

# Safeguarding Adults Review

## The case of Aubrey

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**Commissioned by:** West of Berkshire Safeguarding Adults Board

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**Cover Sheet**

## Table of Contents

	Page No
Introduction.....	Page 3
Safeguarding Adult Review Process.....	Page 3
Safeguarding Adult Review Governance.....	Page 4
Methodology.....	Page 4
Background of the Case.....	Page 5
Key Events and Appraisal of Practice.....	Page 5
Summary and Analysis.....	Page 9
Consultation and Involvement from Family Members and Other Relevant Persons.....	Page 11
Findings and Lessons Learnt.....	Page 11
Recommendations.....	Page 13

## Introduction

This review has been commissioned by the West of Berkshire Safeguarding Adults Board (SAB) in line with its accountabilities under Section 44 of the Care Act 2014. The author has been selected to ensure independence of the review and in terms of her background experience inclusive of enhanced and substantial experience of operational and strategic multi-agency safeguarding practice.

The core timescale for the review spans the period from April 2016 to August 2017 but also has regard to any relevant previous history in this case. By request of his family and for the purposes of this report the individual's name will be used. Aubrey's family are committed to ensure Aubrey's story is not depersonalised in any way.

## Safeguarding Adults Review (SAR) Process

This review process is an individual case and appreciative systemic enquiry into the actions and decisions taken by the relevant agencies in relation to Aubrey, and a review of those decisions in the context of the real working conditions which existed at the time.

Research has shown that methodologies that engage practitioners in reviews are more likely to achieve learning and promote change in practice, therefore the participation of frontline staff is extremely valuable, and such engagement aims to improve the quality of the overall review and the commitment to taking the lessons learnt back into practice.

A SAR is not an enquiry into how someone died or suffered injury, or to find out who is responsible or apportion blame. Its purpose is to:

- Look at any lessons we can learn from the case about the way all local professionals and agencies worked together;
- Review the effectiveness of safeguarding adults' practice, policy and procedures;
- Inform and improve local safeguarding practice for all agencies involved; and
- Deliver an overview report with findings for consideration by the SAB.

The key outcome of a SAR is to improve the safeguarding of adults in future. For this to happen as widely and thoroughly as possible, professionals need to be able to understand fully what happened and what needs to change to prevent the likelihood of reoccurrence.

It is the aim of the West of Berkshire SAB to further promote a learning culture by nature of this review and to effect maximum positive change in both single agency and multi-agency working arrangements to ensure the best outcomes for adults at risk and the wider community. It is equally important to highlight areas of good practice and to share that learning.

## Safeguarding Adults Review Governance

The Chair of the SAR Panel will be responsible for regularly advising the SAB Chair of any emerging findings that require attention as matters arise throughout the review process and before the SAR Overview Report is drafted. In terms of any risks identified in the review that may have immediate impact on adults with current care and support needs, review panel members are responsible for taking any relevant immediate action or escalating within their own agency.

The draft Overview Report will be sent firstly to the SAR Review Panel for comment and subsequently to the SAR Panel and its Chair for sign off, prior to its submission to the SAB and its Independent Chair.

The SAB will be responsible for the co-ordination of any media management in relation to this SAR and its publication, in line with an agreed media strategy.

### **Methodology**

This Review was undertaken using a 'Significant Events Analysis' approach. All agencies submitted detailed chronologies of involvement with Aubrey during the period within the scope of the review. These were then combined, Terms of Reference were set, a review panel of senior agency representatives was established and detailed information relating to policy, procedures and practice was gathered from a range of sources. Two facilitated workshops were held with multi-agency frontline workers and managers to analyse data and add context to the review in terms of current working practice within agencies, and the way in which agencies interact and work with each other. The lead reviewer has held regular meetings with family members and their views have been central to this process and its lines of enquiry.

The review has aimed to engage with senior managers in the various organisations involved. They may have had no direct involvement with Aubrey himself, but help to shed light on how their organisations and the wider health and care system responded to identified risks.

This approach was agreed by the SAR Panel as a proportionate response that will offer the most learning, embed learning into practice and support cultural change within organisations where required.

