Trafford Strategic Safeguarding Board

SAFEGUARDING ADULT REVIEW
SAR JOHN

MAY 2019

NHS Trafford Clinical Commissioning Group

TRAFFORD COUNCIL

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Introduction

1.1 John has a diagnosis of learning disability and schizophrenia and had been residing in supported living accommodation with on-site 24 hour support for many years when a series of falls led to a number of hospital admissions during 2017. Following discharges from hospital to his supported living accommodation, John had further falls leading to readmissions to hospital. John suffered serious injuries as a result of this series of falls.

1.2 Trafford Strategic Safeguarding Board decided to commission a Safeguarding Adults Review (SAR) on the grounds that John experienced serious neglect and there was concern that partner agencies could have worked together more effectively to safeguard him.

1.3 A panel of senior managers from partner agencies oversaw this review and membership of this panel is shown in Appendix A. The methodology adopted for this review is also shown in Appendix A. David Mellor was commissioned to be the independent chair of the panel and author of this report. He is a retired chief officer of police and former independent chair of a safeguarding adults board. He has been the independent author of a number of safeguarding adults reviews and other statutory reviews and has no connection to services in Trafford.

2.0 Terms of Reference

2.1 The scope or timeframe for this SAR is from 1st January 2017 until 31st October 2017. Significant events which took place prior to this date will also be considered.

2.2 The lines of enquiry for this SAR are as follows:

- To what extent did practitioners listen to the voice of John? Were his wishes and feelings heard and understood?
- Did John have/should John have had access to advocacy? As an unbefriended person how effectively was John supported? Were there any missed opportunities for advocacy support?
- Did practitioners work with John in accordance with the principles of the Mental Capacity Act? Did practitioners act in John's best interests?
- Was John deprived of his liberty during the time period covered by the safeguarding adults review? If a deprivation occurred, was this managed in accordance with relevant statutory frameworks and practice guidance?
- To what extent were safeguarding adults procedures followed in John's case?
- John's GP appears to have responded to changes in his presentation by altering the medication prescribed to him. Were the reasons for the changes in John's presentation fully explored and were alternatives to altering his medication fully considered?
- To what extent did agencies consider the impact of changes in medication for John on his care and support needs, particularly any increased risk of falls?
- When John suffered significant injuries, apparently as a result of falls, were those injuries recognised, documented and treated appropriately?
- How appropriate was John's placement? Did the care and support provided to him in his placement fully meet his needs? Was the physical environment of the placement appropriate for John? What action was taken by the provider in respect of John's risk of falls including any contact with the commissioner of the placement?
- How effective were agencies in considering the needs of John when it was necessary to place him in an out of area hospital following the Manchester Arena attack?
- How effective was discharge planning from hospitals for John?
- How effectively was information sharing between agencies involved in providing treatment, care and support for John?

- To what extent were agency interventions with John informed by relevant prior concerns?

- To what extent did agencies make reasonable adjustments for John, given his learning disability?

3.0 Glossary

The ABC chart can be used to record behavioural concerns.

- 'A' stands for antecedents, that is, what happens immediately before the behavioural outburst and can include any triggers, signs of distress or environmental information.

- 'B' refers to the behaviour itself and is a description of what actually happened during the outburst or what the behaviour 'looked' like.

- 'C' refers to the consequences of the behaviour, or what happened immediately after the behaviour and can include information about other people's responses to the behaviour and the eventual outcome for the person.

Best Interests - if a person has been assessed as lacking mental capacity then any action taken, or any decision made for, or on behalf of that person, must be made in his or her best interests

Care Programme Approach (CPA) - is a framework to assess the care and support needs of people with mental health problems, develop a care plan and provide the necessary support. A care coordinator monitors the care and support provided.

NHS Continuing Healthcare (CHC) – NHS continuing healthcare, also known as NHS continuing care or "fully funded NHS care", is free care for outside of hospital that is arranged and funded by the NHS.

Deprivation of Liberty Safeguards (DoLS) were introduced in 2009 and protect the rights of people aged 18 or above who lack the ability to make certain decisions for themselves and make sure that their freedom is not inappropriately restricted. No one can be deprived of their liberty unless it is done in accordance with a legal procedure. The DoLS is the legal procedure to be followed when it is necessary for a resident or patient who lacks capacity to consent to their care and treatment to be deprived of their liberty in order to keep them safe from harm. The DoLS can only be used if the person will be deprived of their liberty in a care home or hospital. In other settings, and for children aged 16 and above the Court of Protection may authorise a deprivation of liberty.

Independent Mental Capacity Advocate (IMCA) - The purpose of the Independent Mental Capacity Advocacy Service is to help particularly vulnerable people who lack the capacity to make important decisions about serious medical treatment and changes of accommodation, and who have no family or friends that it would be appropriate to consult about those decisions. The role of the Independent Mental Capacity Advocate (IMCA) is to work with and support people who lack capacity, and represent their views to those who are working out their best interests.

Hospital Passport - the aim of the hospital passport is to assist people with learning disabilities to provide hospital staff with important information about them and their health when they are admitted to hospital.

Making Safeguarding Personal - is a sector-led programme of change which seeks to put the person being safeguarded at the centre of decision making. It involves having conversations with people about how agencies might respond in safeguarding situations in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety. It is about seeing people as experts in their own lives and working alongside them. It envisages a shift from a process supported by conversations to a series of conversations supported by a process.

Mental Capacity Act (MCA): The Mental Capacity Act 2005 came into force in 2007. It is designed to protect and restore power to those vulnerable people who may lack capacity to make certain decisions, due to the way their mind is affected by illness or disability, or the effects of drugs or alcohol. The MCA also supports those who have capacity and choose to plan for their future. The MCA applies to everyone working in social care, health and other sectors who is involved in the support and treatment of people aged 16 and over who live in England and Wales, and who are unable to make all or some decisions for themselves.

Section 117 Mental Health Act 'aftercare' - is the help provided to people who have been detained under the Mental Health Act after they leave hospital. The support can include healthcare, social care and supported accommodation.

Section 42 Care Act 2014 Enquiry by local authority

This section applies where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there):

- has needs for care and support (whether or not the authority is meeting any of those needs),
- is experiencing, or is at risk of, abuse or neglect, and
- as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case and, if so, what and by whom.

Unbefriended – service users who lack the capacity to make decisions in respect of care or treatment and have no family members to speak on their behalf.

4.0 Synopsis

4.1 John has a diagnosis of learning disability and schizophrenia. He was detained under the Mental Health Act in November 1998 although the circumstances are unknown. From June 2006 until June 2007 John was under the care of Trafford West community mental health team (CMHT). During this period the Trafford West CMHT consultant rationalised his medication. He was referred for transfer to Trafford North CMHT when he moved to Premier Care accommodation but the Trafford North CMHT consultant felt that his needs were being met by Learning Disability services and that mental health intervention was no longer required at that time.

4.2 'Premier Care Limited - Specialised Services' has supported John to live in a community setting since January 2007. 'Premier Care Limited – Specialised Services' is registered to provide personal care to people living in their own homes. The service provides support to people with a learning disability, or who require support in relation to their mental health, including people who required support with medicines administration. The service is provided through both a domiciliary care service and care to people living in supported living arrangements, such as John.

4.3 John has lived in a property at Address 1 in Stretford with another service user since August 2008. One Premier Care carer supported both John and the other service user twenty four hours per day. John was unbefriended. Address 1 is a three bedroomed terraced house. The bedrooms and the only bathroom are situated on the first (upper) floor. There is no bathroom or toilet on the ground floor. The property has a steep set of stairs. Records indicated that 'due to the steepness of the stairs there was no intervention e.g. handrails, which could be put in place to mitigate the risk of falls on the stairs'.

4.4 On 5th February 2014 Premier Care reported a safeguarding concern to Trafford Community Learning Disability Team (CLDT) (social work) as a result of John 'recently having a few falls due to mobility'. In the most recent fall he had fallen over on the way to the toilet and fractured a finger. The outcome of the safeguarding concern was that John's social worker was to work with him to minimise risks. His care plan and risk assessment were updated. A falls sensor and a sensory light were put in place. John's GP was said to have carried out 'various tests'.

4.5 In September 2014 John was seen by psychiatry and discharged. There is no record of this appointment in his clinical records.

4.6 On 30th June 2015 John was referred by his GP to Trafford CLDT (health) for assessment for walking aids as he had a shuffling gait and would lean on staff when walking. There was also a reference to a mobility assessment. John was said to be safe on stairs and have had had no falls. On 26th August 2015 John was placed on a physiotherapy waiting list and noted to be low risk.

4.7 On 31st March 2016 John was taken to Manchester Royal Infirmary (MRI) by ambulance after suffering a fall at home. MRI A&E records state that he had fallen head first down a full flight of stairs. He was said to have been ascending the stairs unassisted, against advice, over recent weeks. He had sustained a laceration to the top of his head. He was noted to be unable to communicate whether or not he was experiencing any pain. John was not admitted to the MRI.

4.8 During the morning of 12th April 2016 John was reported missing to the police by his carer. He was later found safe and well near the canal not far from Stretford Mall.

4.9 On 24th May 2016 a Trafford CLDT social worker carried out an assessment of John who was said to have lost all motivation to perform self-help and household tasks. He had also become verbally abusive and threatening to neighbours and anyone who made eye contact with him whilst he was out with carers. He had begun referring to himself in the first person and calling carers by random names. He was also noted to have lost weight and appeared gaunt despite his diet and appetite remaining unchanged. He was having trouble sleeping and constantly getting up during the night. Following this assessment, John was referred for 'health/psychiatric input' due to a noticeable deterioration in his mental health.

4.10 The above referral for psychiatry was considered at a CLDT (Health) allocations meeting 7 days later (31st May 2016). In addition to the concerns referred to in the previous paragraph, John was said to generally show no emotion other than being in a low mood. He appeared to be 'angry at everybody and everything'. His balance and gait were also reported to have worsened. An action was for the consultant psychiatrist for learning disabilities to request John's GP to refer him to the community mental health team (CMHT). There is no record of any referral being received by CMHT.

4.11 On 6th June 2016 a CLDT physiotherapist contacted Premier Care in respect of the physiotherapy referral from August 2015 (Paragraph 4.6) but John was subsequently discharged from the physiotherapy service after Premier Care did not respond to telephone calls and a letter to arrange for physiotherapy input.

4.12 On 17th January 2017 John was seen at his GP practice in company with his carer who reported that John was not sleeping and was walking around at night 'causing a disturbance'. His prescription of oxazepam was increased from 10mg to 15mg.

4.13 On Monday 8th May 2017 John was seen at his GP practice in company with a carer. The carer said John used the toilet frequently and appeared quite hyperactive at night. The GP noted difficulty in eliciting information from John. Urine and blood samples were taken to investigate his urinary symptoms but it was not possible to carry out a prostate examination due to John's agitation. His oxazepam dosage was increased from 15mg to 20mg for one month only. If there was no improvement, a different sedative was to be tried. Unfortunately, John's repeat prescription of 15mg was not discontinued and Premier Care continued to administer the 15mg prescription of Oxazepam whilst giving the 20mg. There was a period of two weeks during which John was being given both the 20mg and 15mg prescription of Oxazepam daily. There appears to have been no mention of a fall John may have had in late April or early May 2017 during the GP appointment (See Paragraph 4.17).

4.14 On Sunday 21st May 2017 John was taken to Trafford General Hospital (TGH) Urgent Care Centre (UCC) by his carer as a result of concerns that John was sleeping a lot and sleeping in an awkward position on his sofa. The UCC doctor said that his oxazepam was causing sleepiness and reduced the dose to 20mg and advised that John should be taken to his GP in a day or two if the problem of sleepiness persisted. John's GP practice was notified by the UCC of this reduction in the dosage of oxazepam prescribed to him.

4.15 During the afternoon of Monday 22nd May 2017 John appears to have fallen off the sofa in his ground floor living room. He was found to be lying on his back on the floor but had no visible injuries. His carer initially thought John might have had a seizure. That carer said that John had been visiting the first floor toilet frequently, not only because he needed to use the toilet but also because of repetitive behaviour. He would climb and descend the stairs independently to do so. That carer said John would also come up the stairs to the staff office hourly to request an E-cig.

4.16 John was transported to the MRI by ambulance. The ambulance records indicated that his carer had told them that John had been presenting as lethargic prior to the fall. John was unaccompanied by a carer at this point but Premier Care arranged for John's incoming evening carer to go directly to the MRI.

4.17 John was seen in the MRI Emergency Department (ED). He had suffered a head injury and had an abrasion to the front of his head. His past medical history of schizophrenia was noted as was his learning disability. His carer stated that John had been generally unwell and had refused to mobilise for three days prior to admission. It was reported that he had fallen downstairs three weeks previously but his carer said he didn't think John was seen in hospital at that time. The carer reported that he had been increasingly drowsy since then*. It was possible to obtain only limited information from John who complained of a headache but otherwise said he felt fine. A CT scan was ordered and neuro-observations commenced.

