Serious Case Review

Executive Summary

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Executive Summary

Serious Case Review in context

1. This Serious Case Review (SCR) was undertaken in line with Northamptonshire’s County Council’s (NCC) Serious Case Review guidance dated July 2009. Safeguarding is a function of the Local Authority and is overseen by a multi-agency Northamptonshire Safeguarding Vulnerable Adults (SOVA) Board. The Review was tasked to consider the level of intervention, care and support provided to William Lawrence (William) principally during the period 1 January 2008 - 5 August 2009.

2. The main points highlighted in this report and the agencies responses and corrective actions are contained within the main recommendations and action plan.

3. William died in Hospital on the 5 August 2009. William had complex needs, health and social care and was also registered blind. He had a diagnosis of Down’s syndrome. He had lived with his parents until his admission to Berrywood Lodge in 1997; a registered residential care service regulated by the Care Quality Commission where he stayed until 1 June 2009.

4. The records from a number of key agencies involved with this Serious Case Review (SCR) indicate William’s health and social care needs started to change noticeably from the beginning of 2008. His increasing frailty can be seen to continue in the multi-agency recordings and in the latter part of 2008 a move for William to a care service with nursing capability was being discussed; but not implemented prior to his admission to Northampton General Hospital NHS Trust (NGH) by Ambulance on the 1st June 2009. His presenting physical condition was of marked concern to William’s Father. He was admitted with sores, dehydration, and infections. He subsequently died in Hospital on the 5th August 2009.

Northamptonshire County Council Contracts Section (NCC)

5. Berrywood Lodge between September 2008 - January 2009 was a concern to NCC. There was non-compliance with the NCC’s care contract, concerns from the Mental Health Service, and repeated changes of Registered Manager; collectively providing evidence that the care home had serious performance and service delivery concerns. No formal notices of non-compliance were issued to Berrywood Lodge between the periods between September 2008 - January 2009.

6. CQC visited unannounced in February 2009. This visit resulted in issuing to the management 10 requirements to make improvements to service delivery. The regulator conducted a further visit in July 2009 and identified serious concerns resulting in 11 further requirements. Three of the requirements related directly to the safety of the people living in the home. The regulator at this point judged that the care home was providing a poor service.

7. Enduring performance concerns were heightened in September 2009 with weekly contract monitoring visits from NCC and then monthly for a period.
8. An unannounced inspection was conducted in November 2009 where the service was found to be improving. The service was judged to be providing adequate outcomes and one requirement for improvement only.

9. Although work was done by the Contract Monitoring Team to try to raise standards at Berrywood Lodge, little progress by the care home was noted over a sustained period and evidence that the home was failing to deliver a reasonable quality of service and therefore potentially placing residents at risk.

10. There is evidence from different sources that Berrywood Lodge was not being well run but it does not appear that this information was brought together at any point to provide an overview of the collective concerns.

**Berrywood Lodge (BWL) – Minster Pathways**

11. The organisation’s own IMR indicates prior to April 2009 the care plans were problematic for William. Support plans did not cover all his needs; they lacked details and were not person centred. There was also evidence that some of the staff showed a lack of attention to detail and knowledge of care planning. Also some cases where cut and pasting had captured other service user details. There was no documentation to support the use of a hoist.

12. The training delivered at this time did not take into account the specific needs of William as his health deteriorated. The company acknowledged in their IMR that it had been difficult for them to establish the training skills and knowledge of Managers working there at the time. They acknowledge this as having led to gaps and inconsistency in the continuity of support and guidance to staff.

13. Other key systems such as handovers were not written, team meetings were not recorded, supervision was being established but no records available to confirm these practices were taking place were acknowledged by Berrywood Lodge.

14. Berrywood Lodge acknowledges that staff were not competent to correctly assess risks, identify controls or carry out evaluations. They also acknowledge the increasing risks associated with William's deteriorating position which could have been reasonably foreseen, were not highlighted and indicate risk assessments did not cover areas such as moving and handling or sufficient details around pressure care. Systems for audit, monitoring and compliance of risk assessments were not evident. Berrywood Lodge make the point that they did access other agencies for support and were dependent on other professionals for support or in some cases effecting decisions pertinent to William.

15. They indicate that they were not registered for nursing care. They acknowledge that there were shortcomings identified by the regulator around compliance and agree these ran into a number of areas.

16. Berrywood Lodge make the point that they consider that William’s reassessment on the 2nd March 2009 identified he had nursing care needs. However it was not until a further 3 months had elapsed before a transfer was agreed and they indicate they consider the delay was due to funding agreements not being reached.
17. They also consider that William’s position should have been escalated by funders with his needs having been identified. They also highlight what they see as failings by the District Nursing Service, pointing to gaps in attendance and poor care support and guidance regarding body mapping and pressure area care.

**Care Management - Northamptonshire County Council (NCC)**

18. In September 2008 NCC Care Management undertook an overview assessment and this noted both physical and mental health deterioration. Also evidenced through 1-1 support for William being described by the care home. This level of support only being sustainable in the short term as the care needs of other service users was at a lower level than normally expected. It is restated that William’s Father wished for his Son to remain at the home.

19. The care home William was placed at by NCC was struggling to meet its contractual and regulatory obligations (September 2008-Autumn 2009) coincided with the time when William’s health was deteriorating and there were concerns about the care homes ability to properly meet his needs.

20. Care management reviews of William did take place at reasonable intervals in 2008/09 but having identified that his needs were not being met at the care home, the assessment that he needed to move to a different service was not followed up. The father’s wish that he should not be moved was a factor but was at a point where William’s deterioration was not fully understood. There was a failure to consider whether this represented a conflict of interest about William’s well-being and whether he should have been assessed in terms of his mental capacity and given access to an independent advocate.

**Continuing Health Care (CHC)**

21. There was a delay in agreeing CHC funding and organising a move.

22. The first contact with CHC is recorded on the 10th October 2008 when there was a meeting at the care home with Mr Lawrence Senior and the home manager. This was followed on the 13th October with a telephone call from the CHC assessor to the Care Manager asking for details of William’s service package. The CHC assessor indicated that funding had been agreed but they still needed to determine the percentage of funding that would be provided.

23. The next entry is on the 23rd April which confirmed that the “PCT had agreed to fund 50% of the cost of William’s new placement at the prospective Nursing care home.

24. These details are at odds with CHC’s own IMR which refers to only two formal CHC funding references. The CHC Chronology describes CHC assessment for eligibility formally in August 2008, finding William not eligible. A further formal application in 2009 whilst William was in hospital which was never completed as William subsequently died.
The combined Chronology indicates quite clearly that a telephone call from the CHC Assessor confirmed that funding had been agreed. A visit to the care home was also made shortly before this phone call.

The care home Provider’s Chronology also makes reference to CHC funding being agreed.

There were significant unexplained delays in taking forward the joint funding arrangement with CHC to the extent that before this was completed William had been admitted to hospital.

Northamptonshire Healthcare NHS Foundation Trust (NHfT)

The Trust's IMR record the following findings of relevance, some of these indicate missed opportunities to further revaluate the health care needs of William;

There was no reference to any Waterlow assessment or body mapping in the notes of the initial internal review having been undertaken by the DNs or shared with the CTPLD or vice versa.

On 02.07.2008 the duty Wheelchair service OT requested that a Waterlow score (pressure ulcer risk assessment/prevention tool) be undertaken as part of William's assessment for a wheelchair. There is no evidence that this was ever undertaken at any of the subsequent wheelchair assessments.

Wheelchair assessments carried out on 20.06.2008, 25.09.2008 record that William had good vision. William was blind from birth.

In the 'Assessment' section a 'Changing Skills Assessment' showing a score of 84/256 was completed in August 2008, to be next assessed in February 2009. There is no record of the review having been undertaken.

Professionals from the CTPLD and District Nursing service are described by the Trust as not working in an integrated way or develop an integrated plan of care for William. This would have improved communication. There is evidence of good and thorough assessments of William’s needs on the part of the CTPLD; these assessments did not lead to an effective care plan.

The letters of 24 January 2009 and 24 April 2009 identify to the GP that William’s Consultant Psychiatrist, considers that a change in residency is needed to cope with William deteriorating cognitive and physical abilities.

There were unresolved areas relating to whether or not DN appointments were kept, and it remains unclear as to what happened to the ‘blue book’ that should contain DN care plans. The reviewers also found that there were gaps in the record keeping of the DNs. Some of the CTPLD records, while detailed, appear to have been entered retrospectively.

The loss and subsequent incompleteness of the patient records indicates a failure of the DN team to assess or manage the risks to William appropriately.

A variety of means to record information relating to William’s care and treatment were used by the different teams involved in his care. The reviewers could find no common, cohesive
communication tool relating to William’s needs for use across all agencies. This clearly interfered with information sharing between professionals and agencies. There was no central electronic recording system in place for all the professionals and differing organisations to use, and those that were in place in the organisations were not being used effectively at this time.

38. Poor use of the hoist in relation to William was identified in a report following a visit by CQC to BWL on 27.03.2009 as reported by William’s Father and friend. Mr Lawrence Senior has stated that the Manager of BWL said subsequently that the hoist could not be used because staff were not trained in its operation. Consequently staff in the home resorted to other means of transferring William. Poor manual handling techniques were also identified by a CTPLD staff member.

39. An assessment by the Speech and language therapist (SALT) for William to address problems with food and fluid intake was made by the care home on the 18.09.2008. A partial assessment by SALT was carried out on 27.04.2009, it was ascertained that he struggled to take fluids, and that he required a ‘thickener’ to help with this. Further assessment was noted to be needed in the future. There was a 7 month delay from referral to initial assessment.

40. Chronological information for May 2009 identifies that the care home had, on two occasions contacted the DNs and specifically requested help for sore testicles, legs and heels.

41. The message book “notes” of the DN team for 01.05.2009 and 15.05.2009 confirm that the BWL contacted William’s GP surgery to inform them that William had ‘sore testicles that need looking at’ and later that ‘William has lots of sores to his leg, heels and testicles’. There are no entries on the ‘5 visit’ sheet that was being used at that time by the DNs to give any indication of any appointments or treatment that was carried out in response to BWL requests.

42. GP records show an “acute” visit by Dr, requested by BWL, on 27.05.2009. The GP records indicate that, in addition to a chest infection, perineal sores were identified and that these were for the DNS to treat. BWL Staff reported to the GP at this contact that they had expected a DN visit that day that did not take place. This is corroborated in the 5 visit sheet where the DN visit of 25.05.2009 for a dressing to William’s heel states the next visit will take place on 27.05.2009, but there is no entry in the records indicating that a visit took place.

43. Care interventions treating sores to William’s left heel are evidenced on the ‘5 visit’ sheet, but no evidence of treatment to sacral or scrotal areas can be found until 01.06.2009 when DN attended BWL in response to their request for DN intervention and William was admitted to hospital.

44. William had Down’s Syndrome and later developed dementia. In combination, these two diagnoses are likely to contribute to a person’s physical deterioration. Dr (GP) in her review of William on 22.01.2009 recorded that he was “for TLC”. An understanding of the implications of care and management when working with people with Learning Disabilities and dementia was needed.
45. There were a range of different agencies and individuals involved in William’s care. The reviewers have found that effective communication, particularly with Mr Lawrence Senior was limited. Inter-agency and inter-professional communication was piecemeal and task focused; there was no coordinated planning of care by professionals of all agencies. The annual review could have been an effective means for this to have happened.

46. Patient recording systems did not support seamless patient care across service boundaries. Where electronic patient records were available they were either not used at all, or only as a means of recording dates of contacts. NHFT is currently working on creating an electronic Single Patient Record system.

47. Standards of record keeping did not always meet required professional standards. The reviewers have found failure to record reported visits, retrospective entries regarding contact visits, and inadequate detail to describe clinical interventions.

48. Delays in decision-making and actions led to William remaining at BWL where his care needs could not be properly met and to delays in receiving assessments and treatment.

Northamptonshire General Hospital NHS Trust (NGH)

49. William’s period in hospital and direct care provided to him following admission on the 1st June 2009 did not generate concerns.

50. The Hospital Trust did not make a sufficiently strong link with William’s presenting poor physical health and whether this should be grounds for concern and referral to safeguarding. NGH have since strengthened these areas.

51. The guidelines on referral to safeguarding and to the Coroner need to include specific reference to neglect.

Safeguarding – Northamptonshire County Council Safeguarding Adults Team

52. The first safeguarding investigation began with the first CQC notification on the 27th March 2009 and ended with the case being re-allocated to a Care Manager on the 5th October 2010, a period of about 18 months.

53. The first point of note is the time it took to allocate the case for investigation- from the end of March to the 15th June- approximately 11 weeks. An unacceptably long time

54. The second issue is that further matters kept being added to the initial concerns- a second CQC notification, the report from the Mental Health service, and additional concerns raised by William's Father and his advocate/friend Mrs A.

55. It should have been clear to someone at a management level that this matter was becoming complicated and needed pulling together into a clear plan for investigation and resolution. This would have provided support to the worker who was leading on the safeguarding investigation and would also have enabled clear information to be given to William's Father and Supporter about the scope and process of the investigation.
56. By July the Worker recorded that they thought the allegations were substantiated and on the 15th July informed Mr Lawrence Senior of the outcome. However this did not close the matter and between September and March 2010 the Chronology shows the Worker as trying to get information from Health about the involvement of the GP and District Nurse relating to the other safeguarding concerns that were logged into the system. By March 2010 the Worker had recorded that they had completed the investigation and waiting for approval from “Senior Management”.

57. There was an issue about accessing Health records concerning the involvement of the GP and District Nursing service with William. There is evidence of both the CC and CM trying to resolve this but the Chronology shows very little about the role of managers in supporting or escalating matters between their other agency colleagues.

58. There had been numerous delays at all stages and although there are some factors that have contributed to this, there was a general failure to monitor and manage the investigation to ensure that it was completed thoroughly and in a timely fashion.

59. There was a lack of urgency in allocating the first safeguarding concern for investigation and once the case was allocated there were serious failings in managing the progress of the investigation.

60. There was a failure by first line managers in the Safeguarding Team to sign off the investigation as having been completed. This almost certainly led to Mr Lawrence Senior making a complaint and the case’s subsequent escalation to the MP and Ombudsman.

61. There was inconsistent and confusing communication with Mr Lawrence Senior about the progress of the investigation and later about the handling of his complaint.

62. The two investigation reports went some way to answering the concerns raised but they lacked clarity of approach. There was no evidence of quality assurance by managers to ensure that the investigations were rigorous and thorough.

63. There was a general failure to get an overview of the different issues and concerns that existed about the care home and William’s care while he was there.

64. Control of the process improved to a degree once Mr Lawrence Senior had registered a complaint and the Corporate Customer Team took over the role of co-ordinating the response to the complainant. This also follows for the complaints to the local MP and Ombudsman. The overall time taken to process and respond to the complainant was 11 months which is not acceptable and there were lessons to learn here about the need for better mechanisms for ensuring that complaints in complex cases are effectively managed and responded to.

65. Communication with Mr Lawrence Senior could have been markedly better and the significant periods of inactivity almost certainly contributed to the escalation of the case to a complaint and subsequent involvement of the MP and Local Ombudsman.
66. It is clear that for many months certainly in excess of 1 year the home was without a Registered Manager. It is a statutory requirement to have this position filled. The sustained period of noncompliance in this area would by most benchmarks to be an attributable factor to ensuring effective leadership and management. Furthermore the Regulator when re-registering the Provider had the opportunity to apply further compliance leverage. Again when the Providers application was submitted no Registered Manager was in place.

67. The level of non-compliance and repeated/sustained non-compliance should be specifically considered as a learning point when the regulator reviews their enforcement tolerances. No formal notices of non-compliance were ever issued. Almost certainly most perceptions would consider the noncompliance position on their second inspection in July 2009 as grounds for “raising the bar”.

**Mental Capacity**

68. Agencies considered in this review have all demonstrated that in 2009 they had not brought Mental Capacity and Deprivation of Liberty Safeguards into policy and practice in a meaningful way. This did not allow for William’s best interests to be considered as would now be the case. The Mental Capacity Act provides a framework to empower and protect people who may lack capacity to make some decisions for themselves.

69. The Mental Capacity Act makes clear who can take decisions in which situations, and how they should go about this. Anyone who works with or cares for an adult who lacks capacity must comply with the MCA when making decisions or acting for that person.

70. This applies whether decisions are life changing events or more everyday matters and is relevant to adults of any age, regardless of when they lost capacity.

71. The underlying philosophy of the MCA is to ensure that those who lack capacity are empowered to make as many decisions for themselves as possible and that any decision made, or action taken, on their behalf is made in their best interests.

72. Recommendations across the agencies under this area are made.

**Concluding remarks**

73. All agencies have engaged with and co-operated with this Serious Case Review and supplied information which in many cases is self-critical and reflective. Recommendations from the agencies and from the Serious Care Review Panel have been assembled and referenced in the main body of the document. These have been also entered into an action plan monitoring tool which will be overseen by the Northamptonshire’s Adult Safeguarding Board.
Consideration of Inter-agency Lessons Learnt and Recommendations

74. All of the individual agencies covered in this report, taken in isolation, suggest that there were deficits in the care provided to William at BWL.

75. Poor communication and sharing of information between different professionals and agencies meant that this information was never brought together and analysed in a way that a complete picture of William’s care and treatment at BWL could be properly assessed.

76. There is no evidence at the time that cross information sharing and care planning was undertaken between the DN team and CTPLD and associated specialist services.

77. Equally across the other sectors involved in William’s care the sharing and care planning was not integrated or easily accessible by other parties involved in William’s care.

78. The further integration of care planning across care agencies is a factor that the SCR Panel wishes to understand and have a base line audit established.

79. There were a number of missed opportunities where individual professional assessments could have triggered a more comprehensive review of William’s needs. This in particular as William had mental capacity considerations. The absence of escalation policies in differing agencies was also not well developed and appears in the recommendation of this report.

80. A variety of means to record information relating to William’s care and treatment was used by the different teams involved in his care. The NHFT report could find no common, cohesive communication tool relating to William’s needs for use across all agencies. This clearly interfered with information sharing between professionals and agencies. There was no central electronic recording system in place for all the professionals and differing organisations to use, and those that were in place in the organisations were not being used effectively at this time. The SCR Panel would want to see where agencies are with these issues and whether there was any progress in key health and social care agencies with these issues.

81. It needs to be recognised by agencies that regard for record keeping and accounting for this by reference to the working day is not always understood and given priority.

82. Risk assessment and risk management are reliant on up to date care plans. The absence of care plans in the CTPLD at the time made it difficult to assess what interventions were being offered and if they were successful in reducing and managing the risks associated with William’s care. The reviewers were told that at the time covered by this investigation, care plans were not used by the CTPLD. (All)

83. Professionals are accountable for ensuring that communication takes place between agencies, in the interests of their patients. A Health Action Plan as recommended in ‘Valuing People’ would have addressed this. Health action plans were not a practice issue as well developed or seen by the regulator as a factor to consider in 2009. It would be essential that Health Care Plans across agencies are implementing these practices including regulated care services. The SCR Panel would want to understand whether there has been any base lining or audit of the cross agency position. (All)
84. Complex cases where there are different sources of concern and a number of agencies involved should be subject to a multi-agency strategy meeting that is minuted and followed up once the investigation is underway. (NCC)

**Mental Capacity**

85. Agencies considered in this review have all demonstrated that in 2009 they had not brought Mental Capacity and Deprivation of Liberty Safeguards into policy and practice in a meaningful way. This allowed for William’s Best interests to not be considered as would now be the case. The Mental Capacity Act provides a framework to empower and protect people who may lack capacity to make some decisions for themselves.

86. The Mental Capacity Act makes clear who can take decisions in which situations, and how they should go about this. Anyone who works with or cares for an adult who lacks capacity must comply with the MCA when making decisions or acting for that person.

87. This applies whether decisions are life changing events or more every day matters and is relevant to adults of any age, regardless of when they lost capacity.

88. The underlying philosophy of the MCA is to ensure that those who lack capacity are empowered to make as many decisions for themselves as possible and that any decision made, or action taken, on their behalf is made in their best interests.

89. Recommendations across the agencies under this area are made.

**Multi-Agency Recommendations**

90. To review and improve multi-agency procedures for multi-agency Safeguarding conferences.
   - In particular, to recommend to the SOVA Board (SOVA) the development of agreed single agency and multi-agency “triggers” to assist and guide staff for when a multi-agency conference should be convened including

91. Improved Information Sharing Across Statutory Agencies
   - To audit the use of existing information sharing protocols across statutory agencies and to identify any gaps in such protocols.
   - To include in this audit whether existing electronic information sharing systems across statutory agencies are being considered and details about where actions are being progressed. This to inform the cross agency strategic picture in order to ensure that the SOVA Board can establish what progress is planned and comment on developments going forward.

92. Improving practitioner awareness of Regulatory limitations in care settings
   - Increasing practitioners’ awareness of regulatory constraints and Provider limitations to care needs and their delivery in care homes without nursing and care homes with nursing competencies as registered with CQC.
Safeguarding agency training and resultant practice - verifiably strengthening

There were a number of missed agency opportunities to make adult safeguarding alerts for William when there was a clear indication that it was appropriate to do.

- SOVA Board needs to review how it obtains and measures practice information about how confident and competent frontline staff and managers across all agencies working with vulnerable adults.
- In particular:
  - Escalation arrangements in their agencies and competencies in this regard including specific reference to capacity and consent linked to the Mental Health Act and DOLS. A questionnaire approach may be an option to consider led by the agencies themselves and reporting this information back to the Safeguarding Board for strategic oversight and reporting.

With this information to hand, the SOVA Board will be able to review the adequacy of existing learning and development activities (which are already evaluated for how good a learning experience they provide) and ensure that confidence with using adult protection procedures is matched by competency in doing so. In summary:

- To consider the results of the most recent Adult Protection Training Audit
- To undertake an anonymous and representative sample survey of operational staff and managers across all APC member agencies measuring people’s knowledge of existing adult protection procedures, confidence in using these procedures and feedback in doing so.
- For each agency member of the SOVA Board to continue to bring a report to the SOVA Board detailing how it has embedded adult protection policies and practices – and to provide evidence of the effectiveness of their adult safeguarding work.
- To convene an annual joint meeting of the Local Safeguarding Children’s Board (LSCB) and the SOVA Board (SOVA) in order to share best practice, compare systems and approaches, identify issues of common concern and interest and agree joint areas of development work.
Main Recommendations and Conclusions

Northamptonshire Health Foundation Trust (NHFT)

Recommendations

- An individual key worker in the CTPLD should take responsibility for the care coordination and the development of integrated care plans when multiple disciplines are involved in the care of patients when they make internal and external referrals to other services.

- Nursing competencies within the Northampton District Nursing team should be reviewed and lessons shared with the wider District Nursing Teams.

- CTPLD and DN Team Leaders must take steps to ensure that the key workers communicate with carers appropriately about their relatives' condition and prognosis.

- The teams involved in the care of William should receive refresher safeguarding training, using this case as a case study.

- When complaints are received where there is an inference of neglect, the Safeguarding process should be triggered.