For this review, chronologies were requested and provided by the following agencies:

- o West Berkshire Council, Adult Safeguarding Service
- o West Berkshire Council, Care Quality and Commissioning Teams
- o West Berkshire Council, Adult Social Care (ASC)
- o Royal Berkshire Hospital Foundation Trust (RBFT)
- o Berkshire Health Foundation Trust, District Nursing Service (DNS)
- o Thames Valley Police (TVP)
- o Care Quality Commission (CQC)
- o Bee Friends (Regulated Domiciliary Care Provider)

### **Background of the case**

Aubrey was a 45-year-old white British male who lived alone. He had complex health needs and a terminal diagnosis of disseminated colorectal cancer. Aubrey maintained a high degree of independence and was well known within his community. He is described by all that knew him as having a good sense of humour and a strong and independent character. He had a supportive family network with which he maintained regular contact. His family often supported Aubrey to attend medical appointments and to respond to any arising issues in his life and care.

Aubrey had complex medical needs, from both his longstanding conditions and from disseminated colon cancer. He had spina bifida, which resulted in marked mobility challenges. These difficulties were compounded by Aubrey requiring amputations of both his legs during the 1990s because of leg ulcers. Aubrey required haemodialysis three times a week for his end stage kidney failure. The cause of his kidney failure was presumed to be recurrent infections (including episodes of sepsis which on one occasion required treatment on intensive care). However, a formal renal biopsy and diagnosis had not been possible. His kidney failure was, unsurprisingly, complicated by high blood pressure and anaemia. Aubrey had an element of ischaemic heart disease, and cardiology review in 2015 showed evidence of a probable previous heart attack and some limitation of blood flow to the heart muscle.

In 2016, Aubrey was diagnosed with bowel cancer, and in June 2016 he had the cancer removed, and a permanent colostomy formed. Sadly, a follow up CT scan in late 2016 showed that the cancer had spread both within his abdomen and also to his lungs. Aubrey was offered chemotherapy to alleviate symptoms and to allow him a longer time with fewer symptoms. The chemotherapy would have been palliative, rather than curative. Aubrey made a decision not to have chemotherapy because he did not want to feel more unwell from chemotherapy than he already felt. On June 14<sup>th</sup> a plan was made for GP and community palliative care team input, should Aubrey require help with pain control or symptoms.

However, on June 23<sup>rd</sup> Aubrey was admitted to the Royal Berkshire Hospital with back pain, sepsis, and a sudden and marked deterioration in his speech and level of consciousness. His reduced conscious level was found to be caused by a secondary obstructive hydrocephalus (a build up of liquid under pressure in the brain due to obstructed flow of cerebrospinal fluid), secondary to his widespread cancer. Advice was sought from the regional neurosurgical centre: there was no option of surgical management of the hydrocephalus. A decision was therefore made to provide Aubrey with palliative care to ensure comfort, and he was cared for at the Royal Berkshire Hospital until sadly he passed away on the 29<sup>th</sup> June 2017. The cause of death was noted as: acute cerebral event, metastatic colorectal cancer, sepsis and kidney disease.

Prior to his death, RBFT had raised a safeguarding concern on Monday 26th June 2017 stating Aubrey had 3 sacrum grade 2-4 sores, moisture lesions to the crease below the stomach and an open Grade 2 sore on his penis and scrotum

Prior to admission, Aubrey was in receipt of a care package from a regulated domiciliary care provider of two daily calls including a morning call with 2 carers. The package of care had been reviewed and adjusted on 26 May 2017 with Aubrey's involvement which resulted in a reduction in the length of his care calls. On 30th June 2017, Aubrey's family raised concerns about the quality of the care provided by Bee Friends. The provider had been judged as an inadequate provider by Care Quality Commission following their inspection of March 2017 and was as such subject to a red embargo with the local authority under their care quality framework which meant no new placements were to be made with the provider until improvements were made and the embargo was lifted. After receipt of the safeguarding concern raised by the hospital further strategy meetings and reviews by Thames Valley Police, health, social care and care quality partners identified ongoing concerns relating to the provider's organisational management and supervision of carers. The provider had been subject to an improvement plan for a period of approximately 12 months prior to Aubrey's death, and making inconsistent progress towards achieving the plan's objectives.

