identifying details have been removed.

4.2 R is deemed to have a mild learning disability and well controlled epilepsy. Prior to his mother's death in 2004 he had lived at home, cared for and supported by his parents. When R subsequently inherited the family home, concerns about his capacity to make certain decisions led to the Court of Protection appointing a Receiver in relation to the property and R's financial affairs. The Court subsequently (17th March 2008) appointed a Deputy under the Mental Capacity Act 2005 to manage these issues on an on-going basis, with the Court receiving a report on an annual basis.

4.3 In 2006, safeguarding concerns regarding R's ability to care for himself resulted in Gloucestershire County Council (GCC) undertaking an assessment and commissioning care and respite support, funded directly by R (via his Deputy). Between then and 2009, the amount of support provided was gradually reduced by the care provider at that time at R's request, despite concerns expressed by his Deputy, the 2gether Trust, and GCC staff. R was regarded as socially isolated and difficult to engage, although with capacity to make choices about the care offered to him, which he increasingly chose to decline. He was also assessed as needing time to get to know and trust people, with a tendency to withdraw if asked to carry out activities he does not like. He had a history of declining other services; including those offered by his GP (he had not had a health/medication review for approximately 30 years).

5. Events June 2009 – August 2014

5.1 2009

5.1.1 In June 2009 GCC's Learning Disabilities (LD) Assessment Team reviewed R's care needs, identifying eligible needs under Fair Access to Care Services (FACS) in the following areas:

- Management of finances and bills
- Shopping
- Arranging and attending health appointments
- Maintaining his home
- Social isolation
- Emotional support
- Cleaning his home

15 hours per week of care and support were commissioned to meet these needs from a provider who was already providing support to R at that time.

5.1.2 In September 2009, following concerns raised by R's Deputy about the quality

of care he was receiving, a new provider, P, was commissioned. GCC held the contract with P, reclaiming the costs from R. The rationale given for this arrangement was that GCC could negotiate a better price and meant they would be responsible for reviewing and responding to any concerns/issues about the care provided. There is no evidence of a care plan being given to P advising of required outcomes however.

5.1.3 At around this time R moved from the historic family home, which was deemed unsuitable for habitation, to a more suitable property. Support by P and the 2gether Trust was therefore focussed upon assisting him with this move during this period.

5.1.4 Concerns about R's welfare, and whether the care he was receiving from P was meeting his needs, began early in the new contract, raised by the 2gether Trust and R's Deputy, the first record being 22nd October 2009. Specifically, concerns related to a 'serious decline' in personal hygiene and R's apparent inability or unwillingness to use the cooker. The view at that time of staff in both GCC and P was that progress was being made, albeit in small steps and that pushing R too hard could result in him withdrawing his engagement.

5.1.5 P reduced the amount of care being delivered to 10 hours weekly from 25th November 2009, although there is no evidence of a review or agreement being sought from GCC. GCC staff were aware that a 'flexible' approach was being adopted by P to the number of hours support delivered in December 2009, but no-one queried or challenged this. The reduction was attributed to 'difficulties with engagement'. GCC records also state that the hours 'always remain under review', although no frequency or process for a review is defined.

5.2 2010 & 2011

5.2.1 By February 2010, there was a reported improvement in R's personal hygiene and engagement in other self-care tasks, such as cooking and laundry. A review was carried out by the GCC's LD team in March 2010, and whilst concerns remained about his unwillingness to engage with his GP for health checks, he was deemed to have made good progress. The care hours commissioned were formally reduced from 15 to 5 at the end of August 2010, although P actually implemented this change from 28th June 2010. This reduction was at R's request, agreed by all parties at the March review. Although it was recommended the hours were delivered over 2 days, R insisted on just one weekly visit. At this point R's case was de-allocated by GCC as assessment was complete and the provision of support was in place. Any concerns about R's care were to be referred to the GCC duty team.

5.2.2 Although de-allocated, the record indicates R's needs were to be reviewed on an annual basis. There is no evidence of a further review by the GCC LD Team until July 2012. GCC staff advise that whilst it was standard practice to set the review period at a year, pressure on resources meant only those cases where

there were concerns were reviewed, a situation that is ongoing, and it is therefore not unusual that this milestone was missed.

5.3 2012

5.3.1 On 24th April 2012, a referral was received by the GCC's LD team from the 2gether Trust due to increasing concerns about R's welfare and response to support. His case was re-activated and a Social Worker allocated. A review meeting was held on 4th July 2012 to consider the following concerns;

- Personal care
- Poor diet
- No phone in the house therefore unable to seek help in emergency
- Refusing health appointments/investigations (unsure if taking medication and required regular blood tests but refusing tests)
- Mental Capacity regarding medication
- Social isolation
- Refused psychological assessment from 2gether Trust
- Attended local Drop In for a short time only
- Home conditions variable (tidies before visitors but is known to hoard)
- P seem to have little success with engagement

Actions agreed included investigation to ascertain how often and by what methods P were supporting R during their visits, a risk assessment regarding medication, safety and isolation, a Mental Capacity Act (MCA) assessment regarding home safety, including medication, and a referral to an advocate. Despite the 2gether Trust having triggered the meeting due to their concerns about R, other agencies present were told that 2Gether Trust would be discharging R in the light of the support planned and a recent history of poor engagement. There is no record of this decision being challenged at the meeting.

5.3.2 Following this review meeting, having liaised with P, a Functional Analysis of Care Environments (FACE) assessment meeting was held by GCC's LD Team on 19th July 2012, which R attended. The meeting concluded there were no concerns at this point about home conditions or personal care and no concerns were raised about the quality of care support being provided by P. This assessment was not actually approved for a further 3 months, 3 days after the case was de-allocated (25th October 2012).