* The Premier Care carer with knowledge of the prior fall had made an entry relating to the fall in the Premier Care log on 1st May 2017. The carer said that John had sustained a mark on his back, head and the three middle toes of his left foot were swollen as a result of this earlier fall. However, the carer who would have been supporting John at the likely times of the earlier fall has said they had no recollection of the fall. (No contemporaneous record of the earlier fall has been found by Premier Care although some records are missing).

4.18 The CT scan showed evidence of acute on chronic subdural haematoma (clot between skull and surface of the brain). Salford Royal Neurosurgery was contacted and it was agreed that John would transfer to that hospital. He would remain in the MRI ED for observation until an ambulance was arranged to transport him. It was also documented that a safeguarding referral was to be made as no medical attention appeared to have been sought following the previous fall. It was also documented that a Mental Capacity Act (MCA) assessment needed to be completed for transfer.

4.19 At 22.31 on Monday 22nd May 2017 the Manchester Arena attack took place which placed considerable strain on hospitals in Manchester and Greater Manchester. John was amongst the patients it was necessary to disperse to appropriate hospitals not treating casualties of the Manchester Arena attack. John was made comfortable in MRI ED overnight and the following morning the neurosurgeon from Salford Royal made contact to advise that he had arranged a neurosurgical bed for John at the Royal Preston Hospital. This transfer took place around 1pm on Tuesday 23rd May 2017. On the same date a Section 2 (of the Community Care (Delayed Discharges) Act 2003) notification of John's admission to hospital with injuries relating to 'multiple falls' was sent to Trafford CLDT (social care). (Section 2 notices are the mechanism by which the NHS notifies councils of any patient's likely need for community care services following discharge from hospital (1)).

4.20 John was accepted by the Royal Preston hospital at 4pm on Tuesday 23rd May 2017. Notes provided by the MRI indicated that John had fallen down stairs three weeks earlier but that there had been no fall or head injury on 22nd May as far as his care worker was aware. Royal Preston staff noted that John's evening dose of oxazepam had been increased by 10mg and that they decided to reduce to 15mg in hospital.

4.21 Trafford CLDT (health) appears to have become aware of John's hospital admission on Tuesday 23rd May 2017 noting his condition as 'bleed on the brain, possibly an old bleed' and that he had been 'admitted for observation' and 'may be discharged the same evening'. Contact was made with Premier Care who are said to have stated that they did not need any support from the CLDT other than hospital passport templates. There is no reference in the CLDT notes to a prior fall(s) or the incident which may have precipitated admission.

4.22 The following day (Wednesday 24th May 2017), Trafford CLDT (health) became aware that John had transferred to Preston and was awaiting surgery for subdural haematoma.

Trafford CLDT noted that John had no family so an Independent Mental Capacity Advocate (IMCA) would be required. (The IMCA role was created by the Mental Capacity Act 2005. A local council or NHS body has a duty to involve an IMCA when a vulnerable person who lacks mental capacity needs to make a decision about serious medical treatment, or an accommodation move).

On Thursday 25th May 2017 John had a right mini craniotomy. (A craniotomy may be performed to remove a blood clot and control hemorrhage, inspect the brain, perform a biopsy, or relieve pressure inside the skull).

4.23 On the same date Trafford CLDT (health) was advised that John was doing well and that the plan was to transfer him to a local hospital once a bed became available. The CLDT informed Premier Care who said they would visit John in Preston and keep the CLDT updated.

4.24 On the same date the Royal Preston experienced difficulty in obtaining a social history from John and queried whether this was due to confusion on his part. John was considered to need 'functional assessment' to inform discharge planning. At that point the Royal Preston was awaiting referral back to Manchester during the period 26th-30th May inclusive.

4.25 On Tuesday 30th May 2017 Trafford CLDT (health) was advised that John was doing well 'although remained unsteady on his feet'. The plan remained to transfer him to a Manchester hospital when a bed became available.

4.26 On Friday 2nd June 2017 John was discharged from Royal Preston to his Premier Care provided accommodation. Physiotherapy and Occupational Therapy (OT) assessments indicated that John was back to his prior baseline (i.e. his state of health prior to the fall). The physiotherapist observed John mobilising to stairs and completing one flight up and downstairs and mobilising back to bed. The physiotherapist discharged John with 'no follow up required'. 'Neuro' observation was also completed and he was found to require supervision if walking to the bathroom. The ward liaised with Premier Care and provided advice to help recovery and reduce cognitive stressors. The hospital noted John had 24 hour 'support and care'. He was considered medically fit for discharge and Premier Care carers transported John back to his accommodation. Trafford CLDT (health) was advised of his discharge.

4.27 During the late afternoon of Sunday 4th June 2017 (two days after discharge from the Royal Preston) John's carer heard him leave the toilet and fall down the stairs. John was said to have been going up and down the stairs all day without assistance. North West Ambulance Service (NWAS) transported him to Salford Royal ED following what they recorded as an unwitnessed fall from the top of the stairs onto a hard laminate flooring. NWAS records also stated that John had fallen forwards, striking his head multiple times.

4.28 On arrival at Salford Royal ED tenderness in John's cervical (upper) and thoracic (mid) spine was noted. He was noted to have lost consciousness for five minutes following the fall. His recent brain surgery following a 'fall down the stairs' at what was inaccurately described as his 'residential home' when he sustained a significant head injury was also noted. Clinical staff found it difficult to assess his level of pain due to his learning disability. John was noted to say 'no' when asked if he was in pain whilst wincing and looking distressed. In light of his mechanism of injury, recent history and clinical examination, a CT scan was requested.

4.29 Later the same evening Salford Royal ED submitted a safeguarding referral in respect of John. The referral stated that the Salford Royal clinical team had concerns that John had experienced two significant reported falls in the last few weeks whilst in 'residential care'. This referral was subsequently received by Trafford Council but there is no record of any action being taken in response other than noting the referral.

4.30 The CT scan disclosed a right sided subdural haematoma measuring up to 11 mm leading to a midline shift (shift of brain past centre line) measuring up to 5 mm. Right sided pneumocephalus (presence of air or gas within the cranial cavity) was also noted as was a mildly displaced fracture of the right parietal bone (parietal bones form the posterior roof of the skull). An undisplaced double fracture of the right lateral mass (pillars of support for the skull) was also noted. John was admitted to the Trauma Assessment Unit (TAU). He was considered to need further neurosurgical and spinal input.

4.31 On Monday 5th June 2017 John was discussed at a Multi-Disciplinary Team (MDT) meeting. A spinal review was awaited. There was also reference to 'mobilisation with a hard collar'. Later that day Occupational Therapy (OT) discussed John with a Premier Care carer. It was concluded that a post traumatic amnesia assessment would not be appropriate on the basis that he would not have been able to answer the questions included in the assessment as a result of his learning disability. The carer was to visit the ward in order to see John in company with the occupational therapist to consider whether John's current presentation differed from his prior baseline.

4.32 A further MDT discussion appears to have taken place later the same day at which it was noted that John's regular carers had concluded that there was no change from John's baseline. It was decided that following X ray, he could be discharged and followed up as an outpatient. A nursing evaluation concluded that John did not require assessment under the Deprivation of Liberty Safeguards (DoLS) or a mental capacity assessment. John was said to be mobilising independently but he would require monitoring to prevent falls. He would also require input from physiotherapy.

4.33 The same date (Monday 5th June 2017) Trafford CLDT (health) was advised of John's readmission and that Salford Royal had raised the safeguarding concern referred to in Paragraph 4.29 above.

4.34 During the early hours of Tuesday 6th June 2017 John was noted not be complying with bed rest and was mobilising around the ward. Nor was he compliant with the wearing of the Aspen collar (cervical collar). A clinical note completed during the morning of 6th June 2017 cast doubt on whether staying in the hospital environment was beneficial for John.

4.35 Later on the morning of Tuesday 6th June 2017 a hospital discharge summary was completed which stated that John was showing no ill effects from his fall and injuries and that he should be encouraged to wear his aspen collar, particularly when mobilising. The summary added that if he complains of increasing neck pain, headaches or weakness in his arms and legs, he should be returned to the ED. There was no evidence of completion of an MCA assessment and no reference to any follow up to the safeguarding concerns which had prompted the adult safeguarding referral two days earlier.

4.36 Prior to his discharge, John was seen by a trauma co-ordinator who was unable to provide more than limited information due to John's cognition and he was provided with a major trauma leaflet.

4.37 During that day (Tuesday 6th June 2017) Trafford CLDT (health) was advised by Salford Royal that John was medically fit for discharge. Moving John to a downstairs bedroom on discharge 'so he wouldn't have to use the stairs' was discussed. The CLDT recorded that physiotherapy had assessed John on stairs and concluded he was at high risk of falls. This information was shared with John's social worker who was to see John on discharge. (There is no reference to this in the Trafford CLDT (social care) chronology).

4.38 John was discharged by Salford Royal during the afternoon of Tuesday 6th June 2017. Premier Care state that they had no prior notice of this discharge and had phoned the hospital for an update and been told John was on his way to them in an ambulance.

4.39 During the late evening of Wednesday 7th June 2017 (the day following discharge from Salford Royal) John fell out of bed. His carer noticed blood on John's carpet. He was transported to Salford Royal by ambulance who noted that his fall out of bed had caused a re-opening of a wound on the side of his head. John was admitted and a clinical assessment completed during the early hours of Thursday 8th June 2017 noted evidence of bleeding from a surgical wound to the right parietal region which had now ceased. It was concluded that if a CT scan found nothing of concern, John could go home in the morning. There was no reference to the discharge from Salford Royal two days earlier or the safeguarding concern raised during that admission. A nursing assessment completed shortly afterwards highlighted an increased risk of falls. Later in the night John was noted to be uncooperative, swearing and physically aggressive to staff when approached to check on his health.

4.40 A clinical assessment of John took place during the morning on 8th June 2017 and noted that he had been readmitted. An MCA assessment was completed but was not decision specific. The outcome of the MCA assessment is not known but it is assumed John was found to lack capacity as DoLS were subsequently considered. DoLS were not pursued as John was said to be 'cooperating'. He was noted to be verbally and physically aggressive to staff. Premier Care were contacted and requested to provide a carer to sit with John due to his challenging behaviour. He was also referred to hospital based mental health services.

4.41 On the same day Trafford CLDT (health) was contacted by the Premier Care manager to advise that John had been re-admitted to Salford Royal the previous night after falling out of bed. No discharge planning meeting had taken place on 6th June 2017 and a safeguarding referral relating to unsafe discharge was completed by Premier Care. The referral was received by Trafford Council but no action was taken under local safeguarding processes. The Premier Care manager also contacted Trafford CLDT (social care) to advise that John's recent falls and injuries reflected a change in his care needs. He also advised that he was investigating previous falls in order to minimise the risks of John experiencing further falls in his accommodation. As an interim measure his mattress was to be placed on his bedroom floor.

4.42 Later that day a Trafford CLDT social worker attempted to contact the Salford Royal named nurse to advise that discharge would be unsafe due to John's provider feeling they would be unable to manage the risks. Trafford CLDT (health) contacted Salford Royal and the need to increase the hours of support John's received was discussed. This was to be explored by John's CLDT social worker. Trafford CLDT (health) advised Salford Royal that a best interests/ MDT meeting needed to take place.

4.43 During the afternoon of Thursday 8th June 2017 John was seen by the Salford Royal mental health liaison team. His carer was also present. The mental health practitioner attributed John's verbal and physical aggression towards Salford Royal staff to his fear of being in an unfamiliar setting and not recognising/knowing staff. He was noted to become calm and settled once his regular carers arrived. The practitioner added the caveat that he could still become verbally and physically aggressive even with staff he knew. Due to his diagnosis and limited cognition, John was considered not to have capacity but this was not formally tested at this time. The mental health practitioner recommended that his care package be reviewed with a view to increasing carer support.

4.44 John was discharged later the same afternoon. A clinical note completed shortly prior to discharge stated that from a medical perspective the hospital was happy for him to return home. It was said that the social care concerns could be resolved in the community. The clinical note went on to state that it would seem wasteful to keep John in an acute medical bed when there had been no change in function. It was noted that Trafford CLDT (social care) were to undertake a home visit the following day. A section 2 notification had been completed by Salford Royal.

4.45 The following day (Friday 9th June 2017) a Trafford CLDT social worker made a home visit. An 'extra' bannister was to be fitted to the stairs that day. A CLDT referral to physiotherapy for falls management was discussed but Premier Care were asked to arrange an in-house physiotherapy assessment as 'this would be quicker'. John was said to be resistant to sleeping downstairs. Extra care package hours were discussed. The social worker arranged to visit again on 14th June 2017 to check on progress.

4.46 On Sunday 11th June 2017 John's carer took him to a supermarket in her car. He was unsteady on his feet on arrival so the store provided a wheelchair. He couldn't bear weight when attempting to get back into the carer's car. During the early afternoon he was transported to Salford Royal by ambulance. The NWAS record also mentioned a recent episode of incontinence and periodic left side weakness. John was clinically assessed and after a discussion with a neurosurgeon, he was admitted to a hospital ward. He was assessed as lacking capacity to agree to remain in hospital, agree to restraint and consent to a specific procedure. As John was under continuous supervision and was not judged to be free to leave the hospital, DoLS were considered and were to be reviewed the following day.