### **Key events and appraisal of practice**

During the period of 14th June 2016 to 22nd June 2016 Aubrey was admitted to Hospital for a five-day period to undergo a colostomy procedure. During this admission it was known that Aubrey had pressure wounds. There was no evidence of the referral notification being sent to notify the District Nursing service of discharge and therefore Aubrey did not receive the required dressing to his pressure wounds for a two-day period. On the 24th June 2016 Aubrey independently contacted the District Nursing Service requesting they attend as his wound was leaking through dressing and into his pressure sore on his sacrum. The District Nursing Service offered to admit Aubrey to hospital, which he refused. The service also advised him that he would need specialist pressure relieving equipment. Aubrey also refused this.

Despite the identified needs and associated risk to Aubrey's health and wellbeing in terms of pressure care management no immediate action or risk assessment was undertaken by the District Nursing Service. Aubrey was considered to have capacity to refuse intervention based on an assumption of capacity. However, no formal capacity assessment was undertaken at the time, even though the decision was a high risk, unwise decision. This was a missed opportunity to engage a multi-disciplinary approach and relevant frameworks such as complex case management, 'difficult to engage' pathway or safeguarding framework to fully assess the risks.

Aubrey was found unresponsive at home on 25th June 2016 and was admitted to the Intensive Care Unit (ICU). The District Nursing Service closed his case but requested the hospital to re-refer him on discharge. This admission lasted until 26th July 2016. During this admission Aubrey was not engaging with the medical advice given to him and a subsequent delayed discharge period occurred because he was receiving ongoing health investigations, and a suitable care package could not be found.

On 5th July 2016 a hospital notification was made to Adult Social Care (ASC) due to a grade 3-4 pressure sore. There were also concerns that Aubrey was neglecting himself and refusing required pressure relieving equipment. This referral indicates that he was unwilling to accept an increased care package in line with his assessed needs to promote his health and wellbeing. Concerns were also raised relating to Aubrey's reluctance to comply with care whilst on the ward. On the 6th July 2016 the hospital raised a safeguarding concern to ASC due to the pressure sore. This is good practice in line with safeguarding policy and procedures.

A discharge planning meeting was undertaken on 11th July 2016, at which Aubrey agreed to accept the equipment to enable a discharge from hospital. Aubrey was discharged home on 26th July 2016 with the support of the reablement service alongside two 45-minute double calls per day from his preferred domiciliary care provider. Aubrey refused to allow his carers to use the equipment provided and was unhappy with the times available for his care calls. The potential risk to community staff in terms of their safe moving and handling and to Aubrey in terms of further pressure damage were not seen within this context and therefore unassessed risks remained for a five-day period as the Occupational Therapy (OT) assessment was not initiated until the 31st July 2016.

Care was commissioned with Aubrey's choice of provider. However, the provider was, at this time, already within a care quality concerns framework with the local authority and had evidenced minimal improvement on progressing their action plans agreed with the local authority over a substantial period. There is no evidence that a discussion was ever had with Aubrey regarding the quality concerns with this provider to enable him to make informed decisions or provide a reviewing framework to identify and respond to any emerging risks in care delivery to Aubrey despite the complexity of his needs.

On 31st July 2016 an OT assessment was undertaken and in line with Aubrey's preference it was agreed that he could manage transfers with a slide board. The hoist was therefore removed from his home. There is no evidence of a risk assessment surrounding this decision nor any review of the impact that changing equipment may have on pressure damage. A subsequent referral was made to the Tissue Viability Service on the 2nd August 2016 as Aubrey was stating he was unhappy with the pressure relieving mattress which he had previously agreed to accept to aid his discharge from hospital. An OT agreed that the mattress could be changed as his pressure sore was slowly healing.

