CONFIDENTIAL

Safeguarding Adult Review

Owen

Overview Report

Author: Sheila Lock

Presented to PR&A subgroup March 2023

CONTENTS:

1. Introduction

This report is produced and summarised together with its findings in an accessible way, the intent being to allow agencies and practitioners to reflect on aspects of practice that ultimately will benefit service users who have a learning disability.

1.1 Why was this case chosen for review?

The case of Owen generated a considerable debate amongst professionals involved with his care. The debate centered around whether the sequence of events articulated below constituted medical negligence or whether they raised issues of a safeguarding nature that warranted consideration under the Care act 2014 legislation. Ultimately the Safeguarding Board made the decision to commission a Safeguarding Adult Review (SAR) under section 44 of the Care Act (2014). This was because the circumstances of this case appeared to have a wider implication for practice, both in relation to access to health provisions for adults with learning disabilities, and in relation to professionals being confident to access additional specialist resources when that becomes necessary. As a Board we were concerned about the additional vulnerability of Owen and the absence of an appropriate and reasonable adjustment to his care. I would add that the lack of initial candour and disclosure from the optometrist who saw Owen added further to levels of concern. We were keen to reinforce that safeguarding is not just about acts of commission, but it is also about acts of omission, particularly when these cause significant harm to those with additional vulnerability, and where there is a detrimental impact on the quality of life for the individual.

1.2 Succinct summary of the case

Owen is a gentleman with profound learning disability, he has epilepsy, autism and communication difficulties, leaving him unable to use verbal communication and he is unable to use Makaton, he has lived in his current supported accommodation since March 2001. This has been with the support of a lone working/sleeping in service, which has successfully supported Owen and one other tenant to live semi independently. The case concerns the care Owen received from his local opticians, where he had received routine eye care since 2017. In May 2021 he had a routine check-up and received glasses, in August 2021, his behaviour changed considerably. The staff at his accommodation were concerned that, he was unable to find his bed after visiting the toilet at night, he began urinating in his bedroom after struggling to find his ensuite toilet and generally he appeared to be stumbling more. The staff took him back to the opticians where it was discovered that he had a Brunescent cataract on one eye, which had caused visual impairment. Following subsequent treatment at Moorfields Eye Hospital, Owen was registered as blind on 23rd February 2022.

1.3 Family composition

Owen has a brother, who lives outside of the area, but who plays an active role liaising with professionals, being involved in planning and visiting his brother regularly.

1.4 Timeframe

Owen was registered as blind in February 2022 and Ealing Safeguarding Adult Board (ESAB) discussed the case on the 15th September 2022. This followed attempts by the Community Team for People with Learning Disability (CTPLD) to discuss the situation with the local optician and their internal consideration of the available information which had been

provided to them. The information they received highlighted the need for a Review of the circumstances leading up to Owen's loss of sight and given the profound implications for his quality of life as a result of his blindness the ESAB, concluded that this met the criteria for a SAR to be conducted. The Review has considered information from the point of Owen requiring optical care but has recognised that this needs to sit alongside an overview of his medical history in order to consider if that may be relevant to the circumstances.

1.5 Organisational learning and improvement

Following discussion, ESAB identified that the Review of this case held the potential to shed light on particular areas of practice, including addressing the question:

How are all practitioners and providers in Ealing identifying and managing the health needs for people with a learning disability and complex needs?

The use of this key question at the beginning of the process sat alongside our Terms of Reference and brought together all the issues raised in our discussions to help us identify the key lines of enquiry that we believed would highlight learning from this case and support us in improving current practice.

2. Methodology

2.1 Reviewing expertise and independence

This SAR has been led by Sheila Lock who was independent of the case under review and of the organisations whose actions are being reviewed. There has been no previous involvement with this case. The author has 36-years' experience of working in safeguarding and has been a previous Director of services for Children, Adults and Public Health as well as a local government Chief Executive.

