
# SAFEGUARDING ADULTS REVIEW

## Report into a Safeguarding Incident on 5th January 2016

Adult (JT) aged 70 years

Report produced by Kathryn Shaw

Independent Chair and Author

October 2017

# ACKNOWLEDGEMENTS

*Calderdale Safeguarding Adults Board would like to acknowledge the impact and difficulties of professional involvement and formal proceedings for family members.*

*This Safeguarding Adults Review would not have been possible without the co-operation and information supplied to the SAR Panel by those invited to contribute to the merged chronology and the learning event in May 2017.*

*This report reflects the views of the SAR Panel who have invested their time, commitment and expertise which was invaluable throughout this process. The Panel and Overview Author also benefitted from the input and professional support provided by the Business and Quality Assurance Manager, Designated Nurse for Safeguarding Adults, and Business Support Co-ordinator.*

CONTENTS

Mrs. Joyce Taylor

All names in this report have been anonymised for publication and dissemination.

## 1. Introduction

Calderdale Safeguarding Adults Board is legally required to arrange a Safeguarding Adults Review (SAR) when an adult in its area dies and abuse or neglect is known or suspected; there is concern that partner agencies could have worked more effectively to protect them, or if an adult has not died but has experienced serious abuse or neglect.

In the context of this particular case the Board made a decision to arrange a SAR based on s44 (4) of the Care Act.

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

The decision to undertake a review in this case was primarily concerned with providing the type of review process that would promote effective learning and improvement. It was felt there were aspects of this event which could provide useful insights into the way organisations work together; and the SAR could also be used to explore examples of good practice which identify opportunities to improve multi-agency practice in the future.

### 1.1. Personal history

Mrs Taylor is 70 years old and has been a resident at Care Home 1 since March 2014. She has a diagnosis of Alzheimer's Dementia and requires support 24 hours a day, the care home accommodates 106 residents and specialises in dementia care. There has been a new provider since May 2016, four months after the incident, and the most recent CQC inspection was September 2015. Mrs Taylor has no record of previous bruising or safeguarding concerns prior to January 2016.

### 1.2. Incident description

Mrs Taylor experienced an unwitnessed incident at the care home on 5th January 2016. The current Falls Protocol for Care Homes defines this as follows:

**'Unwitnessed fall'**: Any fall that is deemed as unwitnessed, and resulting in injury should be reported through safeguarding procedures. In this context it is more helpful to use the term '**unexplained injury'** rather than 'unwitnessed fall'. In circumstances where a person has sustained an injury the manager on duty should use judgement based on the evidence

available to determine what may have happened. If the person has an injury which cannot be explained then this should be referred as a Safeguarding Concern. (Falls Protocol for Care Homes; Calderdale Council August 2016).

An accident form and body map were completed at the time by care home staff and a 48 hour fall monitoring chart was put in place. The care home did not inform the family of the event; this was an issue highlighted at the subsequent Case Conference and is discussed further in the report.

A Quest Matron[1] was requested by the home to provide an assessment and if possible identify the cause of the event; the Matron attended the following day. She did not visibly see the bruising but looked at the body maps and carried out a full nursing and physical assessment regarding pain and movement and observations, which showed no physical underlying cause for a fall. The reason the Matron did not look at the bruising was that she didn't feel she needed to look at this again as the nursing staff from the care home had seen the bruises and completed body maps. Although she had an appropriate and professional rationale for this judgement this is not documented. Improvements to recording are highlighted in areas of learning and as a recommendation.

At a visit on Sunday 10th January the family discovered extensive bruising and were upset and concerned. Staff at the care home did not offer an adequate explanation and the family believed them to be evasive. The event causing the injury was unwitnessed therefore the home could offer no concrete explanation for how the bruising occurred. The care staff offered a possible explanation that as Mrs Taylor was in the habit of misjudging distances when she sat down she may have caught her herself on the edge of the chair. The family took photographs and contacted Adult Social Care that weekend to raise their safeguarding concerns.

### 1.3. Outcome of incident

It was assumed that Mrs Taylor had no capacity to consent to the safeguarding procedures; although this was not recorded in the case or clinical records and no formal capacity assessment appears to have been undertaken until 24th February. The Mental Capacity Act states that everyone has the right to make his or her own decisions. Health and care professionals should always assume an individual has the capacity to make a decision

[1] Calderdale and Huddersfield Foundation trust are the provider service for Quest for Quality and provides a team of specialist clinical support in the form of Community Matrons to act as links to other local health professionals

themselves, unless it is proved otherwise through a capacity assessment. Where someone is judged not to have the capacity to make a specific decision (following a capacity assessment) that decision can be taken for them, but it must be made in their best interests. Her husband and family supported Mrs Taylor to make decisions in her best interests and opted to refer the matter to Adult Social Care.

The Duty Safeguarding Social worker from the Safeguarding Adults Team (SAT) contacted the care provider. As there was insufficient explanation from the care home or details of what actions would be taken to prevent similar incidents this was raised as a safeguarding alert on 12th January 2016.