SCR Panel Additional Recommendations

- Nursing training competencies should be reviewed to also be assured they understand the regulatory differences between care homes without nursing and those with those competencies and the implications of this difference for their practice.

- Where in DN case allocation there are/is a client with mental capacity issues then particular attention should be given to whether care is suitable and sufficient and where they have concerns in this respect there is a procedure for escalation before it becomes a safeguarding concern.

- There is a review of DN oversight not just in performance but regular formal supervision is ensured as a key organisational practice. This is audited and part of the reporting through Governance structures to Senior Management.

- In end of life care circumstances in particular where a client is in a residential care environment and has limited or mental capacity issues then there should be a multi-disciplinary meeting to ensure that all appropriate care arrangements have been considered fully.

NHS Milton Keynes/NHS Northamptonshire

Key Recommendations

For Northamptonshire Healthcare NHS Foundation Trust:

- The Trust's own 5 recommendations arising out of its own IMR are repeated.
For Northampton General Hospital NHS Trust:

- The Hospital Trust’s own 4 recommendations are repeated.

For Continuing Healthcare:

- Two of the teams own recommendations are repeated.
- A third recommendation concerns clarity regarding who is the lead agency and the report goes on to stress this should include liaising with the care providers and having oversight of safeguarding and quality issues for the client/patient.

For the General Practitioner Services

- The GP’s own IMR report recommendation is repeated.

Additional Recommendations from the Independent Clinical Reviewer

Some of the recommendations were observations and have been redacted to sharpen their focus where that is possible. This is indicated after the recommendation for clarity.

- The regular weighing of patients where nutritional status is a concern should be part of care planning and records kept. This recommendation was focused on NHFT and NGH Trusts.
- When any patient is admitted with a learning disability as co-morbidity, the Trust’s learning disability nurse should be informed straightaway, (NGH).
- Record-keeping in the district nursing service in particular was concerning. There were also gaps in other records. Staff need to understand that this is a core requirement of their employment and that sanctions will be used if members of staff continue not to ensure they keep accurate, contemporary and clear records of visits and decisions made on all patients. Redacted.
- Electronic data records need to be given priority in respect to the system being available to all practitioners. This should assist in the sharing of records between the givers of care. Redacted.
- The Department of Health's complaints procedures were updated and came into force on 1 April 2009 awareness training needs to be in place to ensure complaints staff are up to date on current guidance.
- The general practice staff should have a system in place to review prescriptions that are not collected and make a clinical judgement about actions required taking account of the particular vulnerabilities and health needs of the patient.
- When problems surfaced regarding the care of William in the community setting and in the residential care home, including the delays in responding to referrals, delays in responding to prescriptions, and missing of appointments and revisits, staff should have refresher training in the critical clinical areas regarding their responsibility to refer problems to senior staff for action or support. Redacted.
- The performance management of staff who are engaged in clinical practice in the community setting should be reviewed. Redacted.
The lessons learnt from this particular review should be used to refresh and trained staff in improving communication and the importance of record-keeping.

Continuing Health Care (CHC)

SCR Panel Further Recommendations

- Where the CHC Team request information that concerns a vulnerable adult such as William and this information is not forthcoming then every effort should be made to either follow this up or escalate the position to management or if information is putting the client at risk of compromise in their health and well being position report as a safeguarding concern.

- Efforts should always be made where there are mental capacity issues to ensure the assessor is aware of any best interest guidance for the client.

- Where there are mental capacity issues, unless there are specific exclusions subject to the family lead members should always be involved and consulted with.

- For the key commissioning agencies involved there needs to be an escalation policy preferably jointly agreed in order that inertia for whatever reason in decisions reaching action can be escalated by concerned professionals involved.

- The Adult Safeguarding Board considers the irregularities in the accounts of the Continuing Health Care Team report and Northamptonshire County Council’s report and the matter is escalated for review in an appropriate senior governance forum to be recommended by the Board.

Northamptonshire County Council (NCC)

Contract Monitoring

- Where a contracted home persistently fails to meet its obligations there should be a clear route that the council follows in order to enforce compliance (an escalation policy). This should specify requirements, timescales and consequences of failure to comply and should be part of the legal contract signed by the council and the provider.

- There needs to be clear communication routes for sharing information between different agencies and different arms of NCC. There should also be a forum for discussing provider services which appear to be failing so that their viability as contracted services can be examined with inputs from all relevant parties. This should be linked procedurally to the safeguarding policies and procedures in NCC.

- The position of informing self-funders or their advocates needs to be also considered and appropriate means of ensuring either the individual or their representatives are aware of the Council’s concerns and interventions; respecting the balance that needs to be struck between the Councils safeguarding role and duty of care with actions prejudicing the livelihood and reputational interests of a Care Provider.
Care Management

- Where a review identifies the possible need to move an individual who does not have mental capacity and there is an emerging conflict with the person’s family then advice should always be sought from a senior manager and consideration given to whether there may be a conflict of interest between the needs of the individual and their relative(s). This should include consideration of mental capacity and whether the individual requires a separate independent advocate. The outcome of these discussions should be clearly recorded on the case file.

Safeguarding

- There needs to be significant improvement in the process for tracking the progress of investigations carried out by the Safeguarding Adults Team. This should include clear timescales for each stage of the process and a system for “flagging” cases that fall outside of the timeframe.

- Apart from straightforward low level concerns there should always be an investigation plan that is drawn up by the worker and agreed by the supervisor/manager. This should include arrangements for keeping referrers and interested parties informed of progress throughout.

- Managers should ensure that all active investigations are discussed in supervision and that where obstacles occur these are escalated if they cannot be resolved by the worker or manager. The supervisor/manager should ensure that all reports are quality assured and signed off immediately after completion.

- Complex cases where there are different sources of concern and a number of agencies involved should be subject to a multi-agency strategy meeting that is minuted and followed up once the investigation is underway.

- The SOVA procedures need to be checked to ensure that they refer to any party being able to request this multi-agency meeting.

Mental Capacity

- Where there is evidence that an individual may lack the capacity to give a view about an important decision, this should be assessed and consideration given as to whether there is a need for independent advocacy.

Internal NCC arrangements for handling complaints and investigations

- Managers within the different arms of NCC should jointly consider whether there is clarity about roles and cross-over when concerns are raised about individuals or standards in residential care. This could be done through a short one-off piece of work. If there is a need for clarity that would help to ensure that there is “joined-up” working then this should be provided either through some form of guidance or a joint seminar for staff. This should be
completed within 3 Months of the completion of this report through its approval stages at the Safeguarding report.

Actions Taken to date by NCC

- In the spring of 2011 another IMR relating to a man (MC) identified a number of issues that are also relevant to this IMR. As a result a number of actions were taken by NCC and these are listed below.

- The Northamptonshire Inter-Agency Safeguarding Procedures have been revised (issued November 2010) and now provide a clearer procedural framework for managing safeguarding cases.

- Additionally in June 2010 threshold criteria were introduced and a screening process using these criteria included in the procedures. This allows cases to be screened and weighted for complexity. Within the Safeguarding Team the person with the case lead role is identified for each case and Principal Care Managers prioritise and track cases.

- A new template for strategy meetings has been developed and implemented which specifically covers what needs to be considered and agreed at Strategy Meetings.

- For cases that are handled outside of the Safeguarding Adults Team, either by other agencies or other NCC teams, there is a tracking process that throws up warnings after 21 and 28 days if cases are not completed. These warnings continue until the cases have been signed off. This system does not currently extend to cases where the Safeguarding Adult Team leads although they are picked up through case discussions in supervision. **A recommendation to include tracking of Safeguarding Adults Team cases is therefore made in accordance with the above.**

- The latest NCC Safeguarding Vulnerable Adults’ inter-agency procedures include a section on resolution of professional differences (15.1) and the process by which staff are encouraged to take action if they feel that they are being “blocked” by managers or others is included in the supervision procedure. The same message has been given by management to staff informally but this may not be sufficient and a recommendation about putting this clearly in writing to staff forms part of the recommendations from this report.

- The SOVA Board now has a standing SCR sub-group chaired by the Board’s Deputy Chair. This provides a regular forum for consideration of possible SCR cases using the existing procedure on SCRs.

Other Actions Taken by NCC to improve internal and inter-agency working

- In July 2011 Health and Social Care colleagues in Northamptonshire implemented the DoH guidance on ‘Clinical governance arrangements in Health for Serious Incidents, Complaints and Safeguarding Notifications’. This guidance seeks to underpin the existing threshold criteria introduced in June 2010 with a focus on proportionality, transparency and partnership. This framework provides clear guidelines for a multi-agency approach to complex cases avoiding duplication of process whilst seeking to aid good communication,
terms of reference and timescales. The oversight and governance of such cases are managed by NHS Northamptonshire and the SOVA Board SCR sub-group.

- In July 2010 a joint escalation policy was written and agreed by all key agencies. The guidance creates a multi-agency framework where the contract monitoring process identifies concerns about the management and operation of a care home and therefore its suitability to care for service users. This involves a process that brings together information from all agencies that have placements in that home and CQC. This process will then ensure that it is safe for residents to remain in the home and that steps are taken to rectify the areas of concern.

- A scheduled monthly Information Sharing meeting hosted by NHS Northamptonshire has been in existence since 2011. This is a forum for all operational staff involved with domiciliary and home care providers to share information, concerns and monitor themes.

- NHSN and NCC hold joint meetings with families and residents when there are concerns about a care home. CHQM Team write to all GP's seeking their views of the service provision prior to undertaking a monitoring assessment.

- A Mental Capacity Act (MCA) training module has been in place for all staff since 2009. A new e-learning package was commissioned in 2012 which is available for all, including Private, Voluntary and Independent (PVI) sector.

- MCA practice guidance and toolkit is in place to put support staff with assessment and decision making. This also includes guidance on capacity and consent. A DoH audit was undertaken in 2011 and the findings from this will focus on further training for staff which will look particularly at Best Interests Assessments, a “refresh” of the existing assessment toolkit and how to record decisions accurately. Planning is underway to repeat the audit in 2012 with all key agencies.

- The client database and the supporting assessment and review documents were amended in 2011 to ensure that capacity and consent is a consideration in all assessment activity.

- In September 2010 Protection plans for all individuals subject to a safeguarding investigation became mandatory. In cases related to service provision such as care homes there is a further requirement to assess level of risk to other customers/residents who are in receipt of the service but not subject to an investigation.

- Since 2010 all complex cases (level 3 and above) are routinely subject of a case conference. Case conferences are used during and at the end of the investigation to discuss progress, feedback the conclusions of the investigation and report the outcomes to all those who have been involved.

**Serious Case Review Panel Additional Recommendation**

- Contract monitoring staff need to be clear that when they hear from senior staff in care homes as is the case in this review, serious concerns regarding whistle blowing, that immediate actions linked to safeguarding are triggered.
Care Quality Commission (CQC)

Recommendations for Action

- CQC have not identified any specific actions for improvement.

SCR Panel Observations

- It is clear that for many months if not years the home was without a registered Manager. Firstly it is a statutory requirement to have this position filled. The sustained period of noncompliance in this area would by most benchmarks to be an attributable factor to ensuring effective leadership and management. This was not acted upon adequately. Furthermore the Regulator when re registering the Provider had the Opportunity to apply greater leverage. Again when the application was submitted no Registered Manager was in place.

- The regulator has also indicated that they do not hold records of the safeguarding notifications and that their current system requires information to be redacted once a safeguarding referral has been made and satisfactory evidence of action taken received from either the local authority or the provider. This is taken to mean that sources of information are edited into one entity and therefore established in a format for historical generic referencing rather than specifically carrying detail regarding individuals.

- The regulator also indicated in their evidence that during their compliance review in January 2011. Berrywood Lodge had continued to restrict the number of people living at the service to 15 residents.

SCR Panel Recommendations

- It is recommended that the Regulator considers whether its system of holding safeguarding records and redaction procedure requires revision as the Regulator struggled for detail in discussing these issues with the SCR Panel.

- It is recommended that where there are sustained periods where a care home does not have a registered manager that the regulator considers enforcement action at an earlier stage than was apparent in this case.

- The level of non-compliance and repeated/sustained non-compliance should be specifically considered as a learning point when the regulator reviews their enforcement tolerances. No formal notices of non-compliance were issued between the periods between September 2008 - January 2009. Almost certainly most perceptions of the position would consider the non compliance position on their second inspection in July 2009 as grounds for “raising the bar”.

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East Midlands Ambulance Service (EMAS)

- Lessons Learnt were identified and implemented by the organisation.
- No further recommendations were made from the SCR Panel.

Berrywood Lodge (Minster Care)

Recommendations

- Pathways Care Group to ensure that comprehensive systems are implemented. This is, key working, training, induction and interagency communication and that these are monitored and maintained.
- Pathways Care Group need to ensure that their policies and procedures and general documentation is reviewed to ensure fit with best practice.
- Pathways Care Group should ensure that quality monitoring arrangements are prioritised for services known to have compliance or quality concerns.
- Pathways Care Group should ensure that any future service acquisitions are subject to rigorous quality assessment and close monitoring.
- As part of any future acquisition concerns with quality are detected, consideration should be given to what measures will be put in place to ensure concerning practices are not continuing.
- Pathways Care Group should review their safeguarding training and processes to ensure that any allegations concerning lack of financial support from families is formally raised and addressed.
- Pathways Care Group should identify and record senior management contact details for partner agencies. Make this information available to staff so that escalating concerns about practice or delays in the provision of services can be more appropriately escalated.

Key Additional SCR Recommendations

- It is acknowledged that the Pathways Care Group has learnt lessons and identified these in their IMR report together with specific examples of where changes have been made to improve procedures, practices and service delivery. Further recommendations are made as follows:
- Pathway Care Group should introduce an audit of the clients it has in its care settings to ensure that their dependency and care needs are not in breach of their registered conditions.
- The regulation 10 Outcome 16 requirement to conduct monthly monitoring and quality checks on its registered services incorporates within its format specific reference to the
dependency of clients and those whose condition is of concern highlighted for specific discussion.

- Where in the future service users are being accommodated in the care home and it is clear that a review of their care has not been undertaken regularly by the placing authority as agreed at placement inception; or the client’s needs deteriorate significantly, either mentally or physically they are formally referred to the placing authority for review. This referral needs to be formally communicated.

- Where a review connected with the previous bullet point above is made and a response from the placing authority is not readily forthcoming then this should be formally escalated to the authority and if need be reported to the Regulator as an incident affecting the health and welfare of the client.

**Northampton General Hospital**

**Recommendations**

- **Accident and Emergency Care pathway:** - developed to identify people with a learning disability at the earliest opportunity and to enable reasonable adjustments to be made.

- **Communication Passports:** - development of communication sheet/passports, providing essential information about the patient has been developed and implemented. This information will ensure staff are aware of the patient needs. Care and treatment plans can be formulated using the information provided.

- **Carers Policy:** - Development of Carers policy to support both formal and informal carers.

- **Patient Experience:** - To ensure that patients with learning disabilities and/or their carers are informed and participate in patient satisfaction survey. Development of resource/tools, with reasonable adjustments so that patient’s experiences within NGH are recorded.

**Key SCR Recommendation**

- The guidelines on referral to Safeguarding and to the Coroner need to include more specific reference to neglect.

**General Practitioner IMR**

- None are identified in the GP’s own IMR.
Multi-Agency Recommendations

To review and improve Inter-agency Procedures for inter-agency Safeguarding conferences

- In particular, to recommend to the SOVA Board (SOVA) the development of agreed single agency and Inter-agency “triggers” to assist and guide staff for when inter-agency conference should be convened including:

Improved Information Sharing Across Statutory Agencies

- To audit the use of existing information sharing protocols across statutory agencies and to identify any gaps in such protocols.

- To include in this audit whether existing electronic information sharing systems across statutory agencies are being considered and details about where actions are being progressed. This to inform the cross agency strategic picture in order to ensure that the SOVA Board can establish what progress is planned and comment on developments going forward.

- For agencies to consider the extent that they use activities such as supervision or one to one sessions in their agencies formally and the degree to which this covers safeguarding areas and concerns.

Improving practitioner awareness of Regulatory limitations in care settings

- Increasing practitioners’ awareness of regulatory constraints and Provider limitations to care needs and their delivery in care homes without nursing and care homes with nursing competencies as registered with CQC.

Safeguarding agency training and resultant practice - verifiably strengthening

There were a number of missed agency opportunities to make adult safeguarding alerts for William when there was a clear indication that it was appropriate to do.

- SOVA Board needs to review how it obtains and measures practice information about how confident and competent frontline staff and managers across all agencies working with vulnerable adults. In particular;
  
  o Escalation arrangements in their agencies and competencies in this regard including specific reference to capacity and consent linked to the Mental Health Act and DOLS. A questionnaire approach may be an option to consider led by the agencies themselves and reporting this information back to the Safeguarding Board for strategic oversight and reporting.
With this information to hand, the SOVA Board will be able to review the adequacy of existing learning and development activities (which are already evaluated for how good a learning experience they provide) and ensure that confidence with using adult protection procedures is matched by competency in doing so. In summary:

- To consider the results of the most recent Adult Protection Training Audit
- To undertake an anonymous and representative sample survey of operational staff and managers across all APC member agencies measuring people’s knowledge of existing adult protection procedures, confidence in using these procedures and feedback in doing so.
- For each agency member of the SOVA Board to continue to bring a report to the SOVA Board detailing how it has embedded adult protection policies and practices – and to provide evidence of the effectiveness of their adult safeguarding work.
- To convene an annual joint meeting of the Local Safeguarding Children’s Board (LSCB) and the SOVA Board (SOVA) in order to share best practice, compare systems and approaches, identify issues of common concern and interest and agree joint areas of development work.
References

• “No Secrets” – Guidance on developing and implementing multi agency policies and procedures to protect vulnerable adults from abuse – Department of Health 2000.

• “Safeguarding Adults” – A National Framework of standards for good practice and outcomes in adult protection work – Association of Directors of Social Services 2005.


• The Mental Capacity Act 2005 and code of practice.

• Association of Directors of Adult Social Services (2006), Vulnerable Adult Serious Case Review Guidance: Developing a Local Protocol


• Department of Health (2009), Report on the Consultation: The Review of No Secrets Guidance

• Mandelstam M (2009), Safeguarding Vulnerable Adults and the Law, Jessica Kingsley Publishers

Glossary

NCC  Northamptonshire County Council
BWL  Berrywood Lodge (Minster Pathways)
CHC  Continuing Health Care
NHT  Northamptonshire Healthcare NHS Foundation Trust
CQC  Care Quality Commission
SCR  Serious Case Review
EMAS  East Midlands Ambulance Service NHS Trust
IMR  Independent Management Review
SOVA  Northamptonshire Safeguarding Vulnerable Adults Board
NGH  Northampton General Hospital NHS Trust
NHSMKN NHS Milton Keynes and Northamptonshire (Primary Care Trust)
PCT  Primary Care Trust (NHS Milton Keynes and Northamptonshire)
CTPLD  Community Team for People with Learning Disabilities
DN  District Nurse
OT  Occupational Therapy
CC  Care Co-ordinator
CM  Care Manager
MP  Member of Parliament
MCA  Mental Capacity Act 2007
DoLS  Deprivation of Liberty Safeguards
LSCBN  Local Safeguarding Children’s Board Northamptonshire
DoH  Department of Health
QMT  Quality Monitoring Team
PVI  Private Voluntary and Independent sector
APC  Adult Protection Committee
Main Body of the report

Brief Introduction

1.1 This Serious Case review is undertaken in line with Northamptonshire’s County Council’s (NCC) Serious Case Review guidance dated July 2009. Safeguarding is a function of the Local Authority and is overseen by a multi-agency Safeguarding of Vulnerable Adults Board. The Board exists to ensure all agencies and organizations in the Northamptonshire area work together effectively to ensure Adults who suffer or are at risk of suffering abuse or neglect are protected and enabled to live without abuse and neglect occurring.

1.2 The context for this Serious Case Review is referenced in the SCR referral form as meeting the criteria for a SCR as outlined in NCC SCR guidance 2009 Para 4.8; “When a vulnerable adult dies and abuse or neglect is known or suspected to be a factor in their death”.

1.3 William Lawrence (William) died in Hospital on the 5th August 2009. William had complex needs both health and social care and was also registered blind. He had a diagnosis of Down’s syndrome. He had lived with his parents up until his admission to Berrywood Lodge in 1997. Berrywood Lodge was a registered residential care service regulated by the Care Quality Commission where he stayed until 1st June 2009.

1.4 William was transferred into Northampton General Hospital (NGH) on the 2nd June 2009 with a chest infection and general ill health, including sores to the legs and scrotum area.

1.5 William died in NGH on the 5th August 2009. No post mortem was carried out.

Safeguarding adults – policy background

1.6 Unlike safeguarding children, where there are responsibilities in statute, arrangements for adults fall under the Department of Health policy framework of ‘No Secrets’ guidance (2000), which gives councils the responsibility for establishing and coordinating local multi-agency procedures for responding to allegations of abuse. It also introduced the principle that social services departments and their partners should set up adult protection committees (now sometimes referred to as safeguarding
adult’s partnership boards).

1.7 In 2005, the Association of Directors of Social Services published a set of standards in Safeguarding Adults – A National Framework of Standards for good practice and outcomes in adult protection work. These are a non-mandatory set of good practice standards

1.8 ‘Adult protection’ focuses on responding to abuse after it happens. ‘Safeguarding adults’ involves the systems, processes and practices to enable people to live a life that is free from abuse and neglect through:

1 Awareness of issues about the abuse of adults – including, for example, easily accessible information for the public about what is abuse and where/how to get help.

2 Ensuring priority is given to keeping people safe from abuse – including, for example, leadership within organisations and a clear commitment to stamp out abuse wherever it happens.

3 Helping to prevent people from experiencing abuse in the first place – including actions that can be taken to reduce the potential for abuse.

4 Recognising and acting appropriately when there are allegations of abuse – including prompt referrals to councils under the multi-agency procedures.

5 Supporting the person who has experienced abuse – including supporting them through the process and involving them where and as appropriate in the development of a protection plan.

1.9 In October 2008, the Department of Health launched a public consultation on its review of No Secrets. In January 2010, the Government announced its response to the consultation which included:

1 Its vision of safeguarding adults as encompassing protection, justice and empowerment

2 National leadership through an Inter-Departmental Ministerial Group (IDMG) on Safeguarding Vulnerable Adults.

3 New legislation to put local safeguarding adults boards on a statutory footing.

4 A programme of work including the development of new multi-agency guidance.

**Purpose of a Serious Case Review (SCR)**

1.10 The Author reminds the reader that NCC indicates in their SCR guidance that the purpose of a SCR is not to reinvestigate or to apportion blame, it is:
1 To establish whether there are lessons to be learnt from the circumstances of the case about the way in which local professionals and agencies work together to safeguard vulnerable adults

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

3 To inform and improve social interagency practice

4 To improve practice by acting on learning

5 To prepare or commission an overview report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action.

1.11 SCRs provide a positive opportunity for agencies and individuals to learn and to improve policy and practice on behalf of Service Users. These are an essential part of service reflection and development and the lessons learnt can lead to important changes that will reduce the likelihood of similar concerns arising again and interagency working strengthened and informed going forward.