It was subsequently identified the following day on 3rd August 2016 that a multi-disciplinary meeting (MDT) would be required due to the complexities of Aubrey's care and treatment needs. Aubrey agreed to this. However, there is no record of a meeting ever being convened. Aubrey was by this time refusing to use the pressure relieving cushion on his wheelchair. The Dialysis unit were informed that Aubrey was no longer using the pressure mattress, which he was required to do so whilst receiving dialysis to reduce the associated risks of having such treatment on skin integrity and pressure damage. It is not clear from records how the difference of professional opinion relating to the required mattress was assessed or resolved. Between the period of 3rd August to 10th August 2016 Aubrey received daily district nursing visits due to deterioration in his pressure wounds. During this period a further referral was made to the Tissue Viability Nursing Service by the District Nurse for review of pressure care and specialist advice.

On 12th August 2016 the District Nurse raised concerns in the form of an incident inquiry due to the fact that Aubrey had been discharged from hospital, but no referral had been made to ensure appropriate treatment of pressure wounds. In effect Aubrey was without appropriate pressure care from his discharge on 26th July 2016 to 3rd August 2016.

On 15th August 2016, the domiciliary care provider contacted ASC to advise they were struggling to provide adequate care to Aubrey because the current pressure mattress did not meet requirements for moving and handling safely. This information should have led to a review of Aubrey's care and support needs and to exploration with Aubrey as to why he was refusing to use the equipment provided to manage the risks to his pressure areas. There was a missed opportunity to assess Aubrey's capacity and his understanding of the risks associated with this decision. A six-week review was undertaken by ASC on 7th September 2016. The review does not identify issues relating to moving and handling risk or evaluate the quality of care being received by Aubrey despite information being available which should have informed this review. This was seen as a standard six-week review and does not detail a person-centred approach in the context of Aubrey's individual circumstances.

The District Nurse identified the need for a further OT assessment on 23rd October 2016, which was good practice., However Aubrey refused this, and no action was taken to progress the referral despite the recognised concern that not using specialist equipment would be likely to have a negative impact on his pressure care.

On 3rd November 2016 Aubrey stopped attending the day centre due to a disagreement with another service user. Aubrey was offered an opportunity to undertake voluntary work as an alternative to using the centre but refused to engage with this. No further exploration of social activity was discussed or offered.

A further referral was made again to the TVN service on 11th January 2017 when Aubrey reported to the nurse on 18th January 2017 that he was experiencing rib pain, the nurse advised him to call the GP, but Aubrey refused to do so and no further action was taken.

Aubrey had a fall during transferring on 3rd February 2017 then on 13th February 2017 Aubrey developed further deterioration to his pressure wound; a black area (necrotic) was noted, with wound odour and Aubrey reported to be feeling unwell with vomiting. The wound was reviewed by the DN sister and consultation with the GP was undertaken. Appropriate antibiotic treatment was prescribed.

On 14th March 2017 CQC undertook inspection of the provider service in response to receiving whistle-blowing concerns. CQC found issues which correlated with the issues already identified by the Care Quality Team and incorporated into their action plans for this provider. This information was communicated to the Care Quality Team by CQC. The Care Quality Team made a responsive visit to the provider to review and support them with improving documentation. The visit identified additional concerns regarding the leadership of the service and their ability and skills to be able to make adequate improvement to the service. As a result of these findings a review was undertaken by ASC with Aubrey due to care quality concerns with his provider on 20th March 2017. The record of this review contains very limited assessment of the identified risks. The outcome the review, which is that there weren't any concerns regarding the quality of care being delivered to Aubrey appears to be solely based on Aubrey's expressed view that he was happy with his care. No effort was made to seek Aubrey's agreement to discuss his care with his family in order to involve them in considering the quality of his care at this point. Due to the limited quality of the review this was a missed opportunity to fully assess the quality of care being delivered and the subsequent impact this had on Aubrey. It is evident from discussion with the family and from a substantial amount of text message correspondence between Aubrey and the provider that there were ongoing issues in care delivery with inconsistent care call times and inconsistent carers, which left Aubrey at potential risk because of the provider's actions.