2.2 Acronyms used and terminology explained

The report endeavours to be written in an accessible way, but in order to explain any terms used, Appendix 1 contains a section on terminology to support readers who are not familiar with the processes and language of Adult Social Care and Health provision.

2.3 Methodological comment and limitations

In order to be proportionate, the author elected to use a practitioner event workshop as the central mechanism for gathering information, posing hypothesis and for beginning an analysis. This was instead of conducting a lengthier process that included more detailed conversations with individual agency practitioners. It has brought additional value in promoting cross agency discussion regarding the issues and has promoted ongoing learning. Not all agencies involved with Owen were able to attend the practitioner event. However, this gap was mitigated by using written submissions sent to the Board for its deliberations in September 2022, and by two additional interviews conducted by the Review author. This included an interview with

- The professional services Consultant from the optician chain
- A consultant Ophthalmologist from Moorfields – the secondary care provider

In addition, the author had a telephone discussion with Owen's brother and wrote reminding him of the offer of further involvement in the review process. This at the time of

writing has not been taken up and it must be recognised that the process can be difficult for family members.

It is also worth noting that it has not been possible to speak with the practitioner who undertook the examination in May. It is understood by the reviewer that he sold the practice.

2.4 The review team

The author has worked closely with managers of the organisations providing care for Owen and with the Integrated Care Board (ICB) Senior Safeguarding lead. The role has been to provide expert knowledge in relation to the practice of their individual agency and to contribute to the analysis of practice. This has included expert advice on NHS commissioned services and a valuable role in interfacing with NHS England. It has also included raising concerns regarding professional standards for Opticians with the General Optical Council (GOC).

2.5 Which Practitioners have been involved?

The following attended the practitioner workshop:

Substantive Role	Agency
Designated Professional Safeguarding Adults (Ealing)	Integrated Care Board
Safeguarding Adults Coordinator	Adult Social Care
Designated Nurse	Community Team for People with Learning Disability (CTPLD)
Social Worker	CPTLD
Service Manager	CPTLD
Care Manager	Supported Accommodation Provider
Safeguarding Advisor	NHS Trust
Practice Manager /Owner	Local optician branch
Business Manager	Ealing Safeguarding Adults Board

2.6 Structure of the Review Process

Gathering information and making sense of what it tells us is a gradual and cumulative process. This Review was able to use the multi-agency workshop held on the 18th January 2023 as a central mechanism for gathering information and case analysis. This sat alongside reports and additional information provided by request to the Ealing Safeguarding Adults Board.

2.7 Sources of information

This case was reviewed using a systems approach, information came from three main sources; case information provided by individual agencies from case records, exploration with practitioners as to how they saw things at the time, supplemented by additional interviews to fill in the gaps. Those involved in the case played a part in analysing how and why practice unfolded in the way it did.

As is explained above this process was in part hampered by the fact that the professional optician who saw Owen and determined that he was a routine follow up, has sold his practice, and attempts to encourage his participation have been met with no response. The new practice owner has sought to cooperate fully and has participated, although he is

working from records that were left by the previous practitioner and which contain some gaps.

The written information provided to this Review came from the agencies listed below and was a key strand of understanding the health history for Owen, it also formed part of the consideration by the Board at its September meeting.

a) Adult Social care
b) CTPLD - Social work
c) CTPLD - Nursing team
d) The Care Provider
e) LNWH NHST
f) WLNHST
g) Metropolitan police
h) GP
i) Moorfields Eye Hospital

3. A snapshot of Owen

Owen was born in 1955 and is of African Caribbean heritage, until recent events and despite a complex set of health needs, he has lived semi independently. His health needs were complex with epilepsy, autism and learning disability. He lives with one other person and has sleeping and working support each day. Staff describe him as quite a character, who likes listening to music and enjoys television- they smile when talking about him. His appetite is good, and he enjoys a beer, although largely non-verbal, Owen can often be heard shouting “beer and tea“ when staff refer to it being mealtime. Staff looking after him become animated when talking about him, and say he is good fun. He knows staff in his home, and they generally have good interactions with him, his mood is mostly a good one. Generally, he has kept active, enjoying going out with his support staff to swimming and bowling activities. They describe visits out from home and would go on the bus which Owen enjoyed. They describe him liking to go out occasionally to eat out, loving his food and enjoying the change of scene.