4.47 On 12th June 2017 Premier Care informed Trafford CLDT (health) that John had been readmitted to Salford Royal the previous day. Mention was made of a possible urinary tract infection.

4.48 The same day a clinical note was completed following a CT scan. From a neurosurgical perspective, John was considered ready for discharge home once nursing and other specialisms were content and John's home situation has been assessed.

4.49 On 13th June 2017 adjustments to John's medication were considered. It was noted that olanzapine had been 'abruptly withdrawn' whilst John was admitted to Royal Preston and an alternative agent had not apparently been started. Advice was to be sought from mental health services to avoid risks of relapse/withdrawal. No surgical intervention was planned and managing John's condition with a hard collar was to continue.

4.50 On 14th June 2017 physiotherapy treatment and assessment were performed in John's best interests as he had been assessed as lacking capacity to consent to specific procedures.

4.51 On the same day Trafford CLDT (health) contacted Salford Royal and were advised that John was progressing well but his mobility had not returned to his baseline. He had a cervical spine fracture for which it was recommended that he wore a neck collar but he wasn't tolerating this. Trafford CLDT (health) advised that a discharge planning meeting would be required but were told that there were no immediate plans for discharge. The CLDT asked for the contact details of a discharge co-ordinator but the hospital was unable

to provide these. John's social worker made the planned follow up home visit (See Paragraph 4.45), unaware that he had been readmitted to hospital.

4.52 On 16th June 2017 Trafford CLDT (health) was advised that a discharge planning meeting would take place on 20th June 2017. On the same date Trafford CLDT (social care) received a Section 2 notification in respect of his most recent hospital admission.

4.53 On 19th June 2017 Trafford CLDT (health) spoke with the Premier Care manager. Whilst it was noted that John could be moved to a downstairs bedroom there was no bathroom or toilet downstairs. A stair gate had been fitted although it was queried whether John would have the capacity to comply with this intervention. It was agreed that Premier Care staff would require manual handling training. CLDT (health) made contact with John's social worker to discuss previous safeguarding concerns together with risks associated with discharge from hospital.

4.54 The discharge planning meeting for John took place on 20th June 2017 and it was decided that he would be repatriated to TGH for complex discharge planning given the recurrent falls he had suffered. John was not back to his baseline as he was no longer mobilising, and whilst he was able to stand up and transfer with the support of a single carer, but could not or would not walk 'even one step'. It was unclear if this was because he was in a strange environment, and was being supported by people he didn't know, or whether this might change when he returned home. It was agreed that it would be unsafe to discharge John home without a full reassessment including the environment in which he would be cared for. John had been assessed as lacking capacity to consent to stay in hospital. A DoLS application was to be made. A further MCA assessment was to be completed in respect of his discharge destination. Trafford CDLT (health) was to follow up on physiotherapy and OT. Premier Care were to check whether John had fallen in the 'two week' period prior to the MRI admission. The various safeguarding referrals were to be reviewed by the CLDT social worker to check whether they were to be treated as separate incidents or consolidated into a single series of incidents. His UTI was referred to and the medication prescribed for this condition would continue for a further two days.

4.55 On 21st June 2017 John was transferred to the TGH acute medical unit. His head wound was clean and almost healed. A Premier Care carer visited John at Salford Royal to find that he had already been transferred to TGH.

4.56 Following reports of challenging behaviour by John on 22nd June 2017, the TGH safeguarding adults matron requested on ward support from Premier Care. This request was escalated to Trafford CLDT (social care) management who said that this could not be facilitated (TGH chronology). The Trafford CLDT (health) chronology states that the possibility of funding additional hours for Premier Care staff to support John in hospital and on his discharge was under consideration. However, a Premier Care carer attended later

that day but left at 5pm. An MCA assessment concluded that John lacked the capacity to decide whether or not to remain in hospital.

4.57 On 23rd June 2017 the TGH Rapid Assessment Interface and Discharge (RAID) consultant psychiatrist visited John. The consultant psychiatrist concluded that his agitation was in relation to the change in environment and gave advice about maintaining a calm environment in a side room with staff well known to him. She also noted that John was being treated in accordance with the Mental Capacity Act and that MAU staff had referred him to the IMCA. The consultant psychiatrist noted the long waiting time for the IMCA and suggested it would not be in John's best interests to delay any discharge planning decisions by waiting for this to be in place, as he has community staff and carers who know him very well. RAID would continue to monitor John during his admission.

4.58 On the same day a hospital incident form was submitted after John followed a student nurse to the kitchen where she was making him a cup of tea, and allegedly hit her across the head and neck. Security witnessed the incident but failed to lead John away until instructed to do so numerous times by the student nurse.

An MDT took place the following day (23rd June 2017) at which it was noted that John appeared very settled with the care being provided by Premier Care but became very agitated and physically and verbally aggressive when they are not present. It was also noted that he had not been receiving his nicotine spray which can be administered six times a day. The nurse in charge was advised to ensure this took place as it could help to reduce his agitation. John was considered to be back to his baseline. However, it was pointed out that he had a newly acquired brain injury and that this could affect his cognition. Discharge was considered but difficulty in arranging an OT environmental visit was said to preclude this. An increase in John's 1:1 support from Premier Care was apparently under consideration by Trafford CLDT (social care) management. The Premier Care manager did not support an imminent discharge as the changes necessary to safeguard John, including moving and handling training for staff, had not yet been implemented.

4.59 Over the weekend of 24th/25th June 2017 John again assaulted hospital staff. Premier Care had been unable to provide carers on the Sunday of that weekend due to staff sickness. Additionally, John had fallen over on the ward. An MCA assessment in respect of discharge, IMCA referral and funding for increased hours on discharge remained outstanding issues to be addressed.

4.60 On 28th June 2017 the TGH safeguarding matron escalated concerns regarding the on-ward support provided by Premier Care to the management of Trafford CLDT (social care), adding that this was an ongoing commissioning issue and that appropriate funding systems needed to be established. There seemed to be some disagreement over whether Trafford CLDT (social care) or the TGH should be responsible for commissioning on ward care and support from Premier Care at this point.

4.61 On 30th June 2017 a Trafford CLDT physiotherapist visited John in hospital and also visited his accommodation to complete an assessment. The physiotherapist was mostly concerned about the angle of the stairs rather than the height and depth as the angle presented risks to both staff and John as staff could not move to the side. Also, at the top of the stairs there were two steps which would require John to turn, increasing his risk of falls. John was said to be anxious about using stairs independently as he was frightened of falling. It was therefore thought that the risk of stairs may not be as problematic as first thought if John continued to reject the option of using them. The issue was to be further discussed after capacity assessment regarding John's discharge destination.

4.62 On 4th July 2017 a hospital incident form was submitted after John was found to have a wound to his right ankle and the surrounding area was swollen. The cause of the wound was unclear. Premier Care subsequently raised a concern about this injury with Trafford CLDT (health).

4.63 On 6th July 2017 a hospital incident form was submitted after John was taken off the hospital site for lunch by his Premier Care carer.

4.64 On 7th July 2017 John's capacity was assessed by his CLDT social worker. A referral for an IMCA had been made and John placed on a waiting list for this service. He was assessed as having capacity in respect of his discharge destination and went on to clearly state he wished to return home and agreed to live downstairs although it was acknowledged that there were no bathroom facilities on the ground floor.

4.65 At an MDT and best interests meeting held at TGH on 11th July 2017 John's capacity assessment (see previous paragraph) was challenged on the basis that no copy of the MCA assessment documentation was provided and no IMCA had been present. It was agreed that a further MCA assessment in respect of the discharge destination would be completed and a carer who knew John well would be present. Premier Care were requested to provide costings for in ward care and a risk assessment was to be completed in respect of taking John off the hospital site whilst an in-patient.

4.66 On the same date the Trafford CLDT health facilitator and TGH safeguarding nurse jointly completed an adult safeguarding referral in respect of the safeguarding concerns arising from John's initial admission to the MRI on 22nd June 2017 as any safeguarding referral submitted on that occasion had gone astray. (See Paragraph 4.18) It was said that the number of separate safeguarding referrals in respect of John raised the question of whether the criteria for carrying out a SAR may have been met. The adult safeguarding referral should have prompted an enquiry under Section 42 of the Care Act but this did not happen.

4.67 On 12th July 2017 a DoLS application in respect of John's stay in TGH was submitted to Trafford Council for authorisation. It was pointed out that an IMCA would be required for John.

4.68 The following day a Premier Care carer took John back to his accommodation which led to a hospital incident form and then an adult safeguarding referral being submitted. Premier Care said that John had gone to Address 1 for an appointment with his advocate although the TGH chronology indicates that the advocate had called to see John on the ward and then gone to see him at Address 1 after finding him to be absent from the ward.

4.69 On 14th July 2017 a hospital incident form was submitted after John tripped and banged his knee after having been accompanied off the ward for a walk by security.

4.70 On the same date the further capacity assessment in respect of John's discharge destination found that he did not have capacity. John was to be assessed for an interim placement at Ascot House in Sale which provides short term care and accommodation for adults.

4.71 On 16th July 2017 several hospital incident forms were submitted in respect of John after he punched a member of staff in the back and was later physically restrained by two security guards.

4.72 On 18th July 2017 a best interests meeting was held at TGH. Ascot House had declined to place John. St. Mark's Care Centre in Sale was now under consideration. Twenty four hour 1:1 care for John had now been approved. Adapting his current property to enable him to live, sleep and use a bathroom on the ground floor would require significant work. Premier Care said that in the interim a commode could be provided for John in a ground floor bedroom.

4.73 The following day Trafford CLDT (health) advised Premier Care that due to John's high risk of falls, and having sustained some very serious injuries over the past weeks, it was not safe to return to Address 1. The search for suitable accommodation for John post discharge was said to have been referred to the 'commissioning team'. NHS continuing healthcare (CHC) funding was to be considered. The issue of whether John's previous detention under the Mental Health Act entitled him to Section 117 aftercare was also under consideration.

4.74 On 20th July 2017 a hospital incident form was submitted after a security guard was observed to push John into a side room and raise his fist to him.

4.75 On 24th July 2017 Trafford CLDT (health) was informed by the TGH safeguarding nurse that John had been held in a headlock by a security guard during the previous week after he had pushed a nurse on the AMU. The security guard, who was employed by an agency, had been dismissed. The security guard was said to have been supporting John on 'bed watch'. The incident had led the ward to review the process of 'bed watch' support which now included a full handover at shift commencement and patient behaviour management plans.

4.76 On 27th July 2017 John was transferred to the TGH complex discharge unit. On the same date Trafford CLDT (health) completed an assessment tool in respect of John which helped practitioners identify people with learning disability and/or autism who were at risk of hospital admission. Clinical Commissioning Groups are required to keep a Dynamic Support Register (DSR) of individuals with learning disability and/or autism who are at risk of admission. The outcome of applying the tool to John was a 'red' rating meaning that the longer he remained in hospital, the greater the risk of inpatient admission to a mental health hospital, and if not discharged appropriately this would also be a risk. The 'red' rating triggered a 'blue light' care and treatment review and John's social worker and a CCG commissioner were contacted to facilitate this. He was now to be managed on the care programme approach (CPA) with his Trafford CLDT health facilitator fulfilling the role of care coordinator. Additionally, it was said that a strategy meeting was to be held in respect of all the prior safeguarding referrals which it was said had been escalated to Section 42 of the Care Act 2014 (Enquiry by Local Authority). No such strategy meeting was held.

4.77 The following day the Trafford CLDT health facilitator completed a 'nursing needs assessment' as part of the CHC assessment (See Paragraph 4.73), the outcome of which was that John did not meet the criteria for elderly mental infirm (EMI) or nursing home care but that he required level accommodation with consistent support from carers who knew him well.

4.78 On 3rd August 2017 Trafford CLDT (health) was informed that the challenging behaviour nurse specialist at TGH had referred John to psychology for cognitive and functioning assessments with a view to informing his future care package needs. An OT referral would also be necessary to assess John and his accommodation.

4.79 On 5th August 2017 a hospital incident form was submitted after John fell after bumping into the side of his bed. His falls care plan was re-evaluated as a result.

4.80 On 7th August 2017 a principal OT completed an assessment of John's home environment (Address 1) and concluded that the proposed adaptations would not meet his needs. However, the OT noted that accommodation at Address 2 or Address 3 could meet his needs.

4.81 On 11th August 2017 Trafford CLDT (health) was informed by the Premier Care manager that John's behaviour was deteriorating and he was attempting to hit and kick staff he was familiar with for the first time. A RAID review was requested.

4.82 On 18th August 2017 concerns arose over (unspecified) legal issues relating to the tenancy agreement for the Address 2 accommodation which needed to be resolved. Trafford CLDT (social care) sought advice from Trafford Council's legal department.

4.83 On 22nd August 2017 a hospital incident form was submitted after John was physically aggressive to a security guard and specialist learning disability support worker. He was said to have thrown knives at his carers and lashed out repeatedly but was said to lack insight into his actions.