Because of the above review Aubrey's care call times were reduced in agreement with Aubrey on 26th March 2017. It is not clear how or why this decision was made given the nature of his identified care needs.

On 5th March 2017, the District Nurse identified significant concerns relating to the quality of care by the provider. These were recorded, but no notification was made about any safeguarding concern, nor was any care quality notification made to the local authority. As such a further missed opportunity arose to reassess the quality of care and Aubrey's welfare. .

In attending Aubrey on 19th June 2017, the District Nurse offered hospital admission to Aubrey for treatment of pressure wounds and to undertake further investigations. Aubrey refused admission and no subsequent risk assessment or mitigating action was taken following this refusal.

Aubrey refused a district nurse visit on 21st June 2017; this was not seen in the context of a deterioration of his condition, the possibility of self-neglect or disengagement from services. No communication was made with other agencies or family members. And no consent for such communication was sought from Aubrey.

Aubrey again refused intervention from the DN for his pressure care on 23rd June 2017. This too did not prompt any multi-agency communication or review of Aubrey's care and treatment needs. On the same day Aubrey's sister attended his home following a telephone call with him. Aubrey told his sister he has been in his wheelchair all night in pain and discomfort. His sister was very concerned and took Aubrey to his GP surgery where they said they were advised he could not be seen and they should take him home and call a paramedic, which they did. Paramedics attended, and decided that hospital admission was required, however Aubrey's sister transported him to hospital in order

to reduce discomfort for him caused by being removed from his chair as the family have a specially adapted vehicle. Aubrey was admitted to hospital and treated for sepsis in addition to his other complex medical needs.

Aubrey was refusing treatment for his pressure wounds and on 26th June 2017 a palliative care discussion was held with his family who wanted to manage Aubrey's care at home to promote his dignity in line with what they believed would be his wishes and views. Given the complexity of Aubrey's condition and his terminal prognosis it would have been beneficial to Aubrey, his family and professionals to engage in earlier person-centred discussions to develop a coordinated approach to his ongoing and end of life care and treatment needs. This should have been influenced by Aubrey's wishes and views and would have promoted dignity for Aubrey whilst recognising the significant contribution his family network made to maintaining his independence and wellbeing. A timely safeguarding concern was raised by the hospital on the same day to ASC due to concern about neglect and omission to act by the provider regarding Aubrey's pressure wounds. This referral was good practice and in line with safeguarding policy and procedures.

Aubrey sadly passed away in hospital on 29th June 2017.

On 3rd July 2017 Family members made a complaint to West Berks complaints department and the concerns were raised to the Head of Service for Safeguarding and Prevention. The system worked well to escalate these concerns and the next day a Safeguarding Strategy Meeting was convened to review information available in Aubrey's case. As a result of the strategy meeting, CQC were notified of the care quality concerns linked to Aubrey's death. To support the Section 42 enquiry, relevant records were secured and TVP were notified of the concerns. In preparation for the strategy meeting care plans and risk assessments previously undertaken by ASC were reviewed. This was good practice in line with safeguarding policy and procedures and enabled a coordinated multi-agency framework to identify and address transferable risk to other adults however exposed concerns relating to practice and recording standards in frontline practice. The review identified that the most recent risk assessments and reviewed care plans were duplications of previous documents.

On 6th July 2017 a meeting was held with the provider Bee Friends and the CQC. Multiple issues were identified including delay by the provider to adequately progress their agreed action plan with the regulator (CQC) and that the provider had failed to notify its customers of their inadequate rating by CQC inspection under their Duty of Candour as defined in The Care Act 2014. A follow up review by the safeguarding service of Aubrey's care records completed by the provider identified a series of concerns having been recorded which would have impacted on Aubrey's health and wellbeing. However, the provider had failed to notify ASC of significant issues, leaving Aubrey at risk. If this information had been reported it should have led to a comprehensive review of Aubrey's care and more robust review by the care quality team to safeguard Aubrey and other adults with care and support needs receiving this service. Later that day a meeting was held with the family by a complaints officer and Adult Safeguarding manager to hear their views in addition to offering support and advice.