5.3.3 When this assessment was shared with R's deputy (who had been unable to attend the meeting), he again expressed his concerns to GCC staff about the quality of care provided by P, as well as the withdrawal of the 2gether Trust and R's lack of engagement. The response to this was a meeting at R's home on 27th July 2012, attended by R's Deputy and P, when an outcome plan was agreed. An internal referral was also made within GCC to the LD Enablement Team, although R declined their intervention. P were asked to investigate the

concerns raised about the quality of care being provided.

5.3.4 Whilst it is reported that GCC staff began working on the action plan agreed at the meeting, there is no evidence that the actions to undertake a MCA assessment or a referral to an advocate were progressed as agreed. On 20th August 2012, however, an internal discussion within GCC concluded that, "Health professionals may be imposing own values regarding bathing/personal care". It is not clear what the evidence to support this was.

5.3.5 On 10th October 2012, GCC staff contacted P in relation to their continuing concerns about R's care and appearance. Despite this, on 22nd October 2012, a GCC manager decided to de-allocate the case on the grounds that "assessment was not necessary as R self-funding" and he was deemed to "have ability to meet needs and capacity to understand and is refusing support". There is no evidence of a clear plan being in place to address or manage the risks previously identified in the FACE assessment (which had not been approved at that point). In addition, the outcome of P's investigation into the concerns raised was still outstanding.

5.3.6 In December 2012 the Care Quality Commission (CQC) received a whistleblowing report about lack of staff levels and support at P, although this did not relate specifically to R. This was followed up by CQC and P's response accepted.

5.4 2013

5.4.1 P's report about the concerns raised regarding R's care was eventually received 2 months after the original request on 2nd January 2013 following a prompt by GCC staff. The report described 'minimal progress' and there was reference to 2 hours per week support being provided rather than the 5 hours commissioned. There is no evidence that this contractual change was agreed with commissioners prior to implementation. There is also no evidence the discrepancy in hours delivered and commissioned was investigated further by GCC staff once they became aware. The report also made reference to capacity and an undertaking that P would carry out a MCA assessment, although there is no evidence this was progressed. GCC staff decided no further action was required at this point.

5.4.2 P's records indicate there was deterioration in R's motivation and willingness to accept support throughout the rest of 2013. They describe resistance from R to receiving the full 5 hours support agreed, and that he would ask the care worker to leave after 2. There is evidence that this was occurring for a number of months before P's records formally note a reduction in the support package in October 2013 due to R's lack of engagement. Again P did not alert commissioners to the difficulties they were experiencing nor gain agreement before making any such change. GCC staff were only informed of this situation when R's Deputy queried why he was still being charged for 5 hours support.

There was no follow-up from GCC about this unauthorised change to support hours, however, nor any further investigation as to why P had been overcharging.

5.4.3 At the point the support hours were reduced by P, R's Deputy contacted them, again raising his concerns about R's welfare. He was told that as much as possible was being done

5.5 2014

5.5.1 In January and February 2014, CQC received further whistleblowing reports about lack of staff training at P. This was followed up by a responsive inspection in March 2014, when breaches of 6 regulations were identified for the organisation as a whole. Most cases inspected were in Swindon but CQC informed GCC safeguarding team of the concerns and non-compliance.

5.5.2 Following a re-referral to GCC's LD team in March 2014 and a subsequent meeting with R in May, it was agreed to provide enablement support to R at home. He declined to attend the drop-in facility on offer, however. An email was sent by GCC staff to R's Deputy, who had not been notified about the meeting, requesting he speak to R about the lack of smoke detectors in the house. In response, R's Deputy once again raised his concerns with GCC staff about the quality of care and support R was receiving and the evidence of self-neglect.

5.5.3 On 15th April 2014 R's Deputy once again raised his concerns about R's care directly with P.

5.5.4 On 14th May 2014, R's Deputy contacted GCC, suggesting that a general review of R's circumstances should be undertaken. He was advised there was no allocated social worker and R would simply come up on a review list, although in fact the LD Team was undertaking a review at this point.

5.5.5 In the light of CQC's findings in Swindon, GCC decided to conduct quality reviews for all P services in Gloucestershire, including the service delivered to R. A quality review visit to R was undertaken by the GCC Quality Team on 23rd May 2014. They identified significant concerns that R was at risk of self-neglect, was isolated and did not appear to be receiving the allocated support hours. The team was also concerned that the FACE assessment had been started in October 2012 but follow up actions had not been completed as the case had been closed. Since there was a difference of view about R's situation and level of risk within GCC, particularly in relation to self-neglect, an independent review, was commissioned. Although not all relevant GCC staff were aware of this action, it is reported concerns about R's welfare were the subject of regular discussion between the LD teams.

5.5.6 GCC staff contacted R's Deputy who shared his continuing concerns about R's welfare and the quality of the care he was receiving. It was agreed a safeguarding alert should be raised, but this was not done until 28th May, 5 days

after the concerns were identified. From records and discussion with staff involved, it seems the level of concern felt was not effectively communicated between staff, resulting in the allocation of an enablement support worker rather than any follow-up investigation. Other than this referral there is no evidence of any other immediate practical action being taken by GCC staff to safeguard R's welfare in response to these presenting risks.

5.5.7 GCC staff did contact P about their concerns and those of R's Deputy. They were advised P would be implementing an action plan. This included sending in a Team Leader to undertake some shifts with a view to trying to encourage R with his personal hygiene, healthy eating, regular haircuts, social integration and better kept house and garden.

5.5.8 R's Deputy contacted GCC on 6th June 2014 and following a detailed discussion was assured his concerns would be escalated appropriately.