4.84 On the same date a hospital incident form was submitted after TGH was informed by a visitor that on a previous evening her boyfriend had intervened between a patient (John) and a member of staff. The member of staff was an agency worker and did not inform anyone that a patient had been aggressive towards her and chased her around the ward. Security had been dealing with another violent patient at the time.

4.85 On 25th August 2017 an MDT/discharge planning meeting took place at TGH. Issues relating to John's discharge destination (Address 2) needed to be addressed including the Premier Care staff rota and keys and furniture for John's flat. Premier Care were to put a 'contingency plan' in place setting out action to take if John's behaviours escalated and he became difficult to manage. It was acknowledged that a best interests meeting needed to take place. The IMCA did not attend but when contacted said that she had not been made aware of the meeting. The IMCA raised concerns regarding John's level of agitation and apparent deterioration since her last visit. Hospital discharge was to take place on 30th August 2017.

4.86 On 29th August 2017 John was seen on the ward by a physiotherapist who found that there remained an inherent risk of falling whilst outside because of his shuffling gait and the catching of his heels each time he stepped forward. However, it was said that Address 2 would meet all John's needs from a physiotherapy perspective.

4.87 On 30th August 2017 John was discharged from TGH to Address 2, which was regarded as a temporary placement until such time as a permanent placement could be secured. Premier Care were to complete a risk assessment, positive behaviour support plan, mental health relapse plan, and an antecedent behaviour consequences (ABC) chart should John become aggressive. Premier Care confirmed that John had 1:1 care and 24/7 support. TGH expressed concern that the best interests paperwork was to be completed retrospectively by Trafford CLDT (social care), adding that neither RAID or the TGH medical

team had been involved in the best interests process and that no best interest meeting had apparently taken place with the IMCA.

5.0 Views of John

5.1 It was hoped that it could be possible to find some way of involving John personally in this SAR. However, the review was advised that John would almost certainly struggle to contribute due to his cognitive impairment and mental health issues. It was also thought that he may find the process quite stressful.

5.2 However, his current advocate has shared a number of insights with this review on behalf of John.

5.3 John no longer has contact with his family. He continues to reside at Address 2 although this was never regarded as a permanent option. He is being supported to look for a permanent accessible flat where he can be supported by the same carers who currently support him at Address 2. He has known some of his carers for a long time and appears to enjoy a positive rapport with them. He enjoys sharing a laugh and joke with his carers. It is important to John that he is supported by people who know him well.

5.4 John has specific needs around communication which are understood by staff who know him well. For people who have less knowledge of John's mode of communication, the language he uses and his topics of conversations could be misinterpreted or misunderstood. When misunderstood by people who do not know him well, this can lead to distress and challenging behaviour.

5.5 John is interested in the military and enjoys activities, films, books and museums associated with World War 2. He also enjoys gardening, painting and likes the freedom to go out for walks or shopping. He is supported to visit friends he has lived with whilst being supported by Premier Care.

5.6 John finds changes of routine difficult to manage and also becomes frustrated if he feels too restricted. His carers say that he finds health appointments difficult and particularly health interventions such as injections.

5.7 He was able to give his advocate some information and express his views about what happened to him during the period covered by this SAR. He said "I fell down the stairs and broke my neck" and went onto say " they cut open my head". When asked about his periods in hospital, John said that "I was in hospital for a couple of months when I broke my neck",

adding that “I don’t like hospitals”. Asked how he found being in hospital, John said that “they treated me horribly”.

5.8 A support worker who has worked with John for over a decade expressed the view that since the events described in this SAR, John has become more negative about hospitals and health professionals and appears to show signs of increased upset and agitation when faced with a health appointment either at hospital or with his GP.

6.0 Analysis

6.1 In this section each of the lines of enquiry agreed for this SAR will be addressed in turn.

To what extent did practitioners listen to the voice of John? Were his wishes and feelings heard and understood?

6.2 John's voice is not a prominent feature in the chronologies provided to this review by the agencies which were in contact with him. This was partly because the majority of staff involved in his care, with the exception of Premier Care staff, during the period covered by this SAR (1st January until 31st October 2017) did not know John well. There was also a large number of staff involved in his care. For example, thirty three different members of staff were involved, to varying degrees, in his care and treatment during his admissions to Salford Royal hospital.

6.3 Staff who were unfamiliar with John's needs frequently struggled to communicate with him. When treated at the MRI in March 2016 following a headfirst fall down a full flight of stairs (Paragraph 4.7), John was noted to be unable to communicate whether or not he was experiencing any pain. His GP had difficulty in eliciting comprehensive information from him during the consultation on 8th May 2017 (Paragraph 4.13) and appeared to largely rely upon his carer to provide information about his presentation and needs. For John's carers to be able to provide health services with this information they were reliant on the completeness of Premier Care's service user record keeping. Details of the recent fall John may have had did not appear to be shared with the GP during the above mentioned 8th May 2017 appointment. The absence of a contemporaneous record of this fall may have been a factor in the details not being shared with John's GP (Paragraph 4.17).

6.4 Opportunities to hear John's voice were sometimes missed. In May 2016 Trafford CLDT (health) decided to request John's GP to refer him to the community mental health team to explore his presentation as being 'angry at everybody and everything' and generally low mood. However, there is no indication that this referral was ever made (Paragraph 4.10).

6.5 When seen in MRI ED on 22nd May 2017 following a fall which would require a craniotomy, John complained only of a headache and said he felt fine otherwise (Paragraph 4.17). Similarly, staff at Salford Royal hospital found it difficult to assess John's level of pain 'due to his learning disability', observing that he said 'no' when asked if he was in pain whilst wincing and looking distressed (Paragraph 4.28).

6.6 Staff in Salford Royal hospital responded constructively to John's 'voice' when he became uncooperative, swearing and physically aggressive to staff (Paragraph 4.39).

Arrangements were made for a mental health practitioner to see John who concluded that his verbal and physical aggression towards staff was due to his fear of being in an unfamiliar setting and not recognising/knowing staff. He was noted to become calm and settled once his regular carer arrived (Paragraph 4.43 and 4.57). Additionally, his carers were able to provide hospital staff with a more detailed history for John which supported a more person centred approach.

6.7 At neither Salford Royal nor Royal Preston was consideration given to asking for, or developing, a passport of care. Professionals would have had better insight into John's baseline had he had a passport of care which accompanied him from his community placement or one completed in hospital. Staff in Trafford General Hospital had access to a Learning Disability patient passport to better inform the care and treatment provided and enabled John's wishes and feelings to be embedded within his care planning.

6.8 A patient passport would have disclosed that John is a person with complex needs who can be misunderstood by people who do not know him well, which can lead to distress and challenging behaviour. As previously stated, he is said to find changes of routine difficult to manage and finds health appointments difficult and particularly health interventions such as injections.

Did John have/should John have had access to advocacy? As an unbefriended person how effectively was John supported? Were there any missed opportunities for advocacy support?

6.9 The Mental Capacity Act requires that any person who lacks capacity to make important decisions who is unbefriended is entitled to advocacy. An IMCA *must* be instructed, and then consulted, for people lacking capacity who have no-one else to support them (other than paid staff), whenever:

- an NHS body is proposing to provide serious medical treatment, or
- an NHS body or local authority is proposing to arrange accommodation (or a change of accommodation) in hospital or a care home, and the person will stay in hospital longer than 28 days, or they will stay in the care home for more than eight weeks.

An IMCA *may* be instructed to support someone who lacks capacity to make decisions concerning:

- care reviews, where no-one else is available to be consulted
- adult protection cases, whether or not family, friends or others are involved

6.10 In addition to his eligibility for advocacy under the Mental Capacity Act, John had a right to advocacy under the Care Act 2015. The latter act requires a local authority to arrange an independent advocate to facilitate the involvement of a person in their assessments, preparation and review of their care and support plans and through safeguarding adult enquiries and reviews under the Care Act 2014 if they consider that the person would experience substantial difficulty in understanding the processes or in communicating their views, wishes or feelings and

there is no appropriate individual to help them. It would appear that John was eligible for advocacy as a result of the safeguarding adult enquiries initiated as a result of the various adult safeguarding referrals made by agencies from May 2017 onwards.

6.11 Additionally, had John been subject to a DoLS authorisation, he would have been eligible for advocacy to support him in the assessment process for the DoLS authorisation.

6.12 Following John's transfer to the Royal Preston Hospital, Trafford CLDT (health) noted that John had no contact with his family so an Independent Mental Capacity Advocate (IMCA) would be required (Paragraph 4.22). Royal Preston acknowledge that advocacy should have been considered throughout John's admission and that this could have been prompted had a Mental Capacity Assessment been carried out.

6.13 No independent advocate was sought for John during his three admissions to Salford Royal although his Premier Care carers were involved in his inpatient care. As with the Royal Preston, the Mental Capacity Act was not appropriately applied. The raising of safeguarding concerns on 4th June 2017 should also have prompted advocacy support under the Care Act 2014 (See Paragraph 6.10).

6.14 John was referred for IMCA support by Trafford General hospital but there was such a long waiting time for this service that the consultant psychiatrist who saw him on 23rd June 2017 (Paragraph 4.57) was concerned that discharge planning decisions should not be held up whilst awaiting an IMCA. An IMCA was allocated to John whilst an in-patient at TGH although there appeared to be difficulties experienced in providing IMCA support to John at appropriate times. The IMCA did not attend the MDT/discharge planning meeting on 25th August 2017 (Paragraph 4.85) and was not involved in best interests discussions in respect of John prior to his discharge from TGH to Address 2 (Paragraph 4.87).

6.15 Trafford CLDT (social work) has advised this review that an IMCA was not sought for John prior to 6th July 2017 because he was considered to have fluctuating capacity prior to that time. The basis for the judgement that John had fluctuating capacity prior to 6th July 2017 is unclear as John's capacity frequently went unassessed.

6.16 John was provided with advocacy following his discharge from TGH on 30th August 2017. The provider of John's advocacy service was subsequently decommissioned and ceased to operate. When contacted for the purposes of this SAR, the former advocacy provider advised the review that they had destroyed John's records. It is understood that the former provider may have destroyed all service user advocacy records except for those cases which were active at the point at which the provider ceased to operate.

6.17 John was supported by carers from Premier Care, some of whom had known him for many years and understood his needs well. These carers were well placed to advocate for him but may have needed more support to consistently do so given the range of specialisms involved in John's care and support during the period reviewed by this SAR.

Did practitioners work with John in accordance with the principles of the Mental Capacity Act? Did practitioners act in John's best interests?

6.18 The Mental Capacity Act (MCA) sets out a number of principles which must govern all decisions made and actions taken under its powers. A fundamental principle of the Act and English law generally is that adults have the right to make decisions on their own behalf and are assumed to have the capacity to do so, unless it is proven otherwise. The responsibility for proving that an adult lacks capacity falls upon the person who challenges it.

6.19 In order to assess John's capacity, the two stages of the MCA assessment would have been followed. The first stage is to ask if there is an impairment of, or disturbance in, the functioning of the person's mind or brain. In John's case he had a diagnosis of schizophrenia and learning disability and acquired a brain injury as a result of the fall which precipitated his admission to the MRI. The second stage is to ask if the impairment or disturbance sufficient that the person lacks the capacity to make that particular decision. The second stage of the test dictates that the person is unable to make a decision if they cannot:

- understand the information relevant to the decision
- retain the information relevant to the decision
- use or weigh the information, or
- communicate the decision (by any means)

In John's case, he may have had difficulty in communicating any decision to practitioners who did not know him well.

6.20 The Royal Preston hospital patient notes state that John consented to treatment yet the notes make frequent reference to the difficulty in understanding John's communication with one entry stating that he was 'unintelligible'. Royal Preston felt that this should have prompted a Mental Capacity Assessment, a subsequent Best Interests meeting (where it is

determined that individuals lack capacity, any decision or action taken on their behalf must be in their best interests) and a referral for an IMCA. A crucial part of any best interests judgement will involve a discussion with those close to the individual, including family, friends or in John's case, carers. Additionally, on handover from the MRI to the Royal Preston there was an entry stating 'DoLS?' which should have also indicated that there was doubt about John's mental capacity.

6.21 Entries in the Salford Royal medical notes in respect of John's three admissions invariably recognise that he had a learning disability but do not go on to consider what this means for John and how it could have impacted on his ability to consent to care and treatment and stay in or be discharged from hospital. On several occasions, John was described in patient records as 'non-compliant' which often related to his reluctance to wear his aspen neck collar for conservative (non-surgical) treatment of the fracture to his cervical spine. It does not appear to have been reasonable to describe John as non-compliant as his capacity to understand the specific instructions given, and the consequences of not following these instructions, had not been assessed.

6.22 Salford Royal completed three mental capacity assessments of John. He was found to lack capacity to consent to stay in hospital on 8th June 2017 (Paragraph 4.40). On 11th June 2017 he was assessed as lacking capacity to agree to remain in hospital, agree to restraint and consent to a specific procedure (Paragraph 4.46). The patient records indicate that John's mental capacity was assessed each time the specific procedure was repeated but the author of the Salford Royal agency report took the view that it was more likely that the mental capacity assessment entry was copied and pasted onto subsequent entries. A further mental capacity assessment was completed on 20th June 2017 in relation to John's capacity to stay in hospital. This was the day prior to his transfer to Trafford General Hospital so his capacity in respect of the discharge process should have been assessed at that time.