An allocated safeguarding investigator (Social Care) met the family on 15th January and advised them to contact the Police. An investigation followed to establish if a crime had occurred which included the police seizing notes from the care home and interviewing staff and family members. Copies of the notes were not left at the care home at the time which was acknowledged by the police as an error. On 3rd February the Police closed their criminal investigation and referred the case to Adult Health and Social Care (AHSC) and the Care Quality Commission (CQC[2]) finding no evidence for criminal neglect, but identifying clear omissions and failures in record keeping and family liaison.

At a case conference on 22nd February the case was closed to the safeguarding team, to be followed through by care management who are the local team with responsibility for leading the multi-agency actions from case conference. The focus of care management was on rebuilding the relationship between family and care home, a Mental Capacity and Best Interest decision assessment was also completed with regards to the placement. The outcome was that Mrs Taylor was deemed as lacking capacity about where she resides; it was agreed that it was in Mrs Taylor's best interests to remain at the Care Home and the family were happy with this outcome. The Home identified it is standard practice to undertake a DoLS assessment of capacity to consent to live there with all residents (Deprivation of Liberty Safeguards – Mental Capacity Act 2005). This authorisation was in place was in place for Mrs Taylor at the time of the incident and is reassessed as required.

Identified areas for learning for this review were generated by a combination of human error, largely due to staff being newly appointed in post, lack of training or adequate induction support for newly appointed staff; poor record keeping and a lack of documented rationale for decisions. These are addressed in the Recommendations.

[2] Care Quality Commission regulates health and social care, in this case Care Home 1

2. Summary of service involvement during the period of the chronology 5.1.16 to 30.6.16.

- Service contact

  - Mrs Taylor is a resident at Care Home 1 which is a privately owned care home with nursing; specialising in dementia care.
  - The local GP provides a weekly surgery at the care home but did not see Mrs Taylor in the week including the 5th January. He saw and assessed Mrs Taylor after a request from the family on 11.1.16.
  - Mrs Taylor was seen by Quest Matrons on 7 occasions following the incident; to provide a nursing assessment on 6.1.16 the day after the incident; a full skin assessment after a further unwitnessed event on 2.2.16; on 26.2.16 after a witnessed fall left significant bruising to left eye and cheek; and 3 follow up visits on 27.2.16, 2.3.16 and 4.3.16 when nursing assessments were completed and advice given to care home staff.
  - West Yorkshire Police were involved as part of the safeguarding investigation after the incident on 5th January.
  - Calderdale Adult Health and Social Care (AHSC) were involved as part of the safeguarding investigation after the incident on 5th January.
  - The Care Home Liaison team (employed by South West Yorkshire Partnership NHS Foundation Trust) were involved in Safeguarding Adults Strategy discussions led by AHSC.
  - Following the unwitnessed incident in January 2016 the CPN (Community Psychiatric Nurse) was involved in reviews of medication and Best Interest meetings to address medication concerns.
  - The Intermediate Care physiotherapist provided a detailed falls assessment and gave advice to care home staff on 2nd March.
  - A Junior Doctor from Hospital 1 contributed to the Best Interest review of medication on 11th May.

3. Terms of Reference

Terms of Reference were agreed by the SAR Panel on 12th April 2017.

The Care Act 2014 provides a legal framework to protect adults at risk of abuse or neglect. Roles, responsibilities and accountability are set out and include guidance on the principles which should underpin all work in adult safeguarding.

The review process, overview report and learning event will include the six safeguarding principles set out in this statutory guidance.

1. **Empowerment** - presumption of person led decisions and informed consent
2. **Prevention** - it is better to take action before harm occurs
3. **Proportionality** - proportionate and least intrusive response appropriate to the risk
4. **Protection** - support and representation for those in greatest need
5. **Partnerships** - local solutions through services working with their communities
6. **Accountability** - accountability and transparency in delivering safeguarding.

## Terms of Reference

1. Empowerment

- In this case consider how you feel the principles of empowerment were present in agency contact with Mrs. Taylor.
  - Consider how as an agency you make safeguarding personal in the services you deliver
  - Mrs. Taylor did not have capacity to make some decisions; tell us how your agency responds to these challenges and where and how you would get support.
  - Could the care provided for Mrs. Taylor be changed or improved to be more person centred?

2. Protection

- Consider this safeguarding investigation from your agency perspective. Are there ways in which partner agencies worked together to protect Mrs. Taylor which could be improved? Any information about other agency roles and actions it would be helpful to know and understand?
  - In this case were there any safeguarding policies or protocols in your own organisation that in the light of this incident need to be strengthened?

3. Prevention

- Considering the safeguarding training in place for your workforce, is everyone equipped with the necessary skills and knowledge for appropriate actions to be carried out?
  - How did your organisation learn from the significant events in this case?
  - Were the correct resources and responses in place to prevent the safeguarding incident in this case?
  - Are there any areas where you could improve your agency responses to warning signs to make people safer?

4. Proportionality

- In this case were the right people involved at the right time and were all the actions taken appropriate to the presented risk?
  - Do the right people in your organisation make the decisions or take appropriate action?
  - How were Mrs Taylor and her family included in relevant decisions?
  - Are there areas where in future this could be improved?

5. Partnership

- Consider how your organisation works with other agencies. In this case did staff involved in delivering this care know how and when to share appropriate information and involve other relevant service providers.
  - Tell us if this is a particular strength in your service or where there are areas where this can be improved.
  - Are there any gaps in services, obstacles to getting the help you need?