5.5.9 In the meantime GCC's Quality Team continued to gather further information, including requesting support plans and records of visits from P (eventually provided 10th July 2014). They also updated R's Deputy on 11th June about action being taken to address concerns.

5.5.10 An internal GCC management request was made on 17th June 2014 for an MCA assessment to be carried out regarding R's capacity to make decisions about the fitting of smoke alarms. This was not progressed by the Social Worker on the grounds that R had now agreed to a smoke alarm and an MCA was "unlikely to be helpful as R has difficulties with new people". The decision not to follow up on this planned action was not agreed by a manager, however.

5.5.11 On 24th June 2014 R's Deputy again contacted GCC requesting a review of R's circumstances. At this point GCC also began to notify CQC of concerns about the care provided to R by P and the actions they were taking via a fortnightly report, although this information does not appear to have been disseminated within CQC.

5.5.12 Intervention by GCC's LD team continued on a weekly basis. There were concerns about R's clothing, which was badly stained, although he was resistant to suggestions to purchase new. On 27th June an unpleasant odour was noted, but was put down to a lack of fresh air circulating in the property.

5.5.13 When staff from GCC visited R again on 4th July he reported having had a bath and his hair appeared clean. When they visited again on the 9th July with the independent reviewer, however, they were all concerned about R's appearance, living conditions and the quality of care he was receiving. The review report, received 30th July 2014, recommended an immediate change of care provider and that P should be investigated for not following the care plan, not identifying risks and raising alerts and for potentially charging for support hours R was not getting. Although GCC staff shared the concerns of the independent report writer, there is no evidence of any immediate direct or practical action being

taken in response to the concerns about R's welfare following this visit.

5.5.14 At the following visit by a GCC worker on 11th July, R appeared unkempt. R's support worker from P was also present at this visit. He noticed heavy soiling on the floor and offered to arrange a carpet cleaner, but R declined. Again, despite these concerns being recorded, there is no evidence of any practical action being taken to address the situation.

5.5.15 On Friday 18th July, a Team Leader from P called to take R to a hairdresser's appointment. He told her he could not go due to an 'accident'. There was again an unpleasant odour in the house and dark brown/black stain marks in the hallway, stairs, dining room and kitchen. The worker also reported a squelching noise coming from R's shoes, which R said was mud, although the worker's view was that it smelt like faeces. She sent R to change his shoes and socks and attempted to clean the premises. As she lifted a rug she found live maggots crawling on the floor. R refused to accept any further help with cleaning and asked her to leave. The worker left, despite feeling R needed "extensive personal care". There is no evidence P took steps to check whether R was unwell or the reasons for the 'accident', nor any other immediate action in response to his declining physical demeanour and environment.

5.5.16 No further action was taken until 22nd July when P raised a safeguarding alert to GCC. The report was reviewed by a member of the LD team, who concluded that there was no evidence R was at risk of harm. Again it seems there was not a shared understanding about the level of concern felt by those dealing directly with R. Actions agreed were for P to pursue cleaning the property, liaising with R's Deputy in relation to finance, and for them to also contact the LD team to discuss any further actions required. The records show a concern that P "appeared to accept R's lack of engagement and refusal rather than attempting to re-visit a second time during the day or week or attempt to use creative approaches to motivate him". There is no evidence this concern was followed up, however, and the referral was closed.

5.5.17 P contacted the office of R's Deputy (who had notified P he was on annual leave 7-22nd July and made alternative contact arrangements at his office). The message left was that R had soiled himself and the house was in a mess. There was also mention of 'things decaying under the carpet'.

5.5.18 R was visited by a member of GCC staff on Friday 25th July. The worker noticed flies at the window in the lounge and dried stains on the floors and furnishings that the worker took to be dried faeces. R told them the flies had been there for a couple of days but refused help offered to clean the kitchen, which was dirty and untidy. The worker noticed R was unkempt and quieter than usual but again R insisted he was fine and refused suggestions to change his clothes. As this was a Friday the worker from P was expected to visit R but this did not take place, although no reason for this is recorded.

5.5.19 The GCC worker visited R again on Monday 28th July, when they report finding R pale, repetitive in his communication and confused about when he had last seen the worker. R stated he did not want the worker to contact P. Despite feeling concerned, the worker left R, checking he had access to food and fluids.

5.5.20 The same day, the GCC worker raised concerns internally that P were not delivering the commissioned support hours and that the home had not been cleaned since the incident report of 22nd July. It was agreed that R's Deputy was responsible for following up any quality issues regarding R's care, (which was inaccurate), and that he should be contacted to progress this. GCC staff also contacted P who said they were unaware their support worker had not visited R on 25th July but would investigate. They also stated they were hoping R's Deputy would agree to fund an industrial clean of R's property.

5.5.21 In a conversation later that day (28th July), P advised R's Deputy that they considered R was failing to engage, deliberately neglecting himself and they would be serving notice. R's deputy visited him at 5pm that evening and found him to be obviously unwell, limping heavily, pale and with a tremor. There was also a large amount of flies. R resisted suggestions by his Deputy to contact his GP.

5.5.22 R's Deputy raised his concerns with GCC the next morning. During an internal discussion, the duty Social Worker (whose team also carried out the assessment in response to the Safeguarding Alert raised on 22nd July by P) stated she had known R for a long time and this was 'usual behaviour' for him. Still concerned, GCC staff visited R but were unable to gain access. There was an unpleasant smell coming from the property and a large amount of flies on the inside of the windows.