6.23 There are a number of entries in John's Salford Royal patient notes, particularly from therapy staff which stated that he 'lacked capacity to consent' to therapeutic interventions but that verbal consent was obtained and therapy undertaken in his best interests. There is no evidence that therapy staff attempted to complete a mental capacity assessment. The assumption of consent appeared to be inferred because John did not object. The author of the Salford Royal agency report concluded that staff were more likely to consider the use of the Mental Capacity Act for uncooperative patients and particularly those who were attempting to leave. This represents a basic misunderstanding of the application of the Mental Capacity Act.

6.24 No best interests meeting was arranged during John's three admissions to Salford Royal.

6.25 Whilst a patient at Trafford General Hospital there were clear references to John's learning disability in his patient notes, but frequently no evidence of mental capacity assessments in respect of his care and treatment. A mental capacity assessment was conducted prior to the DoLS urgent authorisation application (Paragraph 4.54).

6.26 Trafford CLDT (social work) was responsible for capacity assessments in respect of the discharge planning for John. His social worker assessed John as having capacity in respect of his discharge location on 7th July 2017 (Paragraph 4.64) although this capacity assessment was subsequently challenged on a number of grounds (Paragraph 4.65) and was completed again. On this subsequent occasion John was found not to have capacity (Paragraph 4.70). The delay in assessing John's capacity may have delayed his otherwise successful discharge from TGH.

Was John deprived of his liberty during the time period covered by the safeguarding adults review? If a deprivation occurred, was this managed in accordance with relevant statutory frameworks and practice guidance?

6.27 As previously stated, the Royal Preston hospital has advised this review that there is evidence within John's patient records to suggest that he lacked the capacity to consent to stay in hospital. Whilst the Deprivation of Liberty Safeguards 'acid test' (as set out in the Supreme Court judgement of March 2014) of whether John was subject to continuous supervision and control and whether he was free to leave, may have applied, Royal Preston hospital has advised this review that they adopt a pragmatic approach to DoLS applications in Lancashire. Due to the well documented national DoLS application backlog, there is an agreement with Lancashire County Council that they only submit DoLS applications for patients in hospital for a prolonged period of time and/or are wandersome, have additional restrictions and restraints in place and/or object to their admission. As John appeared compliant and the aggressive and agitated behaviour noted during subsequent hospital admissions did not manifest itself, Royal Preston advise that a DoLS application would not have been considered necessary for John.

6.28 However, the omission of any Mental Capacity assessment, Best Interests meeting or referral for an IMCA left John in quite a powerless situation. Had a Best Interests meeting been held and had John benefitted from the support of an IMCA, the issue of whether he was being unlawfully deprived of his liberty could have been raised on his behalf.

6.29 Salford Royal advises that as John's first two admissions were relatively short, it was not necessary to put a DoLS in place. This policy is underpinned by the DoLS Code of Practice (2) which suggests that an urgent deprivation of liberty authorisation should not be granted if a person is in ED '*and it is anticipated that within a matter of a few hours or a few days the person will no longer be in that environment'.*

6.30 However, Salford Royal acknowledge that during the third admission, between 11th and 21st June 2017, John was deprived of his liberty and no process of DoLS assessment was undertaken. His patient records indicate that John did not have the capacity to consent to stay in hospital, that he was under continuous supervision and was not free to leave. The Salford Royal agency report author therefore concludes that John was unlawfully deprived of his liberty during this hospital admission.

6.31 The Trafford General hospital agency report author also concludes that John was unlawfully detained prior to the DoLS application being submitted on 12th July 2017 (Paragraph 4.67).

6.32 This SAR has highlighted subtle variations in the approaches taken by different hospitals to DoLS. Salford Royal hospital has advised the review that they submit approximately 400 DoLS applications each month to various managing authorities and only three or four of these are authorised each month. In these circumstances it is not surprising that hospitals adopt a pragmatic approach although in John's case he appears to have been particularly disadvantaged by the frequent omission of Mental Capacity assessments which would precede any consideration of DoLS and the lack of advocacy support.

6.33 Following the 2014 Supreme Court decision (See Paragraph 6.27) the accommodation settings in which a person might be deemed to be deprived of their liberty include 'domestic settings' such as supported housing (where support is provided on a 24/7 basis). Trafford Council would therefore need to consider a DoLS in Domestic Setting (DIDs) application in respect of John's supported living accomodation. This review has been advised that Trafford Council has risk profiled all DIDs cases and is recruiting staff to complete applications.

To what extent were safeguarding adults procedures followed in John's case?

6.34 A number of safeguarding referrals were made in response to the falls suffered by John and his frequent admissions, discharges and readmissions to hospital.

6.35 When John was admitted to the MRI on Monday 21st May 2017 it was documented that a safeguarding referral was to be made as no medical attention appeared to have been sought following the fall which may have taken place within John's supported living accomodation (Paragraph 4.18) but this appears to have been overlooked. It seems possible that the demands arising from the Manchester Arena attack on the same date may have been a factor in this omission.

6.36 Staff at the Royal Preston Hospital noticed that the documentation which accompanied John from the MRI included a reference to a 'safeguarding referral required' but this wasn't

followed up locally, or by contacting the trust's own safeguarding team, or by liaising with the MRI.

6.37 When John was admitted to the Salford Royal Hospital on the first occasion, two days after being discharged from the Royal Preston Hospital, a safeguarding referral was submitted in respect of John (Paragraph 4.29). The referral stated that the Salford Royal clinical team had concerns that John had experienced two significant reported falls in the last few weeks whilst in 'residential care'. The referral was received by Trafford Adult Social Care. Unfortunately, the safeguarding referral was not logged within the Salford Royal safeguarding database and was therefore not followed up by the Trust's safeguarding team. Had the Trust's safeguarding team been made aware of the safeguarding referral, contact would have been made with the ward on which John was being cared for and, together with the hospital adult social care team, there would have been follow up to ensure that safeguarding adult procedures were adhered to. This could have been via a virtual strategy meeting including liaison with Trafford Adult social care.

6.38 Premier Care submitted a safeguarding referral on 8th June 2017 after John had been discharged from Salford Royal for the first time and then readmitted (Paragraph 4.41). The referral expressed concern about an unsafe discharge from Salford Royal and was received by Trafford Adult Social Care.

6.39 These two referrals in quick succession from Salford Royal and Premier Care raised similar concerns in respect of John. Trafford Adult Social Care has advised this SAR that expected practice is that adult safeguarding referrals relating to falls resulting in a significant injury would trigger the local safeguarding process. This process involves the launch of a safeguarding episode on their information system on which all actions in response to the safeguarding referral(s) would be recorded. There is no indication that this happened following the above mentioned referrals from Salford Royal and Premier Care as there are no recordings in the safeguarding case notes. Instead, discussions regarding the referrals were recorded in general notes making it very difficult to identify exactly what actions were taken. Additionally it is expected that a discussion would have taken place with the adult and/or their representative to establish what, where, when, how and why the falls happened. The discussion would also have sought to ascertain the adult's views, wishes and desired outcomes. There is no indication that this happened either. Had it been ascertained that John's falls were not as a result of neglect, then the concerns would have been dealt with under a risk management route which should have involved a professionals meeting aimed at identifying how best to manage the risks and safeguard the adult. There is no indication that the risk management process was followed either.

6.40 On 11th July 2017 a safeguarding referral was jointly completed by the Trafford CLDT health facilitator and the TGH safeguarding nurse to replace the safeguarding referral which does not appear to have been submitted following John's original admission to the MRI on 22nd May 2017 (Paragraph 4.66). At this point the number of separate safeguarding referrals

in respect of John caused practitioners to question whether the criteria for carrying out a SAR may have been met.

6.41 This safeguarding referral was received by Trafford Adult Social Care who have advised the SAR that a Section 42 Care Act enquiry should have been prompted by the fact that the referral indicated that John's admission to the MRI on 22nd May 2017 may have followed a prior fall for which medical attention had not been sought. No Section 42 enquiry was initiated but John's social worker responded by conducting a reassessment of his needs.

6.42 The safeguarding referral made by TGH on 13th July 2017 after John had been taken off the ward back to Address 1 by his Premier Care carer (Paragraph 4.68) was received by Trafford Adult Social Care. This referral would not necessarily have triggered the Section 42 process as John did not come to any harm, although he had been put at risk by being taken to Address 1 which was no longer considered to be a safe place for him to be. The referral would have been treated as 'other safeguarding' and steps taken to prevent a reoccurrence. In this case assurances were received from Premier Care that staff had been informed of the risks of taking John out of hospital to Address 1.

6.43 On 27th July 2017 it was decided that a strategy meeting was to be held in respect of all the prior safeguarding referrals in respect of John which had all been escalated to Section 42 of the Care Act 2014 (Enquiry by Local Authority) (Paragraph 4.76). This review has been provided with no indication that such a strategy meeting was held.

6.44 A proactive response to the safeguarding concerns which quickly began to arise following John's initial admission to the MRI on 22nd May 2017 was hampered by the non-completion or loss of the initial safeguarding referral in respect of John and the fact that the safeguarding referral submitted by Salford Royal appeared to bypass that Trust's internal safeguarding referral system. However, by 8th June 2017 (the point at which John had been readmitted to Salford Royal after his first discharge from that hospital) Trafford Adult Social Care had received two safeguarding referrals in respect of John. Safeguarding adult processes were not followed and the response to the concerns detailed in the various safeguarding referrals became subsumed within the overall response to the concerns about John. The need for a strategy meeting was identified but not actioned but by this stage multi-agency decision making was taking place with MDT and then discharge planning meetings held at TGH. Trafford CLDT (health) have advised this review that they were concerned that John should not be discharged without a definitive outcome to the inquiries into the safeguarding concerns.

John's GP appears to have responded to changes in his presentation by altering the medication prescribed to him. Were the reasons for the changes in John's presentation fully explored and were alternatives to altering his medication fully considered?

6.45 John's dosage of Oxazepam was increased from 10mg to 15mg by his GP on 17th January 2017 (Paragraph 4.12). John was accompanied to this GP appointment by a carer who said that John had not been sleeping and had been walking around at night 'causing a disturbance'. On Monday 8th May 2017 John was again seen by his GP and his dosage of Oxazepam was further increased from 15mg to 20mg although this increase was to be time-limited to one month. If there was no improvement, a different sedative was to be tried. On this occasion, John's carer told the GP that John appeared quite hyperactive at night and was using the toilet frequently. Urine and blood samples were taken to investigate John's urinary symptoms but a prostate examination did not take place because of John's agitation. This visit to the GP took place after the fall which John may have had in late April or early May 2017 but there is no record of the incident being shared with John's GP.

6.46 Unfortunately, John's repeat prescription of 15mg of Oxazepam was not discontinued at the 8th May 2017 GP appointment and Premier Care continued to administer the 15mg prescription whilst also giving John the 20mg prescription.

During the following two weeks John was given both the 20mg and 15mg prescription of Oxazepam daily. This period of heavy sedation only came to an end when one of John's carers, concerned about his excessive sleeping, took him to TGH UCC, where the dosage was reduced back to 20mg (Paragraph 4.14). The following day (22nd May 2017) the sequence of hospital admissions, discharges and readmissions began.

6.47 The failure to discontinue John's repeat prescription of Oxazepam was not noticed by his GP practice until October 2018 when they carried out a 'significant event review'. The significant event review acknowledged that the 15mg Oxazepam prescription remained on repeat and was not discontinued. Premier Care continued to additionally administer the 15mg prescription. It is not completely clear whether the carer accompanying John was advised by the GP that John's dosage was being increased from 15mg to 20mg. The GP chronology submitted to this review is silent on this point other than stating that the prescription of Oxazepam was to be increased to 20mg. The Premier Care chronology does not include an entry for John's visit to the GP on 8th May 2017 but states that in the Premier Care communications log for the same date there is record of a further (unspecified) increase in the dosage of Oxazepam. The Premier Care chronology later states that a carer had been told that the dosage had been increased from 15mg to 20mg on 18th May 2017. The significant event review concluded that as a result of these errors there was a risk of falls as a result of John being so strongly sedated and that any falls may have put John's life at risk. It is unclear why the 15mg prescription was not discontinued although the significant event review recommends that when alteration of a dose of medication is required, GPs 'will need to put clear instructions on the box on the white side' of the prescription form, 'so it is clear'. It is also of concern that the GP practice appeared to have no system to check on

prescribing errors. The error went unnoticed either at the time, when the GP practice was advised of the reduction in John's dosage made by a TGH UCC Doctor on 21st May 2017 or when the GP practice completed an agency report for this SAR. Following receipt of their significant event review report, the GP practice has been requested to complete a safeguarding referral. Premier Care have advised this review that the 15mg prescription of Oxazepam prescribed to 'John' was part of a repeat prescription of four weeks supply and at the time of the visit to the GP practice on 8th May 2017 there was an amount of the 15mg Oxazepam to be dispensed. This suggests that it may have been prudent for John's GP to have asked his carer when was the last repeat prescription and how much supply did Premier Care still have.