**Scope of the Serious Case Review**

The Review will consider the level of intervention, care and support provided to William Lawrence (William) during the period 1 January 2008 – 5 August 2009.

The Review will specifically address what happened and whether the organisations involved responded to the respective concerns raised, and in particular the following:

1 To determine the effectiveness of key organisations to protect vulnerable adults during this period. Was consideration given to issues relating to Mental Capacity and Best Interest decision making.

2 To seek to understand if these events could have been avoided and what lessons have been learnt since.

3 To consider the overall scrutiny and monitoring arrangements of the care home during this time in order to determine a) whether regulations, policies and procedures were followed and b) whether staff acted to reasonable standards of professional practice.

4 To consider the respective organisations’ involvement with William’s family.

5 To consider the overall effectiveness of inter-agency and intra-agency working at that time. Were agencies working within the framework of safeguarding procedures and guidelines.
The organisations/Individuals involved

4 The Family of the deceased

5 NHS Milton Keynes and Northamptonshire (NHSMKN) – formerly known as NHS Northamptonshire

6 Northamptonshire Health Foundation Trust (NHFT)

7 Care Quality Commission (CQC)

8 East Midlands Ambulance Service NHS Trust (EMAS)

9 Northamptonshire County Council (NCC)

10 Provider Minster Pathways – Berrywood Lodge (BWL)

11 Northampton General Hospital NHS Trust (NGH)

1.12 All of the above parties were asked to outline their Management reviews and respond by way of a structure as follows:

Analysis of involvement paying particular reference to the following guide headings and these are summarised as follows;

1 Were practitioners sensitive to the needs of the individual concerned, knowledgeable about potential indicators of abuse or neglect and clear about what actions they should take if they had concerns?

2 Did the agency have effective policies and procedures in place for safeguarding vulnerable adults?

3 What assessments took place of the individual concerned and what decisions did the assessments lead to? Were the assessments and subsequent decisions reached in an informed and professional manner?

4 Were actions taken and services provided in accord with the assessed needs of the individual and the decisions reached?

5 Where plans had previously been put in place to protect the individual concerned, were these plans executed appropriately?

6 Had the views of the individual concerned and (where appropriate) their Carers, been ascertained and taken into account?

The report Author

1.13 The terms of reference also established that the Author should have specific expertise. This has been achieved. The Author having occupied
positions as Director of Local Authority Adult, Children and Families and Housing Services, PCT Operational Director (Integration), Chief Inspector in Regulation pre CSCI, NSCI AND CQC arrangements.

Connection with other formal or statutory processes

1.15 This SCR is also linked to a letter of enquiry from The Minister for Social Care on the 19th March 2012 to both the Director of Social Services and Chief Executive of NHS Milton Keynes/NHS Northamptonshire as a result of Mr Lawrence Senior raising of his concerns with the Minister.

1.16 Associated with 1.15 above, an Independent clinical review into the care of William was commissioned by NHS Milton Keynes/NHS Northamptonshire and is drawn into this report.

1.17 The involvement of the Local Ombudsman details of which are contained in a letter dated the 8th February 2012.

1.18 Formal complaint to Northamptonshire Local Authority from Mr Lawrence Senior in March 2011.

The structure of this report

1.19 Local Authorities in England have generally established Safeguarding arrangements in their areas and most have clear safeguarding policies, procedures and an overarching Safeguarding Vulnerable Adults Board. This is the case for Northamptonshire. The manner in which serious case reviews are conducted, organised and communicated varies as do reports commissioned for these purposes.

1.20 The tendency over the last few years has seen these reports growing in detail and sometimes arguably including detail and complexity of style that does not allow the key issues to surface readily. The report is designed to pull the lessons learnt for all the agencies involved into a composite document for all interested parties to readily understand the key organisational learning points and corrective actions going forward in order to hold parties accountable for making improvements where these have been acknowledged and agreed.
1.21 The Family were invited to meet with the Independent Author and this was occasioned on the 16th August 2012. This meeting is referred to as the first separate part of this document review. The individual agencies are then covered.

1.22 The methodology is therefore as follows:

1. Background to the SCR

2. Consideration of single agency/individual reports, highlighting lessons learnt and recommendations

2. Consideration of interagency lessons learnt and recommendations

3. Key lessons learnt

4. Main recommendations and conclusions.

An integrated agency Chronology has also been drawn together and this is included as Appendix A to this report.

Background

1.23 Following a meeting of the Northamptonshire Serious Case Review sub group held on the 26th April 2012 a recommendation to conduct a Serious Case Review (SCR) on the late William Lawrence (deceased) - Pseudonym was agreed. The recommendations from that meeting were referred to the Safeguarding of Vulnerable Adult Board (SOVA) on the 24th May 2012, and the Board confirmed the sub-groups recommendation to commission a serious case review.

1.24 William Lawrence died shortly before his 52nd birthday on 5th August 2009 in Northampton General Hospital. William had a diagnosis of Down’s syndrome, an appreciable learning disability and registered blind. Prior to his hospital admission he was diagnosed with Early Onset Dementia. This latter diagnosis was never made known to the family and is covered in this report.

1.25 William was cared for by his Mother and Father up until 1997 when he moved into residential care at Berrywood Lodge. This was further to an assessment by the Local Authority into his needs.

1.26 The records from a number of key contact agencies with William indicate that his health and social care needs started to change and professionals from a number of agencies started to visit him at Berrywood Lodge, most noticeably from the beginning of 2008. His increasing frailty can be seen to continue in the multi-agency recordings and in the latter part of 2008 a move for William to a care service with nursing capability was being discussed.
A transfer to an alternative nursing care service was agreed on the 8th May 2009. However this was still to be actioned by the time William was admitted to hospital.

His admission to NGH via ambulance on the 1st June 2009 followed referral from the GP service following concerns raised by a visiting District Nurse on the 1st June 2009. Recent visits from his GP on the 27th May 2012, where he received treatment for sore looking skin on his scrotum and perineum and a possible emerging chest infection.

Following admission he underwent a surgical procedure to the sore areas referred to in [redacted] letter of the 1st August 2011. After an initial period of improvement, William’s health deteriorated and he subsequently died on the 5th August 2009.

Following William’s death safeguarding referrals continued to be investigated, these concerning William’s care. One received in March 2009. The second on 20th August 2009 expressing concern about William’s care and condition. Both Safeguarding investigations became joined for completeness however the outcome of both was not reached until March 2010.

Formal concerns for a number of months and eventually a complaint about the outcome of the Safeguarding investigation was raised by William’s Father on the 28th March 2011.

The Family : Their present position
Synopsis of the meeting on the 16 August 2012

A meeting between this report’s Author, William’s Father, and occurred on the 16th August 2012. This so that the Author could hear directly from Mr Lawrence Senior his account and enduring concerns for the report.

It was reiterated William Lawrence was born in 1957 with a medical diagnosis of Down’s syndrome, associated significant learning disabilities and registered blind. He lived with his Father and Mother and Brother at home until he was 36 years old. During these years he received some periods of respite care at Princess Marina Hospital. He also came into contact with the Behavioural assessment unit at Perveril Road and Nene House during the 1960’s.

As his care needs increased, William was transferred to a residential care service Berrywood Lodge in 1997 where he lived for the next 12 years. He received regular visits from his Family. In discussion with William’s Father he was satisfied with the care his son received until the care home’s sale to Minster Pathways the current Owners.
1.35 William’s Mother sadly and unexpectedly died in 2005 following a routine operation however Williams Father made regular, at least weekly visits to the care home shortly up until his own operation in May 2009 where his visiting reduced whilst convalescing.

1.36 William through his life, at home and whilst in Berrywood Lodge had been in contact from a number of health professionals and Local Authority. These are commented upon in detail in this report.

1.37 Mr Lawrence Senior described his dissatisfaction with what he viewed as progressive deteriorating standards of care for his son at Berrywood Lodge following the transfer of the care home to new Owners. There is evidence of this in particular in the section concerning the Regulator’s own management review (IMR) included later in this report and information from Northamptonshire County Council visiting the home prior to Williams admission to hospital and the outcome of Northamptonshire’s safeguarding investigations which started prior to Williams death.

1.38 Mr Lawrence Senior described key areas of concern and matters of importance to him and these are summarised below and covered later by reference to the Agencies IM reports.

1.39 **GP Services** – Concern that the GP having prescribed medication shortly prior to his son’s admission to hospital did not receive these. Were the prescriptions at the surgery without reminder to Berrywood Lodge staff, this causing delay?

1.40 **District Nursing Services** – Records of nursing interventions going missing. Also the position of being told, having written to the Trust by the Governance Manager initially, that the records were in cold storage and then subsequently had been despatched and had been lost. It is acknowledged that a separate investigation into this has been actioned but it took from September 2009 until August 2011 to inform Mr Lawrence Senior formally that they had been lost.

1.41 **Speech and language service** – delays following referral on the 18th September 2008 to assessment/interventions of some 7 months.

1.42 **The Northampton General Hospital** – Mr Lawrence Senior had been shocked at the condition of his son on reaching the Hospital on the night of the admission. He remembers staff remarking on his poor condition, and raising their concerns using words such as bed sores, gangrene and malnourishment. Mr Lawrence Senior agrees that William did start to recover and made progress, only to relapse and decline over a number of weeks.

1.43 Mr Lawrence Senior was not wishing to see a post mortem conducted on his son. His wife who had tragically died in Hospital was subject to an inquest. This took many months to conclude and was not an experience he wished to experience or go through again. He is accepting that in
retrospect it may have been a decision which should have been revisited set against his son’s initial presenting condition on admission.

1.44 Northamptonshire County Council – concerns regarding Safeguarding effectiveness. Turnover of staff not allowing continuity. Slowness of dealing with their safeguarding concerns over many months. Concern at having to formally raise complaints and finally having to resort to the Local Ombudsman and MP.

1.45 Care Quality Commission (CQC) – having communicated their concerns about the quality of service delivery by reference to William, concerns that CQC were aware of quality/care issues and when formally inspecting, and having received safeguarding referrals there seems to be no follow up and no consideration when reregistering under the then new care standards act. This, through a self-assessment process.

1.46 Berrywood Lodge Care Home – Mr Lawrence Senior’s concerns regarding the care homes new ownership and this resulting in deteriorating care for his son.

4 Care Plans not discussed with him or reviews being involved.

5 His son’s growing isolation in his bedroom sitting for long periods without seeing his son in communal areas of the home for company and social stimulation.

6 No receipts for money spent and clothes going missing on numerous occasions.

7 Reduced bathing, Hoists not being used continuously from receipt.

8 Information regarding professional interventions and judgement not being communicated, in particular emergence of epilepsy considerations and early onset dementia.

9 Complaints book going missing and soiled clothes on floor when visiting.

10 Reduction in social activities thought to link with staff reductions and care staff having to cook where there previously a cook.

11 No responses to any of their letters and communications raising concerns with the Management.
Single agency/individual reports, highlighting Lessons Learnt and Recommendations

Northamptonshire Health Foundation Trust (NHFT)

1.47 Northamptonshire Health Foundation Trust’s IMR did not respond to the specific headings requested by the SCR Panel however their IMR structure is relevant and very detailed. I have tried where possible to redact their IMR report against the SCR Panel questions where this has been possible.

Context

1.48 During 2009, William received care from two health teams; the Community Team for People with Learning Disabilities (CTPLD) and District Nurses (DNs). These teams were part of different organisations; CTPLD was part of Northamptonshire Healthcare Foundation Trust (NHFT) and DNs were part of Northamptonshire NHS Provider Services (NPS). In July 2011, NPS were assimilated by NHFT and now responsible for the District Nursing Service.

1.49 NHFT has established from NCC [redacted] within Safeguarding Adult Team, that NCC did not complete the investigation in 2009 because they could not obtain the relevant records from the District Nurses. NCC said the case was looked at again in late 2010 but they were still unable to conclude.

1.50 Mr Lawrence Senior made a request to the former NPS for access to his son’s records in November 2009 and an ‘internal investigation’ was prompted as a result of the records not being found. The ‘internal investigation’ found the DN notes to be missing and this was cited as a reason for not providing information as requested by Mr Lawrence Senior. Mr Lawrence Senior had to resort to significant formal escalation regarding the accessing of the notes.

1.51 The loss of the records combined with allegations of neglect is acknowledged by the Trust’s senior managers as reasons for treating the position as a serious incident and investigated accordingly.

1.52 The Serious Incident investigation considered the following areas of concern which are relevant to this SCR Panel report.

1 the amount of visits and treatment that William had been receiving from the Community Nursing Team (District Nurses, DNs) in the four
weeks leading up to William’s admittance to hospital;

2 who was the last medical professional to see William at Berrywood Lodge (BWL) before he was admitted to hospital;

3 the lack of communication and being unable to obtain relevant information.

1.53 One of the questions asked of all agencies by this SCR Panel is whether the agency has effective policies and procedures in place for safeguarding vulnerable adult? Secondly, were practitioners sensitive to the needs of the individual concerned, knowledgeable about potential indicators of abuse or neglect and clear about what actions they should take if they had concerns?

1.54 At the time covered by this investigation a number of appropriate policies were in existence, clear, up to date and readily available on the local intranet sites of NHFT and NPS to support staff.

1 Policy for Safeguarding Vulnerable Adults - NHFT CLP 055; PROV 05
2 Medical Devices Management Policy – NHFT CLP 009
3 Incident Policy – NHFT CRM002
4 Complaints Policy – NHFT CRM003

1.55 NPS had their own policies that have since been superseded by those of NHFT.

1.56 All staff interviewed by NHFT said they were aware of Safeguarding Adults Policies and procedures and where to get advice should they be concerned regarding possible abuse. The [redacted] interviewed was less sure about whether she had received training in Safeguarding Adults, and wasn’t clear whether it was mandatory 2009. The professionals involved in William’s care in 2009 would have been working to two Trust’s’ policies that may have differed. The staff should have been guided at the time by their organisations’ respective policies for Safeguarding Vulnerable Adults.

1.57 All staff interviewed said that they had not identified any safeguarding concerns in respect of William’s care, even though he was developing sores, not eating or drinking and was declining physically. Whilst some were able to identify some areas of poor practice, they said that they had seen nothing that might have caused them to seek advice from the appropriate sources or to make a safeguarding adult referral to NCC.

1.58 Staff in the CTPLD and the DN service had a duty of care to William, which included being able recognise and address deficits in respect of poor care, and to identify when these become safeguarding concerns and refer them according to policy. There is evidence that there were failures in care at BWL that were not recognised or reported as safeguarding of vulnerable adult concerns.
These were identified by Northamptonshire Health Foundation Trust (NHFT) as follows:

1 14.08.2008 – frequency of staff turnover at BWL which means that no one in the home has known William for longer than 12 months.

2 14.08.2008 – the Manager of BWL needs to be reminded to arrange for William to undergo the blood tests ordered by the CTPLD psychiatrist on 29.07.2008. This represents a delay of in excess of 2 weeks.

3 27.02.2009 – CTPLD psychiatrist prescribes Clobazam to counteract William’s seizures and requests that a seizure chart be commenced. On 06.03.2009 records indicate that the prescribed Clobazam has not been collected by the home, nor has the seizure chart been commenced. They were reminded to address these omissions. This was a delay in receiving care and treatment of more than 1 week. There is no recorded evidence of a seizure chart having been subsequently monitored by the CTPLD, so it is not known whether it was commenced. However records of 16.04.2009 indicate that BWL staff reported to Dr that William was, by this time, experiencing fewer seizures. It is not recorded as to whether there was any evidence of this fact noted on a seizure chart.

4 16.04.2009 – CTPLD staff member notes poor manual handling technique in respect of William by BWL staff. This was reported to the staff member’s line manager who addressed the issue with the home manager on 17.04.2009. The Home Manager assured the Senior Nurse, CTPLD that she would ensure that staff were reminded of correct manual handling techniques. There is no recorded evidence of whether this happened, or whether manual handling in BWL improved.

5 27/04/2009 – assessment by SALT results in request for Carobel thickener for William’s drinks so that he would be better able to swallow liquids. The SALT wrote to William’s GP on 30.04.2009, setting out her request. The prescription for the thickener was not collected from the GP until 20.05.2009. This represents a 3 week delay.

6 01.06.2009 – DN visit at the end of her working day, prior to William’s admission to hospital. Staff tell her that they still haven’t picked up the prescription ordered by the out-of-hours GP during his visit of 31.05.2009 at 19:35 hours. This is a delay of almost 24 hours and suggests that BWL staff had not grasped the importance of the therapy prescribed by the GP. Records indicate that several prescriptions for antibiotics had been either requested or issued over the preceding days. It is not clear whether William was able to gain much benefit from the treatments, since they were prescribed in liquid (suspension) form and William was experiencing difficulties with.
swallowing.

1.60 All of the points set out above, taken in isolation, suggest that there were deficits in the care provided to William at BWL. Poor communication and sharing of information between different professionals and agencies meant that this information was never brought together and analysed in a way that a complete picture of William’s care and treatment at BWL could be properly assessed.

1.61 What assessments took place of the individual concerned and what decisions did the assessments lead to? Were the assessments and subsequent decisions reached in an informed and professional manner? Appropriateness of Clinical Record, Assessment, Care Planning and Treatment.

1.62 The Trust’s IMR record the following findings of relevance some of these indicate missed opportunities to further revaluate the health care needs of William;

1 There was no evidence of a fully worked up care plan in either CTPLD or DN records. The DNs continued to record their care on a 5 visit sheet rather than complete a new set of records that should have incorporated a care plan, for William. The reviewers were told that care plans were not used by CTPLD at this time.

2 There was no reference to any Waterlow assessment or body mapping in the notes of the initial internal review having been undertaken by the DNs or shared with the CTPLD or vice versa.

3 On 01.07.2008 the duty Wheelchair service requested that a Waterlow score (pressure ulcer risk assessment/prevention tool) be undertaken as part of William’s assessment for a wheelchair. There is no evidence that this was ever undertaken at any of the subsequent wheelchair assessments.

4 Wheelchair assessments carried out on 20.06.2008, 25.09.2008 record that William had good vision. William was blind from birth.

5 In the ‘Assessment’ section a ‘Changing Skills Assessment’ showing a score of 84/256 was completed in August 2008, to be next assessed in February 2009. There is no record of the review having been undertaken.

6 Professionals from the CTPLD and District Nursing service are described by the Trust as not working in an integrated way or develop an integrated plan of care for William. This would have improved communication. There is evidence of good and thorough assessments of William’s needs on the part of the CTPLD; these assessments did not lead to a care plan.

NHFT reviewers report that this was normal practice at the time, but that practice has now changed in that care plans are the norm where
there is on-going involvement of the CTPLD.

7 There are letters from the consultant and SALT to the GP that include details and plans for William’s care.

8 The letters of 24 January 2009 and 24 April 2009 identify to the GP that Dr considers that a change in residency is needed to cope with William’s deteriorating cognitive and physical abilities. Due to NCC leading on William’s care, it would be appropriate for them to assume responsibility for his move. Both these letters make no mention of deterioration in the integrity of William’s skin or any loss of weight.

9 The letter of 30th April 2009 from the SALT informs the GP of William’s problems eating and drinking and concludes that a further review will be necessary.

1.63 There were unresolved areas relating to whether or not DN appointments were kept, and it remains unclear as to what happened to the ‘blue book’ that should contain DN care plans. The reviewers also found that there are gaps in the record keeping of the DNs. Some of the CTPLD records, while detailed, appear to have been entered retrospectively.

1.64 The loss and subsequent incompleteness of the patient records indicates a failure of the DN team to assess or manage the risks to William appropriately.

1.65 A variety of means to record information relating to William’s care and treatment was used by the different teams involved in his care. The reviewers could find no common, cohesive communication tool relating to William’s needs for use across all agencies. This clearly interfered with information sharing between professionals and agencies. There was no central electronic recording system in place for all the professionals and differing organisations to use, and those that were in place in the organisations were not being used effectively at this time.

1.66 Risk assessment and risk management are reliant on up to date care plans. The absence of care plans in the CTPLD at the time made it difficult to assess what interventions were being offered and if they were successful in reducing and managing the risks associated with Williams care. The reviewers were told that at the time covered by this investigation, care plans were not used by the CTPLD.

1.67 Professionals are accountable for ensuring that communication takes place between agencies, in the interests of their patients. A Health Action Plan as recommended in ‘Valuing People’ would have addressed this. Health action plans were not as a practice issue as well developed or seen by the regulator as a factor to consider in 2009.

1.68 There is no evidence that cross information sharing and care planning was undertaken between the DN team and CTPLD and associated specialist
William received appropriate assessments from the CTPLD (29.07.2008) resulting in a recommendation that a hoist should be used for all transfers. Requisitioning of the hoist enabled William to be bathed, something that Mr Lawrence Senior said his son had not been able to enjoy, sometimes for up to 6 weeks.

Poor use of the hoist in relation to William was identified in a report following a visit by CQC to BWL on 27.03.2009 as reported by Mr Lawrence Senior and friend. Mr Lawrence Senior has stated that the Manager of BWL said subsequently that the hoist could not be used because staff were not trained in its operation.

Consequently staff in the home resorted to other means of transferring William. Poor manual handling techniques were identified by a CTPLD staff member. This poor practice was appropriately addressed by the worker via his line manager. It is also clear that not having the hoist fully utilised would mean manual handling of William was unnecessarily compromised when addressing care needs associated with double continence care needs.

An assessment by the Speech and language therapist (SALT) for William to address problems with food and fluid intake was made by the care home on the 18.09.2008. A partial assessment by SALT was carried out on 27.04.2009. It was ascertained that he struggled to take fluids, and that he required a ‘thickener’ to help with this. Further assessment was noted to be needed in the future. There was a 7 month delay from referral to initial assessment. The reviewers were informed that during this time the SALT team were short staffed.

A letter dated 30.04.2009 outlining the plan of action was sent to the GP by SALT recorded as having been received by the GP on 30.04.2009. The prescription for the thickener recommended was not issued until 20.05.2009 following a “surgery consultation”. This represents a delay of 3 weeks from the thickener having been recommended to it being made available on prescription.

BWL staff reported to the CTPLD Nurse on 24.02.2009 that William was no longer calling for drinks as he used to do. The reviewers can find no evidence that any recommendation was made to the staff in the home by any professional attending to William’s care that they should monitor William’s fluid intake and output by the use of a fluid balance chart.

Chronological information for May 2009 identifies that the care home had, on two occasions, contacted the DNs and specifically requested help for sore testicles, legs and heels.

The message book “notes” of the DN team for 01.05.2009 and 15.05.2009 confirm that the BWL contacted William’s GP surgery to inform them that William had ‘sore testicles that need looking at’ and
later that ‘William has lots of sores to his leg, heels and testicles’. There are no entries on the ‘5 visit’ sheet that was being used at that time by the DNs to give any indication of any appointments or treatment that was carried out in response to BWL requests. The reviewers found that the original ‘internal investigation’ included interviews with 2 staff of the DN team that gave information relating to the visits and treatment verbally, but nothing recorded that confirms this.