5.5.23 GCC staff raised a safeguarding alert to the Safeguarding Team upon their return to the office. The Duty Social Worker visited on 29th July, although required assistance from R's Deputy to gain access to the property. They found R confused and the property in an unsanitary and neglected state. There were flies crawling on R's shoes, although the worker recorded there was no evidence of injuries. R again refused any medical intervention. He was offered the option of either a break at one of the LD respite accommodations or to remain at home whilst a doctor visited. The underlying assumption was that R had capacity to make this decision, although this was not tested. R became agitated, but did agree to a further visit from those present the following day.

5.5.24 The same day P emailed GCC and R's Deputy giving notice of termination on R's care package.

5.5.25 When practitioners from GCC's LD team returned the following day, 30th July, they found R even more unwell. When questioned it emerged he was not passing fluids, despite having drunk 6-7 litres of water since the previous day, and had not eaten for around 24 hours. Closer examination of the stains in the

house suggested they were blood rather than faeces and the practitioners noticed maggots around R's shoe and foot. R continued to refuse medical intervention but after seeking management agreement, R's consent was overridden and an ambulance called.

5.5.26 Paramedics attended within 6 minutes and R was taken to Gloucestershire Royal Hospital. Here he was found to have an increased heart rate, a temperature and a circular wound on his lower right leg near his foot, surrounded by redness and infested with maggots. His toenails were also coming away.

5.5.27 A capacity assessment was undertaken in relation to medical care and treatment and R was identified as lacking capacity in relation to a decision to leave hospital. The care plan included provision for a Deprivation of Liberty Safeguards (DoLS) application and appointment of an Independent Mental Capacity Advocate (IMCA) if required.

5.5.28 R required surgery under general anaesthetic to clean and treat the wound on his leg. His in-patient treatment continued over several weeks and he made good progress, being deemed medically fit for discharge on 19th August 2014. His property was not considered fit for him to return to at that point, however, and a Best Interests/Safeguarding meeting was held on 27th August to agree next steps. He was discharged to a respite placement the following day.

6. Analysis

6.1 R is a man with a mild learning disability who has been assessed as requiring care and support to enable him to live independently. A number of agencies and individuals had a role to play in keeping him safe and supporting his independence, individually and collectively.

6.2 It is clear R is an individual with whom it is not always easy to engage. He is fearful of medical professionals and interventions and takes time to build trust with people he does not know. He has a track record of self-neglect in terms of personal hygiene and care of his wider living environment, and struggles with basic tasks linked to cooking and cleaning. On the other hand, there is also evidence that it is possible to engage effectively with R. Examples include periods where he was working well with the 2gether Trust (prior to the review period) and in particular whilst a hospital in-patient in August 2014, when against all expectations he cooperated with hospital staff and responded well to having others around him.

6.3 Whilst recognising, there are challenges in supporting R, a number of issues have emerged from this review;

6.3.1 *P's delivery of the service commissioned*

The contract to provide care to R was between GCC and P. P had a clear responsibility throughout the contract period to deliver good quality care and

support to meet R's identified needs. Any problems encountered with delivery or achieving outcomes should therefore have been raised by P with GCC at the earliest opportunity. Proposed changes to delivery hours should also have been agreed with GCC before any changes were made.

There is no evidence P sought prior agreement from commissioners to reduce the weekly care hours from 15 to 10 in November 2009. Whilst a reduction from 10-5 hours was agreed with GCC in 2010, P further reduced the hours delivered in October 2013. They did not get agreement from GCC or inform practitioners of this decision.

The rationale for the reduction in care hours delivered was R's lack of engagement. No account seems to have been taken of the impact upon the level of support R had been assessed as requiring based upon his needs, nor upon the desired outcomes of that support. Had P instead made changes to their approach with a view to securing engagement with R (e.g. supporting the worker in motivating R, allocating a different worker who had the skills to motivate R) or raised these concerns with GCC if difficulties persisted, the pattern of reducing engagement might have been stopped and the harm suffered by R prevented.

R's Deputy regularly raised concerns directly with P about the quality of care R was receiving throughout the review period. There is no evidence that managers at P followed up these concerns adequately, however. Had they done so, they could have provided the allocated support worker with additional support and training or deployed different staff in order to ensure outcomes for R were achieved.

On 22nd July 2014 P raised a safeguarding alert with GCC following concerns about the appalling state of R's home, including the discovery of maggots under a carpet. They agreed with GCC to arrange to have the property cleaned. This was not followed through by P, however, nor did they take any other immediate action to address R's obviously deteriorating physical condition. As the care provider, P had a responsibility to ensure R's immediate safety and welfare. Leaving him in a maggot-infested environment without taking any practical safeguarding measures fell short of fulfilling that responsibility and was arguably neglectful.

Furthermore P did not attend the planned support visit on 25th July and notified GCC on 29th July that they were terminating the contract. Had P properly fulfilled their contractual and safeguarding obligations and followed through on actions agreed promptly, the extent of the issues and impact on R's health may have been recognised sooner and the harm he suffered lessened or avoided.

6.3.2 *Monitoring by GCC of R's needs and the care provided*

The rationale for GCC holding the contract with P and being reimbursed by R was partly so that GCC would be responsible for reviewing and responding to

any concerns or issues about the quality of care provided.

There is no evidence P were given a clear support plan at the beginning of the contract. This would have set out the care to be provided and outcomes required, and would have been a clear means against which to measure the quality of care and progress.

GCC staff became aware that the agreed level of care was not being provided in December 2009, yet this was not questioned or any review of R's care or care needs undertaken. When the amount of care provided was further reduced in August 2010 following a period of reported improvement, the case was de-allocated, with the arrangement that any concerns were to be reported to the Duty Team. Records indicate there would be an annual review of R's needs, an understanding R's Deputy also held. In practice, due to the need to effectively manage resources, only a change in circumstance or concerns about increased risk would trigger a review. It would have been helpful if this had been clearly stated, although it is recognised there is no evidence it would have resulted in a different outcome in this case.