6.48 It is also of concern that Premier Care continued to administer the 15mg Oxazepam prescription alongside the 20mg prescription for a period of two weeks. Until January 2017 John's prescription of Oxazepam was 10mg daily but during the period from 8th- 21st May 2017 35mg was being administered on a daily basis. One of John's carers eventually sought medical advice after noticing the impact of the heavy sedation on his presentation. It is of concern that two weeks elapsed before John was taken to TGH UCC where his Oxazepam dosage was reduced to 20mg. Premier Care advises that there was no record of unusual behaviour or health concerns for John in their communication log between 9 May and 17 May 2017. (The log for the period 18th – 21st May 2017 is missing). During this period there is no evidence that the error in medication was noticed, questioned or escalated by Premier Care staff. Premier Care advise that it is unrealistic to expect them to notice the medication prescribing error as none of their staff are medically trained and could not be expected to conclude that 35mg of Oxazepam was an unduly high dose.

6.49 Both the SAR Panel and the practitioner learning event arranged to inform this SAR questioned whether the GP fully considered John's symptoms before increasing his prescription and had the GP done so, whether less restrictive options than increasing medication were available. Both the SAR panel and the learning event questioned whether, having increased John's dosage, the potential side effects were fully considered, including any increased risk of falls arising from drowsiness. The SAR Panel also questioned whether John's medication changes should have been signed off by a psychiatrist.

To what extent did agencies consider the impact of changes in medication for John on his care and support needs, particularly any increased risk of falls?

6.50 There is no indication that the impact of the changes in John's medication by his GP in January and May 2017 on his care and support needs were considered. As previously stated, John's GP does not appear to have been made aware of a fall which John may have suffered in late April or early May 2017. Nor is there any indication that John's GP took his 2016 fall down stairs into account (Paragraph 4.7). Trafford CLDT reviewed John annually and in the review which preceded these visits to his GP, which took place in April 2016, John's balance and gait was reported to have worsened (Paragraph 4.10). However, this CLDT annual

review was to have led to a referral to the CMHT but there is no indication that this happened.

When John suffered significant injuries, apparently as a result of falls, were those injuries recognised, documented and treated appropriately?

6.51 Following admission to the Preston Royal hospital John received high level medical and nursing input. On each of the three admissions to Salford Royal hospital the injuries relating to John's falls were clearly recognised, documented and treated appropriately. John received a high level of medical and nursing input during each of these admissions.

6.52 John required continuing treatment and care following his discharges from hospital and this will be addressed later in the report.

How appropriate was John's placement? Did the care and support provided to John in his placement fully meet his needs? Was the physical environment of the placement appropriate for him? What action was taken by the provider in respect of John's risk of falls, including any contact with the commissioner of the placement?

6.53 Trafford CLDT (social work) carried out annual reviews of John during the period 2006 – 2016 with the exception of 2015. No details have been provided of these annual reviews except for a 2016 assessment (Paragraph 4.9). However, the SAR has been advised that the annual reviews did not indicate that John was inappropriately placed.

6.54 John had lived in Address 1 with another service user since 2008 where they were supported by 'Premier Care – Specialised Services'. John was said to have experienced a 'few falls due to mobility' in 2014 which resulted in a safeguarding concern being made. As a result, his care plan and risk assessment were updated and a falls sensor and sensory lighting were put in place (Paragraph 4.4).

6.55 Despite the evidence of prior falls, John was said to have had 'no falls' when concerns arose about his shuffling gait and tendency to lean on staff for support in 2015 (Paragraph 4.6). A physiotherapy referral was made but after being on a waiting list for ten months, John was discharged from the service when his provider failed to bring him to the appointments offered (Paragraph 4.11).

6.56 John suffered what appeared to be quite a serious fall at Address 1 in March 2016 (Paragraph 4.7) but there is no indication that this led to a safeguarding referral or prompted a falls risk assessment. A Trafford CLDT (social work) assessment carried out later the same year found a noticeable deterioration in John's mental health (Paragraph 4.9) but

the planned referral by CLDT (health) to psychiatry does not appear to have taken place. The CLDT (social work) assessment found that his balance and gait appeared to have worsened.

6.57 John may have fallen at Address 1 towards the end of April 2017 (Paragraph 4.17). Although the details of this fall are far from clear, a carer recorded the fall but there is no indication that this led to a falls risk assessment.

6.58 At the point at which John was about to be discharged from Salford Royal for the first time there appears to have been consideration of moving John to a downstairs bedroom 'so he wouldn't have to use the stairs' (Paragraph 4.37). John was later said to be resistant to sleeping downstairs (Paragraph 4.45).

6.59 Following John's second admission to Salford Royal a nursing assessment highlighted an increased risk of falls (Paragraph 4.39). During the same admission, the Premier Care manager advised Trafford CLDT (social care) that he was investigating previous falls in order to minimise the risks of John experiencing further falls in his accomodation. As an interim measure his mattress was to be placed on his bedroom floor (Paragraph 4.41). Also, during the same admission John was seen by a mental health practitioner who recommended that his care package should be reviewed with a view to increasing carer support (Paragraph 4.43). Additionally, a referral to physiotherapy for fall management was to be made (Paragraph 4.45). An extra bannister was to be fitted to the stairs at Address 1 'that day' (9th June 2017).

6.60 By 19th June 2017 the option of moving John to a downstairs bedroom at Address 1 was still under consideration although it was pointed out that there was no bathroom or toilet downstairs (Paragraph 4.53). A stair gate had been fitted but there were doubts whether John had the capacity to comply with this safety measure.

6.61 Following the earlier physiotherapy referral (Paragraph 6.54) a Trafford CLDT physiotherapist visited John in hospital on 30th June 2017 and also visited his accommodation to complete an assessment. The physiotherapist was primarily concerned about the angle of the stairs at Address 1 and the fact that at the top of the stairs there were two steps which would require John to turn, increasing his risk of falls. John was said to be anxious about using stairs independently as he was frightened of falling. It was therefore thought that the risk of stairs may not be as problematic as first thought if he continued to reject the option of using them. However, John had previously been said to frequently visit the first floor toilet, not only because he needed to use the toilet but also because of repetitive behaviour. He had also been said to go up the stairs to the staff office hourly to request an E-cig (Paragraph 4.15).

6.62 By 18th July 2017 it was said that adapting Address 1 to enable John to live, sleep and use a bathroom on the ground floor would require significant work. Premier Care offered to provide a commode downstairs as an interim measure. (Paragraph 4.72). It was eventually decided that it was not safe to discharge John back to Address 1 and so he was discharged to Address 2 as an interim measure where his living, sleeping and toilet facilities were on one level.

How effective were agencies in considering the needs of John when it was necessary to place him in an out of area hospital following the Manchester Arena attack?

6.63 The need to generate 'surge capacity" within Greater Manchester hospitals to treat the victims of the Manchester Arena attack impacted on John. Under normal circumstances, he would have been transferred from the MRI to Salford Royal for neurosurgery. In the absence of neuro beds in Salford Royal, John was transferred to the next appropriate neuro specialist area which was the Royal Preston hospital.

6.64 After being operated on at the Royal Preston, the initial plan was to transfer John back to a hospital in Manchester but he was ultimately discharged directly to Address 1 from the Royal Preston. The transfer to Preston had created some logistical issues. The distance involved made it more challenging for Premier Care to provide on-ward support for John and may have been a factor in the physiotherapy assessment being limited to observing John mobilising and using stairs in the hospital environment only.

6.65 The decision to transfer John to the Royal Preston was entirely appropriate in the circumstances. It is not known whether the continuing impact of the Manchester Arena attack on hospital capacity prevented John being transferred back to a Manchester hospital. Although the distance involved and the lack of established links between services in Trafford and the Royal Preston undoubtedly made John's hospital discharge more challenging, it was not unreasonable to expect his discharge to have been managed in a co-ordinated and safe manner.

How effective was discharge planning from hospitals for John?

6.66 During the twenty one day period beginning on 22nd May 2017, John was readmitted to hospital on three occasions within a short time of hospital discharge. The timeline is as follows:

Day 1 (Monday 22.5.2017) – admitted to MRI following a fall from a sofa and probably an earlier fall. Chronic subdural haematoma diagnosed.

Day 2 (Tuesday 23.5.2017) – transferred to Royal Preston hospital.

Day 4 (Thursday 25.5.2017) – right mini-craniotomy performed.

Day 12 (Friday 2.6.2017) – discharged by Royal Preston to placement.

Day 14 (Sunday 4.6.2017) – admitted to Salford Royal following fall from top of stairs. Skull fractures and injuries to mid and upper spine diagnosed.

Day 16 (Tuesday 6.6.2017) – discharged by Salford Royal to placement.

Day 17 (Wednesday 7.6.2017) – admitted to Salford Royal following fall out of bed.

Day 18 (Thursday 8.6.2017) – discharged by Salford Royal to placement.

Day 21 (Sunday 11.6.2017) – admitted to Salford Royal after being unable to stand.

6.67 John was considered medically fit for discharge from the Royal Preston although the plan had been for him to be transferred to a Manchester hospital until three days prior to discharge. Little attention was paid to the mechanism of injury which had to John's initial admission to the MRI nor was there sufficient curiosity about the risks John might be exposed to once he returned to his discharge destination. Hospital 'neuro' observations were that John required supervision when walking to the bathroom yet the hospital physiotherapist discharged John with 'no follow up required'. John was readmitted to hospital (Salford Royal) only 48 hours after his discharge from the Royal Preston.

6.68 John was found to be medically fit for discharge in respect of both discharges from Salford Royal. The first discharge took place on 6th June 2017 and whilst there is evidence of a multi-disciplinary approach, no wider multi-agency discussions took place other than with Premier Care. Given the safeguarding concerns which were raised on admission, just two days before, there is no documentary evidence of consideration that a multi-agency risk assessment may be required to ensure the home environment was a safe place for John to be discharged to. The fact that John suffered a further fall and readmission less than 48 hours later suggests that discharge planning could have been more effective.

6.69 The second discharge from Salford Royal took place on 8th June 2017 after a short admission (16 hours). There was liaison with Trafford CLDT (social care) who were to undertake a home visit the day after discharge. The mental health liaison team concluded that John was distressed by the unfamiliar environment and that a prolonged admission

could cause more harm. The Salford Royal agency report author concluded that whilst it is not unreasonable that admissions such as this should be time limited and focused on getting patients home as quickly as possible, in this case there were concerns about John's home environment which were not well enough understood for his safety to be assured. Once more, a multi-agency approach may have supported a more effective discharge. John was readmitted to Salford Royal within 72 hours of this second discharge.

6.70 John's admission to Trafford General hospital was for complex discharge planning and he was successfully discharged to Address 2 on 31st August 2017.

6.71 Overall, once John was considered medically fit for discharge from hospital, there seemed to be an emphasis on completing the discharge without delay. Concerns that remaining in hospital for longer than necessary might be harmful to John informed one discharge decision (Paragraph 6.69). Decision making in respect of John's medical fitness for discharge was multi-disciplinary although on one occasion an inconsistency in the multi-disciplinary assessments did not appear to be picked up on (Paragraph 6.67). Although each hospital consulted with Premier Care prior to discharge there seemed to be insufficient curiosity or understanding of the type of placement which John was returning to. The question of whether it was safe to discharge John to a placement where he had sustained injuries which had necessitated his admissions, did not appear to exert any influence over the unsuccessful hospital discharge decisions despite safeguarding concerns having been considered at an earlier stage in each admission. Effective multi-agency working between the hospitals and community based services was not a prominent feature of the unsuccessful discharges. Trafford CLDT (health) takes the view that if multi-agency discharge planning taken place it is likely that an environmental assessment would have been requested prior to the unsuccessful discharges.

6.72 Discharge letters were sent to John's GP practice. From the limited information provided to this SAR by John's GP practice, it is unclear how quickly the practice received the hospital discharge letters and what, if any, action was prompted by the letters. It may have been difficult for the GP practice to respond effectively to each individual hospital discharge letter as John may have been readmitted to hospital by the time they received and considered the discharge information. However, one might have expected the flurry of discharge letters to have prompted some action or enquiry.

How effectively was information sharing between agencies involved in providing treatment, care and support for John?

6.73 Prior to John's third admission to Salford Royal, information sharing between the agencies involved in John's treatment, care and support was generally unsatisfactory. Many of the factors which contributed to this are highlighted elsewhere in this report.

6.74 Following John's third admission to Salford Royal, information sharing between agencies greatly improved and was one of the foundations of John's successful discharge from TGH.

To what extent were agency interventions with John informed by relevant prior concerns?

6.75 Information sharing by Premier Care appears to have been undermined by less than complete recording of incidents. The absence of a hospital passport for John meant that staff providing care and treatment for John during his earlier admissions were less well informed about his needs. During John's earlier hospital admissions far greater attention was paid to his medical needs than his social care needs.

6.76 Following John's third admission to Salford Royal and subsequent transfer to Trafford General Hospital for complex discharge planning, the care and treatment provided and the planning for John's discharge from hospital were much more fully informed by prior medical and social care concerns.