1.77 GP records show an “acute” visit by Dr, requested by BWL, on 27.05.2009. The GP records indicate that, in addition to a chest infection, perineal sores were identified and that these were for the DNS to treat. BWL Staff reported to the GP at this contact that they had expected a DN visit that day that did not take place. This is corroborated in the 5 visit sheet where the DN visit of 25.05.2009... for a dressing to William’s heel states the next visit will take place on 27.05.2009..., but there is no entry in the records indicating that a visit took place.

1.78 5 visit sheet records that someone (signature not recognised) attended BWL on 28.05.2009 to see William and that “William was out”. The reviewers could find no explanation for William, in his then poor state of health, not being at home. The next recorded visit by the DN service was on 01.06.2009...

1.79 Care interventions treating sores to William’s left heel are evidenced on the ‘5 visit’ sheet, but no evidence of treatment to sacral or scrotal areas can be found until 01.06.2009 when DN attended BWL in response to their request for DN intervention and William was admitted to hospital. However, in the initial ‘internal investigation’ led by NPS, verbal evidence was given that indicated treatment for scrotal sores was delivered to William on 15th May 2009... The Trust’s reviewers were not been able to substantiate the verbal evidence as the staff members in question have left the Trust.

Key Issues

1.80 The investigation has found that District nurses failed to examine or treat William’s sore scrotum on 20th..., 22nd..., and 25th May... 2009 when they visited, despite notification by BWL staff of the problem dating back 1st May 2009... and 15th May 2009... There was no DN visit as planned on 27th May. This is indicative of a failure in care. The GP referral for admission to NGH on 1st June 2009 states that the skin around William’s scrotum was very inflamed with possible abscess formation.

1.81 William was referred to the Speech and Language Therapy service on 18th September 2008 for a ‘feeding positioning’ assessment due to having poor head control. There was an unacceptable 7 month delay from referral to first assessment by the Speech and Language Therapy service. It is likely that William had difficulty eating and drinking during this time with
increased risks of aspiration of food and fluids leading to a risk of chest infections. A poor diet may also lead to skin breakdown and makes a person more prone to infection.

1.82 Care plans outlining actions to address William’s care needs, were not created by CTPLD and could not be found for DNs. The lack of a nursing care plan is a failure in care delivery.

1.83 There was a failure to address Mr Lawrence Senior’s concerns from the start when he approached NPS for access to his son’s notes. The original ‘internal investigation’ by NPS focussed on locating the missing DN records - no report was produced, but Mr Lawrence Senior was told the DN notes were missing.

1.84 Inconsistencies have been uncovered, for example the initial ‘internal investigation’ refers to Mr Lawrence Senior being difficult to engage. The reviewers found Mr Lawrence Senior, and his friend, to be very keen to engage. Further, opportunities to respond effectively to a recent complaint were missed and responses were based on information of the previous investigation that has compounded Mr Lawrence Senior’s anxieties.

1.85 The failure of care contributed to William’s admission to NGH where he recovered from his chest and scrotal infections, and dehydration prior to his final illness. The diagnosis of dementia was not communicated to Mr Lawrence Senior or the multidisciplinary team, nor was the implication of this diagnosis for William’s presenting conditions.

Lessons Learnt

1.86 William had Down’s syndrome and later developed dementia. In combination, these two diagnoses are likely to contribute to a person’s physical deterioration. Dr (GP) in [redacted] review of William on 22.01.2009 recorded that he was “for TLC”. An understanding of the implications of this for the care and management when working with people with Learning Disabilities and dementia is needed. NHFT has commenced a review of nursing competencies which will cover the nursing teams identified in this report.

1.87 There were a range of different agencies and individuals involved in William’s care. The reviewers have found that effective communication, particularly with Mr Lawrence Senior was limited. Inter-agency and inter professional communication was piecemeal and task focused; there was no coordinated planning of care by professionals of all agencies. The annual review could have been an effective means for this to have happened.

1.88 Patient recording systems did not support seamless patient care across service boundaries. Where electronic patient records were available they were either not used at all, or only as a means of recording dates of contacts. NHFT is currently working on creating an electronic Single Patient
Record system.

1.89 Standards of record keeping did not always meet required professional standards. The reviewers have found failure to record reported visits, retrospective entries regarding contact visits, and inadequate detail to describe clinical interventions.

1.90 Delays in decision making and actions led to William remaining at BWL where his care needs could not be properly met and to delays in receiving assessments and treatment.

1.91 The original 'internal investigation' focused on the failure to locate the missing DN notes and did not address the concerns of Mr Lawrence Senior.

1.92 There were shortcomings on the part of NHFT personnel in respect of communication with Mr Lawrence Senior, both prior to and after his son's death in August 2009, and more recently. These personnel include CTPLD, NPS and staff at a corporate level.

Recommendations

1.93 An individual key worker in the CTPLD should take responsibility for the care coordination and the development of integrated care plans when multiple disciplines are involved in the care of patients when they make internal and external referrals to other services.

1.94 Nursing competencies within the Northampton District Nursing team should be reviewed and lessons shared with the wider District Nursing Teams.

1.95 CTPLD and DN Team Leaders must take steps to ensure that the key workers communicate with carers appropriately about their relatives' condition and prognosis.

1.96 The teams involved in the care of William should receive refresher safeguarding training, using this case as a case study.

1.97 When complaints are received where there is an inference of neglect, the Safeguarding process should be triggered.

Issues raised by the Serious Case Review Panel on 1 August 2012

1.98 The Serious Case Review Panel identified a further 11 points for the organisation to address in its updated IMR report. This has been responded to by the organisation by way of extending its original Action Plan.

1.99 The extended Action Plan is clear in some cases with regards to the points
raised; however there are some points where it is still ambiguous.

1.100 It is therefore easier to consider the SCR Panel’s further recommendations which pick up on these ambiguities and track their progress in the attached Action Plan as Appendix B to this report.

SCR Panel Additional Recommendations

1.101 Nursing training competencies should be reviewed to also be assured they understand the regulatory differences between care homes without nursing and those with those competencies and the implications of this difference for their practice.

1.102 Where in DN case allocation there are/is a client with mental capacity issues then particular attention should be given to whether care is suitable and sufficient and where they have concerns in this respect there is a procedure for escalation before it becomes a safeguarding concern.

1.103 There is a review of DN oversight not just in performance but regular formal supervision is ensured as a key organisational practice. This is audited and part of the reporting through Governance structures to Senior Management.

1.104 In end of life care circumstances in particular where a client is in a residential care environment and has limited or mental capacity issues then there should be a multi-disciplinary meeting to ensure that all appropriate care arrangements have been considered fully.
NHS Milton Keynes and Northamptonshire (formerly known as NHS Northamptonshire)

1.105 An independent clinical review into the care and treatment provided to William Lawrence by Health Services in Northamptonshire undertaken by \[\text{redacted}\] provides an overarching view relating to the care and the treatment provided to William over the period 2008 – June 2009 and was also considered as part of this report. It covers much of the same ground as the IMR for Northamptonshire Healthcare NHS Foundation Trust, Northampton General Hospital NHS Trust, Continuing Healthcare Team and General Practitioner. Resultantly, the key recommendations are covered.

Key Recommendations

1.106 For Northamptonshire Healthcare NHS Foundation Trust:

5 The Trust’s own 5 recommendations arising out of its own IMR are repeated.

1.107 For Northampton General Hospital NHS Trust:

6 The Hospital Trust’s own 4 recommendations are repeated.

1.108 For Continuing Health Care:

7 Two of the teams own recommendations are repeated.

8 A third recommendation concerns clarity regarding who is the lead agency and the report goes on to stress this should include liaising with the care providers and having oversight of safeguarding and quality issues for the client/patient.

1.109 For the General Practitioner Services:

The GP’s own IMR report recommendation is repeated.

Additional Recommendations from the Independent Clinical Reviewer

Some of the recommendations were observations and have been
redacted to sharpen their focus where that is possible. This is indicated after the recommendation for clarity.

a. The regular weighing of patients where nutritional status is a concern should be part of care planning and records kept. This recommendation was focused on NHFT and NGH Trust’s.

b. When any patient is admitted with a learning disability as co-morbidity, the Trust’s learning disability nurse should be informed straightaway. (MGH)

c. Record-keeping in the district nursing service in particular was concerning. There were also gaps in other records. Staff need to understand that this is a core requirement of their employment and that sanctions will be used if members of staff continue not to ensure they keep accurate, contemporary and clear records of visits and decisions made on all patients. Redacted.

d. Electronic data records need to be given priority in respect to the system being available to all practitioners. This should assist in the sharing of records between the givers of care. Redacted.

e. The Department of Health’s complaints procedures were updated and came into force on 1 April 2009 awareness training needs to be in place to ensure complaints staff are up to date on current guidance.

f. The general practice staff should have a system in place to review prescriptions that are not collected and make a clinical judgement about actions required taking account of the particular vulnerabilities and health needs of the patient.

g. When problems surfaced regarding the care of William in the community setting and in the residential care home, including the delays in responding to referrals, delays in responding to prescriptions, and missing of appointments and revisits, staff should have refresher training in the critical clinical areas regarding their responsibility to refer problems to senior staff for action or support. Redacted.

h. The performance management of staff who are engaged in clinical practice in the community setting should be reviewed. Redacted.

i. The lessons learnt from this particular review should be used to refresh and train staff in improving communication and the importance of record-keeping.

Issues raised by the Serious Case Review Panel on 1 August 2012

None.
Continuing Health Care (CHC)

Background

1.110 The involvement of continuing Healthcare (CHC) started following a CHC assessment in August 2008. This determined that William was not eligible for 100% CHC funding. The CHC remained involved, however the Chronology does indicate involvement by CHC staff in their own Chronology in November 2008 responding to contact from the councils care management team indicating the environment for William was not suitable for his needs. This is covered later in this section.

1.111 a) Were practitioners sensitive to the needs of the individual concerned, knowledgeable about potential indicators of abuse or neglect and clear about what actions they should take if they had concerns?

1.112 CHC IMR indicates that they felt that their practitioners were sensitive to the needs of William as evidenced by checklists and subsequent CHC assessments for eligibility for CHC funding.

1.113 b) Did the agency have effective policies and procedures in place for safeguarding vulnerable adult?

1.114 CHC Independent Management Report indicates that they did have policies and procedures in place for safeguarding but that they did not require application at the point of CHC involvement. It then goes on to describe that the CHC nurse was in contact with the lead agency (NCC) and NHT about the safeguarding concerns around the environment at the care home.

1.115 c) What assessments took place of the individual concerned and what decisions did the assessments lead to? Were the assessments and subsequent decisions reached in an informed and professional manner?

1.116 The Chronology describes CHC assessment for eligibility formally in August
2008 (CC 26 and 27), finding William not eligible. Then a further formal application in 2009 whilst William was in hospital, which was never completed as William subsequently died.

Comment 1

1.117 There are irregularities with this statement linked with Northampton county council’s own Chronology and this is commented upon later in this report.

1.118 d) Were actions taken and services provided in accord with the assessed needs of the individual and the decision reached?

1.119 CHC assessor remained in contact with the case and professionals as can be seen from the Chronology relating in particular to Northampton County Council’s own IMR. The CHC report considers that this may have added to the perception that William was being funded by CHC.

1.120 e) Where plans had previously been put in place to protect the individual concerned, were these plans executed appropriately?

1.121 CHC IMR describes the CHC assessor visiting the care home on 18th December 2008 and being generally satisfied with what the care home staff were doing (CC 59). The IMR goes onto indicate that e-mail correspondence from in particular (NCC) was trying to get confirmation of who and when a learning disability review for William would take place.

1.122 f) Had the views of the individual concerned and (where appropriate) their Carers, been ascertained and taken into account?

1.123 The decision support tool that CHC team use or used does not include as a routine a consideration of best interest. The CHC team as they were not leading the case indicate that they would not have been responsible for leading best interest discussions.

Comment 2

1.124 This practice position is developed into a recommendation later in this report.

1.125 g) Was the practice sensitive to the racial and cultural background of the individual concerned, their language and their religion?

1.126 CHC IMR does not make any comment under this area of enquiry.

Comment 3

1.127 In practice the assessment tool does consider communication as an area of assessment so it is puzzling that this is not referred to.

1.128 h) Were decisions taken at an appropriate level in the organisation by professional and managers with the experience and authority to make
such decisions?

1.129 The CHC considers that decision-making around the eligibility for CHC was correct.

Comment 4

1.130 If focusing on the CHC assessment activities purely undertaken in August 2008 and in July 2009, then this would be correct. The CHC IMR does not reflect the position contained within. NCC’s IMR and Chronology which indicates CHC assessment and funding agreement outside of the two areas cited by CHC.

1.131 i) Was the work undertaken in the case consistent with national standards, codes of practice and guidance, inter-agency procedures and wider professional standards?

1.132 The CHC IMR is reported to have been at the time and I would concur with this position. The new national framework (DH 2009) now means that if the person is not eligible for CHC funding the application (case) is closed down.

1.133 j) Was communication within the agency and with other agencies appropriate to the requirements of the case?

The CHC IMR references the new national framework for CHC and funded nursing care review by the Department of Health in 2009.

Comment 5

1.134 The IMR then references the ambiguity concerned with cases not being closed down as is now current practice and this leading to ambiguity in respect to other agencies or parties considering that CHC was still an active process being considered.

1.135 k) Were any other contributory or fundamental underlying factors identified during the review?

1.136 The IMR refers back to the CHC nurse remaining involved and therefore the case appearing to be open to CHC funding.

Lessons Learnt

a. The first learning point is not directly related to William however is described by the CHC IMR as improved processes now in place for determining and managing shared care packages, where both the PCT and Northamptonshire county council fund packages of care and in addition, determining who is the lead agency.

b. There is now a care home monitoring quality team established. The
monitoring team works closely with the CHC team and other partners and it is concluded that where poor care is now identified, a series of interventions are instigated to manage the risk and drive improvements. This includes intensive monitoring, suspending new placements meeting residents and family members and liaising with regulators.

c. Lastly, CHC IMR indicates that processes are now in place as a result of the new national framework which means that if the person is not eligible for CHC funding the application (case) is closed down.

Recommendations

There were two recommendation within the CHC IMR report, both of these are not recommendations but statements about ensuring current practice is maintained.

Issues raised by the Serious Case Review Panel on 1 August 2012

1.137 More clarity is needed on why the Continuing Health Care (CHC) Nurse was at Berrywood Lodge on 18 December 2008.

1.138 **Answer** – the response from the continuing health care nurse is as follows

“It is my recollection that following email from [redacted] I agreed to re-visit Berrywood Lodge on 18th December [redacted] with [redacted] to see if improvements had been made in relation to William and the environment. I recall that his condition had been deteriorating and there were real concerns regarding this and the appropriateness of Berrywood Lodge”. In an email dated the 12th January 2009 [redacted] the position reported in shared correspondence with CHC Team is that the position had improved and in particular for William.

1.139 **Comment** - It is clear that the CHC Nurse was involved in multi-agency discussions regarding his needs. This is highlighted in an email from NCC Contracts officer dated the 27th November 2008. This is at odds with the IMR. This discussion including the CHC Nurse describes increasing health care needs and the CHC Nurse requesting a breakdown of William’s support needs [redacted]

1.140 **Clarification is needed on why the first referral was made to CHC.**

1.141 **Answer** - William had been resident at Berrywood Lodge for 12 years prior to the checklist being submitted. First referral was made for CHC assessment in August 2008 by [redacted] from NHT as William had been referred to the CTPLD due to a significant change and deterioration in his skills.

1.142 **Was William Lawrence eligible for CHC? Please check comments on this in your IMR, as it appears that Northamptonshire County Council**
(NCC) was notified of this and your IMR and comments indicate that William was not eligible.

1.143 **Answer** – As reported by the Head of Continuing Healthcare. “File states that William was not eligible for fully funded Continuing care but joint funding once package costs had been explored. It was the CHC practice at the time to identify what the specific Health needs were and what would be needed to meet these and a cost. The starting point was always to receive a detailed breakdown of the current package costs and any 1 to 1 staffing included in this. I cannot see a record of 50% CHC being awarded on the IMR and this would not have been agreed in this case prior to specific needs and costs of these being identified. There is nothing on the files I have access to that suggests that any specific CHC amount was awarded.

1.144 **Was there a CHC assessment?**

1.145 **Answer** - Yes as conducted by [redacted]

1.146 **Who communicated the result to Mr Lawrence Senior?**

1.147 **Answer** – CHC report Mr Lawrence Senior was not present at the CHC assessment as I was informed by the [redacted] that he would not wish to be involved. I do not recollect who informed his father but do recall that despite our concerns that an alternative placement be found he was initially reluctant. This was discussed with him by [redacted] from NHT. The file that NHSN has on William is not complete and there is no outcome letter on file.

1.148 **Was the District Nurse involved in the first referral for CHC?**

1.149 **Answer** - District Nurse was not involved in the August 2008 referral that was completed by [redacted] from CTPLD NHT.

1.150 **State the reasons why William was not eligible for CHC, notes in IMR do not give details as to why he did not meet criteria for fully funded CHC.**

1.151 **Answer** - At the time criteria for fully funded required a priority score in certain areas or a number of high/severe scores. As can be seen from the assessment William scored Severe x 1 (in Cognition)-This score alone in this domain did not equate to eligibility for fully funded, Moderate x 4 (Communication had initially been scored by the assessor as High But I see on the assessment that this had then been circled as Moderate at panel), Low x 2 and No Needs in 4 domains. This level of scoring would not normally have attracted any health funding but it was recognised at the time of the assessment that deterioration had occurred which was very likely to continue and further input would be required in the future. The main report details the efforts to establish what additional health needs there were and this was never quantified by either NCC or the care home.
SCR Panel Further Recommendations

1.152 Where the CHC Team request information that concerns a vulnerable adult such as William and this information is not forthcoming then every effort should be made to either follow this up or escalate the position to management or if information is putting the client at risk of compromise in their health and wellbeing position report as a safeguarding concern.

1.153 Efforts should always be made where there are mental capacity issues to ensure the assessor is aware of any best interest guidance for the client.

1.154 Where there are mental capacity issues, unless there are specific exclusions subject to 1.153 above then the family lead members should always be involved and consulted with.

1.155 For the key commissioning agencies involved there needs to be an escalation policy preferably jointly agreed in order that inertia for whatever reason in decisions reaching action can be escalated by concerned professionals involved.

1.156 The Adult Safeguarding Board considers the irregularities in the accounts of the Continuing Health Care Team report and Northamptonshire County Council’s report and the matter is escalated for review in an appropriate senior governance forum to be recommended by the Board.
Northamptonshire County Council (NCC)

Analysis – and summarised key issues from the agencies IMR

Northamptonshire's County Council (NCC) IMR did not respond to the specific headings requested by the SCR Panel however their IMR structure is relevant and covers the following pertinent areas. Significant detail is taken directly from NCC's safeguarding entries regarding their investigation into this area. This as several safeguarding referrals were received by the Council's Safeguarding Team and its function was hampered by a number of factors. These require careful consideration as the Team and the Council are the Lead Agency for Safeguarding and at the heart of coordinating cross agency investigations. The concerns raised by Mr Lawrence Senior were regarding this area of the Council's function. The formal complaint by Mr Lawrence Senior which was later escalated to The Local Ombudsman and MP are covered later in this section of the report.

1. Contract Monitoring
2. Care Management Reviews
3. Safeguarding Investigations
4. Mental capacity
5. The delay in agreeing CHC funding and organising a move
6. Internal NCC arrangements for handling complaints and investigations
7. Issues raised by the Ombudsman (if not covered in any of above)
8. Summary of key findings
9. Summary of Recommendations
10. Action taken to date by NCC

Contract Monitoring

1.157 On the 1st September 2008 a visit by NCC Contract Monitoring team raised a number of contract compliance issues [REDACTED] The Contract Monitoring officer also requested reviews for 6 of the service users placed by NCC although the details do not confirm why this is the case. It is usual for reviews to be requested by Contract Monitoring officers if there are concerns regarding the infrequency of service users placed by their own Authority or linked to their concerns regarding the quality and suitability of the care or placements.

1.158 In November 2008, 2 Contract Monitoring Officers visited the care home [REDACTED]. They were also in possession of information that the latest Berrywood Lodge CQC draft report [REDACTED] which indicated the care home was rated as a poor service. The Home Manager on this visit also indicated key statements declaring that their management were not truthful regarding
improvements that they had indicated and NCC were seeking and gave examples.

1.159 **Comment** – This is a most serious revelation by the then [redacted] and should have become a safeguarding notification. This is commented upon again later in this report.

1.160 Despite contract monitoring actions and follow up visits in December 08 [redacted] January 09 [redacted] and June 09 [redacted] actions against concerns regarding health and safety, policy and procedures, medication, training matrix audits and person centred planning were still of concern.

1.161 Between September 2008 and August 2009 there were on-going concerns about the home’s failure to meet the requirements of their contract with little progress being made when these issues were raised by NCC. Secondly there are a number of changes of manager recorded which would have impacted on the home’s ability to grasp and deal with the identified deficiencies. Thirdly the statements by the Home Manager declaring management were being untruthful regarding improvements were serious concerns.

1.162 A contracts compliance visit occurred on the 4th August 2009 and again reference to poor progress with previous concerns raised and further new manager in post. This triggered enhanced Contract Monitoring arrangements [redacted].

**Good Practice**

1.163 The [redacted] did contact Care Management to request that reviews were carried out on the 6 individuals in the care home who were funded by NCC.

1.164 Contract Monitoring was significantly enhanced from September 2009 initially weekly to monthly visiting in the short term.

**Key Issues Arising and Lessons Learnt**

1.165 NCC are clear in their IMR that the period when the home was struggling to meet its contractual obligations (September 2008-Autumn 2009) coincided with the time when William’s health was deteriorating and there were concerns about their ability to properly meet his needs. The home also had a number of changes of manager and had a regulatory inspection which rated them as poor.

1.166 No formal notices of non-compliance were issued to Berrywood Lodge between the periods between September 2008 – January 2009. Almost
certainly there were grounds for such a consideration - non-compliance with the contract, the “poor” CSCI (CQC) rating, information from the Mental Health Service, the repeated changes of manager and the safeguarding concerns arising from William’s death collectively provided evidence that the care home was not functioning well and may have posed a risk to residents.

**Recommendations**

1.167 Where a contracted home persistently fails to meet its obligations there should be a clear route that the council follows in order to enforce compliance (an escalation policy). This should specify requirements, timescales and consequences of failure to comply and should be part of the legal contract signed by the council and the provider.

1.168 There needs to be clear communication routes for sharing information between different agencies and different arms of NCC. There should also be a forum for discussing provider services which appear to be failing so that their viability as contracted services can be examined with inputs from all relevant parties. This should be linked procedurally to the safeguarding policies and procedures in NCC.

1.169 The position of informing self-funders or their advocates needs to be also considered and appropriate means of ensuring either the individual or their representatives are aware of the Council’s concerns and interventions; respecting the balance that needs to be struck between the Councils safeguarding role and duty of care with actions prejudicing the livelihood and reputational interests of a Care Provider.