When concerns were raised about the quality of care provided at the July 2012 review, it took GCC 3 months to follow up those concerns with P and a further 2 months for P to respond. The response included reference to the support hours having been further reduced to 2. This was not queried by GCC and the case was closed. On a number of occasions there was no follow up action when concerns were raised (for example by R's deputy).

Towards the end of 2013, it emerged that P had formally reduced the hours of care delivered. GCC became aware of this when R's Deputy queried why R was still being charged for more hours than were being delivered. GCC staff did not challenge P as to why the hours had been reduced without a review of R's need or agreement with them as commissioners: nor was there any follow-up by them as to why P had been overcharging. Had they taken action in response to these issues and ensured the level and quality of care being provided was meeting R's needs, the subsequent decline in his health and wellbeing could have been prevented.

There is no evidence that the frequency with which issues were raised directly with GCC teams about the quality and quantity of care delivered by P to R (9 times between October 2009 and June 2014), was seen as a cause for concern, nor that any additional weight was given to the fact that these concerns were coming from a variety of sources, including within GCC. Even when concerns were raised by GCC's Quality Team when they visited R in May 2014 in response to the wider concerns about P, this history and pattern does not appear to have been taken into account. Had a 'cumulative' approach been taken to these concerns, speedier and more robust action to address them might have been taken.

When P raised a safeguarding alert on 22nd July 2014, GCC LD Duty Team did make an assessment. Their conclusion was that there was no evidence R was at risk of harm. Despite the records indicating a concern that P were not working effectively with R to engage with and motivate him, this was not followed up. Some practical actions were agreed, including for P to arrange to have the property cleaned. No one at GCC took responsibility to ensure these actions were carried out. Had someone at GCC ensured P acted promptly to get the property cleaned the extent of the issues and impact on R's health may have been recognised earlier.

6.3.3 *Response to R's lack of engagement*

There is a history of R not engaging or gradually disengaging with a range of agencies, both prior to and during the review period. It is recognised this is one of the challenges of supporting R: nevertheless there is a pattern of relevant agencies either not finding effective ways to engage with him (for example his GP) or disengaging with him as a result of declining engagement (for example the 2gether Trust and P). Even assuming R had capacity in relation to all care decisions, it is possible a more creative and persistent approach to trying to achieve and sustain his engagement might have been effective. In particular there is evidence of successful engagement during some periods (for example with P during 2010 and 2011, and whilst an inpatient at GRH). This could have been an area where sharing experience of what was effective in engaging with R across agencies might have been beneficial. Had an effective engagement strategy been deployed, the extent of R's self-neglect might have been prevented.

6.3.4 *R's Capacity to make decisions in relation to his care*

The Court of Protection had deemed R not to have capacity to make decisions relating to property management and finances, hence the appointment of a Deputy. R's capacity to make decisions about his care was questioned by professionals on several occasions during the review period, but no MCA assessment was undertaken until he was admitted to GRH in July 2014. This is despite an MCA assessment being agreed as part of action plans on 4th July 2012 (in relation to home safety including medication), 2nd January 2013 (as part of P's action plan to address concerns raised) and 17th June 2013 (in relation to the fitting of smoke alarms). The hospital assessment concluded he did not to have capacity to make decisions about his medical care and treatment at the time of his admission.

Reasons recorded for these assessments not being completed on two of these occasions were linked to R's short-term compliance in addressing the issues. Evidence of compliance is not the same as evidence of capacity, however.

It has emerged from the evidence and discussion with staff in the preparation of this review that some practitioners lack understanding and confidence about

when and how to undertake mental capacity assessments. It is clear that staff across all agencies were committed to respecting R's rights as an individual and were well aware that there should be an assumption of capacity unless there is evidence to the contrary. Finding the right balance between respecting the right of an individual to take risks and knowing when to intervene to ensure the vulnerable are adequately safeguarded is clearly a complex area. For example, even when an individual appears to have a good understanding of potential consequences of their decisions, this does not necessarily mean they have the capacity to follow through on actions or changes of behaviour agreed.

Given that R's refusal to accept certain elements of care and support offered to him (e.g. reduction in care provided, failure to engage with health services) directly contributed to the decline in his health and wellbeing, his ability to fully understand the consequences of his decisions and implement agreed actions should have been checked in the light of the doubts raised. Had staff followed up on their doubts and concerns about R's mental capacity in some or all of these areas, different decisions and actions may have resulted.

6.3.5 *Response to Decline in R's Welfare in July 2014*

There was a rapid decline in R's physical appearance and environment during July 2014. In addition to his unkempt appearance, workers from a number of agencies witnessed an increasing number of stains on floors and furnishings, a bad odour, squelching noises from R's shoes, flies and maggots in R's home. In the few days preceding his hospitalisation there were also signs of confusion. Other than checking the fridge, there appear to have been limited efforts to find the root cause of these problems. R's account that he had had an 'accident' was accepted, despite the evidence that the situation was continuing and worsening. Although P did eventually raise a safeguarding alert, the response agreed was to clean the property (although this did not happen as agreed). The focus of attention seems to have been exclusively on the environment and R's clothing, with no evidence his physical wellbeing was checked. Whilst recognising that R's account of the soiling might have been credible initially, there seems to have been no review of that as the situation deteriorated. Had further investigation been made about R's physical wellbeing and the root cause of the environmental problems, it is possible the need for medical intervention would have been identified earlier.