On 10th July 2017 a second follow up strategy meeting was held to review actions and information, this was good practice and further promoted a coordinated multi-agency safeguarding response in terms of the provider quality concerns. A forensic post mortem was confirmed as being required by the Coroner and TVP on 12th July 2017. Following initial investigation, police involvement ceased as the investigation concluded there was no evidence of neglect by the provider reaching a criminal threshold. Subsequent meetings were held with the family on 20th of July 2017 and 8th of August 2017.

On 9th of August a decision was made to decommission services provided by Bee Friends for West Berkshire service users. The provider subsequently made the decision to end its registration as a regulated service due to business viability issues. West Berkshire worked with the provider to ensure the safe recommissioning of services for their clients. The service closed completely in November 2017.

### **Summary and Analysis**

Aubrey had complex health and social care needs. However initial assessment, risk assessment and review did not take account of the need for a multidisciplinary, coordinated approach to care or review of his changing needs considering these complexities and his terminal prognosis. A multi-professional meeting was not arranged. This would have been a forum where Aubrey's views, wishes and feelings could have been further explored. The lack of a coordinated approach or sufficiently rigorous assessment of need led to Aubrey's care being commissioned from a provider about which there were already concerns. The information about the weaknesses in the care provider was not shared with Aubrey or other individuals using the service to enable them to make fully informed choices about their care. The agencies did not recognise or fully assess risks resulting in Aubrey directing his own care without the full impact of these risks being mitigating by commissioners. Although agencies worked in what can be viewed as person-centred ways during direct interventions with Aubrey, there was a lack of professional curiosity and multi-disciplinary discussion.

In terms of the role of family and carers, although Aubrey received significant emotional and other forms of support from his family, the various assessments and interventions undertaken did not recognise this as was intended by implementation of the Care Act 2014 (section 2 statutory guidance). As such wider opportunities to safeguarding Aubrey in terms of prevention principles and utilising this support in his care planning were missed.

When considering the context of Making Safeguarding Personal (MSP) in the case of Aubrey, although a good safeguarding response was made to Aubrey's refusal to accept required equipment aimed to ensure his health, wellbeing and safety at the time of hospital discharge, the safeguarding did not take account the broader concerns relating to what can be seen as unwise decision-making in terms of his reluctance to accept care and equipment and the likely subsequent decision to refuse or change arrangements implemented. This could have been seen terms of 'self-neglect' prompting a different approach to assessment and outcomes for Aubrey. The safeguarding framework appears to have acted as an isolated intervention to facilitate discharge and was not seen in the wider context or the need for a safeguarding continuum in broader terms of a coordinated multi-agency strategy to review risk or changes associated with unwise decision making. It did not ensure contingency planning in such an event given the complexity of Aubrey's care and treatment needs, particularly in view of the care quality concerns known for the provider.

No formal capacity assessment was undertaken or recorded by any agency throughout their involvement with Aubrey. This was due to practitioners' application of the first principle of the Mental Capacity Act "the assumption of capacity" which is in general good practice. However, there were multiple opportunities when practitioners could have given consideration to applying the legislation to fully assess, explore and understand Aubrey's decision-making capacity better in line with his wishes and feelings. This would have engaged all relevant family members and professionals. Practitioners need to see the use of this legislation and its code of practice as a positive tool and framework to enable a person-centred, empowering approach. Such an approach informs risk identification and care planning rather than the assumption of capacity becoming a

barrier to undertaking capacity assessments when decision making has associated risk and is viewed as an unwise decision. The standard of recording of such assessments will ensure appropriate evidenced decision-making by professionals and provides protection both to the individual at risk and professionals involved in their care.

The review found the system did not work to ensure proportionate prevention of harm or an appropriate response to safeguard Aubrey in a holistic sense, given the information available in different parts of the system. It enabled care to be commissioned with a provider for which there were long standing and known quality concerns over a significant period with only marginal improvements being achieved. This was based on Aubrey's personal choice, but without recognition of the associated risks and it therefore failed to ensure adequate assessment, review and risk management in Aubrey's case and within this context. The review undertaken by Adult Social Care of Aubrey's care package was not effective in evaluating the quality of the care he was receiving or in risk identification and therefore did not translate into ongoing care planning and review.