**Care Management**

1.170 Pre 1st Jan 2008 [redacted] information of note covered in NCC’s IMR describes in November 2007 that there was building work in the care home and moving of rooms for William causing concern regarding equipment required to lift William and some discussion about moving to a more suitable care environment however Mr Lawrence Senior wanted to avoid a move. NCC report in August 2008 that William was not required to move and that his needs were being met and the case closed [redacted]

1.171 In September 2008 NCC Care Management undertook an overview assessment and this noted both physical and mental health deterioration [redacted] Also evidenced through 1-1 support for William being described by the care home. This level of support only being sustainable in the short term as the care needs of other service users was at a lower level than normally expected. It is restated that Mr Lawrence Senior wished for William to remain at the home.
Comment – it is easy with hindsight to make comment however this overview assessment was an opportunity to raise William’s position more appropriately.

November 2008 saw the involvement of the Continuing Health Care Assessor and contradictory information in the supplied agency chronologies as to whether this was agreed or to be agreed. The recordings indicate again that Mr Lawrence Senior did not want William moving for the home.

Comment - there is still no appreciation at this point that William’s increasing frailty and physical care needs might be beyond the care of the staff at Berrywood Lodge. The decision to move any vulnerable adult who had lived at this care home for 12 years requires very careful consideration and it is clear that the view of Mr Lawrence Senior not to move his son would have carried considerable weight even though the reviews showed that the home was not meeting his needs fully. It is not possible to say that the assessment of William’s situation in September 2008 been carried through and resulted in a move, then his needs would have been better met and the deterioration in his health might not have occurred. Nor is it appropriate or possible to say that resistance to his son being moved contributed to his deterioration.

It is not clear from the Chronology whether the person sought advice from in this more complex situation. Nor is it known what deliberations there were about the weight that should be given to Mr Lawrence Senior’s views against William’s assessed needs. The issue of mental capacity is raised in this context and is discussed later in this report and the specific recommendation made in following recommendation.

Recommendations

Where an Annual review identifies the possible need to move an individual who does not have mental capacity and there is an emerging conflict with the person’s family then advice should always be sought from a senior manager and consideration given to whether there may be a conflict of interest between the needs of the individual and their relative(s). This should include consideration of mental capacity and whether the individual requires a separate independent advocate. The outcome of these discussions should be clearly recorded on the case file.

Safeguarding Investigations

The recording of the safeguarding investigations on the Chronology is complex and gaining clarity in this report follows NCC’s position of breaking down the Chronology into parts. Were there to be an accuracy challenge this would make the comparison more straightforward and adherence to
the Chronology referencing is also more easily achieved:

1. The first investigation carried out by the [redacted] between 8th June 2009 and 5th May 2010 [redacted]

2. The second investigation carried out by NCC Commissioning between 16th July 2009 and 21st October 2009 [redacted]

3. The third investigation carried out by the [redacted] between 5th October 2010 and circa 23rd March 2011 [redacted]

4. The fourth investigation and complaint from 28th March 2011 onwards.

June 2009 to May 2010

1.178 The initial safeguarding notification was anonymous and came via CQC on the 27th March 2009 and the Chronology shows that this was forwarded to the Safeguarding Team for investigation.

1.179 The case was allocated to a [redacted] on the 15th June 2009 [redacted]. This is a significant time delay and is commented upon in the recommendations. On the 3rd July [redacted] the [redacted] recorded that the outcome of the investigation was that the concerns were partly substantiated and this outcome was passed on to William’s father in a telephone conversation on the 15th July [redacted]

1.180 The outcome discussed poor manual handling, care plans did not reflect William’s needs, lack of risk assessments, William’s needs were greater than the care home could manage and little evidence of the forward planning to Southleigh a nursing care home operated by the same Care Provider. NCC indicates that there was no evidence of a protection plan being completed.

1.181 Further safeguarding notifications were received from CQC on the 7th July 2009 [redacted], this time highlighting general financial irregularities concerning a number of service users at the care home. A second issue from CQC at this time also referred to inappropriate recruitment practices concerning one individual.

1.182 NCC’s Chronology goes on to state that “all issues above were discussed in the strategy meeting held on 20.7.09”. The entry goes on to state that “it was agreed that NCC Commissioning would invite the home manager in to discuss some of the allegations in order for her to prepare for the next meeting scheduled for 17.8.09” [redacted] However the entry on the 13.8.09 states that “there is no evidence that this meeting took place” [redacted] However there is a record of a safeguarding meeting in the Chronology taking place on the 10th August and the Contract compliance team being asked to follow up the concerns on their weekly monitoring visits [redacted]

1.183 On the 28th July 2009 there is entry recording information received from
Mental Health about an accommodation review. This identified a number of concerns about the care home and concluded that "within Mental Health we have no intention of making any further placements and are actively seeking alternatives for our existing service users".

On the 19th August 2009 the CC spoke to Mr Lawrence Senior and arranged a meeting on the 10th September 2009 to discuss the findings of the investigation. This meeting did not take place due to the person being off sick although Mr Lawrence Senior was not made aware of this until he rang the office.

On the 15th September 2009 a duty worker in Safeguarding visited Mr Lawrence Senior and his friend (presumably because the person was still not at work) and there is a detailed record of that meeting. However, the Chronology entry goes on to state that "there is no evidence on the case file that the agreed actions/requirements were acted upon following the meeting".

In reality NCC do not know that the meeting of safeguarding on the 17th August had established follow up by the Contract monitoring Team. We are not clear from the Chronology just what concerns were being followed up. All, or only some, of those that had been raised.

On the 24th September 2009 the person contacted Mr Lawrence Senior to apologise for missing the meeting and to tell him that as a result of further matters raised by CQC the case had been further escalated.

His refers to a third CQC notification on the 20.8.09 (the second CQC notification was in July from Mr Lawrence Senior’s friend regarding concerns as to the circumstances leading to William’s admission to Northamptonshire General Hospital and the care provided by William’s care home running up to this.

The Chronology indicates the person is trying to get information about the involvement of the District Nursing service with William. This is the first of a number of entries in which the person is trying to access District Nursing notes. The Chronology also shows two attempts to access information from the GP on the 24th September 2009 and the 24th November.

On the 18th March 2010 the person records that she has completed the investigation as far as possible and is awaiting approval from senior management. This was passed on to Mr Lawrence Senior who was told that there would be a meeting to discuss the outcome.

The Chronology indicates further delays caused through requests from DN notes and confirmation on funding queries through CHC continued for a number of months.

Although there were many warning signals and concerns raised by Mr Lawrence Senior regarding the slowness of finalising the safeguarding
investigation a formal complaint was logged in a meeting between Mr Lawrence Senior and [REDACTED] in April 2011.

1.193 NCC’s Customer feedback team were noted to chase the progress of the complaint evidenced through till June 2011.

1.194 It is clear through July 2011 from the Chronology that Mr Lawrence Senior had by this time raised a complaint on NHFT who would be responding separately.

October 2010 to March 2011

1.195 The case was allocated to a [REDACTED] on the 5th October 2010 and the Chronology entries indicate the [REDACTED] having difficulty in getting information from Health about the arrangements for Continuing Health Care (CHC) Funding and the missing District Nurse notes.

1.196 On the 10th and 11th of November 2010 the [REDACTED] had contact with Mr Lawrence Senior who had rung to speak to the [REDACTED] responsible for the case [REDACTED]. She offered a home visit on the 24th November and although the Chronology records that a confirming letter was sent there is no entry showing whether that visit took place and the outcome.

1.197 A letter is mentioned in the Chronology as having been sent to Mr Lawrence Senior in November updating him [REDACTED]. Further correspondence in January updating Mr Lawrence Senior that the investigation would now go forward as health documentation received [REDACTED]. Contradictory information was given to Mr Lawrence Senior’s friend in February when she phoned for an update [REDACTED]. This to the effect that the District Nursing information was still not forthcoming.

1.198 Mr Lawrence Senior and his friend issued a number of warnings to NCC staff regarding their frustration and potential actions in respect to negligence.

1.199 Again a 7 month period in which only limited progress was made towards resolution and nothing to suggest that it was brought together by the manager.

March 2011 to present

1.200 On the 28th March 2011, Mr Lawrence Senior made his first formal complaint via the Customer Feedback Team (CFT) about the progress of the investigation and staff conduct [REDACTED].

1.201 On the 5th April 2011 Mr Lawrence Senior was visited by an [REDACTED] who passed on Mr Lawrence Senior’s concerns to the [REDACTED].
1.202 On the 12th May a follow up was sent by CFT to the [REDACTED], asking if the meeting had been held with Mr Lawrence Senior to give feedback. He replied that it had but at Mr Lawrence Senior’s request the outcome of the report had not been discussed. This appears to have been because he wanted his advocate to be present as a further meeting had been arranged for 2/3 weeks’ time. On the 14th June the [REDACTED] advised that the meeting had taken place.

1.203 A draft was prepared by the [REDACTED] for approval by the [REDACTED] although the Chronology raises a query as to whether this was ever sent. This was later clarified as sent on the 2nd July but that this did not deal with the additional matters raised by Mr Lawrence Senior in his letter to Health of the 30th June.

1.204 There then follows a number of entries that mainly concern liaison between NCC and Health over responses to the complaint which run through until November 2011 at which point Mr Lawrence Senior contacted his MP. On the 2nd December 2011 a multi-disciplinary meeting was held to review the history of the case and try to plan a way forward. On the 21st December 2011 a joint meeting involving NCC was offered to Mr Lawrence Senior and his advocate but this was turned down as they wanted to see a written response first.

1.205 An update and apology letter was sent to Mr Lawrence Senior on the 27th January 2012 [REDACTED] followed on the 22nd February by a detailed response sent by the [REDACTED] [REDACTED]

**Issues Arising and Lessons Learnt**

1.206 The first part of the investigation began with the first CQC notification on the 27th March 2009 and ended with the case being re-allocated to a [REDACTED] on the 5th October 2010, a period of about 18 months.

1.207 The first point of note is the time it took to allocate the case for investigation - from the end of March to the 15th June - approximately 11 weeks. An unacceptably long time.

1.208 The second issue is that further matters kept being added to the initial concerns - the second CQC notification, the anonymous concerns, the report from the Mental Health service, and additional concerns raised by Mr Lawrence Senior’s friend [REDACTED]
1.209 It should have been clear to someone at [redacted] that this matter was becoming complicated and needed pulling together into a clear plan for investigation and resolution. This would have provided support to the [redacted] who was leading on the safeguarding investigation and would also have enabled clear information to be given to Mr Lawrence Senior and [redacted] about the scope and process of the investigation.

1.210 By July she recorded that she thought the allegations were substantiated and on the 15th July informed Mr Lawrence Senior of the outcome. However this did not close the matter and between September and March 2010 the Chronology shows the [redacted] as trying to get information from Health about the involvement of the GP and District Nurse relating to the other safeguarding concerns that were logged into the system. By March 2010 the [redacted] had recorded that she had completed the investigation and was waiting for approval from “Senior Management”.

1.211 There was an issue about accessing Health records concerning the involvement of the GP and District Nursing service with William. There is evidence of both the [redacted] and [redacted] trying to resolve this but the Chronology shows very little about the role of managers in supporting or escalating matters between their other agency colleagues.

1.212 There have been numerous delays at all stages and although there are some factors that have contributed to this, there was a general failure to monitor and manage the investigation to ensure that it was completed thoroughly and in a timely fashion.

1.213 There was a general failure to get an overview of the different issues and concerns that existed about the care home and William’s care while he was there.

1.214 Control of the process improved to a degree once Mr Lawrence Senior had registered a complaint and CFT took over the role of co-ordinating the response to the complainant. This follows for the complaints to the local MP and Ombudsman. The overall time taken to process and respond to the complainant was 11 months which is not acceptable and there must be lessons here about the need for better mechanisms for ensuring that complaints in complex cases are effectively managed and responded to.

1.215 Communication with William’s father could have been markedly better and
the significant periods of inactivity almost certainly contributed to the escalation of the case to a complaint and subsequent involvement of the MP and Ombudsman.

Recommendations

1.216 There needs to be significant improvement in the process for tracking the progress of investigations carried out by the Safeguarding Adults Team. This should include clear timescales for each stage of the process and a system for “flagging” cases that fall outside of the timeframe.

1.217 Apart from straightforward low level concerns there should always be an investigation plan that is drawn up by the worker and agreed by the supervisor/manager. This should include arrangements for keeping referers and interested parties informed of progress throughout.

1.218 Managers should ensure that all active investigations are discussed in supervision and that where obstacles occur these are escalated if they cannot be resolved by the worker or manager. The supervisor/manager should ensure that all reports are quality assured and signed off immediately after completion.

1.219 Complex cases where there are different sources of concern and a number of agencies involved should be subject to a multi-agency strategy meeting that is minuted and followed up once the investigation is underway.

1.220 The SOVA procedures need to be checked to ensure that they refer to any party being able to request this multi-agency meeting.

Mental Capacity

1.221 It is clear Mr Lawrence Senior (who was his appointee for his finances) acted as his advocate and there is no suggestion that he acted in any way other than what he believed was best for William.

1.222 The views of family must be listened to and considered carefully when there is a need to make important decisions about the best interests of a service user.
1.223 This can lead to differences of view about what is best for the individual and in these circumstances it is important that consideration is given to assessing mental capacity and providing an advocate.

1.224 In this case taking such action may not have led to a different view since the impact of moving William may have been as, if not more, detrimental than leaving him at Gordon House.

Issues Arising and Lessons Learnt

1.225 The learning point centres on there should have been a mental capacity assessment and independent advocacy involvement.

Recommendation

1.226 Where there is evidence that an individual may lack the capacity to give a view about an important decision, this should be assessed and consideration given as to whether there is a need for independent advocacy.

The delay in agreeing CHC funding and organising a move

1.227 The first contact with CHC is recorded in August 2008 when there was a meeting at the care home with Mr Lawrence Senior and the home manager. This was followed on the 13th October with a telephone call from the CHC assessor to the asking for details of William’s service package. This was not known by the but the CHC assessor indicated that funding had been agreed but they still needed to determine the percentage of funding that would be provided.

1.228 The next entry is on the 23rd April which confirmed that the “PCT have agreed to fund 50% of the cost of William’s new placement at the prospective Nursing care home”

Comment

1.229 These details are at odds with the CHC IMR which refers to only two formal CHC funding references. The CHC Chronology describes CHC assessment for eligibility formally in August 2008, finding William not eligible. And a
further formal application in 2009 whilst William was in hospital which was never completed as William subsequently died.

1.230 The combined Chronology attached to this report indicates quite clearly at point [redacted] a telephone call from the CHC Assessor that funding had been agreed. A visit to the care home was also made shortly before this phone call [redacted]

1.231 The care home Provider’s Chronology also makes reference to CHC funding being agreed [redacted]

**Internal NCC arrangements for handling complaints and investigations**

1.232 The Chronology shows that four internal NCC teams were involved in this case- the Safeguarding Adults Team (SAT), the Contract Monitoring Team (CMT), the Ordinary Living Team (OLT) and the Customer Feedback Team (CFT). Within these different parts of NCC there are a number of levels of staff, for example in the SAT there was involvement from a [redacted] and [redacted]. Each of these parts of NCC has a different function and staff carry out different roles.

**Issues Arising and Lessons Learnt**

1.233 The main point that arises from this case is the overlap between issues that are deemed to be safeguarding (SAT), those that are to do with compliance (CMT) and matters that relate to individual service users (OLT). This can be confusing, for example, the original concern raised through CQC about William went to the SAT when under current arrangements it would have been passed to William’s [redacted] from the OLT. Later when two anonymous notifications were received about missing money, the behaviour of staff and medication errors (31) these were dealt with by Commissioning suggesting that these were felt to be more about contract compliance than safeguarding.

1.234 This links back to the safeguarding analysis in this report and how the initial concerns grew as more issues were raised. Somehow there needs to be an understanding of when compliance might become safeguarding and conversely that sometimes concerns raised under safeguarding may actually be more about compliance.
Recommendation

1.235 Managers within the different arms of NCC should jointly consider whether there is clarity about roles and cross-over when concerns are raised about individuals or standards in residential care. This could be done through a short one-off piece of work. If there is a need for clarity that would help to ensure that there is "joined-up" working then this should be provided either through some form of guidance or a joint seminar for staff. This should be completed within 3 Months of the completion of this report through its approval stages at the Safeguarding report.
Issues raised by the Ombudsman

1.236 This section relates to the Ombudsman’s letter of the 6th February 2012, written by [redacted]. This raised 14 points for Northamptonshire County Council to respond to. As it was agreed this SCR Report would be the vehicle for responding to the concerns. It also allowed a greater level of context and consideration of the learning and corrective actions to be more easily seen.

1. **By way of a Chronology show how “William Lawrence” was known to and supported by the council**

1.237 A Chronology has been prepared by NCC and this has been integrated into the multi-agency Chronology which forms part of this report.

2. **Say what services he was entitled to receive from the council**

1.238 William was funded by NCC in his placement at Berrywood Lodge care home which was a home for people with Learning Disabilities and Mental Health Problems. This report and in particular the specific IMR from NCC which is addressed in this report identifies the main ways in which individuals placed in residential care by the council are protected. In summary he was placed in a service that was contracted to NCC and which would have been expected to comply with the terms of that contract. He would have been subject to a review at least annually to ensure that the contracted service continues to meet his needs. He would have been protected through the County’s Safeguarding of Vulnerable Adults (SOVA) procedures. Clearly there were deficiencies and this report addresses those deficiencies and outlines the corrective actions taken and planned.

3. **Outline the council’s responsibilities with regard to the quality of care for which it was providing support**

1.239 The council employs contract monitoring officers who are responsible for visiting contracted homes to assess whether they are contract compliant. In areas where they are not compliant they can specify actions that the provider must take. Ultimately if the home persistently fails to comply with its contractual obligations, the contract with that home could be terminated. The quality of the safeguarding and care management functions are also reviewed and recommendations for improvement have been included in the corrective actions taken and planned contained within the recommendations in this report.

4. **Outline the council’s responsibilities for safeguarding William from possible harm, neglect or abuse**

1.240 The council is required to investigate allegations of harm, neglect or abuse. To carry out this function the council has a dedicated Safeguarding Adults Team (SAT) which operates in accordance with procedures drawn up by
the county’s multi-agency Safeguarding of Vulnerable Adults (SOVA) Board. However the initial notification received in March 2009 was not followed up until June by which time William was in hospital.

5. **Show when the council first received complaints from anyone about the quality of William’s care**

   The date of this was the 27th March 2009.

6. **Show what regular visits, inspections and reviews there were of William’s care and whether or not the care provided by this organisation was meeting his needs**

   This is contained in the Chronology and is referred to in earlier sections of this report.

7. **Show what quality control measures were in place to regularly review the quality of care for which the council was providing support**

   This is contained in an earlier section above and includes two recommendations for improving the monitoring of contracted services.

8. **Say what safeguarding measures were in place to ensure all relevant records and action was being taken to keep William safe**

   This is covered in points 1.173 – 1.201 of this report.

9. **Explain why William’s family were denied a copy of the report into care he received on the grounds, it is alleged ’...of the Baby P report’ and explain what the reference to Baby P means**

   The use of this specific wording is not agreed by the workers involved. Nor is it completely clear from the Chronology why the report had not been signed off by the ... However it does appear that the problems accessing the District Nursing and GP records may have led the ... to consider that it had not been possible to complete the investigation completely which may have caused the reluctance to sign the report and share it with Mr Lawrence Senior.

10. **Explain the long delay in reaching a conclusion to the complaint submitted by the family of over a year ago and say if an when a conclusion has or will be reached**

    Please see the detailed coverage of the safeguarding actions by NCC as specifically referenced between points 1.173 – 1.201. There is not a satisfactory answer to this. It can only be said that a letter apologising for the delay was sent to Mr Lawrence Senior on the 27th January 2012. As stated above some of the delay can be attributed to liaison with Health about how to respond to Mr Lawrence Senior’s letter of the 30th June which
clearly laid out the issues to which he was seeking answers. This culminated with a multi-disciplinary meeting on the 2nd December 2011 after which a meeting was offered to Mr Lawrence Senior, his friend and his advocate (21.12.11- entry 135). This was declined because he wanted a written response before having a meeting. His advocate was updated on progress on the 27th January 2012 (136) and also advised that the timescale for completion would be the 23rd February 2012. The letter was sent to him by the 5th February 2012 and is dated 21st February 2012. These areas are given considerable coverage in this report and specific recommendations for improvement are clarified.

11. **Confirm what records were examined to consider if William had been at risk and say why action was not taken earlier to minimise the risk or remove him from that risk.**

1.247 See Chronology details 1.173 – 1.215 above which also provides details of the attempts made by members of the Safeguarding Adults Team to locate information from the GP and District Nursing Service. The issue of risk to William is also outlined earlier in this report which describes the concerns about the suitability of the care home that arose following two reviews and considers why William was not moved from the home at an earlier point.

12. **Provide copies of all reports into the matter**

1.248 This report contains detailed coverage of Northamptonshire’s actions linked to the matters raised. These can be individualised if this is required.

13. **Provide a copy of the initial report originally denied to the family**

1.249 A copy of the report as requested has been actioned separately to this report.

14. **Show what if any proposals have been made to improve or change service procedures to help prevent similar issues arising again**

1.250 A summary of recommendations from NCC’s Individual Management Review is contained in this report. Multi-agency recommendations are also be included in this Report.

**Summary of Key Findings**

1.251 Although work was done by the Contract Monitoring Team to try to raise standards at Berrywood Lodge, the situation was allowed to run on for quite some time with little progress and mounting evidence that the home was failing to deliver a reasonable quality of service and therefore was potentially placing residents at risk.

1.252 There is evidence from different sources that Berrywood Lodge was not
being well run but it does not appear that this information was brought together at any point to provide an overview of concerns.

1.253 Care management reviews of William did take place at reasonable intervals in 2008/09 but having identified that his needs were not being met at Berrywood lodge, the assessment that he needed to move to a different home was not followed up mainly, it appears, because of his father’s wish that he should not be moved. There was a failure to consider whether this represented a conflict of interest about William’s well-being and whether he should have been assessed in terms of his mental capacity and given access to an independent advocate.

1.254 There were significant unexplained delays in taking forward the joint funding arrangement with CHC to the extent that before this was completed William had been admitted to hospital.

1.255 There was a lack of urgency in allocating the first safeguarding concern for investigation and once the case was allocated there were serious failings in managing the progress of the investigation.

1.256 There was a failure by [REDACTED] in the Safeguarding Team to sign off the investigation as having been completed. This almost certainly led to Mr Lawrence Senior making a complaint and the case’s subsequent escalation to the MP and Ombudsman.

1.257 There was inconsistent and confusing communication with Mr Lawrence Senior about the progress of the investigation and later about the handling of his complaint.

1.258 The two investigation reports went some way to answering the concerns raised but they lacked clarity of approach. There was no evidence of quality assurance by managers to ensure that the investigations were rigorous and thorough.