To what extent did agencies make reasonable adjustments for John, given his learning disability?

6.77 Since the enactment of the Disability Discrimination Act 1995, people with a learning disability have had a legal entitlement to equal access to public services. The Equality Act 2010 places a general equality duty on all public authorities. In the exercise of their functions they are obliged to have due regard to the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act
- Advance equality of opportunity between people who share a protected characteristic and those who do not
- Foster good relations between people who share a protected characteristic and those who do not

6.78 The second of the three aims listed above involves having due regard to the need to:

- Remove or minimise disadvantages suffered by people due to their protected characteristics

- Take steps to meet the needs of people with certain protected characteristics where these are different from the needs of other people

- Encourage people with certain protected characteristics to participate in public life or in other activities where their participation is disproportionately low.

Disability is a “protected characteristic”.

6.79 The broad purpose of the general equality duty is to integrate consideration of equality and good relations into the day-to-day business of public authorities.

6.80 All public authorities have a legal duty to make “reasonable adjustments” to the way they make their services available to people with a learning disability, to make those services as accessible and effective as possible. Reasonable adjustments may include making whatever alterations necessary to policies, procedures, staff training and service delivery to ensure they work equally well for people with a learning disability (3).

6.81 Notwithstanding the advances made in enhancing legal rights, the past quarter of a century has seen the substantial and wide-ranging health inequalities experienced by people with learning disabilities become increasingly well documented (4). For example, the deaths reviewed by the Learning Disabilities Mortality Review show that the median age of death for people with a learning disability is 23 years younger for men and 29 years younger for women compared with the general population, and that these deaths are often for entirely avoidable reasons (5).

6.82 In John’s case reasonable adjustments were not made consistently. Whilst there is no reason to doubt that all the clinical interventions carried out were done in John’s best interests, the process of involving John, via an independent advocate in decisions about his care was only infrequently accessible to him.

6.83 Specific examples of the absence of reasonable adjustments being made for John include; On 5th June 2017 occupational therapy at Salford Royal concluded that a post traumatic amnesia assessment would not be appropriate on the basis that John would not have been able to answer the questions included in the assessment prior to his fall as a result of his learning disability (Paragraph 4.31). Prior to his discharge from Salford Royal on 6th June 2017, John was seen by a trauma co-ordinator who was unable to provide more than limited information due to his cognition. John was provided with a major trauma leaflet which it seems unlikely he would have been unable to understand (Paragraph 4.36).

6.84 TGH worked in partnership with the Trafford CLDT which was aware of John's needs and commissioned Premier Care to provide familiar carers known to John in an effort to reduce his agitation and anxiety. TGH also identified a copy of John's patient passport on admission to inform care planning.

Good Practice:

6.85 Examples of good practice included:

The action taken by the Premier Care carer in taking John to Trafford General Hospital on 21st May 2017 after becoming concerned by John's excessive sleeping.

The referral to the Salford Royal mental health liaison team on 8th June 2017 enabled insight to be gained into why John was verbally and physically aggressive to hospital staff and informed his subsequent treatment and care as an in-patient.

Premier Care provided staff to support John during his hospital admissions which provided him with staff with whom he was familiar and reduced his agitation.

7.0 Findings and Recommendations

Hospital Discharge

7.1 John was discharged from hospital on four occasions during the period under review. Three of the hospital discharges were unsuccessful in that John was re-admitted to hospital within two days of his discharge from Royal Preston hospital, within 36 hours of his first discharge from Salford Royal hospital and within three days of his second discharge from Salford Royal.

7.2 For each of the unsuccessful hospital discharges, John was considered to be medically fit for discharge. Although there was evidence of a multi-disciplinary approach to discharging John, including the involvement of hospital physiotherapy and occupation therapy for example, multi-agency working was less evident. Additionally, there appeared to be insufficient awareness or curiosity on behalf of hospital staff about the environment to which John would be returning.

7.3 Royal Preston liaised with Trafford CLDT (health) and Premier Care but neither agency was invited to any discharge planning meeting. The hospital based physiotherapy service discharged John with 'no follow up required'. It is unclear how this judgement could have been reached particularly as hospital 'neuro' observations concluded that John would require supervision when walking to the bathroom.

7.4 Prior to his first discharge from Salford Royal, John was assessed by the hospital physiotherapy service and found to be at high risk of falls. Although the hospital liaised with both Trafford CLDT (health) and Premier Care they appeared to misunderstand his community placement, twice referring to it as 'residential' care. The safeguarding referral made by the hospital shortly after John's admission to Salford Royal two days earlier, in which concern had been expressed about two serious falls during a relatively short period, did not appear to inform discharge planning.

7.5 Prior to his second discharge from Salford Royal, John was assessed by the hospital's mental health team and there was again liaison with Trafford CLDT (health) and Premier Care. At the time of discharge, it was said that social care concerns could be resolved in the community.

7.6 Improving hospital discharge is a key NHS objective on the grounds that when 'people no longer need hospital care, being at home or in a community setting (such as a care home) is the best place to continue recovery' (6). It is also acknowledged that longer stays in hospital can lead to worse health outcomes for patients, particularly older people (7). However, members of the SAR Panel and those attending the practitioner learning event which informed the SAR, expressed concern that the NHS emphasis on reducing delayed transfers of care (DTOC) can lead to unsafe discharges from hospital. John's rapid re-admissions tend to support this view and these re-admissions also applied even greater pressure on hospital beds and resulted in poor health outcomes for him. This is often described as 'failure demand' which is demand arising from the organisation's failure to do something or to do the right thing in the first place.

7.7 This issue was commented upon in the Care Quality Commission's (CQC) 2018 *State of Care* report (8). The CQC stated that they had repeatedly been told that the pressure on local systems to reduce delays in hospital discharge had 'almost overwhelmed other health and social care priorities' (9). Whilst welcoming the reduction in DTOC, the CQC found examples where the focus on DTOC had compromised the safety of people moving through services (as in John's case). The CQC took the view that a focus on DTOC alone will not fully address problems that people sometimes face when they need to access ongoing care, and emphasised the need for strong coordination between hospitals and community and primary care services and improved information sharing and communication on discharge (10).

7.8 In John's case a key dynamic appeared to be the different pace at which hospital and community services were operating at. The former moved at a fast pace and as soon as John was considered to be medically fit, there was a strong emphasis on discharging him as quickly as possible. A clinical note completed just prior to John's second unsuccessful discharge from Salford Royal stated that 'it would seem wasteful to keep John in an acute medical bed when there has been no change in function'. Although Trafford CLDT (health) was quite proactive in responding to John's admissions to hospital, it appeared to be very challenging to co-ordinate the efforts of Trafford CLDT (health), CLDT (social care) and Premier Care at the pace at which the hospitals were operating. It is unclear from this review how effective the Section 2 and Section 5 notification system is in improving co-ordination between hospital and social care services.

7.9 Another factor driving John's discharge from hospital was the realisation that he tended to become agitated and aggressive in unfamiliar hospital environments, although this was mitigated by arranging for Premier Care carers to provide support in hospital. However, there appeared to be a lack of clarity about how in-hospital support for John by Premier Care was to be commissioned. Given his increased agitation whilst admitted to hospital, it was not in John's best interests to remain in hospital any longer than was necessary to ensure his discharge was safe. John's agitated behaviour whilst in hospital also brought him into contact with hospital security staff who did not always demonstrate the range of skills necessary to address challenging behaviour.

7.10 *The State of Care* makes it clear that the challenges involved in ensuring safe and effective discharge from hospitals are not limited to John's case or the Trafford Council area. However, making progress in Trafford may be slightly more challenging than other areas as Trafford General Hospital is not an acute hospital, therefore patients who live in the Trafford Council area may frequently find themselves being discharged from out of area hospitals such as Salford Royal and the MRI. Ensuring there are effective links between Trafford community health and social care services and out of area hospitals is likely to be more challenging than working in partnership with Trafford General hospital colleagues.

7.11 In John's case unsuccessful discharges from hospitals resulted in significant harm and a number of adult safeguarding concerns. It is therefore recommended that Trafford Strategic Safeguarding Board obtains an enhanced appreciation of the impact of unsafe hospital discharges by monitoring safeguarding referrals arising from them. (In order to successfully monitor such safeguarding referrals, the Board will need to seek assurance that adult safeguarding policies are followed, which they were not in this case – see Paragraph 7.12 and Recommendation 3 below). It is also recommended that the Board obtains assurance about the effectiveness of the links between community based services such as Trafford CLDT (health) and (social care) and the out of area hospitals from which Trafford residents may be discharged.

Recommendation 1

That Trafford Strategic Safeguarding Board obtains an enhanced appreciation of the nature and extent of unsafe hospital discharges by monitoring safeguarding referrals arising from them.

Recommendation 2

That Trafford Strategic Safeguarding Board obtains assurance about the effectiveness of the links between community based services such as Trafford CLDT (health) and (social care) and the out of area hospitals from which Trafford residents are most likely to be discharged.

Management of and response to adult safeguarding referrals.

7.12 Trafford Adult Social Care received a number of adult safeguarding referrals in respect of John during the period under review. None of these referrals were responded to in accordance with law and policy. Referrals relating to falls resulting in a significant injury should have triggered the local safeguarding process but did not (Paragraph 6.39). The response to the concerns set out in the various safeguarding referrals became subsumed within the overall response to the concerns about John. No discussion take place with John to ascertain his views, wishes and desired outcomes. As safeguarding referrals began to

accumulate, it was decided to hold a strategy meeting but this did not happen (Paragraph 6.43). It is therefore recommended that Trafford Strategic Safeguarding Board obtains assurance that adult safeguarding referrals are responded to in accordance with multi-agency policy.

Recommendation 3

That Trafford Strategic Safeguarding Board obtains assurance that adult safeguarding referrals are responded to in accordance with multi-agency policy.

Commissioning of in-hospital support from providers

7.13 After it was established that John's violent and aggressive behaviour towards hospital staff was primarily a response to surroundings he found unfamiliar and stressful, Premier Care provided carers to support John on the hospital ward. Premier Care was unable to sustain this support from within their commissioned resources and so the question of how to commission additional support from Premier Care arose. Confusion arose at times about which agency was responsible for commissioning in-hospital support from Premier Care (Paragraph 4.60). It is therefore recommended that Trafford CLDT (social care) and Trafford General Hospital work together to clarify this issue and develop guidance as necessary. Trafford Strategic Safeguarding Board may wish to be advised of the outcome of this piece of work.

Recommendation 4

That Trafford Strategic Safeguarding Board obtains assurance that clarity exists over the commissioning of in-hospital support by the patient's provider of care and support within the community.

Falls Prevention

7.14 There is strong argument to be advanced that the significant harm John suffered could have been prevented if action had been taken earlier to reduce his risk of falls. The human cost of falling includes distress, pain, injury, loss of confidence, loss of independence and mortality. Falling also affects the family members and carers of people who fall. Falls are estimated to cost the NHS more than £2.3 billion per year. Therefore, falling has an impact on quality of life, health and healthcare costs. (11)

7.15 In John's case, his risk of falling appeared to be identified as early as 2013. He experienced a 'few falls due to mobility' in 2014 and in 2015 he was referred for assessments for walking aids and mobility. It is unclear whether these assessments were to be encompassed in the physiotherapy referral also made that year. In any event, the physiotherapy assessment was not completed as Premier Care did not take John to the appointments offered after he had been on a waiting list for physiotherapy services for ten months.

7.16 John suffered a serious fall in March 2016 and was treated but not admitted to the MRI. No evidence has been provided to this review that Premier Care, Trafford CLDT or John's GP followed up on this incident or that the MRI made a safeguarding referral.

7.17 A proposed referral to psychiatry in 2016 might have assisted those involved in John's care to better understand his presentation, but the community mental health team has no record of ever receiving the referral.

7.18 John's GP twice increased his prescription of Oxazepam in January and May 2017 which may have increased his risk of falling. There seemed to be no consideration of whether the changes in his prescription could indeed increase his risk of falling. The risk of falls was greatly increased by the failure of John's GP practice to cancel the 15mg Oxazepam prescription which should have been replaced by the increased 20mg prescription. Premier Care then administered both prescriptions for a period of two weeks which left John heavily sedated. This was a significant medication error by John's GP practice which substantially increased the risk of falls during the two week period which immediately preceded John's series of hospital admissions. Premier Care has advised the review that there was little they could do to rectify the prescribing error other than the action they took, which was to take John to the TGH UCC when they noticed his excessive drowsiness. As previously stated John's GP practice has been advised to submit a safeguarding referral, the investigation of which will inform what action needs to be taken to ensure that old prescriptions are cancelled. The incident has been escalated to NHS England. Assurance has also been sought from Premier Care on their practices in respect of recording medication changes.

7.19 When John's falls necessitated hospital admissions, measures to reduce his risk of falling in his supported living accomodation were not put in place very quickly. The review has been provided with no indication that John's provider, Premier Care, carried a falls risk assessment in respect of John. A mattress was placed on his bedroom floor as an interim measure on 8th June 2017, an extra bannister was to be fitted to the stairs at Address 1 on 9th June 2017 and a stair gate was also fitted although it was queried whether John had the capacity to use it safely. It wasn't until 30th June 2017 that a physiotherapist assessed both John and his environment at Address 1.