A lack of clear guidance, policy and procedures within the Care Quality framework (in line with section 5 of the Pan Berkshire Safeguarding policy and procedures to manage serious concerns) resulted in poor communication across agencies and internal services. As such, the full impact of provider quality issues for individuals receiving care was not seen. Issues and concerns which should have informed the commissioners' strategy to support and manage the quality concerns and to mitigate risk in a coordinated multi agency framework remained within individual departments and agencies. Tools used to review care packages do not currently support workers to promote evidence-based practice nor do they inform decision making in terms of thresholds for intervention relating to organisational safeguarding or provider concerns.

In West Berkshire the Care Quality system relies on notifications in the form of CQ1's to generate quantitative data to inform a risk rating system to identify the seriousness of care quality concerns. However CQ1s all carry a score rating of 1 regardless of whether the issue is a safeguarding concern or a complaint. As such there is a reliance on the quality of information in CQ1s to inform responses. The review demonstrated confusion within the workforce as to what would be termed a care quality concern and when a matter would be a safeguarding matter under neglect or failure to act by a provider. In Aubrey's case, although analysis of information indicated issues which should have been raised as a safeguarding concern due to omission by the provider, they were not, nor were CQ1 notifications made.

Following Aubrey's death and on receipt of the safeguarding concern a robust multi agency safeguarding response was made which engaged a coordinated strategy in terms of organisational safeguarding concerns with the provider. This model was in line with Pan Berkshire Policy and Procedures and ensured appropriate assessment and review of transferable risks to other individuals with care and support needs, in addition to providing a clear framework of management, communication and review. Such a framework, if implemented earlier when concerns regards the provider had escalated, would have probably been beneficial.

The provider told the review that poor communication and what they viewed as "mixed messages and changing goal posts" received from the regulator and the Care Quality Team created confusion and pressure which impacted on their ability to make and sustain improvements in addition to affecting the viability of their business. Commissioners need to remain mindful of business viability issues when working with providers within any concerns framework to ensure appropriate support is given to improve and monitor quality in a timely manner whilst ensuring clarity is given on roles responsibilities and expectations by key stakeholders.

## Findings and Lessons Learnt

- The Care Act 2014 clearly emphasises the importance of protecting people from abuse and neglect and preventing abuse and neglect from occurring. In any activity which a local authority and its partners undertake, it should consider how to ensure that the person is and remains protected from abuse or neglect, in line with Making Safeguarding Personal principles. This is not confined only to safeguarding issues but should be a general principle applied in every case for those with care and support needs, including with those who self-neglect. The principle needs to remain central to all areas of practice and policy design. The review found that at this time in West Berkshire systems and practice were not coordinated or governed in a way to achieve or promote this in terms of the management of care quality concerns, individual assessment and its commissioning arrangements.
- The review learnt that some staff were not clear and did not feel confident in recognising and applying different thresholds of assessment and interventions for example, Mental Capacity Act 2005. There was also ambiguity in understanding their role and accountabilities in terms of care quality and its management. Demand in the system and the availability within the provider market were cited as significant influencing factors to decision-making of commissioning arrangements. We were told that the process by which care is commissioned in such circumstances by the email of support plans to the provider enables care to commence for individuals expediently, which in the majority of cases will be appropriate and reduces risk to individuals, however in terms of individuals with more complex support needs or associated risks, unless reported, issues would not be identified until the six week review period. Providers and commissioners felt this communication process could be improved to provide a more preventative approach to safeguarding and support providers better. At the point of commissioning care there is a missed opportunity to inform individuals (and their relatives when appropriate) of how and when to report concerns relating to their care provision.
- Achieving a balance between promoting the individual's wellbeing and choice and gaining the views of any friends or relatives or professionals who are involved in caring for the individual is complex. People should be considered in the context of their families and support networks, not just as isolated individuals with needs. Agencies should consider the impact of an individual's need on those who support them and, subject to the appropriate consents being in place, help others to access information or support to seek to engage them in care planning and review wherever possible. In this case it is not evident that agencies worked in collaboration to share information relevant to risk to enable holistic review, this resulted in multiple isolated interventions which prohibited the full deterioration in Aubrey's condition and his escalating needs to be seen. This was further compounded by Aubrey's strong and independent character.