6. Accountability

- Are there areas of learning from this incident, or with the opportunity of hindsight anything in your agency responses to safeguarding that could be changed or improved?
  - Tell us if this has already happened or where plans are in place to make changes to practice, training, resources or support.

## 4. Methodology

To ensure the response is timely and proportionate the review uses the framework of a Significant Event Analysis which tends to emphasise more reflective and action learning approaches. The key principles include a process which does not focus on blame but aims to identify good practice and potential areas for improvement.

The ambition of this SAR is to focus on partnership working and provide opportunities to discuss alternative perspectives and increase collaborative problem solving.

### 4.1. Sources of information

- Merged chronology of key practice events from involved agencies which included care home records from 5th January 2016 to 30th June 2016.
- Case information including safeguarding referral, strategy meeting, relevant emails, police report, safeguarding adults health advisor report
- SAR Panel meetings
- SAR Learning event 24th May 2017 with practitioners involved in the care of Mrs Taylor, Managers and Safeguarding leads

### 4.2. Panel membership

The Panel consisted of members who were senior managers nominated by their agency with no previous involvement in the case, and with authority to effect change in their own agency.

The Chair and author of the Overview Report has been commissioned by CSAB to produce an independent report and has had no involvement in the delivery of identified services; or line management for any service or individual mentioned in the report.

The author and the SAR Panel agreed terms of reference and their responsibility to look openly and critically at individual and agency practice; to see whether this SAR indicates that changes could and should be made and if so, to identify how those changes will be brought about.

| Agency | Role |
|---|---|
| Independent consultant | Chair and review author |
| Calderdale Safeguarding Adults Board | Business and Quality Assurance Manager |
| NHS Calderdale Clinical Commissioning Group | Designated Nurse for Safeguarding Adults |
| West Yorkshire Police<br>Calderdale District | Detective Chief Inspector |
| Calderdale and Huddersfield NHS Foundation Trust | Head of Safeguarding |
| Calderdale Metropolitan Borough Council | Interim Safeguarding Adults Service Manager |
| South West Yorkshire Partnership NHS Foundation Trust | Assistant Director of Nursing and Quality |
| Bondcare Ltd. (care provider) | Director |

### 4.3. Family involvement

Family members were initially contacted by letter in February 2017; there has been no response to three further attempts made to contact the family.

AHSC undertook a capacity assessment with Mrs Taylor on 27th July 2017 to establish if she had capacity to be involved with the Safeguarding Adult Review; this concluded that Mrs Taylor did not have capacity to make this decision. Family members were offered the opportunity to be involved again at this time but declined. Further letters were sent in September to inform them a draft report was completed and to invite their comments but the family did not respond.

On completion of the final report, the Panel agreed that although the absence of any input from family made an incomplete review, the decision not to contribute was understood and respected.

## 5. Areas of Learning

Conclusions and recommendations are informed by the evidence identified in the methodology (4.1) and reflect contributions and suggestions made from participants at the learning event on 24th May 2017.

### 5.1. **Empowerment** - presumption of person led decisions and informed consent

- There is scope to improve the presumption of person led decisions and informed consent, “making safeguarding personal”.

- Statutory agencies did not meet Mrs Taylor as part of the safeguarding investigation, therefore there was no direct information relating to her capacity to be involved in the safeguarding investigation. If a capacity assessment is required in a safeguarding investigation there should be clarity on who will carry this out and when it will be undertaken.
- The police and safeguarding investigators did not initially assess the nature of the bruising and the care home did not liaise adequately with Mrs Taylor or her family. Had these two things happened it might have resulted in a different outcome for Mrs Taylor and her family.
- The review has been unable to provide an analysis of key events due to a lack of recording or rationale for some professional decisions at the time. An outcome of this review includes focussing on improvements to be made in this area of professional practice as detailed in recommendations.
- The review acknowledges the delicate balance of investigation requirements and the personal privacy and dignity of an individual in terms of how many times a bruise in an intimate place should be examined. The Quest Matron didn’t see the bruise on the 5th January but senior staff from the care home saw the initial bruising and completed an accident form and body map and undertook 48 hour monitoring. The bruise was not examined again until the family saw this on 10th January. It is in these situations that appropriate information sharing between agencies is most critical; so that the necessary safeguarding information is collected, but repeated examinations are not required. Best practice would include providing appropriate recording which includes the rationale for decisions at the time.
- Calderdale Safeguarding Adults Board (Vision and Strategic Plan 2014-2017) states that; “all safeguarding adults’ responses keep the person at the heart of the process and supports them to meet their own individual expectations and outcomes”.

Mrs Taylor was not consulted about the outcomes she wanted from the safeguarding enquiry. Following this event AHSC will ensure that any future IT and associated document developments emphasise identifying the outcomes for the individual.

- There is evidence of discussions and explanations given to Mr Taylor for clinical decisions and medication prescriptions. It was identified that Mrs Taylor remained on an anti psychotic medication "at the request of her husband" as he believed it was working and he did not want her to take statins due to the risk of a stroke. He was aware that the medication she was taking also had a number of risks, and it was agreed that a further review was required. The care home staff identified in March 2016 that Mr Taylor had Power of Attorney for finances and property, but not health and wellbeing as previously assumed.