In terms of when R's wishes were overridden and medical help sought, it is clear those in direct contact with R had escalating concerns about his welfare over a number of days and weeks. Efforts were made to persuade him to accept help and support but in the face of his refusal, staff from all agencies involved appeared to feel powerless to intervene further. Had R's wishes been overruled earlier on the basis of what was in his best interest, more timely medical intervention might have prevented the level of harm he subsequently suffered.

6.3.6 *Treatment of Safeguarding Alerts*

Safeguarding alerts were raised on 3 occasions during the review period. The first, on 28th May 2014, was raised by the GCC staff following a quality inspection visit to R's home. The alert was raised 5 days (3 working days) after the concerns were identified and it appears the level of concern was lost in the communication, meaning no further investigation was made.

The second alert was raised by P on 22nd July 2014 following a visit to R's home 4 days (2 working days) previously, when maggots had been discovered on the premises. A duty Social Worker spoke to P, and expressed concern about P's failure to engage and motivate R, but no further investigation was carried out.

The response to the third safeguarding alert on 29th July 2014 resulted in a visit to R the same day, and the development of an action plan, although these actions were not progressed as R was hospitalised the following day.

Safeguarding alerts should be made at the earliest opportunity. Furthermore, raising an alert does not absolve those dealing with a situation from the responsibility to take any immediate action necessary to safeguard an individual. For example, although P stated they were going to arrange for the property to be cleaned, they did not progress this. In fact, having discovered maggots under the carpet, other than the delayed safeguarding referral to GCC, P effectively abandoned R, carried out no further visits and terminated the contract a week later.

6.3.7 *Lack of Clarity about Responsibilities*

Although fully responsible for funding his own care, R had eligible needs. The Court of Protection deemed him to have insufficient mental capacity to manage his own financial or property affairs and had appointed a Deputy. Furthermore, R did not have any living relatives or others who could make decisions on his behalf in respect of other matters.

On that basis it is reasonable that GCC took responsibility for commissioning R's care, which includes ensuring the quality of care delivered. There is evidence this was not always recognised within GCC, however, not helped by the absence of a clear and comprehensive care plan. In 2012, despite the earlier FACE assessment identifying a range of concerns that had still not been addressed, his case was de-allocated, one of the reasons given being that the assessment was not necessary as R was 'self-funding'. This was inaccurate. Actions previously agreed were therefore not followed through, other than obtaining a report about the care concerns from P (and this took 5 months).

Furthermore, it was clear from discussion during the preparation of this review that confusion remains around these definitions and how decisions are made about GCC's involvement in commissioning arrangements when an individual

has funds to pay for their own care.

Had GCC staff consistently recognised their responsibilities as commissioners, closer management of the case should have led to concerns being addressed and the subsequent sequence of events prevented. This could also have provided a more consistent point of reference for R's deputy.

6.3.8 *Interagency Working*

In addition to the issues relating to the relationship between GCC and P referred to above, there was no multi-agency risk management plan put in place to safeguard R, despite evidence of a decline in his welfare and concerns being raised, including safeguarding alerts.

There is some evidence that differences in culture, standards and/or even tensions between and within agencies impacted upon the overall management of R's case and possibly hindered effective interagency working. For example, in 2012, in response to concerns raised by the 2gether Trust about R's welfare, GCC staff took the view that "health professionals may be imposing their own views regarding bathing/personal care". It is not clear what evidence this assessment was based upon.

These differences were simply accepted. Further exploration of what lay behind these views could have led to a more collaborative approach across teams and agencies.

The 2gether Trust triggered a multi-agency review in April 2012, but at the July meeting advised they were discharging R due to his lack of engagement. Whilst acknowledging the need to manage resources effectively, it is not clear whether consideration was given to the fact that the 2gether Trust had an established relationship with R and were therefore in a better position than some other agencies to support R to make changes. The development of an engagement strategy might have identified this and indicated how to build on this strength.

Another example is in May 2014, when an independent review was commissioned due to a "difference in the perspectives" within GCC teams. Whilst there are occasions when an independent review can offer a means to help inform complex situations, a multi-agency review could have offered a more collaborative and quicker means to seek a shared view of the concerns and risks and resulted in a more effective response.

GCC did start notifying CQC via a fortnightly summary of their concerns about the care being provided to R by P in June 2014 and the actions they were undertaking but due to internal communication issues at CQC these do not appear to have been appropriately disseminated. However, whilst appropriate access to these fortnightly summary reports may have resulted in the CQC inspector seeking further information to assist in the focus of the next inspection, CQC advise it would not have triggered any further action from CQC

at this point.

6.3.9 *Similarities with other GSAB Adult Case Reviews (ACRs)*

Although the circumstances and detail were very different, the need to ensure adequate oversight of services commissioned and to identify and follow up on warning signs such as discrepancies in financial transactions were areas of learning identified in the 2015 ACR report "Sexual and Financial Abuse at Supported Living Home X". The dilemma presented by individuals who self-neglect was also a feature in the case of Mr OO (2014).

7. Findings

7.1 There are clearly challenges to engaging effectively with R and sustaining that engagement to support his independence and help him maintain his personal safety and wellbeing. Nevertheless, this review has highlighted a number of areas where different decisions and/or actions taken would almost certainly have resulted in a different outcome.