## Consultation and involvement from Family members and other relevant persons

In conversation and consultation with Aubrey's family, they expressed their concerns relating to lack of recognition by agencies of the role they played in Aubrey's life, care, support and emotional wellbeing which, in their view led to poor or very minimal communication and inclusion in Aubrey's care and support planning over the years. Because of this the family feel they were not afforded the opportunity to provide additional support or advocacy and the extra vigilance and discussion with Aubrey that they would have made if they had of been aware of the wider concerns about the service provider. This also impacted on their ability to provide support to Aubrey at times when his

decision-making capacity may have been affected or in instances when his decision to refuse care or equipment may have had negative impact on his health and wellbeing.

When concerns were identified by themselves or Aubrey, complaints were made to the care agency on an informal basis, but response was never received. Having never been engaged in any discussion, assessment or review for Aubrey the family had not been advised and were unclear of how or to whom they should raise concerns in terms of issues or concerns about the quality of care. The family do not believe any information or discussion was had with Aubrey relating to care quality concerns and as a result question how Aubrey was able to make an informed choice about remaining with the care provider or to consider alternative care provision. It is their view that this impacted on Aubrey's dignity and wellbeing.

Aubrey's mother has sadly suffered failing health during the review; however, she has provided the statement below for inclusion in the report:

"Aubrey was my youngest, my baby boy. He was born with some problems, we loved and cared for him unconditionally. He was a determined, sociable man with such a sense of humour, he would laugh uncontrollably, a real belly laugh when he found something funny. He enjoyed life and lived it to the full. I miss his daily phone calls so much, he would tell me about his day. He was a caring son and worried about me after his dad died. On occasions he would phone me to tell me it was 11pm and no one had come to help him. He was determined and would have wanted to sort things out himself. I feel Aubrey has been let down by people who should have helped him and cared for him. We knew little of the true struggles he was experiencing. Please do not allow any other family or individual experience this. I saw my son into the world and watched as he took his last breath. I feel angry that he was not allowed to slip away the way he would have wanted. He had so much left to do and he and I were not able to do this together." (Aubrey's mum).

To support future practice, the family would like to express the importance of professionals remaining mindful that when entering a safeguarding framework, particularly at a time of bereavement, families often will become aware of new detail and information relating to their loved one. Such information naturally may cause upset, distress or anger especially when the impact has had a negative effect. Sensitivity and time is required to support families to process this information and what this means in the context of safeguarding responses.

### **Recommendations**

1. That a review of the interface between safeguarding and commissioning arrangements in West Berks is undertaken to inform further development of the governance framework for care quality concerns which reflects the principles of the Care Act 2014 in terms of safeguarding and commissioning accountabilities and that it is aligned to section 5 of the Pan Berkshire Safeguarding Adults Policy and Procedures.
2. That development of the Care Quality Framework leads to clear policy, guidance and training for frontline staff and services with appropriate quality assurance mechanisms for practice standards and that the pathway design is embedded into service development.
3. That the Safeguarding Adults Board review the quality of care in tissue viability management training across the partnership to ensure it adequately addresses the pressure care pathway and definitions of self-neglect to ensure it equips staff to identify and respond to such issues in a

preventative and timely manner. The SAB could consider any impact and correlation of pressure care and self-neglect.

4. That the Safeguarding Adults Board seek assurance on how agencies and partners are meeting their responsibilities in terms of the management of Care Quality Concerns, with focus on multi-agency working inclusive of providers and providing information to relevant parties under their Duty of Candour.

5. Agencies should ensure that tools, training and supervision promote the role of families and carers in line with principles of the Care Act 2014 and its aims. Decisions not to consult or share information with relevant family members needs to be clearly recorded and fully explored with individuals.