- The review identified the need to ensure providers have a robust system to ensure they see and record evidence of the Lasting Power of Attorney (LPA) at entry to services, and the level of influence and decision making is discussed and agreed. This should be regularly reviewed and evidence and information appropriately shared with other relevant providers.
- In a safeguarding investigation there should be clarity on who will establish LPA so that this is not based on an assumption. Individual agreements as to what information is shared with family members should be also agreed and regularly reviewed. Areas such as family influence on medication (with or without relevant LPA) should be clarified. It is important that family members are consulted and involved, but they should not unduly influence decisions on medication. Although the legal position on this is clear, the review highlighted this in an area where practice can be strengthened.

- There is a wide range in levels of understanding and confidence applying the Mental Capacity Act (MCA) and some teams have comprehensive knowledge, embedded training and an agency lead. The learning event reflects this is not consistent or universal and further training would be of benefit, including strengthening routes to share existing expertise for example mentoring and introducing multi agency access to forums such as the MCA clinics. This is a positive model led by the MCA lead in AHSC and Principal Social worker; practitioners report they find the opportunity to informally discuss relevant issues useful. There may be scope to consider how this can transfer into multi agency arenas.

Improving skills and knowledge relating to the MCA responds to actions undertaken by agencies in this review; such as understanding when and why to undertake a capacity assessment; and is underpinned by feedback from attendees at the learning event. Similarly training on applying Best Interest decisions in practice were identified as areas where practitioners would welcome further guidance.

5.2. **Prevention** - it is better to take action before harm occurs

- The Falls Protocol (Calderdale Council) is clear and easy to read but the volume of different protocols and audit requirements for different geographic areas and different stakeholders can lead to confusion and difficulty in finding the correct guidance. This can contribute to inappropriate referrals or missed opportunities to raise safeguarding alerts. There may be scope for this to be adapted to be a multi-agency policy. Although the Safeguarding Adults Multi Agency Policy and Procedures cover all West Yorkshire, North Yorkshire and York some providers identify that finding the relevant falls protocol and completing numerous related forms for each area is time consuming. It was stated that this can be up to 4 councils and 3 CCGs with different contractual requirements.

- Protocol language should be consistent; an unwitnessed injury is more appropriate terminology in this case since it was not possible to establish it was an unwitnessed "fall".

- Care Home 1 has a Policy and Procedure around the Prevention and Management of Falls which guides staff through the requirements of immediate management and documentation. In this instance a fall was not observed and the injury could have been caused by a number of scenarios which cannot be proven. There are no witnesses, and Mrs Taylor is unable to recall or communicate her views about this incident. Care Home 1 completed an accident and incident record and body map in a timely manner and created a 48 hour monitoring log which closely monitored Mrs Taylor for any change in presentation; however they did not continue to monitor the progression of her bruising as they should have done in her records. A QUEST Matron was also requested by the Home to review Mrs Taylor for any medical issues they might have overlooked.

- The care home policy states that next of kin "must be informed of their relatives fall". As this was an unwitnessed event and not specifically a fall the safeguarding investigation found there are no grounds to state this policy was not followed,

however in terms of good practice the family should have been informed. The Safeguarding Adults Investigating Officers Report (AHSC form SA7) concludes that this was addressed through the internal investigation undertaken by Care Home 1 and appropriate action has been taken by management to address these issues. The incident form at the Home has now been amended to indicate when contact has been made with the family, and unwitnesssed incidents are now processed through their Falls procedure.

- The requirement of the Home to notify Safeguarding Adults if an event is unwitnessed and thresholds for injury or harm was an area for discussion throughout the investigation. The learning event identifies there is still a lack of clarity relating to safeguarding thresholds following an unwitnessed incident which should be consistent and clear to avoid risk and duplication; this is addressed in Recommendations.

- The learning event identified difficulties relating to demand and capacity. There are 7 Quest Matrons covering 45 homes which are felt by practitioners to be a large demand on a small team. Similarly, the Support and Independence Team (Falls team) comprises of 2 specialist physios and 3 falls prevention workers and covers the same number of homes plus other statutory settings. There may be a 6-8 week wait before attendance after initial referral. This service is not a response service and other services should be referred to if required.

- There needs to be an investment in prevention, more creative use of resources and joint training to increase practitioner confidence in delivering low level responses from the referring agency before referring to the Falls team.
- There needs to be a response from the referring agency before the Falls team can attend as there may be a 6-8 week wait. Attendees at the learning event identified it would be useful if the Falls team could produce some guidance, such as a risk protection plan for other agencies following referral.
- The learning event identified an area to address that potentially, despite evidence of adequate practice and care, a referral to the Falls team is required to avoid professional criticism.

5.3. **Proportionality** - proportionate and least intrusive response appropriate to the risk

- A number of questions have been raised throughout the review as whether the police involvement was proportionate in this case. The Care and support statutory guidance (updated February 2017) states;
  "Although the local authority has the lead role in making enquiries, where criminal activity is suspected, then the early involvement of the police is likely to have benefits in many cases." (14.83)

  From the investigation conducted there was insufficient evidence to suspect a crime had been committed in this case. The review finds there were a number of trigger points where clarity of information would have ensured the intervention and outcome could have been more proportionate, providing the least intrusive response appropriate to the identified risk.