7.20 There are also concerns about the completeness of Premier Care's recording of John's falls (Paragraph 4.17). Without accurate recording it is not possible to observe any escalation in risk of falls.

7.21 John suffered significant harm from the falls he experienced in May and June 2017 as he was admitted, discharged and then readmitted to hospitals. Effective falls prevention practice could have mitigated and possibly prevented this sequence of events taking place. Change in medication is a key factor to consider in assessing the risk of falls but this doesn't appear to have been taken into account by John's GP practice or Premier Care. Additionally, failings led to John being heavily sedated during the period immediately prior to the sequence of falls which necessitated repeated admissions to hospital. It is therefore recommended that Trafford Strategic Safeguarding Board obtain assurance that commissioners of placements for people at risk of falls include the effectiveness of falls policies within their commissioning and monitoring arrangements and that providers of placements for people at risk of falls have robust falls policies in place supported by appropriate staff training.

Recommendation 5

That Trafford Strategic Safeguarding Board obtains assurance that the commissioners of placements for people at risk of falls include the effectiveness of falls policies in placement commissioning and monitoring.

Recommendation 6

That Trafford Strategic Safeguarding Board obtains assurance that providers of placements for people at risk of falls have robust falls policies in place supported by appropriate staff training.

7.22 Because John's GP practice only recently discovered that his old Oxazepam prescription had not been cancelled in May 2017, which led to John being heavily sedated during the period immediately prior to the sequence of falls which necessitated his admissions to hospital, it has not yet been possible to establish the cause of this error and identify what action is needed to prevent a reoccurrence. It is also not yet known whether the error has implications for other GP practices. Nor is it yet known what action Premier Care will need to take to prevent medication errors and whether there are implications for providers generally. It is therefore recommended that Trafford Strategic Safeguarding Board obtains assurance in respect of the safe prescribing and administering of medication when the safeguarding referral John's GP practice has been advised to make has been investigated.

Recommendation 7

That Trafford Strategic Safeguarding Board obtains assurance from NHS Trafford Clinical Commissioning Group in respect of the safe prescribing and administering of medication when the safeguarding referral John's GP practice has been advised to make has been investigated.

Mental Capacity / Deprivation of Liberty

7.23 John's care and treatment in hospital was adversely affected by the inconsistent application of the Mental Capacity Act. Whilst hospital staff were aware of John's learning disability, they only infrequently went on to consider whether his learning disability and the evident difficulties he had in communicating raised the possibility that he may lack mental capacity and that any consent he gave to decisions about his treatment and care may not be true consent. Indeed, this review has been advised that some hospital staff erroneously believe that the Mental Capacity Act primarily applies to patients who are uncooperative or express a wish to leave the hospital.

7.24 The inconsistent application of the Mental Capacity Act contributed to a lack of advocacy for John. NHS guidance to patients on 'being discharged from hospital' states that they should be fully involved in the discharge assessment process and that if the patient needs help putting their views across, an independent advocate may be able to help (12). In John's case he did not benefit from advocacy until his transfer to Trafford General Hospital.

7.25 The inconsistent application of the Mental Capacity Act also impacted on consideration of whether John was being deprived of his liberty whilst admitted to hospital. Whilst a pragmatic approach to applying for DoLS authorisation is considered acceptable where the 'acid test' applies and hospital admissions are brief, there were two periods when John was considered to have been unlawfully detained during hospital admissions.

7.26 This SAR discloses an inconsistent approach to the Mental Capacity Act in each of the hospitals to which John was admitted. It is assumed that each hospital will respond to these inconsistencies and implement single agency action plans in an effort to ensure the consistent application of the Mental Capacity Act. To assist in this process, it is recommended that Trafford Strategic Safeguarding Board shares a copy of this SAR overview report with each of the hospital trusts involved in this case and seeks assurance from each trust in respect of the actions being taken to improve the application of the Mental Capacity Act.

Recommendation 8

That Trafford Strategic Safeguarding Board shares a copy of this SAR overview report with each of the hospital trusts involved in this case and seeks assurance from each trust in respect of the actions being taken to improve the application of the Mental Capacity Act.

7.27 Consideration of advocacy support for John whilst admitted to hospital was delayed and there appeared to be a further delay in providing advocacy once the need had been identified for John. It is therefore recommended that Trafford Strategic Safeguarding Board seeks assurance from the hospital trusts involved in this SAR in respect of recognition when advocacy support is required and the availability of such advocacy support.

Recommendation 9

That Trafford Strategic Safeguarding Board seeks assurance from the hospital trusts involved in this SAR in respect of recognition when advocacy support is required and the availability of such advocacy support.

7.28 Both the authors of the agency reports submitted to this SAR by the Salford Royal and Trafford General Hospitals conclude that John was unlawfully deprived of his liberty whilst admitted to those hospitals. It is therefore recommended that Trafford Strategic Safeguarding Board obtains assurance from the relevant hospital trusts over the steps taken to ensure that Deprivation of Liberty Safeguards are appropriately applied within those hospital trusts.

Recommendation 10

That Trafford Strategic Safeguarding Board obtains assurance from the relevant hospital trusts over the steps taken to ensure that Deprivation of Liberty Safeguards are appropriately applied within those hospital trusts.

Patient Passports

7.29 During his frequent admissions to hospital, John was usually provided with treatment and care by staff who did not know him. In these circumstances staff often had great difficulty communicating with John, ascertaining his wishes and providing him with a personalised service. Had John had a Learning Disability patient passport at all times, this would have been of invaluable assistance to staff in hearing John's 'voice' and better meeting his needs. In this case, only one of the hospitals to which he was admitted used a patient passport.

7.30 It may be necessary to clarify where responsibility for preparing patient passports lies. The NHS guidance on 'going into hospital' (https://www.nhs.uk/conditions/learning-disabilities/going-into-hospital/) indicates that responsibility for 'healthcare passports' resides with the community learning disability team, GP or hospital, with no mention of the provider of care and support (13). In any event it is recommended that Trafford Strategic Safeguarding Board obtains assurance that patient passports are initiated and maintained for all adults with learning disabilities in the Trafford Council area.

Recommendation 11

That Trafford Strategic Safeguarding Board obtains assurance that patient passports are initiated and maintained in respect of all adults with learning disabilities.

Service Users with a Learning Disability

7.31 The largely avoidable reduced life expectancy for adults with a learning disability has been referred to earlier in this report (Paragraph 6.81). John suffered significant harm primarily because agencies did not work together sufficiently effectively and he could easily have suffered fatal injuries. The sequence of falls, admissions, discharges and readmissions to hospital are likely to have been bewildering and highly stressful for John. Reasonable adjustments, as required by law, were not always made for him (Paragraph 6.83). It is therefore recommended that Trafford Strategic Safeguarding Board seeks assurance that the agencies involved in this SAR have reviewed the reasonable adjustments made for people with learning disabilities in the light of the learning which has emerged from this review.

Recommendation 12

That Trafford Strategic Safeguarding Board seeks assurance that the agencies involved in this SAR have reviewed the reasonable adjustments made for people with learning disabilities in the light of the learning which has emerged from this review.

7.32 The Panel overseeing this SAR has requested the lead reviewer to prepare an abbreviated 'easy read' version of this report to be shared with John by his carers or his advocate. In addition, Trafford Strategic Safeguarding Board may wish to consider a formal apology to John for the failings which contributed to the significant harm he suffered during the period covered by this SAR.

Recommendation 13

Trafford Strategic Safeguarding Board may wish to consider a formal apology to John for the failings which contributed to the significant harm he suffered during the period covered by this SAR.

Dissemination of Learning

7.33 Many of the learning themes emerging from this SAR are consistent with findings from other reviews in which people with a learning disability have died or suffered significant harm. The Learning Disabilities Mortality Review (LeDeR) Programme, is commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England and delivered by the University of Bristol (14). The Programme holds a repository of summaries of reviews including Safeguarding Adult Reviews, Serious Case Reviews, and Serious Incident Reports. Key findings from the repository of reviews for the period 2015-17 included the following:

- Insufficient reviewing or monitoring of care placements by commissioners of care.
- Appointing a named care coordinator or lead health professional for each person with learning disabilities and coJohnlex health needs.
- Care and care plans needing to be dynamic to reflect changing needs.
- Lack of communication about concerns over risk, leading to safeguarding issues.
- Poor record keeping by care staff.
- Insufficient or ineffective use of hospital passports leading to poor care.
- All relevant parties to be made aware of discharge information following a patient's stay in hospital.
- Improving awareness of the Mental Capacity Act to ensure it becomes central to professionals' working lives.

- A better understanding and application of when an assessment of capacity is required.

- Greater use of an independent advocate.

- Adherence to guidance on Deprivation of Liberty Safeguards.

Given the range of learning which has emerged from this SAR it is recommended that a case study based on this SAR is prepared in order to disseminate learning as widely as possible.

Recommendation 14

Given the range of learning which has emerged from this SAR it is recommended that Trafford Strategic Safeguarding Board arranges for a case study based on this SAR to be prepared in order to disseminate learning as widely as possible.

References:

(1) retrieved from https://www.england.nhs.uk/wp-content/uploads/2013/08/dis-old-people.pdf

(2) (Department of Health, 2009)

(3) "The Essential Guide to the Public Sector Equality Duty" (2014) Equality and Human Rights

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from: http://www.equalityhumanrights.com/sites/default/files/publication_pdf/PSED%20Essential%20Guide%20-%20Guidance%20for%20English%20Public%20Bodies.pdf

(4) "Reasonable Adjustments for People with a Learning Disability in England" (2010) Learning Disabilities Observatory retrieved
from: http://www.iJohnrovinghealthandlives.org.uk/uploads/doc/vid_10118_IHaL%20NHS%20Trust%20Reasonable%20Adjustments%20survey%202010.pdf

(5) Retrieved from https://www.gov.uk/government/publications/government-response-to-the-learning-disabilities-mortality-review-leder-programme-2nd-annual-report

(6) Retrieved from https://www.england.nhs.uk/urgent-emergency-care/hospital-to-home/iJohnroving-hospital-discharge/

(7) ibid

(8) Retrieved
from https://www.cqc.org.uk/sites/default/files/20171011_stateofcare1718_report.pdf

(9) ibid

(10) ibid

(11) Retrieved from https://www.nice.org.uk/guidance/cg161/chapter/Introduction

(12) https://www.nhs.uk/using-the-nhs/nhs-services/hospitals/being-discharged-from-hospital/

(13) Retrieved from https://www.nice.org.uk/guidance/cg161/chapter/Introduction

(14) Retrieved from http://www.bristol.ac.uk/sps/leder/

Appendix A

Membership of the SAR Panel and the process by which the SAR was completed

A panel of senior managers from partner agencies, chaired by the independent author, oversaw this review and membership of this panel is shown below:

- Safeguarding Board Manager, Trafford Strategic Safeguarding Board (TSSB)
- Deputy Chief Nurse & Designated Nurse Safeguarding Adults, Trafford CCG
- Head of Commissioning, Trafford Council
- Adult Social Care Lead Professional, Trafford Council
- Named Nurse for Adult Safeguarding, Manchester NHS FT
- Assistant Director of Nursing & Safeguarding, Salford Royal NHS FT
- Learning Disability Practitioner, Lancashire Teaching Hospitals NHS FT (LTHTR)
- Safeguarding Adults Lead, LTHTR
- Registered Manager, Premier Care
- Advocacy Development Manager, Advocacy Focus
- Detective Inspector, Greater Manchester Police
- Safeguarding Practitioner, North West Ambulance Service
- Safeguarding Board Officer, TSSB
- Safeguarding Support Officer, TSSB
- David Mellor, Independent Author and Chair of SAR panel

It was decided to adopt a broadly systems approach to conducting this SAR. The systems approach helps identify which factors in the work environment support good practice, and which create unsafe conditions in which unsatisfactory safeguarding practice is more likely. This approach supports an analysis that goes beyond identifying *what* happened to explain *why* it did so – recognising that actions or decisions will usually have seemed sensible at the time they were taken. It is a collaborative approach to case reviews in that those directly involved in the case are centrally and actively involved in the analysis and development of recommendations.

Chronologies which described and analysed relevant contacts with John were completed by the following agencies:

- Cheshire and Wirral Partnership NHS Foundation Trust
- Lancashire Teaching Hospitals NHS Foundation Trust
- Manchester NHS Foundation Trust
- NHS Trafford Clinical Commissioning Group

- North West Ambulance Service
- Premier Care Limited Specialised Services
- Salford Royal Hospital NHS Trust
- Trafford Council Community Learning Disability Team

A report was also provided by Trafford Council Adult Social Care.

A learning event took place, to which all practitioners involved in this case were invited. This proved invaluable in understanding the part played by various agencies and services in supporting John.

Following the learning event, the independent author wrote a draft report. With the assistance of the SAR panel, the report was further developed into a final version and presented to Trafford Strategic Safeguarding Board.