**Summary of Recommendations NCC**

1.259 Where a contracted home persistently fails to meet its obligations there should be a clear route that the council follows in order to enforce compliance (an escalation policy). This should specify requirements, timescales and consequences of failure to comply and should be part of the legal contract signed by the council and the provider.

1.260 There needs to be clear communication routes for sharing information between different agencies and different arms of NCC. There should also be a forum for discussing provider services which appear to be failing so that their viability as contracted services can be examined with inputs from all relevant parties.

1.261 There needs to be significant improvement in the process for tracking the progress of investigations carried out by the Safeguarding Adults Team.
This should include clear timescales for each stage of the process and a system for “flagging” cases that fall outside of the timeframe.

1.262 Apart from straightforward low level concerns there should always be an investigation plan that is drawn up by the worker and agreed by the supervisor/manager. This should include arrangements for keeping referrers and interested parties informed of progress throughout.

1.263 The supervisor/manager should ensure that all active investigations are discussed in supervision and that where obstacles occur these are escalated if they cannot be resolved by the worker or manager. The supervisor/manager should ensure that all reports are quality assured and signed off immediately after completion.

1.264 Complex cases where there are different sources of concern and a number of agencies involved should be subject to a multi-agency strategy meeting that is minuted and followed up once the investigation is underway.

1.265 Where there is evidence that an individual may lack the capacity to give a view about an important decision, this should be assessed and consideration given as to whether there is a need for independent advocacy.

1.266 Managers within the different arms of NCC should jointly consider whether there is clarity about roles and cross-over when concerns are raised about individuals or standards in residential care. This could be done through a short one-off piece of work. If there is a need for clarity that would help to ensure that there is “joined-up” working then this should be provided either through some form of guidance or a joint seminar for staff.

**Actions Taken to date by NCC**

1.267 In the spring of 2011 another IMR relating to a man identified a number of issues that are also relevant to this IMR. As a result a number of actions were taken by NCC and these are listed below.

1.268 The Northamptonshire Inter-Agency Safeguarding Procedures have been revised (issued November 2010) and now provide a clearer procedural framework for managing safeguarding cases.

1.269 Additionally in June 2010 threshold criteria were introduced and a screening process using these criteria included in the procedures. This allows cases to be screened and weighted for complexity. Within the Safeguarding Team the person with the case lead role is identified for each case and Principal Care Managers prioritise and track cases.

1.270 A new template for strategy meetings has been developed and implemented which specifically covers what needs to be considered and agreed at Strategy Meetings.
1.271 For cases that are handled outside of the Safeguarding Adults Team, either by other agencies or other NCC teams, there is a tracking process that throws up warnings after 21 and 28 days if cases are not completed. These warnings continue until the cases have been signed off. This system does not currently extend to cases where the Safeguarding Adult Team leads although they are picked up through case discussions in supervision. A recommendation to include tracking of Safeguarding Adults Team cases is made in recommendation 1.256 above.

1.272 The latest NCC Safeguarding Vulnerable Adults’ inter-agency procedures include a section on resolution of professional differences (15.1) and the process by which staff are encouraged to take action if they feel that they are being “blocked” by managers or others is included in the supervision procedure. The same message has been given by management to staff informally but this may not be sufficient and a recommendation about putting this clearly in writing to staff forms part of the recommendations from this report.

1.273 The SOVA Board now has a standing SCR sub-group chaired by the Board’s Deputy Chair. This provides a regular forum for consideration of possible SCR cases using the existing procedure on SCRs.

Other Actions Taken by NCC to improve internal and inter-agency working

1.274 In July 2011 Health and Social Care colleagues in Northamptonshire implemented the DoH guidance on ‘Clinical governance arrangements in Health for Serious Incidents, Complaints and Safeguarding Notifications’. This guidance seeks to underpin the existing threshold criteria introduced in June 2010 with a focus on proportionality, transparency and partnership. This framework provides clear guidelines for a multi-agency approach to complex cases avoiding duplication of process whilst seeking to aid good communication, terms of reference and timescales. The oversight and governance of such cases are managed by NHS Northamptonshire and the SOVA Board SCR sub-group.

1.275 In July 2010 a joint escalation policy was written and agreed by all key agencies. The guidance creates a multi-agency framework where the contract monitoring process identifies concerns about the management and operation of a care home and therefore its suitability to care for service users. This involves a process that brings together information from all agencies that have placements in that home and CQC. This process will then ensure that it is safe for residents to remain in the home and that steps are taken to rectify the areas of concern.
A scheduled monthly Information Sharing meeting hosted by NHS Northamptonshire has been in existence since 2011. This is a forum for all operational staff involved with domiciliary and home care providers to share information, concerns and monitor themes.

NHSN and NCC hold joint meetings with families and residents when there are concerns about a care home. CHQM Team write to all GP’s seeking their views of the service provision prior to undertaking a monitoring assessment.

A Mental Capacity Act (MCA) training module has been in place for all staff since 2009. A new e-learning package was commissioned in 2012 which is available for all, including Private, Voluntary and Independent (PVI) sector.

MCA practice guidance and toolkit is in place to put support staff with assessment and decision making. This also includes guidance on capacity and consent. A DoH audit was undertaken in 2011 and the findings from this will focus on further training for staff which will look particularly at Best Interests Assessments, a "refresh" of the existing assessment toolkit and how to record decisions accurately. Planning is underway to repeat the audit in 2012 with all key agencies.

The client database and the supporting assessment and review documents were amended in 2011 to ensure that capacity and consent is a consideration in all assessment activity.

In September 2010 Protection plans for all individuals subject to a safeguarding investigation became mandatory. In cases related to service provision such as care homes there is a further requirement to assess level of risk to other customers/residents who are in receipt of the service but not subject to an investigation.

Since 2010 all complex cases (level 3 and above) are routinely subject of a case conference. Case conferences are used during and at the end of the investigation to discuss progress, feedback the conclusions of the investigation and report the outcomes to all those who have been involved.

Issues raised by the Serious Case Review Panel on 1 August 2012
Clarification regarding at what point referrals were being closed down was requested to be added to the updated IMR – this has been responded to.

The anomaly regarding CHC funding being agreed but updated – this has been responded to by both agencies but leaves a polarised position.

Whether any formal notices were issued from the Contracts Team. This has been responded to and is – No.

The SCR Panel asked NCC whether the home on reflection was in a more grave position that they had realised. NCC have confirmed that on reflection the home was in a position were they should have been considering more formal actions and considerations. These issues have also been picked up in their recommendations and action planning.

References to money and financial irregularities have been picked up specifically and there are no concerns regarding these issues bearing on Mr Lawrence Senior. This is an important aspect of the concerns raised by Mr Lawrence Senior when he was seen as part by the Author of this report.

Tightening of safeguarding closure processes. This has been achieved by the agency by trying to clarify three distinct phases of safeguarding activity. Although this is inevitable the separation is helpful and has been carried forward into this report.

Acquiring records of the DN involvement for the GP is covered under the GP IMR section. This has revealed that these entries are not those that would help in understanding the nature of detailed activity recorded in the lost notes.

**Serious Case Review Panel Additional Recommendation**

Contract monitoring staff need to be clear that when they hear from senior staff in care homes as is the case in this review, serious concerns regarding whistle blowing, that immediate actions linked to safeguarding are triggered.
Care Quality Commission (CQC)

Analysis – and summarised key issues from the agencies IMR

1.291 CQC responded to the serious case reviews request to provide a management report. They did respond to the specific headings as indicated below.

a) Were practitioners sensitive to the needs of the individual concerned, knowledgeable about potential indicators of abuse or neglect and clear about what actions they should take if they had concerns?

1.292 Safeguarding is reported as a priority for CQC and reflected in their current processes and methodologies. Inspectors are trained to recognise the signs of abuse and what appropriate actions to take. This is underpinned by CQC’s Safeguarding Protocol.

b) Did the agency have effective policies and procedures in place for safeguarding vulnerable adult?

1.293 CQC’s Safeguarding Protocol, is published on the website and would have been widely available in 2009. The protocol sets out their role in safeguarding procedures and how they manage safeguarding information. The protocol is reviewed regularly to ensure it is up to date and reflect current guidance.

c) What assessments took place of the individual concerned and what decisions did the assessments lead to? Were the assessments and subsequent decisions reached in an informed and professional manner?

1.294 When CQC received information regarding “William Lawrence” it was assessed in accordance with our safeguarding protocol at that time and a decision made to pass it to Northamptonshire Safeguarding Team.

1.295 CQC inspections do not focus on specific individuals but look at the way services are delivered and the impact this has on all the people at a registered location. CQC conducted three inspections and decisions were made as to the overall assessment of the home. In February 2009 they assessed the home as providing adequate outcomes, in July 2009 as providing poor outcomes and providing adequate outcomes in November 2009. These decisions were made based on CQC’s methodology at that time. They do not hold records of the safeguarding notifications and their current system requires information to be redacted once the safeguarding referral has been made and satisfactory evidence of action taken received from either the local authority or the provider.

Comment 1
1.296 There was a prolonged period of time over which the Local Authority was actioning safeguarding investigations and this period covered the timing of more than one inspection. There is no reflection of these safeguarding investigations referenced in the inspection reports and there is no information to suggest any contact with the local authority to check whether the safeguarding investigations had relevance for the regulator as these continued with their visiting.

d) **Were actions taken and services provided in accord with the assessed needs of the individual and the decision reached?**

1.297 CQC correctly indicates in their IMR does not have the authority to take direct action with regard to individuals. however their statutory powers allow them to inform providers that they are in breach of our legislation and to take enforcement action if they subsequently do not comply. During each of these inspections the provider was issued with requirements to make improvements. These actions the regulator believes led to their voluntary ban on admissions in 2009.

e) **Where plans had previously been put in place to protect the individual concerned, were these plans executed appropriately?**

1.298 CQC did not put specific plans in place to protect "William Lawrence", but did pass on information in a timely manner, as per their safeguarding processes at that time.

f) **Had the views of the individual concerned and (where appropriate) their Carers, been ascertained and taken into account?**

1.299 The CQC inspection process did not specifically seek out the views of "William Lawrence". The process at that time included capacity for inspectors to speak with people who were using services and their relatives if available. CQC’s current methodology includes seeking out Service User’s views. Their Inspection reports have a section under each outcome dedicated the views and experiences of people using services. They did not collect the views of “William Lawrence” as part of their reviews but indicate his experiences were reflected in the actions they took and our inspection reports.

**Comment 2**

1.300 The regulator cannot on the one hand indicate they did not collect William’s views as part of the reviews they undertook and then indicate his experiences were reflected in the actions they took. If they do have this view then this requires reassessing when they respond to future Serious Case Reviews.

g) **Was the practice sensitive to the racial and cultural background of the individual concerned, their language and their religion?**
1.301 Diversity issues are part of the inspection processes and methodology.

h) Were decisions taken at an appropriate level in the organisation by professional and managers with the experience and authority to make such decisions?

1.302 The regulator reported that their methodologies ensure that decisions are taken at the appropriate level and by people with the relevant experience. Inspectors make judgements based on the frameworks developed by CQC and published on our website. The Inspection reports in the case of Berrywood Lodge were reviewed by compliance managers. This included reviewing the assessments and judgements made by inspectors to ensure they are based on the evidence presented and stand up to scrutiny. This process was used during the inspections of this home.

**Observation 1**

1.303 With the level of non-compliance covering two inspections it is surprising more formal notices of non-compliance were not issued to the Provider.

i) Was the work undertaken in the case consistent with national standards, codes of practice and guidance, inter-agency procedures and wider professional standards?

1.304 It is clear that the regulator was working within National standards, codes of practice and interagency procedures.

j) Was communication within the agency and with other agencies appropriate to the requirements of the case?

1.305 CQC passed information on to Northamptonshire Safeguarding Team regarding “William Lawrence” in 2009. They found that communication was to an appropriate level and helped to shape their inspection work with Berrywood Lodge.

**Observation 2**

1.306 There are no specific references to dates and timings which would support this statement.

k) Were any other contributory or fundamental underlying factors identified during the review?

1.307 None were identified by the organisation.

**Good Practice**

1.308 CQC introduced a robust, auditable system for receiving, handling and passing on safeguarding information in 2010 which underpins this process.
Lessons Learnt

1.309 CQC report that since this they have strengthened their systems for managing safeguarding and whistle blowing information and follow up issues. There is no specific indication as to what these improvements are or whether they are as a result of this process of enquiry.

Recommendations for Action

1.310 CQC have not identified any specific actions for improvement.

Issues raised by the Serious Case Review Panel on 1 August 2012

1.311 A number of questions were asked by the panel to be considered in the updated IMR. A number of these have been responded to but not all. The panel asked that the IMR be rewritten filling in the gaps, giving more specific dates. To a point this has been addressed.

1.312 The panel asked the CQC to review the section on lessons learned and develop the recommendations such that they are proper, and meaningful. No further development of the section on lessons learnt or recommendations have occurred.

1.313 At the Serious Case Review panel held on 1 August 2012 CQC were asked whether their visiting was announced or unannounced and it was confirmed that the first visit in February 2009 was unannounced. It was further established that the reason for this unannounced visit lay in the regulator receiving anonymous information that the home was not using the required procedures to recruit staff and were not carrying out proper safety checks before the new staff started.

1.314 This visit resulted in issuing to the management 10 requirements to make improvements to service delivery. These mainly relating to 3 outcomes (lifestyle, complaints and protection and management).

1.315 A further visit was undertaken in July 2009. The regulator identified serious concerns in relation to 6 of the outcomes resulting in 11 further requirements for improvement in relation to all six of the outcome groups, (choice of home, health and personal care, complaints and protection, the environment, staffing management). Three of the requirements related directly to the safety of the people living in the home. The regulator at this point judged that the care home was providing a poor service. The regulator has also indicated that following their inspection and because of the concerns identified by the regulator Northampton county council’s commissioners negotiated a voluntary ban on admissions to Berrywood Lodge.

1.316 A third inspection unannounced inspection was conducted in November
2009 where the service was found to be improving. The service was judged to be providing adequate outcomes and one requirement for improvement only.

1.317 The Serious Case Review panel also asked CQC how long the home had been without a Manager. Their later response confirmed that that they were unable to provide this information.

1.318 In 2010 changes in legislation meant that social care providers were required to submit an application to transfer from registration under the Care Standards Act 2000, to registration under the Health and Social Care Act 2008. The assessment comprised of the provider submitting a declaration about their compliance with the regulations.

1.319 On requiring the Provider to reregister under the Health and Social Care Act 2008, this was undertaken - using a self declaration of compliance by the provider, and other information held about the service. As a care manager was not registered at the point of application, a condition requiring the appointment registered manager was issued. The provider subsequently complied with this condition.

1.320 The regulator has also indicated following the Serious Case Review panel meeting on 1 August that for each of their inspection reports cited there was an acting manager. It has not been possible to establish how long the service was without a registered manager but clearly the period of time known covers a significant period of time.

**SCR Panel Observations**

1.321 It is clear that for many months if not years the home was without a registered Manager. Firstly it is a statutory requirement to have this position filled. The sustained period of noncompliance in this area would by most benchmarks to be an attributable factor to ensuring effective leadership and management. This was not acted upon adequately. Furthermore the Regulator when re registering the Provider had the Opportunity to apply greater leverage. Again when the application was submitted no Registered Manager was in place.

1.322 The regulator has also indicated that they do not hold records of the safeguarding notifications and that their current system requires information to be redacted once a safeguarding referral has been made and satisfactory evidence of action taken received from either the local authority or the provider. I take this to mean that sources of information are edited into one entity and therefore established in a format for historical generic referencing rather than specifically carrying detail regarding individuals.

1.323 The regulator also indicated in their evidence that during their compliance review in January 2011. Berrywood Lodge had continued to restrict the
number of people living at the service to 15 residents.

**SCR Panel Recommendations**

1.324 It is recommended that the Regulator considers whether its system of holding safeguarding records and redaction procedure requires revision as the Regulator struggled for detail in discussing these issues with the SCR Panel.

1.325 It is recommended that where there are sustained periods where a care home does not have a registered manager that the regulator considers enforcement action at an earlier stage than was apparent in this case.

1.326 The level of non-compliance and repeated/sustained non-compliance should be specifically considered as a learning point when the regulator reviews their enforcement tolerances. No formal notices of non-compliance were issued between the periods between September 2008 – January 2009. Almost certainly most perceptions of the position would consider the non compliance position on their second inspection in July 2009 as grounds for “raising the bar”.
East Midlands Ambulance Service (EMAS)

Analysis

1.327 The Organisational Management Review report from East Midlands Ambulance Service NHS Trust (EMAS) was received in good time as requested by the Serious Care Review Panel. The report does not follow the headings requested by the SCR and therefore deviates from the normal structure.

1.328 As the contact time was regarding the call and transfer of William over a few hours a Chronology was included within EMAS’s IMR report to the Panel and not separate.

1.329 The report indicates appropriate sources of information for the report including contextual information about how the service responds to calls from GP’s and how these are prioritised.

1.330 The report describes clearly the contact with the emergency operations centre on the 1st June 2009. The request for a 2 hour response being recorded by EMAS. The request was from a and appropriate call back numbers were given routing back to the care home where William was waiting.

1.331 Shortly before the 2 hour response window elapsed a call was made to the care home from EMAS indicating that arrival would be delayed and a specific time could not be given.

1.332 An Ambulance arrived at the care home at 22.04 where initial assessment and observations were undertaken prior to the transfer. Analysis of the logistical pressures on the service was provided in the report underpinning the delays.

1.333 The initial assessment and observations recorded William as conscious calm and presenting for transfer with needs associated with a chest infection, sores on the testicles and also bed sores.

1.334 EMAS recorded confirmation that William also had a learning disability and Downs Syndrome. The matter of Williams mental capacity/consent details in information recorded at the time is not evident and acknowledged by the organisation to have been an issue that they have since considerably strengthened.

1.335 No safeguarding referral was made by the crew at the time. At the time of William’s contact with EMAS there was much less awareness of Adult safeguarding policies, procedures.

1.336 Training records reflect that one of the staff had no training at that time and this is likely for the other staff.
Good Practice
1.337 It is reported that the Patient Record Form (PRF) were the same attending crew (who have since had training as part of the whole service’s reorientation and prioritisation of Safeguarding issues) would now refer.

Key Issues/Findings

Lessons Learnt 1

1.338 The standard operating procedures for delays and their management have since been revised. This allows for rechecking with GP when delays are apparent and if this is not possible contacting the patient/Carer to check on their condition not just that a delay is occurring.

Lessons Learnt 2

1.339 Education and training with regard to the Mental Capacity Act has been delivered. This is included in all core clinical courses and in any continuing professional development sessions. Prompt cards have also been issued with regard to the tests for capacity.

1.340 In summary:- EMAS has appointed to a new role of lead for safeguarding vulnerable adults in mid June 2010, a new lead for safeguarding children and young people in July 2010 and the safeguarding co-ordinated in December 2010. This team was increased again in 2011 with the appointment of a head of safeguarding to oversee the work of the team. Frontline crews have undertaken extensive safeguarding education and also links to genders such as learning disability.

Key SCR Recommendation

Lessons Learnt were identified and implemented by the organisation.

No further recommendations were made from the SCR Panel.
Berrywood Lodge (BWL) - Minster Pathways

Analysis

The organisation’s IMR report does follow the headings requested by the SCR Panel and therefore conforms to the normal structure.

a) Were practitioners sensitive to the needs of the individual concerned, knowledgeable about potential indicators of abuse or neglect and clear about what actions they should take if they had concerns?

1.341 The organisation’s own IMR indicates prior to April 2009 the care plans were problematic for William. Support plans did not cover all his needs, lacked details and were not person centred. There was also evidence that some of the staff showed a lack of attention to detail and knowledge of care planning also some cases where cut and pasting had captured other service user details. There was no documentation to support the use of a hoist. The care plan not being signed.

1.342 The training planned delivered at this time did not take into account the specific needs of William as his health deteriorated. The company acknowledged in their IMR that it had been difficult for them to establish the training skills and knowledge of Managers working there at the time. They acknowledge this as having led to gaps and inconsistency in the continuity of support and guidance to staff.

1.343 Other key systems such as handovers were not written, team meetings were not recorded and supervision was being established but no records available to confirm these practices were taking place were acknowledged by Berrywood Lodge.

Comment

1.344 No documentation regarding the using of the hoist is a major concern arising linked with the care of William. Not having the appropriate instruction is concerning with regard to skin care issues.

b) Did the agency have effective policies and procedures in place for safeguarding vulnerable adult?

1.345 The agency had a range of policies and procedures in place. These included key policies to protect vulnerable adults. However as we have already noted a number of these were not being actioned. The implementation of key policies and procedures is acknowledged by Berrywood Lodge to be linked to the succession of managers and audit and monitoring actions.

1.346 As a result Berrywood Lodge acknowledge that there were three versions of form recording health professional contacts. Some turning charts had the
same date and by their own admissions indicating that there were different expectations of where the turning charts were held and who was completing these.

c) What assessments took place of the individual concerned and what decisions did the assessments lead to? Were the assessments and subsequent decisions reached in an informed and professional manner?

1.347 Berrywood Lodge acknowledge that staff were not trained to check whether they correctly assessed risks, identified controls or carried out evaluations.

1.348 They also acknowledge the increasing risks associated with William’s deteriorating position which could have been reasonably foreseen were not highlighted and indicate risk assessments did not cover areas such as moving and handling or sufficient details around pressure care.

1.349 Systems for audit, monitoring and compliance of risk assessments were not evident.

1.350 Berrywood Lodge make the point that they did access other agencies for support and were dependent on other professionals for support or in some cases to effect decisions pertinent to William.

d) Were actions taken and services provided in accord with the assessed needs of the individual and the decision reached?

1.351 Berrywood Lodge have confirmed that recordkeeping shortcomings mean that a full and accurate picture of events and actions is not possible.

1.352 Of particular note Berrywood Lodge indicate that the community nursing agreed guidelines were not explicit to support non clinical staff in monitoring skin condition of William.

1.353 Turning charts were vague in their entry and in some cases not filled in.

1.354 Berrywood Lodge give a number of examples between the 18th May 2009 and the 31st May 2009 where running up to William’s admission to hospital on the 1st June 2009 records are not completed and this does not therefore allow Berrywood Lodge to confirm that they were taking actions in accord with the assessed needs of the individual.

e) Where plans had previously been put in place to protect the individual concerned, were these plans executed appropriately?

1.355 Berrywood Lodge again acknowledge inconsistent application of plans limited follow through in some cases is raised by Berrywood Lodge. However they do confirm their understanding that following a visit by a health professional on the 20th May 2009 to support William’s nutrition, recording of choking was being recorded.

Author Note: There is reference to the above in their IMR Chronology (26)
but reference in the main Chronology has not been transferred.

f) **Had the views of the individual concerned and (where appropriate) their Carers, been ascertained and taken into account?**

1.356 The majority of documents requiring signature by the Service User had not been completed. To confirm consent had not been obtained from William or a relative such as his Father. Records of review meetings could not be identified by Berrywood Lodge.