- The initial response to the family from the care home was felt to be unsatisfactory as the care home were not aware there was a significant bruise, and the subsequent responses from staff led to them feeling concerned that Mrs Taylor might be at risk from abuse and neglect which led to a safeguarding referral.
- As the safeguarding adult's team (Calderdale Council) felt there was insufficient explanation from the care home or details of what actions would be taken to prevent similar incidents, the safeguarding alert raised by the family was accepted for further enquiries.
- The advice for the family to contact the police escalated events but no other safeguards to manage potential risks to Mrs Taylor or other residents were put in place. Following the referral an interim protection plan should have been considered at the earliest opportunity. As a result of this review AHSC staff will be reminded of the importance of robust protection planning at performance clinics with management oversight; and any future policy developments will ensure there is an emphasis on protection planning.
- It is not the usual process for Social Care to advise the family to phone the police and there is no rationale for why this happened. The review identified that there is a wider need to improve the standard of record keeping and ensure the rationale for decisions is consistently recorded. This is covered in areas of learning and recommendations.

- The necessary speed of a police or safeguarding investigation should not be compromised; but effective inter agency communication and increasing understanding about the process would improve professional relationships with care homes and the wider safeguarding partnership and promote effective safeguarding responses.
- There was no communication with health services during the initial safeguarding investigation such as the Safeguarding Adults Health Advisor or QUEST; therefore a clinical opinion was not considered by the police or AHSC in relation to the bruising at the time of their initial response to the safeguarding referral. If this input had been considered at the earliest opportunity this would have contributed to more informed decision making.
- The review acknowledges that this event occurred in January 2016 and personnel and practice has changed in the last 18 months. The review describes throughout where individual agencies have implemented relevant practice changes.

5.4. **Protection** - support and representation for those in greatest need

- The review identifies a lack of clarity for a number of service providers relating to the safeguarding process. The levels of safeguarding skills and knowledge appear inconsistent, senior staff may have an in depth understanding of policies but this is not consistent across agency staff and practitioner level. Some individual responses reflect gaps in understanding the roles and responsibilities involved in a safeguarding investigation.

- There is a lack of consistency across agencies in safeguarding language which can lead to misconceptions; actions should include defining a safeguarding alert or safeguarding concern, providing clarity of what constitutes a strategy meeting or professionals meeting, phone calls or face to face, and who and how people should be included.
- The notice given to agencies to attend safeguarding strategy, case conference and planning meetings was inconsistent. Important partners were not invited and relevant information was initially missed. The learning event agreed that this situation could happen again without early liaison with appropriate agencies from the outset.
- There is scope to improve the focus, purpose and co-ordination of safeguarding meetings; ensuring responsibility for actions are addressed, also focussing on

consistent invitations, attendance and timeliness and ensuring partners are aware of outcomes.

- The Safeguarding Adults Multi Agency Policy and Procedures cover all West Yorkshire, North Yorkshire and York and make recommendations about timescales; however the learning event identified that timescales were missed. Information should be circulated prior to meetings to ensure time and opportunity for preparation and analysis.
- The SAR provides an opportunity for reviewing and refreshing safeguarding process and procedure. One of the key learning points is that policies do exist but were often not followed; therefore a focus on training, dissemination and accessibility would be appropriate. On several occasions some areas of safeguarding policy were not consistently followed in this case, some newly appointed staff were not familiar with usual practices and this is addressed in recommendations.
- The family report they were unable to discuss their safeguarding concerns on the 10th January, the day they contacted AHSC, as it was a weekend. The case note entry for AHSC states the safeguarding concern was accepted for further enquires on 12.1.16. As the referral was not from the care home or from social care and had occurred over a weekend the usual safeguarding responses were potentially less robust, and this had an impact on gathering information.

- The learning event identified a need for more robust feedback of outcomes on case closure as an essential aspect to inform the risk assessment of future concerns, but that staff capacity is a practical issue to consider. There could be a role for system generated feedback which is less personal, but there is scope to explore the ways in which feedback can be improved.

5.5. **Partnerships** - local solutions through services working with their communities

- There is an over arching information sharing agreement with key partners but attendees at the learning event identified that restrictions in sharing health information are experienced as people believe there are no formal agreements to share records, or staff are unclear whether these are in place.
- Streamlining the process and improving access to records and personal information would be a positive outcome from this review.

- The learning event highlighted the different approaches and perspectives between health providers and social care; examples were given relating to assessment and

responses to risk. Ensuring all agencies provide a stronger rationale for decisions and further opportunities for joint professional meetings to discuss these differences would strengthen the safeguarding process. Safeguarding strategy and relevant multi-agency meetings were identified as very beneficial but often difficult to co-ordinate; in addition they may not happen at the initial stages and may not routinely include everyone, for example care home staff. Video and telephone conferences were suggested as a means to provide information, with the necessary confidentiality considerations.