7.2 Specifically the findings are;

- P did not fulfil their contractual obligations and failed to provide the amount and quality of care required to meet R's need. They did not keep GCC properly informed about difficulties faced with engagement and did not gain agreement of commissioners before making changes to the amount of care provided. Furthermore, despite significant concerns about R's declining welfare in the period prior to his hospitalisation, P failed to take effective practical steps to safeguard R's physical wellbeing. There is also evidence to suggest they charged for hours not provided on occasions.
- GCC as the responsible commissioning body did not ensure that the care provided met R's needs. There was no clear care plan in place, and warning signs such as the reduction in care hours provided and discrepancies in charging were missed. In addition, no account appears to have been taken of the cumulative pattern of concerns raised within GCC and from other agencies
- The response to difficulties in engaging with R by the GP practice, 2gether Trust, and P was to withdraw or reduce services, rather than seeking alternative, proactive and creative approaches to gain and maintain trust and motivation. R was regarded as being difficult and therefore would have to live with the consequences of this, rather than this being a warning sign that a different approach was required.
- No formal assessment of R's capacity was undertaken during the review period until he was admitted to hospital, even though such action was agreed on several occasions. This is despite on-going concerns about his capacity to make decisions. Confusion and a lack of confidence

around when and how to conduct MCA assessments, coupled with the complexity of balancing an individual's right to take informed risks with the need to know when to intervene in someone's best interests seem to have contributed to this.

- There was a lack of understanding within GCC as to who was responsible for commissioning care on behalf of R and the attendant responsibilities. This resulted in erroneous decisions. There is evidence this remains an area of confusion for some staff.
- There were unacceptable delays in following up concerns and raising safeguarding alerts.
- Opportunities to address concerns and risks identified through multi-agency working were missed. For example, a more pro-active approach to developing an engagement strategy could have built upon the strengths of relationships already in place and identified effective motivational techniques.
- The response to differences of culture, practice and standards between teams and agencies adversely affected effective interagency working. There were also occasions where concerns about risk were somehow lost in communication between agencies
- CQC did not have a formal system in place to ensure that the appropriate people were always receiving regular updates from the investigating agencies. Information like this can be used by the CQC to assist in focusing their inspections.

8. Good Practice Identified

8.1 It is worth noting that despite the concerns about the management and delivery of R's care leading up to his hospitalisation, there are a number of examples of good practice that have emerged from this review.

8.2 R's Deputy had court-mandated responsibility for R's property and financial affairs. Throughout this review period he consistently raised his concerns with both GCC and P about the care provided to R and his concerns for R's welfare. Whilst arguably beyond his remit, he made considerable efforts to address the decline in R's welfare through the various agencies.

8.3 GCC responded proactively to quality concerns about P notified by CQC by instigating a quality review of all relevant cases.

8.4 The response from the Ambulance Service was prompt, appropriately prioritised and provided R with the required treatment

8.5 Despite R's fear of medical intervention, hospital staff appear to have engaged well with him using a person-centred approach. They also undertook a MCA

assessment at the earliest opportunity and had plans in place to support R with an IMCA if required.

8.6 Since the review period, CQC and GCC report having improved communication systems in place which both agencies say are working well.

8.7 Prior to 2012, 2gether Trust had demonstrated considerable perseverance in working with R.

9. Recommendations

9.1 In addition to actions emerging from individual agency reports, the following are the recommendations emerging from this review;

1. That P ensure they have systems in place to ensure the quality of care they deliver, alert commissioners where difficulties in delivering care are experienced, ensure any changes to care commissioned are agreed in advance, and that they only charge for the service provided.
2. That GCC reviews the way in which it commissions providers and ensures there are effective systems to provide clear care plans, monitor services delivered, hold providers to account, check achievement of required outcomes and respond to quality concerns.
3. That all GSAB partners review their risk policies to ensure;
    - non-engagement and self-neglect are appropriately recognised as a potential risk factor
    - managers and practitioners have access to information and guidance about good practice in relation to effective engagement strategies and balancing individual rights and choice with best interest and safeguarding needs.
4. That all GSAB partners review the level of confidence and understanding amongst practitioners and managers regarding when and how to undertake MCA assessments where there is doubt about capacity
5. That GCC ensures a clear policy is in place regarding its responsibilities in relation to individuals who are responsible for funding their own care but have eligible needs, and that relevant staff are aware of this
6. That GCC and CQC ensures effective communication systems are in place to inform each other of emerging care quality concerns in a timely manner.
7. That GSAB partners and the GSAB review the way inter-team and inter-agency differences of view are managed to ensure the best outcomes for vulnerable adults.

8. That the findings of this report and the associated learning are shared widely amongst managers and practitioners to inform practice standards, system design and staff development.

Addendum to Safeguarding Adult Review

Learning Process Overview Report

(Comments from R)

Section 3 – Summary of Findings

Bullet Point 1: “I think that [provider] failed quite a lot. The support worker didn’t do very much, he just watched television”

Bullet Point 2: “I think that it’s totally wrong what they [GCC] did. They should have taken some stronger actions to stop that. The council is good at some things, like sorting your garbage and recycling, but they should have been better with me”

Bullet Point 3: “People should have spoken to me about it”

Bullet Point 6: “The council has failed on that one - they should have tightened it up a bit more”

Bullet Point 8: “That is bad communication, I think it should be better but I’m not sure how”

Section 4 – Good Practice Identified

“I think [deputy] is pretty good at looking after my finances and making sure I’m ok”

“The ambulance service was excellent”

“The hospital staff were pretty good. They helped with the treatment on my legs”

Section 5 - Recommendations

“I think it was good that I was helped to get more support at home. Instead of someone else making decisions for me, they should talk to me as part of a team. This happened while in hospital”

“I think it is important that everybody should read this report and learn to make sure the same thing doesn’t happen to anybody else.

The sooner it is published the better”

APPENDIX A

ADULT CASE REVIEW LEARNING PROCESS R

TERMS OF REFERENCE

Framework

The Association of Directors of Social Services in their document 'Safeguarding Adults: Advice and Guidance to Directors of Adult Social Services' described the overriding reasons for holding a review as being to learn from past experience, improve future practice and multi-agency working. There is currently no statutory duty to conduct an Adult Case Review, but the Gloucestershire Safeguarding Adults Board, which has been in existence for over five years, has chosen to undertake Adult Case Reviews. Reviews will become statutory when the Care Act 2014 becomes law from 1st April 2015.