**g) Was the practice sensitive to the racial and cultural background of the individual concerned, their language and their religion?**

1.357 Berrywood Lodge confirm that the care and support plan did identify his wish to attend church however record keeping and evidence form Berrywood Lodge indicated he had not attended although there were records of other leisure activities he had undertaken. The frequency over a period time was not identified.

**h) Were decisions taken at an appropriate level in the organisation by professional and managers with the experience and authority to make such decisions?**

1.358 Earlier comments by Berrywood Lodge indicated issues with Registered Manager continuity and senior staff. However Berrywood Lodge does consider as an organisation that matters were not escalated higher within and external to the organisation sufficiently. This may have expedited the actions of other agencies in particular around assessment and funding for changing care needs.

**i) Was the work undertaken in the case consistent with national standards, codes of practice and guidance, inter-agency procedures and wider professional standards?**

1.359 Berrywood Lodge confirm they were registered with the various regulations over a number of years. However they indicate that they were not registered for nursing care. They acknowledge that there were shortcomings identified by the regulator around compliance and agree these ran into a number of areas.

**j) Was communication within the agency and with other agencies appropriate to the requirements of the case?**

1.360 Berrywood Lodge confirm that whilst their systems for written communication and with other agencies had significant weaknesses. Reiterating a number of the shortcomings identified by the organisation previously.

**k) Were any other contributory or fundamental underlying factors identified during the review?**

1.361 Berrywood Lodge make the point that they consider that William's
reassessment on the ___rd March 2009 identified he had nursing care needs ____. However it was not until a further 3 months had elapsed before a transfer was agreed and they indicate they consider the delay was due to funding agreements not being reached.

1.362 They also consider that William’s position should have been escalated by funders with his needs having been identified. They also highlight what they see as failings by the District Nursing Service pointing to gaps in attendance and poor care support and guidance regarding body mapping and pressure area care.

1.363 There is criticism of Mr Lawrence Senior in Berrywood Lodge’s IMR regarding funding and William having undersized trousers, linking this with skin viability and having to fund some clothing themselves. It should be noted that this point was discussed with the family and was strongly refuted by them.

1.364 They also indicate there being no allocated care manager and the role within the home of a key worker was not established.

Lessons Learnt and Corrective Actions now put in place

1. Pathways Care Group confirms they should have carried out a more comprehensive quality review post acquisition.
   1  This process has now been put in place where a new acquisition to occur.

2. Increased levels of scrutiny from line management have been recognised.
   2  Put in place (rephrased by the Author)

3. Staff compliance with policies and procedures has been strengthened.
   3  This through a read and sign arrangement.

4. Increased line management scrutiny of staff’s performance and compliance.
   4  A number of staff replaced. Only 3 out of the 16 staff are now employed in the home.

5. Expansion of care home was not considered alongside levels of compliance and quality.
   5  Reduced numbers applied whilst CQC and NCC Contracts staff indicated concerns. Pathways Care Group has since further reviewed the position and reduced its original registered number aspirations.

6. Improved training on risk assessment practices would have ensured
better outcomes for William.

6. Revisions to formats and policies and procedures linked to risk assessments have been updated and improved.

7. Care planning was recognised as a key area to improve.

7  Checklists have been introduced to cover these areas and risk assessment completion.

8. The correct and appropriate usage of both turning charts and body maps to identify skin areas problems developing have been agreed as having shortcomings.

8  The company has recognised that nursing care needs at the time for William were not appropriately addressed in a care home. However as they have nursing care services in the Care Group they have introduced improved body mapping and turning charts in their other services as a result of these experiences.

9. Shortcomings concerning continuity of care delivered are recognised.

9  To improve the position there has been an introduction of a key worker role.

10. The Pathways Care Group indicated that there should be clear guidance to staff concerning escalation routes.

Recommendations indicated by the Care Home Provider

1. Pathways Care Group to ensure that comprehensive systems are implemented. This is, key working, training, induction and interagency communication and that these are monitored and maintained.

2. Pathways Care Group need to ensure that their policies and procedures and general documentation is reviewed to ensure fit with best practice.

3. Pathways Care Group should ensure that quality monitoring arrangements are prioritised for services known to have compliance or quality concerns.

4. Pathways Care Group should ensure that any future service acquisitions are subject to rigorous quality assessment and close monitoring.

5. As part of any future acquisition concerns with quality are detected, consideration should be given to what measures will be put in place to ensure concerning practices are not continuing.

6. Pathways Care Group should review their safeguarding training and processes to ensure that any allegations concerning lack of financial support from families is formally raised and addressed.
7. Pathways Care Group should identify and record senior management contact details for partner agencies. Make this information available to staff so that escalating concerns about practice or delays in the provision of services can be more appropriately escalated.

Issues raised by the Serious Case Review Panel on 1 August 2012

1.365 The Serious Case Review panel commented that they felt that the IMR should be written in a style that makes the ownership of the outcomes by Minster Pathways clear. In addition, where Minster Pathways wish to make recommendations in regard to other agencies or to the SOVA Board they should be distinct from those owned by the organisation.

Answer - The updated IMR has been written in the style that more so reflects ownership by Minster Pathways.

1.366 The Serious Case Review panel requested that the provider also included an action plan and that this should be signed off at a company director level or equivalent.

Answer - this has been responded to.

1.367 The Serious Case Review panel also asked Minster Pathways to provide an explanation as to why nobody collected William's prescription and what actions and processes are in place to provide assurance that such an event is not repeated. The panel also asked whether Minster Pathways staff were aware of the contents of the prescription and their understanding of its significance in regard to William's medical conditions.

Answer - The author cannot find any evidence of this being responded to in the updated IMR. There is, however, in their IMR Chronology (32) (reference in the main Chronology has not been transferred); to staff having to visit three separate pharmacies as the medication prescribed was not available. The entry also describes the area manager authorising the use of a taxi for the staff to going collect prescription from a more distant pharmacy.

1.368 The panel was also concerned to understand why so many opportunities were missed to communicate and take action regarding William moving to different and more suitable accommodation.

Answer - the updated IMR has taken on board the lack of escalation guidance to staff and this appears in their action plan.

1.369 The panel also were also concerned that the key working role needed defining in the revised IMR.

Answer - the key working role has been recognised as a shortcoming and area for improvement. This has been included within their action plan.
1.370 The panel raised concerns around the practices for communicating with other agencies.

Answer - this has again been included in the organisation's action plan.

1.371 The panel asked clarification on the date on which ownership was transferred.

Answer - no date has been forthcoming from the organisation.

**Key Additional SCR Recommendations**

1.372 It is acknowledged that the Pathways Care Group has learnt lessons and identified these in their IMR report together with specific examples of where changes have been made to improve procedures, practices and service delivery. Further recommendations are made as follows:

1.373 Pathway Care Group should introduce an audit of the clients it has in its care settings to ensure that their dependency and care needs are not in breach of their registered conditions.

1.374 The regulation 10 Outcome 16 requirement to conduct monthly monitoring and quality checks on its registered services incorporates within its format specific reference to the dependency of clients and those whose condition is of concern highlighted for specific discussion.

1.375 Where in the future service users are being accommodated in the care home and it is clear that a review of their care has not been undertaken regularly by the placing authority as agreed at placement inception; or the client’s needs deteriorate significantly, either mentally or physically they are formally referred to the placing authority for review. This referral needs to be formally communicated.

1.376 Where a review connected with 3. above is made and a response from the placing authority is not readily forthcoming then this should be formally escalated to the authority and if need be reported to the Regulator as an incident affecting the health and welfare of the client.

**Northampton General Hospital Analysis**

The organisations IMR report broadly follows the questions asked of the SCR Panel although some restructuring by the author of this report has been required to make this clearer.

1.377 Within the specific time frame stipulated by the SCR there were two main
incidents where William came into contact with the hospital’s services.

**Incident one - 19/08/2008-26/08/2008**

19/08/2008 - William admitted to NGH via Accident & Emergency department. History given by carers that William had fallen to the ground had an episode of shaking, difficulty breathing, cyanosis and incontinence. Care home stated that William condition had deteriorated over the past six weeks.

**Incident two - 1/06/2009-5/08/2009**

1/06/2009 - William admitted to NGH direct to EAU. GP referral directly to EAU.

William presented with a history of reduced oral intake, groin and scrotal sores. Recently been treated for an upper respiratory infection by GP. William admitted to NGH for care & treatment.

**a) Were practitioners sensitive to the needs of the individual concerned, knowledgeable about potential indicators of abuse or neglect and clear about what actions they should take if they had concerns?**

1.378 On both occasions William was admitted for care and treatment, NGH made adjustments for William’s limited communication, by using family and care staff to assist with assessments and compiling of initial care plans to ensure that William’s needs were met. His needs were also assessed and support given by the Acute Strategic Learning Disability Nurse on William’s second admission to the Trust. Carers attended regularly to support and assist with communication needs while William remained an inpatient. Family were consulted during William’s attendance at NGH. This included discussion on treatment options, discharge plans and care planning. Due to William’s lack of capacity, the principles and actions of the Mental Capacity Act were adhered to. This included consultation with William’s relatives regarding treatment, care and consent for treatment.

**b) Did the agency have effectible policies and procedures in place for safeguarding vulnerable adult?**

1.379 Prior to 2009 NGH had not implemented the safeguarding procedures within the Trust. Therefore the first occasion when William was admitted the Trust was in an early stage of considering the implementation of NCC’s “Procedures for Interagency Approach for Protecting Vulnerable Adults from Abuse” 2007 as published by the Northamptonshire Intra-agency Safeguarding Adults Board.

1.380 Since 2009 NGH has adopted both internal and external process regarding the protection of vulnerable adults. The Trust Safeguarding Vulnerable Adult policy identifies what constitutes abuse and the types of abuse in adults. Neglect / omission are discussed within the policy. In addition the
policy provides additional information for staff regarding examples of abuse. The Trust safeguarding training provides definition and types of abuse and, additional examples and scenarios are discussed with to staff.

c) What assessments took place of the individual concerned and what decisions did the assessments lead to? Were the assessments and subsequent decisions reached in an informed and professional manner?

1.381 The Trust’s Management report and detailed Chronology indicate thorough accurate assessment and in consultation with family and carers that William’s care needs were planned and implemented.

1.382 Where William’s condition started to further deteriorate between the 25/06/2009 – 05/08/2009 the agency’s detailed Chronology highlight the deterioration of William’s condition and this was acted upon by both by medical, nursing and allied professionals. Throughout this period a number of detailed discussions were held with William’s next of kin. In particular in the latter part of July, discussions were held regarding William’s need for further invasive treatment in particular relating to his nutritional needs. William’s family had discussions with medical team and other professionals regarding his poor prognosis and any further treatment. The family opinion regarding on-going treatment and care were taken into consideration when decisions were made for William.

d) Were actions taken and services provided in accord with the assessed needs of the individual and the decision reached?

1.383 The detailed Chronology indicates that actions were taken and services provided in accord to the assessed needs of William throughout his time in Hospital. The principles of the Mental Capacity Act were adhered to regarding the consent for treatment and care and actions taken for William. Due to William’s limited communication, NGH engaged with both his family and Carers regarding the best way to communicate with him. Decisions and actions regarding treatment and care of William were discussed with family and carers.

e) Where plans had previously been put in place to protect the individual concerned, were these plans executed appropriately?

1.384 There were no specific plans in place to protect William. However actions in (d) above are relevant and appropriate.

f) Had the views of the individual concerned and (where appropriate) their Carers, been ascertained and taken into account?

1.385 It was noted by nursing and medical staff, that William had limited communication. NGH engaged with both William’s family and carers regarding the best way to communicate with him. NGH also sought the
support and advice from both family and carers and involved them regarding planning all aspects of care and decisions making. The family were also supported and consideration of their wishes regarding William's end of life treatment were taken into account.

g) Was the practice sensitive to the racial and cultural background of the individual concerned, their language and their religion?

1.386 The Chronology does not indicate any concerns in this area.

h) Were decisions taken at an appropriate level in the organisation by professional and managers with the experience and authority to make such decisions?

1.387 All professionals involved in making decisions for William were appropriate and professionally accountable for their actions. Due to William's lack of capacity, the principles and actions of the Mental Capacity Act were adhered to. This included consultation with family members regarding treatment, care and consent.

i) Was the work undertaken in the case consistent with national standards, codes of practice and guidance, inter-agency procedures and wider professional standards?

1.388 NGH adhered to all standards and professional codes of practice. William was assessed and referrals to agency made appropriately. There was inter-agency working regarding William's on-going care and treatment.

j) Was communication within the agency and with other agencies appropriate to the requirements of the case?

1.389 The Trust had worked in partnership with William's care providers and others community services. During William's initial admission regarding incident two the Trust had no concerns regarding interagency working regarding assessment of need and discharge planning.

k) Were any other contributory or fundamental underlying factors identified during the review?

1.390 The Trust indicated it had not identified any fundamental or contributory factors regarding William's care. However they did identify that the safeguarding process and training of staff had commenced in March 2009. The Trust had not established safeguarding and Mental Capacity Act training for staff as a mandatory subject until November 2009.

1.391 There was also a delay in referring William to the Acute Learning Disability Nurse.

1.392 The Trust at the time of the review had limited support from the Learning Disability Nurse due to the role being shared with Kettering General
Lesson Learnt

1. **Referral to the Acute Learning Disability Nurse:** - within the organisations report it is indicated that the referral to the Acute Learning Disability Nurse did not occur immediately but ten days after William was admitted to NGH. A referral should have been made on William’s admission to NGH. Support from the Learning Disability Nurse would have helped to assess William’s needs, care plans and treatment.

2. **Communication with William:** - it was noted on the initial assessment that William had limited communication. NGH did engage with both William’s family and Carers regarding the best way to communicate with him. If NGH staff had used communication tools such as a communication passport or other tools that were available, this may have given further assistance to staff and ensure William’s needs were communicated.

3. **Carers:** - this report highlighted that there was no formal recognition or support by NGH for the carers who attended to William.

4. **Body Mapping:** - that initial assessment of skin integrity and assessment of pressure areas were not recorded at the earliest opportunity on William’s second admission to the Trust.

5. **Nutritional Assessment:** - a nutritional assessment was completed for William on admission on both occasions to the Trust, there is no record of William having been weighed on either admission.

**Good Practice**

The review highlighted good practices that William had receive during his admission to NGH.

1. **Initial Assessment and Implementation of care plan:** - NGH can demonstrate that William’s needs were assessed not only for his acute physical needs but also his needs as a patient with a learning disability.

2. **Communication with Family and Carers:** - NGH sought the support and advice from both family and carers and involved them regarding planning all aspects of care and decision making. The family were also supported and their wishes taken into consideration regarding William’s end of life treatment.

3. **Consent and Treatment:** - the principles of the Mental Capacity Act were adhered to regarding the consent for treatment and were in the best interests of William.
4. **Multi Disciplinary Team:** there were appropriate referrals to both physiotherapy and occupational therapy service. There were regular multi-disciplinary meetings. Appropriate referrals and assessment were carried out by the Speech and Language Service.

5. **Acute Learning Disability Nurse:** NGH engaged the support and advice of the Acute Learning Disability Nurse.

**Recommendations**

1. **Accident and Emergency Care pathway:** developed to identify people with a learning disability at the earliest opportunity and to enable reasonable adjustments to be made.

2. **Communication Passports:** development of communication sheet/passports, providing essential information about the patient has been developed and implemented. This information will ensure staff are aware of the patient needs. Care and treatment plans can be formulated using the information provided.

3. **Carers Policy:** development of Carers policy to support both formal and informal carers.

4. **Patient Experience:** to ensure that patients with learning disabilities and/or their carers are informed and participate in patient satisfaction survey. Development of resource/tools, with reasonable adjustments so that patient’s experiences within NGH are recorded.

**Actions Taken by the Trust in 2011/12**

1. **Acute Liaison Learning Disability Nurse:** Since August 2011 the Trust have access to a full time Learning Disability nurse.

2. **Communication Tools:** Communication tools have been developed to improve the communication between healthcare staff and patients with a learning disability. This includes the following:

   1. **A Hospital Passport** – this is completed by carers that know the individual well and shares important information about how to support the individual including communication, how they show they are anxious or in pain.

   2. **Core Assessments** – Prompts nursing staff to consider areas such as capacity, carers support, and pain management.

   3. **Re-launch of the A & E Care Pathway.**

   4. **Re-launch of the A & E grab sheet/communication booklet.**
3. **LD Awareness training:** - The training includes:

1. Definition of a Learning Disability
2. The Equality Act 2010 and reasonable adjustments
3. Communication, skills, opportunities and tools available.
4. Mental Capacity Act and the relevance to Learning Disability patients

Bespoke training is also undertaken with ward teams. Staff identify practices and strategies to be implemented which would improve the experience for both the patient with a Learning Disability and health care team.

The Safeguarding Steering Group monitors the action plans and work streams that have been established within the Trust.

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**Issues raised by the Serious Case Review Panel on 1 August 2012**

1.393 The panel were concerned to note if there was a policy criteria needed to be varied to include neglect as a concern. The panel were also concerned at the failure to pick up William’s rapid deterioration. Although his weight had remained the same over a prolonged period of time. The panel also enquired as to whether the hospital considered there was any question of inaction by the home or any other professionals. Lastly, the home had a 24-hour responsibility for care delivery and district nurses were involved. However, it is evident that William was deteriorating should someone have asked for an earlier referral and who should have taken this responsibility on?

1.394 The updated report from the hospital trust and in particular the key lessons learnt and recommendations have responded to their own responsibilities to improve policy and practice, especially in respect to clients presenting with a learning disability. The specific questions as to neglect and whether other professionals had shown in action or should have asked for an earlier referral were not answered in the hospital Trust’s IMR update.

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**Key SCR Recommendation**

1.395 The guidelines on referral to Safeguarding and to the Coroner need to include more specific reference to neglect.
General Practitioner IMR

Analysis
The report does not follow the headings requested by the SCR and therefore deviates from the normal structure and has been edited to convey more meaning in the context of the SCR Panels specific enquiries.

1.396 During 2008 the Chronology from the GP’s IMR indicates frequent interventions and oversight.

1.397 At the beginning of January 2009 William was visited by his GP. A review also occurred by the CPTLD Service in the same month.

1.398 A further visit by the occurred in April 2009 where the diagnosis included a restatement of William’s Learning disability, Alzheimer’s dementia and late onset epilepsy. Later in the same month a chronic health review was occasioned by the GP. Including a physical examination and resultant prescription for a chest infection.

1.399 Towards the end of March 2009 there were two visits to William. Following contact from the District Nurse on the 1st June 2009 a decision was reached and the GP asked for hospital admission.

1.400 He was clearly not a ‘forgotten’ patient viz a vis his late onset epilepsy treatment and full physical and mental assessment in April that year.

Out of Hours Service
1.401 The GP review of the Out of Hours service indicates the service was contacted three times during this period. Their advice and interventions are reported as timely and well within good practice. Notes were made and handed on to GP.

Good Practice
1.402 Requests for visits were promptly carried out and appropriate diagnosis made, advice given including referrals to specialist services. The GP concludes that he considers William was seen promptly, treated and referred onto to other colleagues appropriately.

Key Lessons Learnt – none for the GP’s Practice
1.403 The GP’s IMR does not record and specific practice improvements. He does consider that better care can be provided in care homes if more residents are registered with the same practice. Complex patients with multi-agency input need regular care conferences so that all parties, including relatives, can optimise care for these patients.
Recommendations

1.404 None are identified in the GP’s own IMR.

Issues raised by the Serious Case Review Panel on 1 August 2012

1.405 The GP was asked whether the district nursing notes that he confirmed existed could be provided to the panel. Were the district notes the GP is referring to different to the five visit sheets that the NHF trust referred to?

Answer - the GP confirmed the district nursing notes he had seen were those that were contained within the GP notes. They do not relate to the missing district nursing notes discussed throughout this report.

1.406 The GP was asked whether he felt as Mr Lawrence Senior had suspected that the medical profession were withholding information.

Answer - the GP considers that no medical information is or was being withheld from Mr Lawrence Senior. But in the past he considered medical information did not appear to have been communicated well. The GP did not have any record of Mr Lawrence Senior contacting the surgery in this regard. The GP would welcome Mr Lawrence Senior visiting the surgery where he could look through all the medical records on his son if he wished.

1.407 The GP was asked to explain why he did not communicate the diagnosis to Mr Lawrence Senior of dementia.

Answer - the surgery did not communicate a diagnosis of dementia to the Father as no formal diagnosis had been made to them, nor had they screened William for dementia.

1.408 A further question by the panel asked the GP about whether or not he had approached Mr Bell Senior about his son’s end of life care?

Answer - the GP confirmed that there were no discussions between the practice and Mr Lawrence Senior about end of life care. This care occurred at the hospital and the practice had no communication from either the hospital or Mr Lawrence Senior that his son was on this end of life pathway.

1.409 The GP was asked by the panel about the occasions when prescriptions were not collected for a significant period of time and why no action was taken by the GP to ensure no future repetition of such events.

Answer - prescriptions for collection from the GP surgery are put into a box to be collected from reception. Some collected by the patient in person, or by a friend, relative, some by pharmacies, some by district nurses. A
significant number are not collected and monthly cull of all prescriptions occurs. The reasons for non-collection are highly varied. This is the practice of most GP surgeries. It is difficult to devise a system to check up on prescription collection that is not either highly labour-intensive or inconvenient to the patient.

1.410 The GP was asked to comment on the nature of the medication that was uncollected. And would the timely arrival of the medications have made a significant difference to William’s condition.

Answer - the delayed prescriptions contained topical creams, antibiotics and a food thickener. Of these, the GP felt the most significant was probably the food thickener. The GP did not think the creams or antibiotics would have had a significant impact but thickening his food would have helped his nutrition. However, the GP does not think the delay would have made any significant difference to his final outcome.

Consideration of inter-agency Lessons Learnt and Recommendations

1.411 All of the individual agencies covered in this report, taken in isolation, suggest that there were deficits in the care provided to William at BWL.

1.412 Poor communication and sharing of information between different professionals and agencies meant that this information was never brought together and analysed in a way that a complete picture of William’s care and treatment at BWL could be properly assessed.

1.413 There is no evidence at the time that cross information sharing and care planning was undertaken between the DN team and CTPLD and associated specialist services.

1.414 Equally across the other sectors involved in William’s care the sharing and care planning was not integrated or easily accessible by other parties involved in William’s care.

1.415 The further integration of care planning across care agencies is a factor that the SCR Panel wishes to understand and have a base line audit established.

1.416 There were a number of missed opportunities where individual professional assessments could have triggered a more comprehensive review of William’s needs. This in particular as William had mental capacity considerations. The absence of escalation policies in differing agencies was also not well developed and appears in the recommendation of this report.

1.417 A variety of means to record information relating to William’s care and
treatment was used by the different teams involved in his care. The NHFT report could find no common, cohesive communication tool relating to William’s needs for use across all agencies. This clearly interfered with information sharing between professionals and agencies. There was no central electronic recording system in place for all the professionals and differing organisations to use, and those that were in place in the organisations were not being used effectively at this time. The SCR Panel would want to see where agencies are with these issues and whether there was any progress in key health and social care agencies with these issues.