- Care home staff need to feel and experience the value of their input and expertise as equal partners.
- Investigate whether contracts could include encouragement to attend forums and increase the opportunity to engage with multi agency training.

- On occasion the involvement of a particular partner or provider will be limited where involving the provider put the individual at further risk or risk the impartiality of the investigation. In these circumstances this needs to be clearly explained and measures taken to ensure the agency or care home is represented appropriately; and they are able to contribute to relevant parts of strategy and planning meetings.
- A wider "ownership" of safeguarding was a key theme across the learning event, applying the principles of sharing risk and responsibility. The annual Safeguarding week in October is an opportunity to promote joint ownership and disseminate key policies.

5.6. **Accountability** - accountability and transparency in delivering safeguarding

- When the case notes were taken by the Police as part of the safeguarding investigation these were incomplete as some documents were unavailable and locked in the manager's office. There was a delay of 9 days before all the documents were given to the police on 25.1.16. Some of the necessary notes and relevant records were not available to staff to assist them in the care of Mrs Taylor. In a safeguarding investigation this also leaves agencies open to allegations of potential malpractice; such as providing the opportunity to amend or alter case recording.

- The care home was left without active care plans when Police seized case notes for evidence on Saturday 16.1.16. No copies of the case notes were made before removal and original copies rather than photocopies are required for DNACPR (a

document signed by a doctor to verify a decision has been made not to attempt to resuscitate). Subsequent temporary care plans did not include reference to medical history and current medication so lacked relevant information in providing adequate care.

It is accepted that mistakes were made, and the Police undertook a full review of their investigation. Lessons learned and appropriate training has been cascaded through Calderdale safeguarding department and district frontline staff. Calderdale District now has 2 full time Vulnerable Adult Investigators who will take primacy for investigations in a care home setting, and wherever possible a Safeguarding Officer will attend as a first response. The police are assured this has had a positive response and this has improved the standard of investigations.

The Police identify that further multi agency training for agencies on safeguarding process and investigation would see positive benefits.

- Poor quality record keeping and recording the rationale for key decisions was identified as a gap in several agencies. "Appropriate recording" training is being delivered in the Local Authority and this may be an effective model to inform multi agency developments.
- The learning event identified the provision of a template and case example of quality recording would be helpful in training and induction of new staff.

- Some of the responses to this safeguarding alert were carried out by practitioners who were not familiar with the usual practice across Adult Social Care or the Police because they were newly appointed in post. This led to human error, additionally a lack of training for newly appointed staff were contributing factors. The learning event suggests providing more structured support and guidance to newly appointed staff as part of planned inductions.

5.7. Additional Areas of Learning generated by the Learning Event

A SAR Learning event was undertaken on 24th May 2017 with practitioners involved in the care of Mrs Taylor, Managers and Safeguarding leads.

- The learning event identified that care homes have a wide range of approaches to recording. The best practice model includes evidence of the personal history,

background and personality of the resident and this should be more widely adopted as a standard requirement.

- There is scope to improve the transition into care homes recognising the potentially traumatic experience and loss experienced by the resident and family. This should prioritise a person centred focus before the usual six week review.

- The fast turnover of care home staff and managers means that information sharing forums are also an effective opportunity to disseminate good practice and provide training. However practitioners noted that without ownership or direction they can be less useful, and focus on contract and resource issues.

- The Care homes could use a risk assessment process similar to the risk enablement panel led by Social Care who meet to discuss issues raised in responding to safeguarding and the Mental Capacity Act. This could be an area to explore for a wider use where formal recording is needed that a specific risk has been identified but the individual and family are aware; and in order to facilitate independence they accept the identified risks. This responds to the principle of the right to make unwise decisions, but ensures that the rationale is clearly recorded.

- Health providers will ensure information is shared in line with data protection and Caldicott guidance; but IT systems are complex and potentially impact on effective information sharing. In practice this was highlighted as an area which could be improved. Some partners at the learning event identified difficulty in accessing medical records and mental health information which impacted on safeguarding investigations. They gave examples of where in order to prove the validity of a request to share information, a formal verification request is required across multiple areas of Health and other agencies which cause delays and require staff to chase up responses.

- A neighbouring authority uses an audit model and team managers conduct an audit of safeguarding referrals against agreed standards. This was raised at the learning event as an example of an effective process and may be a useful model of quality assurance.

- With appropriate consideration for data protection there should be an agreed principle that safeguarding is an over-riding priority, and CSAB should ensure that one agreed information sharing protocol with all key partners should be in place.

- Identify strategies to streamline requests for health information and simplify formal verification processes
- Investigate how existing and adapting use of technology can further support effective communication and information sharing as identified in Areas of Learning for example;
  - Exploring options of improving consistent feedback of safeguarding referral outcomes
  - Video and telephone conferences

5.8. Key Findings

- The principle of person centred care was not explicitly or consistently applied during the investigation, seeing and speaking to the person at risk is critical.

- Record keeping did not meet expected standards, there were a number of examples where meetings were not recorded, information was not circulated or the quality of information could be improved. Overall the review identified a need to ensure that in a safeguarding investigation all professionals should consistently record the rationale and relevant evidence for decisions made and this should be communicated to partner agencies.