Purpose of review

The Board has a Serious Case Review Policy that identifies three purposes to be fulfilled by a Case Review:

- To establish whether there are lessons to be learned from the circumstances of the case about the way in which local professionals and agencies work together to safeguard adults at risk.
- To establish what those lessons are, how they will be acted upon and what is expected to change as a result.
- To improve inter-agency working and better safeguarding of adults at risk including the review of procedures where there may have been failures.

Methodology

This review will be conducted using a learning process which is both collaborative and analytical, combining written agency reports with a Learning Event involving practitioners and managers.. It will allow a window on the system, identifying and promoting good practice as well as where things need

to be done differently to lead to improvements.

The review will be facilitated by and the overview report written, by Ms Christina Snell, Chief Executive of Age UK Gloucestershire, who has no involvement with this case and is the current chair of the Adult Case Review Sub Group and member of the Gloucestershire Safeguarding Adults Board.

Case details and time frame of the ACR

Subject of the review: R

Time period to be covered by the Review

The review will concentrate on the period from June 2009 until R's discharge from hospital in August 2014. There were a number of events during this period where concerns were raised in relation to inadequate care, maintaining of his home and independent skill building support, which make this an appropriate time period.

However, if any agency identifies an issue that they feel is significant that falls outside this time frame, they will address it in their agency report.

Involvement of the family / significant others

The Reviewer and a Board representative will meet with R and his Court Appointed Deputy for Financial Affairs over the period of the review, to inform them of the process to be followed, to ensure their views are incorporated, and to inform them of the review's conclusions and outcomes.

Organisations who will be producing reports for the review

- GP Practice
- Court Appointed Deputy for Financial Affairs - Solicitor
- Provider
- GCC Learning Disability Assessment Team
- South West Ambulance Service
- GCC Learning Disability Enablement Team
- GCC Disability Strategy and Transformation Team
- Safeguarding Adult Team Gloucestershire County Council
- CQC
- Gloucestershire Hospitals NHS Foundation Trust

- 2Gether Trust Community Learning Disabilities Team

The issues that the agency and the overview reports will address are:

General

1. To establish whether there are any lessons to be learnt from the circumstances which led to the admission of R into hospital, following a deterioration in his health, about the way in which local professionals and agencies worked together

2. To review the effectiveness of procedures (both multi-agency and those of individual agencies)

3. Identify how the learning can be used to inform the development of best practice

Specific

1. To establish the facts about events leading up to the admission of R into hospital on 30th July 2014 and form an opinion on whether the circumstances were preventable,

2. To examine how agencies and professionals within those agencies worked together, in order to safeguard R from risk of harm and also to meet his care and well-being needs,

3. To establish whether the fact he funded his own care contributed to the standard of care and support he received, and to identify whether there is learning that should be considered in respect of people who fund their own care in general,

4. To identify whether, as a result, there is a need for changes in single agency or inter- agency policy, procedures or practice in Gloucestershire, in order to improve single agency and inter-agency working and better safeguard adults at risk ,especially those that self-fund their own care.

5. To consider any learning from previous GSAB Adult Case Reviews[1]

[1] Amended from original to include all previous GSAB ACR's

that could be applied to this case.

The report will be anonymised.

Publication

This review is being completed with an expectation that it will be published on the website of the GSAB website. However the ultimate decision about publication will rest with the GSAB, in consultation with the family.

Evaluation

As GSAB is currently considering the different methodologies available for conducting adult case reviews the reviewers will undertake a reflection with all the participating agencies, the Board and, if appropriate, the family at the conclusion of the process to evaluate the method for the purposes of informing the Board's choice of future methodological approaches to ACRs.

APPENDIX B

LIST OF AGENCIES INVOLVED INCLUDING INDIVIDUAL TEAMS

Agency	Abbreviation	Team(s)	Role
2gether NHS Foundation Trust	2gether Trust	Community Disability Living Team	Provision of community based mental health services
Care Quality Commission	CQC		Monitoring, inspecting and regulating care services to ensure they meet quality standards.
Deputy appointed by the Court of Protection	Deputy		Responsible for managing affairs relating to R's property and finances
General Practitioner	GP		Provision of general health care services
Gloucestershire Hospital NHS Foundation Trust			Provision of acute healthcare services

Agency	Abbreviation	Team(s)	Role
Gloucestershire County Council	GCC	Learning Disability Assessment Team	Assess needs and determine eligibility against Care Act 2014 national framework. Also triage safeguarding referrals for adult's known to the LD Team. Lead on safeguarding work if it is deemed further enquiries/investigations are required.
		Learning Disability Enablement Team	Promote, develop and support independence.
		Disability Quality Assessment Team	Complete quality assurance checks of providers and work with them to ensure services meet need and are of good quality.
		Safeguarding Adults Team	Working with others to ensure consistent and effective response with safeguarding adults' concerns and improvement in safeguarding adults work.
'P'	P		Care agency responsible for providing personal care and support throughout the review period
South West Ambulance Service Foundation Trust	Ambulance Service		Emergency response to health crisis

APPENDIX C

OTHER ABBREVIATIONS USED

DoLS	Deprivation of Liberty Safeguards
GCC	Gloucestershire County Council
GP	General Practitioner
GSAB	Gloucestershire Safeguarding Adults Board
IMCA	Independent Mental Capacity Advocate
LD	Learning Disability
MCA	Mental Capacity Act
P	Care Provider (during review period)