1.418 It needs to be recognised by agencies that regard for record keeping and accounting for this by reference to the working day is not always understood and given priority.

1.419 Risk assessment and risk management are reliant on up to date care plans. The absence of care plans in the CTPLD at the time made it difficult to assess what interventions were being offered and if they were successful in reducing and managing the risks associated with William’s care. The reviewers were told that at the time covered by this investigation, care plans were not used by the CTPLD. (All)

1.420 Professionals are accountable for ensuring that communication takes place between agencies, in the interests of their patients. A Health Action Plan as recommended in ‘Valuing People’ would have addressed this. Health action plans were not a practice issue as well developed or seen by the regulator as a factor to consider in 2009. It would be essential that Health Care Plans across agencies are implementing these practices including regulated care services. The SCR Panel would want to understand whether there has been any base lining or audit of the cross agency position. (All)

1.421 Complex cases where there are different sources of concern and a number of agencies involved should be subject to a multi-agency strategy meeting that is minuted and followed up once the investigation is underway. (NCC)

Mental Capacity

1.422 Agencies considered in this review have all demonstrated that in 2009 they had not brought Mental Capacity and Deprivation of Liberty Safeguards into policy and practice in a meaningful way. This allowed for William’s Best interests to not be considered as would now be the case. The Mental Capacity Act provides a framework to empower and protect people who may lack capacity to make some decisions for themselves.

1.423 The Mental Capacity Act makes clear who can take decisions in which situations, and how they should go about this. Anyone who works with or cares for an adult who lacks capacity must comply with the MCA when making decisions or acting for that person.

1.424 This applies whether decisions are life changing events or more every day
matters and is relevant to adults of any age, regardless of when they lost capacity.

1.425 The underlying philosophy of the MCA is to ensure that those who lack capacity are empowered to make as many decisions for themselves as possible and that any decision made, or action taken, on their behalf is made in their best interests.

1.426 Recommendations across the agencies under this area are made.

**Multi-Agency Recommendations**

1.427 To review and improve multi-agency procedures for multi-agency Safeguarding conferences.

8 In particular, to recommend to the SOVA Board (SOVA) the development of agreed single agency and multi-agency “triggers” to assist and guide staff for when a multi-agency conference should be convened including

1.428 Improved Information Sharing Across Statutory Agencies

9 To audit the use of existing information sharing protocols across statutory agencies and to identify any gaps in such protocols.

10 To include in this audit whether existing electronic information sharing systems across statutory agencies are being considered and details about where actions are being progressed. This to inform the cross agency strategic picture in order to ensure that the SOVA Board can establish what progress is planned and comment on developments going forward.

1.429 Improving practitioner awareness of Regulatory limitations in care settings

6 Increasing practitioner’s awareness of regulatory constraints and Provider limitations to care needs and their delivery in care homes without nursing and care homes with nursing competencies as registered with CQC.

**1.430 Safeguarding agency training and resultant practice - verifiably strengthening**

There were a number of missed agency opportunities to make adult safeguarding alerts for William when there was a clear indication that it was appropriate to do.

7 SOVA Board needs to review how it obtains and measures practice information about how confident and competent frontline staff and
managers across all agencies working with vulnerable adults.

8 In particular:

- Escalation arrangements in their agencies and competencies in this regard including specific reference to capacity and consent linked to the Mental Health Act and DOLS. A questionnaire approach may be an option to consider led by the agencies themselves and reporting this information back to the Safeguarding Board for strategic oversight and reporting.

With this information to hand, the SOVA Board will be able to review the adequacy of existing learning and development activities (which are already evaluated for how good a learning experience they provide) and ensure that confidence with using adult protection procedures is matched by competency in doing so. In summary:

5 To consider the results of the most recent Adult Protection Training Audit

6 To undertake an anonymous and representative sample survey of operational staff and managers across all APC member agencies measuring people’s knowledge of existing adult protection procedures, confidence in using these procedures and feedback in doing so.

7 For each agency member of the SOVA Board to continue to bring a report to the SOVA Board detailing how it has embedded adult protection policies and practices – and to provide evidence of the effectiveness of their adult safeguarding work.

8 To convene an annual joint meeting of the Local Safeguarding Children’s Board (LSCB) and the SOVA Board (SOVA) in order to share best practice, compare systems and approaches, identify issues of common concern and interest and agree joint areas of development work.

END OF MAIN REPORT
Main Recommendations and Conclusions

Northamptonshire Health Foundation Trust (NHFT)

Recommendations

6 An individual key worker in the CTPLD should take responsibility for the care coordination and the development of integrated care plans when multiple disciplines are involved in the care of patients when they make internal and external referrals to other services.

7 Nursing competencies within the Northampton District Nursing team should be reviewed and lessons shared with the wider District Nursing Teams.

8 CTPLD and DN Team Leaders must take steps to ensure that the key workers communicate with carers appropriately about their relatives’ condition and prognosis.

9 The teams involved in the care of William should receive refresher safeguarding training, using this case as a case study.

10 When complaints are received where there is an inference of neglect, the Safeguarding process should be triggered.

SCR Panel Additional Recommendations

5 Nursing training competencies should be reviewed to also be assured they understand the regulatory differences between care homes without nursing and those with those competencies and the implications of this difference for their practice.

6 Where in DN case allocation there are/is a client with mental capacity issues then particular attention should be given to whether care is suitable and sufficient and where they have concerns in this respect there is a procedure for escalation before it becomes a safeguarding concern.

7 There is a review of DN oversight not just in performance but regular formal supervision is ensured as a key organisational practice. This is audited and part of the reporting through Governance structures to Senior Management.

8 In end of life care circumstances in particular where a client is in a residential care environment and has limited or mental capacity issues then there should be a multi-disciplinary meeting to ensure that all appropriate care arrangements have been considered fully.

NHS Milton Keynes/NHS Northamptonshire
Key Recommendations

For Northamptonshire Healthcare NHS Foundation Trust:

9 The Trust’s own 5 recommendations arising out of its own IMR are repeated.

For Northampton General Hospital NHS Trust:

10 The Hospital Trust’s own 4 recommendations are repeated.

For Continuing Healthcare:

11 Two of the teams own recommendations are repeated.

12 A third recommendation concerns clarity regarding who is the lead agency and the report goes on to stress this should include liaising with the care providers and having oversight of safeguarding and quality issues for the client/patient.

For the General Practitioner Services

2 The GP’s own IMR report recommendation is repeated.

Additional Recommendations from the Independent Clinical Reviewer

Some of the recommendations were observations and have been redacted to sharpen their focus where that is possible. This is indicated after the recommendation for clarity.

10 The regular weighing of patients where nutritional status is a concern should be part of care planning and records kept. This recommendation was focused on NHFT and NGH Trust’s.

11 When any patient is admitted with a learning disability as co-morbidity, the Trust’s learning disability nurse should be informed straightaway, (NGH)

12 Record-keeping in the district nursing service in particular was concerning. There were also gaps in other records. Staff need to understand that this is a core requirement of their employment and that sanctions will be used if members of staff continue not to ensure they keep accurate, contemporary and clear records of visits and decisions made on all patients. **Redacted.**

13 Electronic data records need to be given priority in respect to the system being available to all practitioners. This should assist in the sharing of records between the givers of care. **Redacted.**

14 The Department of Health’s complaints procedures were updated and came into force on 1 April 2009 awareness training needs to be in place to ensure complaints staff are up to date on current guidance.

15 The general practice staff should have a system in place to review prescriptions that are not collected and make a clinical judgement about actions required taking account of the particular vulnerabilities and health needs of the
patient.

16 When problems surfaced regarding the care of William in the community setting and in the residential care home, including the delays in responding to referrals, delays in responding to prescriptions, and missing of appointments and revisits, staff should have refresher training in the critical clinical areas regarding their responsibility to refer problems to senior staff for action or support. Redacted.

17 The performance management of staff who are engaged in clinical practice in the community setting should be reviewed. Redacted.

18 The lessons learnt from this particular review should be used to refresh and trained staff in improving communication and the importance of record-keeping.

Continuing Health Care (CHC)

SCR Panel Further Recommendations

6 Where the CHC Team request information that concerns a vulnerable adult such as William and this information is not forthcoming then every effort should be made to either follow this up or escalate the position to management or if information is putting the client at risk of compromise in their health and well being position report as a safeguarding concern.

7 Efforts should always be made where there are mental capacity issues to ensure the assessor is aware of any best interest guidance for the client.

8 Where there are mental capacity issues, unless there are specific exclusions subject to 1.153 above then the family lead members should always be involved and consulted with.

9 For the key commissioning agencies involved there needs to be an escalation policy preferably jointly agreed in order that inertia for whatever reason in decisions reaching action can be escalated by concerned professionals involved.

10 The Adult Safeguarding Board considers the irregularities in the accounts of the Continuing Health Care Team report and Northamptonshire County Council’s report and the matter is escalated for review in an appropriate senior governance forum to be recommended by the Board.

Northamptonshire County Council (NCC)

Contract Monitoring

4 Where a contracted home persistently fails to meet its obligations there should
be a clear route that the council follows in order to enforce compliance (an escalation policy). This should specify requirements, timescales and consequences of failure to comply and should be part of the legal contract signed by the council and the provider.

5 There needs to be clear communication routes for sharing information between different agencies and different arms of NCC. There should also be a forum for discussing provider services which appear to be failing so that their viability as contracted services can be examined with inputs from all relevant parties. This should be linked procedurally to the safeguarding policies and procedures in NCC.

6 The position of informing self-funders or their advocates needs to be also considered and appropriate means of ensuring either the individual or their representatives are aware of the Council’s concerns and interventions; respecting the balance that needs to be struck between the Council’s safeguarding role and duty of care with actions prejudicing the livelihood and reputational interests of a Care Provider.

**Care Management**

7 Where a review identifies the possible need to move an individual who does not have mental capacity and there is an emerging conflict with the person’s family then advice should always be sought from a senior manager and consideration given to whether there may be a conflict of interest between the needs of the individual and their relative(s). This should include consideration of mental capacity and whether the individual requires a separate independent advocate. The outcome of these discussions should be clearly recorded on the case file.

**Safeguarding**

8 There needs to be significant improvement in the process for tracking the progress of investigations carried out by the Safeguarding Adults Team. This should include clear timescales for each stage of the process and a system for “flagging” cases that fall outside of the timeframe.

9 Apart from straightforward low level concerns there should always be an investigation plan that is drawn up by the worker and agreed by the supervisor/manager. This should include arrangements for keeping referrers and interested parties informed of progress throughout.

10 Managers should ensure that all active investigations are discussed in supervision and that where obstacles occur these are escalated if they cannot be resolved by the worker or manager. The supervisor/manager should ensure that all reports are quality assured and signed off immediately after completion.

11 Complex cases where there are different sources of concern and a number of
agencies involved should be subject to a multi-agency strategy meeting that is minuted and followed up once the investigation is underway.

12 The SOVA procedures need to be checked to ensure that they refer to any party being able to request this multi-agency meeting.

Mental Capacity

3 Where there is evidence that an individual may lack the capacity to give a view about an important decision, this should be assessed and consideration given as to whether there is a need for independent advocacy.

Internal NCC arrangements for handling complaints and investigations

4 Managers within the different arms of NCC should jointly consider whether there is clarity about roles and cross-over when concerns are raised about individuals or standards in residential care. This could be done through a short one-off piece of work. If there is a need for clarity that would help to ensure that there is “joined-up” working then this should be provided either through some form of guidance or a joint seminar for staff. This should be completed within 3 Months of the completion of this report through its approval stages at the Safeguarding report.

Actions Taken to date by NCC

8 In the spring of 2011 another IMR relating to a man identified a number of issues that are also relevant to this IMR. As a result a number of actions were taken by NCC and these are listed below.

9 The Northamptonshire Inter-Agency Safeguarding Procedures have been revised (issued November 2010) and now provide a clearer procedural framework for managing safeguarding cases.

10 Additionally in June 2010 threshold criteria were introduced and a screening process using these criteria included in the procedures. This allows cases to be screened and weighted for complexity. Within the Safeguarding Team the person with the case lead role is identified for each case and Principal Care Managers prioritise and track cases.

11 A new template for strategy meetings has been developed and implemented which specifically covers what needs to be considered and agreed at Strategy Meetings.

12 For cases that are handled outside of the Safeguarding Adults Team, either by other agencies or other NCC teams, there is a tracking process that throws up warnings after 21 and 28 days if cases are not completed. These
warnings continue until the cases have been signed off. This system does not currently extend to cases where the Safeguarding Adult Team leads although they are picked up through case discussions in supervision. **A recommendation to include tracking of Safeguarding Adults Team cases is made in recommendation 1.256 above.**

13 The latest NCC Safeguarding Vulnerable Adults’ inter-agency procedures include a section on resolution of professional differences [redacted] and the process by which staff are encouraged to take action if they feel that they are being “blocked” by managers or others is included in the supervision procedure. The same message has been given by management to staff informally but this may not be sufficient and a recommendation about putting this clearly in writing to staff forms part of the recommendations from this report.

14 The SOVA Board now has a standing SCR sub-group chaired by the Board’s Deputy Chair. This provides a regular forum for consideration of possible SCR cases using the existing procedure on SCRs.

**Other Actions Taken by NCC to improve internal and inter-agency working**

10 In July 2011 Health and Social Care colleagues in Northamptonshire implemented the DoH guidance on ‘Clinical governance arrangements in Health for Serious Incidents, Complaints and Safeguarding Notifications’. This guidance seeks to underpin the existing threshold criteria introduced in June 2010 with a focus on proportionality, transparency and partnership. This framework provides clear guidelines for a multi-agency approach to complex cases avoiding duplication of process whilst seeking to aid good communication, terms of reference and timescales. The oversight and governance of such cases are managed by NHS Northamptonshire and the SOVA Board SCR sub-group.

11 In July 2010 a joint escalation policy was written and agreed by all key agencies. The guidance creates a multi-agency framework where the contract monitoring process identifies concerns about the management and operation of a care home and therefore its suitability to care for service users. This involves a process that brings together information from all agencies that have placements in that home and CQC. This process will then ensure that it is safe for residents to remain in the home and that steps are taken to rectify the areas of concern.

12 A scheduled monthly Information Sharing meeting hosted by NHS Northamptonshire has been in existence since 2011. This is a forum for all operational staff involved with domiciliary and home care providers to share
information, concerns and monitor themes.

13 NHSN and NCC hold joint meetings with families and residents when there are concerns about a care home. CHQM Team write to all GP’s seeking their views of the service provision prior to undertaking a monitoring assessment.

14 A Mental Capacity Act (MCA) training module has been in place for all staff since 2009. A new e-learning package was commissioned in 2012 which is available for all, including Private, Voluntary and Independent (PVI) sector.

15 MCA practice guidance and toolkit is in place to put support staff with assessment and decision making. This also includes guidance on capacity and consent. A DoH audit was undertaken in 2011 and the findings from this will focus on further training for staff which will look particularly at BEST INTEREST Assessments, a “refresh” of the existing assessment toolkit and how to record decisions accurately. Planning is underway to repeat the audit in 2012 with all key agencies.

16 The client database and the supporting assessment and review documents were amended in 2011 to ensure that capacity and consent is a consideration in all assessment activity.

17 In September 2010 Protection plans for all individuals subject to a safeguarding investigation became mandatory. In cases related to service provision such as care homes there is a further requirement to assess level of risk to other customers/residents who are in receipt of the service but not subject to an investigation.

18 Since 2010 all complex cases (level 3 and above) are routinely subject of a case conference. Case conferences are used during and at the end of the investigation to discuss progress, feedback the conclusions of the investigation and report the outcomes to all those who have been involved.

**Serious Case Review Panel Additional Recommendation**

3 Contract monitoring staff need to be clear that when they hear from senior staff
in care homes as is the case in this review, serious concerns regarding whistle blowing, that immediate actions linked to safeguarding are triggered.

Care Quality Commission (CQC)

Recommendations for Action

4 CQC have not identified any specific actions for improvement.

SCR Panel Observations

4 It is clear that for many months if not years the home was without a registered Manager. Firstly it is a statutory requirement to have this position filled. The sustained period of noncompliance in this area would by most benchmarks to be an attributable factor to ensuring effective leadership and management. This was not acted upon adequately. Furthermore the Regulator when re registering the Provider had the Opportunity to apply greater leverage. Again when the application was submitted no Registered Manager was in place.

5 The regulator has also indicated that they do not hold records of the safeguarding notifications and that their current system requires information to be redacted once a safeguarding referral has been made and satisfactory evidence of action taken received from either the local authority or the provider. This is taken to mean that sources of information are edited into one entity and therefore established in a format for historical generic referencing rather than specifically carrying detail regarding individuals.

6 The regulator also indicated in there evidence that during their compliance review in January 2011. Berrywood Lodge had continued to restrict the number of people living at the service to 15 residents.

SCR Panel Recommendations

4 It is recommended that the Regulator considers whether its system of holding safeguarding records and redaction procedure requires revision as the Regulator struggled for detail in discussing these issues with the SCR Panel.

5 It is recommended that where there are sustained periods where a care home does not have a registered manager that the regulator considers enforcement action at an earlier stage than was apparent in this case.

6 The level of non-compliance and repeated/sustained non-compliance should be specifically considered as a learning point when the regulator reviews their
enforcement tolerances. No formal notices of non-compliance were issued between the periods between September 2008 – January 2009. Almost certainly most perceptions of the position would consider the non compliance position on their second inspection in July 2009 as grounds for “raising the bar”.

East Midlands Ambulance Service (EMAS)

3 Lessons Learnt were identified and implemented by the organisation.

4 No further recommendations were made from the SCR Panel.

Berrywood Lodge (Minster Care)

Recommendations

8 Pathways Care Group to ensure that comprehensive systems are implemented. This is, key working, training, induction and interagency communication and that these are monitored and maintained.

9 Pathways Care Group need to ensure that their policies and procedures and general documentation is reviewed to ensure fit with best practice.

10 Pathways Care Group should ensure that quality monitoring arrangements are prioritised for services known to have compliance or quality concerns.

11 Pathways Care Group should ensure that any future service acquisitions are subject to rigorous quality assessment and close monitoring.

12 As part of any future acquisition concerns with quality are detected, consideration should be given to what measures will be put in place to ensure concerning practices are not continuing.

13 Pathways Care Group should review their safeguarding training and processes to ensure that any allegations concerning lack of financial support from families is formally raised and addressed.

14 Pathways Care Group should identify and record senior management contact details for partner agencies. Make this information available to staff so that escalating concerns about practice or delays in the provision of services can be more appropriately escalated.

Key Additional SCR Recommendations

6 It is acknowledged that the Pathways Care Group has learnt lessons and identified these in their IMR report together with specific examples of where changes have been made to improve procedures, practices and service
delivery. Further recommendations are made as follows:

7 Pathway Care Group should introduce an audit of the clients it has in its care settings to ensure that their dependency and care needs are not in breach of their registered conditions.

8 The regulation 10 Outcome 16 requirement to conduct monthly monitoring and quality checks on its registered services incorporates within its format specific reference to the dependency of clients and those whose condition is of concern highlighted for specific discussion.

9 Where in the future service users are being accommodated in the care home and it is clear that a review of their care has not been undertaken regularly by the placing authority as agreed at placement inception; or the client’s needs deteriorate significantly, either mentally or physically they are formally referred to the placing authority for review. This referral needs to be formally communicated.

10 Where a review connected with the previous bullet point above is made and a response from the placing authority is not readily forthcoming then this should be formally escalated to the authority and if need be reported to the Regulator as an incident affecting the health and welfare of the client.

Northampton General Hospital

Recommendations

5 Accident and Emergency Care pathway: - developed to identify people with a learning disability at the earliest opportunity and to enable reasonable adjustments to be made.

6 Communication Passports: - development of communication sheet/passports, providing essential information about the patient has been developed and implemented. This information will ensure staff are aware of the patient needs. Care and treatment plans can be formulated using the information provided.

7 Carers Policy: - Development of Carers policy to support both formal and informal carers.

8 Patient Experience: - To ensure that patients with learning disabilities and/or their carers are informed and participate in patient satisfaction survey. Development of resource/tools, with reasonable adjustments so that patient’s experiences within NGH are recorded.

Key SCR Recommendation

3 The guidelines on referral to Safeguarding and to the Coroner need to include
more specific reference to neglect.

**General Practitioner IMR**

4 None are identified in the GP’s own IMR.

**Multi-Agency Recommendations**

**To review and improve Inter-agency Procedures for inter-agency Safeguarding conferences**

11 In particular, to recommend to the SOVA Board (SOVA) the development of agreed single agency and Inter-agency “triggers” to assist and guide staff for when inter-agency conference should be convened including:

**Improved Information Sharing Across Statutory Agencies**

12 To audit the use of existing information sharing protocols across statutory agencies and to identify any gaps in such protocols.

13 To include in this audit whether existing electronic information sharing systems across statutory agencies are being considered and details about where actions are being progressed. This to inform the cross agency strategic picture in order to ensure that the SOVA Board can establish what progress is planned and comment on developments going forward.

14 For agencies to consider the extent that they use activities such as supervision or one to one sessions in their agencies formally and the degree to which this covers safeguarding areas and concerns.

**Improving practitioner awareness of Regulatory limitations in care settings**

9 Increasing practitioner’s awareness of regulatory constraints and Provider limitations to care needs and their delivery in care homes without nursing and care homes with nursing competencies as registered with CQC.

**Safeguarding agency training and resultant practice - verifiably**
strengthening

There were a number of missed agency opportunities to make adult safeguarding alerts for William when there was a clear indication that it was appropriate to do.

10 SOVA Board needs to review how it obtains and measures practice information about how confident and competent frontline staff and managers across all agencies working with vulnerable adults. In particular;

   o Escalation arrangements in their agencies and competencies in this regard including specific reference to capacity and consent linked to the Mental Health Act and DOLS. A questionnaire approach may be an option to consider led by the agencies themselves and reporting this information back to the Safeguarding Board for strategic oversight and reporting.

With this information to hand, the SOVA Board will be able to review the adequacy of existing learning and development activities (which are already evaluated for how good a learning experience they provide) and ensure that confidence with using adult protection procedures is matched by competency in doing so. In summary:

3 To consider the results of the most recent Adult Protection Training Audit

4 To undertake an anonymous and representative sample survey of operational staff and managers across all APC member agencies measuring people’s knowledge of existing adult protection procedures, confidence in using these procedures and feedback in doing so.

3 For each agency member of the SOVA Board to continue to bring a report to the SOVA Board detailing how it has embedded adult protection policies and practices – and to provide evidence of the effectiveness of their adult safeguarding work.

4 To convene an annual joint meeting of the Local Safeguarding Children’s Board (LSCB) and the SOVA Board (SOVA) in order to share best practice, compare systems and approaches, identify issues of common concern and interest and agree joint areas of development work.
References


14 The Mental Capacity Act 2005 and code of practice.


18 Mandelstam M (2009), Safeguarding Vulnerable Adults and the Law, Jessica Kingsley Publishers