- There is a need to support development of skills and knowledge applying the Mental Capacity Act and understanding the documentation, interpretation and application of Lasting Power of Attorney.

  There is a Next of Kin Decision-Making Authorities leaflet which could be more widely available. [3]This training should include promoting the use of advocates in addition to family members if there is a risk of compromising Best Interest decisions.

[3] http://www.ncpqsw.com/free-publications/nok/ link to Decision Making Authorities leaflet

- There is a need to review and strengthen understanding of Safeguarding Adult protocols, and develop a shared ownership of the safeguarding process. Standardised forms for services and referrals would be a positive outcome from the review; with an ambition to agree thresholds for making a safeguarding referral (particularly following an unwitnessed event) which are easy to evaluate and could be agreed across areas and provision.
- Include a focus on the process for reporting safeguarding concerns out of hours, over a weekend and bank holidays from family or non statutory services.
- More training and guidance is needed on the roles and responsibilities of agencies and individuals during a police and safeguarding investigation.
- Increase opportunities to reflect good practice in safeguarding, not just SARs.

- Within contracts providers are already expected to have a falls policy which is consistent with the existing multi agency protocol, but the learning event highlighted the difficulties in multiple policy requirements. A welcome outcome from this review would include one overarching Falls Protocol signed off through CSAB which advises safeguarding or other action to be taken and evidence requirements.

- Safeguarding systems should include opportunities for professionals to appropriately challenge decisions, including a relevant policy and process, and ensure key partners are consulted and included.

- There needs to be increased opportunities for low level conversations with associated professionals before a safeguarding referral is made.

- With appropriate consideration for data protection there should be an agreed principle that safeguarding is an over-riding priority, and a widely promoted and accessible information sharing protocol with all key partners should be in place.

- There could be a wider use of technology to support effective communication and information sharing; a priority area would be ensuring health and medical information is available and included in safeguarding investigations.

- Investment in multi agency training would nurture partnership working and effective information sharing.

- It would be useful for managers in safeguarding services to evaluate if staff feel listened to in multi agency meetings and forums, particularly focussing on the experiences of care home providers.

5.9. Good Practice Examples

- A good practice model was identified by the police who have a victim code which includes agreeing a level and appropriate method of family contact during an investigation at the outset. The computer system then provides reminders, even for officers to inform them there is no new information; and officers cannot finalise the investigation until this has been completed.

- There is an effective system to disseminate learning in the Police, when officers are instructed to change a process it includes the reasoning.

- The care home is evaluating a gradual integration model with day visits before a resident moves in.

- The care home identified a good practice model of inviting family members to meetings where protocols were discussed; this could be shared with other care homes.

- A good level of liaison was identified between Quest matrons and care home staff.

- Detailed assessment and multi professional liaison was provided through Intermediate Care physio.

- The role of Safeguarding Adults Health Advisor was appointed following a previous review in 2011[4]. This post is no longer in place but the consultation identified the positive advantages of a named co-ordinating role and that many safeguarding cases had a significant health input. It was felt this may improve information sharing and strategy meetings, and in some cases it is possible to appropriately de-escalate referrals through early involvement and communication with the right people.

[4] Serious Case Review: Elm View. Calderdale Council

- Responding to a relationship breakdown between family and professionals it was identified that the principles of being open, honest and transparent were critical; and there needed to be an initial acknowledgement and apology from the outset.

- Safeguarding week in October is a key event and an opportunity to enhance local and wider partnerships.

6. How the Board will oversee and ensure that the recommendations are acted upon

a) The CSAB will ensure that areas of improvement are reflected in the Business Plan as appropriate. This will take account of, but not be limited to the robustness of policies, procedures, local guidance, training and the impact of these on front line practice.
b) Progress and impact will be managed through the appropriate CSAB work streams, with the Safeguarding Adult Review sub group monitoring an overarching action plan.
c) The CSAB and its members will formally and regularly monitor the implementation of the action plan and recommendations in order to ensure progress is being made
d) The CSAB Safeguarding Adult Review sub group will maintain a record of all recommendations and require both the CSAB and its partner organisations to report on progress on a regular basis
e) The CSAB performance management framework will reflect in its core indicators, key areas of learning so that compliance can be evidenced
f) The CSAB multi agency training programme will reflect key learning and will be reported to the Board in annual and quarterly evaluations
g) The CSAB will review policies and procedures and where necessary update or put in place appropriate amendments or new policies
h) The CSAB, in its annual report, will report on the progress made and the wider impact across partners of the learning, in order to consider whether progress and impact has been good enough
i) The CSAB will work with partners to progress the single and multi-agency recommendations
j) A Challenge Event will be held after publication to test out the sustainability of the changes made as a result of this SAR. Learning from this will be reported to the CSAB.

6.1. Dissemination, implementation and monitoring of impact of learning

The Board and its partners have a number of mechanisms to ensure satisfactory dissemination of learning. Across the safeguarding partnership we have a culture of continuous learning and improvement. This must be sustained and we will test this through regular monitoring and review.

The approach of CSAB to this will be outlined in the Learning and Improvement Framework; these are some examples of how the learning from this review will be promoted and embedded in practice:

- Training and briefings to professionals and adults with care and support needs
- Newsletters, briefing papers and learning lessons for front line practitioners
- Quality assurance through audit
- Performance management of indicators which outline practice improvements
- Publication on website
- Challenge events for front line practitioners to ensure the learning has been absorbed

7. Recommendations

Since the date of the safeguarding event several agencies have identified and acted on learning points internally, and made specific changes to practice or identified where existing practice needs to be reiterated and strengthened. Areas of learning may have been identified by the Review but are not included in recommendations or an action plan where these issues have already been addressed.

| Recommendation One |
| --- |
| CSAB to review current safeguarding adult protocols and ensure clear guidance is agreed by all key partners to provide clarity, defining agency rights, roles and responsibilities during a safeguarding investigation, subsequently evaluating if practice has improved.<br><br>- The guidance to clarify the representation of partner agencies, documentation requirements, communication and purpose of multi agency meetings during a safeguarding investigation in order to standardise the process.<br>- ensure professional language is consistently applied for example safeguarding alert/concern/referral and what defines a Strategy meeting<br>- Evaluate the process leading to agreeing and undertaking a SAR to ensure timeliness and avoiding drift. Ensure clarity on methodology and evidence required for reviews. |
| Actions supporting the recommendation |
| • To increase opportunities to ensure key partners are fully represented and involved in the safeguarding process, as identified in the learning from this review;<br>- Health knowledge and skills to be included from the outset<br>- Strengthen relationships with care homes, including them as safeguarding partners. Investigate whether contracts could include encouragement to attend forums and increase the opportunity to engage with multi agency training<br>- Clear guidance on who is to be invited to multi agency meetings<br>• AHSC to assure CSAB that the response to safeguarding concerns reported at evenings and weekends is effective and timely.<br>• AHSC to ensure care home providers in Calderdale are aware of their responsibility to maintain a full and complete set of case notes and care plans which is fully accessible at all times.<br>- That their current safeguarding protocol defines the action required during a safeguarding investigation and is understood by all staff at their care homes. |

| Recommendation Two |
| --- |
| CSAB to lead on identifying if it is possible to standardise and produce one specific Falls Protocol which advises safeguarding or other action to be taken and evidence requirements.<br>- Investigate regional examples to support the principle of clarity and joint working.<br>- Investigate and implement any changes which can be made to improve the system of care homes responding to unwitnessed events. |
| Actions supporting the recommendation |
| • CSAB to be assured that protocol language is consistent and thresholds or reporting requirements following an unwitnessed incident resulting in an injury or potential harm across the partnership are clearly applied and understood.<br>- ensure clarity of safeguarding processes for adults, families and communities |

| Recommendation Three |
| --- |
| Relevant partner agencies to evaluate how practitioners can be further supported in the areas identified as a training need in the review and learning event.<br>- Improving appropriate recording - rationale for decisions<br>- Police and safeguarding investigations – roles and responsibilities of individuals and agencies<br>- Providing clarity for agency thresholds in safeguarding referrals<br>- Strengthening inductions to ensure practitioners in safeguarding agencies have the relevant training and skills to undertake proportionate safeguarding work.<br>- Professional challenge; matched by relevant policy and process to challenge safeguarding decisions<br>- Lasting Power of Attorney; Office of the Public Guardian and Court of Protection<br>- Mental Capacity – Best Interest |
| Actions supporting the recommendation |
| • Models of improving skills and knowledge can include specific guidance, mentoring, shadowing, e-learning and direct multi-agency training sessions. The “gold standard” would be to invest in multi agency training which would nurture partnership working and effective information sharing, meeting other identified needs from this review.<br>• The Escalation Procedure currently being developed in the Safeguarding Children Board could provide a useful model for adaptation, responding to the issues raised relating to professional challenge and providing consistency across service provision. |

| Recommendation Four |
| --- |
| CSAB to ensure that learning from this review is effectively disseminated and shared |
| Actions supporting the recommendation |
| • Review agency responses to this SAR in one year and evaluate how practice has changed and improved. |

REFERENCES

DoH (2016) Care Act Statutory guidance; updated February 2017; Criminal offences and adult safeguarding

BACKGROUND READING

Bournemouth University. Next of Kin; Understanding decision making authorities. http://www.ncpqsw.com/free-publications/nok/ link to Decision Making Authorities leaflet; accessed May 2017

Calderdale Council; Calderdale Safeguarding Adults Board (Vision and Strategic Plan 2014-2017)

Calderdale Council (August 2016). Falls Protocol for Care Homes.

Calderdale Council (2012)Serious Case Review: Elm View. www.calderdale.gov.uk/socialcare/.../cr-elm-view-nursing-home.pdf accessed March 2017

DoH (March 2016); Care Act statutory guidance https://www.gov.uk/government/publications/care-act-statutory-guidance accessed 7.3.17.

Mental Capacity Act 2005

http://www.legislation.gov.uk/ukpga/2005/9/contents accessed throughout review

The West & North Yorkshire & York Safeguarding Adults Project Group; Multi-Agency Safeguarding Adults Policy and Procedure for West Yorkshire, North Yorkshire and York (December 2015) https://www.calderdale.gov.uk/socialcare/safeguardingadults/for-professionals.html accessed April 2017