At home Owen has always been independent, able to get about by himself, and not needing too much apart from supervision appropriate to his disability. At the practitioner event staff were able to talk about the impact that losing his sight has had. Initially he lost confidence and was very disorientated, unable to find his bathroom, and unable to get into bed without support. Increasingly he found it hard to get from one part of the home to another, and it was the continued bumping into things, which led staff to escalate concerns and go back to the opticians. Although Owen is adapting, the life he has now is very different, his activities have become more restricted and more challenging for him to do. Although, our practitioner event heard that he has started to venture out on the bus again with staff.

4. Family engagement in understanding the concern.

4.1 Owen's brother has played an active role in Owen's life, attending planning meetings and reviews, and visiting his brother when he has been able. When concerns first arose regarding Owens eyesight, the Community Team for People with Learning Disability sought to discuss the concerns. They held two meetings, the first on the 22nd April 2022 and a second held on 27th May 2022. Owen's brother attended both meetings, however the meetings were unable to proceed, because the Optician involved in this case did not send any information nor did the optician attend. There was no explanation given for this to the multi-disciplinary team. The Review has been able to see that on both occasions invites were sent directly to the optician who saw Owen at the local branch, he was also the Practice Manager and Branch owner.

4.2 Following escalation to the Ealing Safeguarding Adults Board, Owen's brother was made aware of the decision to initiate a Review under section 44 of the Care Act 2014 in a telephone conversation, this was followed up in writing with an invite to participate.

4.3 In the telephone conversation he was able to provide some useful family perspective on events particularly regarding the impact for Owens life as a result of the perceived failures in care. He was cynical regarding any cooperation from the optical chain and felt that they had failed to explain anything to him or the people caring for his brother. Although remaining involved in aspects of his brother's care, there has been no further contribution to this review. These processes can be quite daunting for family members and that must be acknowledged, the Review author is grateful for the telephone conversation and the perspective provided.

5. The model of practice within the optician store in this case

5.1 Before identifying the key practice episodes in this case, it is worth setting out clearly the model of practice within the optician store attended by Owen. This seems most relevant at this point in the report in order to assist in explaining key events and intervention. The evidence for this section has been gleaned from information shared with the Review process by the new Practice manager and owner of the store . There has also been the opportunity to interview the professional services Consultant from the chain Head office and to exchange emails to clarify matters.

5.2 The store which saw Owen is one of a national chain of stores. They operate independently as a business, owned by a director(s). This is through a franchise model. Each business has responsibility through the Director, to have in place arrangements to ensure that policies and procedures are brought to the attention of staff and that they are implemented. This is within the framework of a core central team through Head Office that provide the policy framework, offer safeguarding support, and manage issues around Fitness to practice and the interface with the GOC. The monitoring of quality in records and responding to requests for information sits locally with Store Directors.

5.3 In the case of this store a, new practice manager and owner took over this role, having bought the practice with two co-directors on 1st September 2022. Prior to this date, the optician who saw Owen at his appointment on the 24th May 2021, was the sole director of this business.

6. Key practice episodes

6.1 A number of key practice episodes have been considered as part of this review. Before discussing those, it is worth noting that consideration has been given by the Review author to Owen's medical history, records from previous hospital admissions, his medications and general health have been considered and expert medical advice sought on issues that might be considered relevant.

6.2 Owen has a diagnosis of learning disability, autism, and epilepsy and this brings with it associated complex needs, although it should be noted that generally Owen has responded well to medications prescribed for his epilepsy.
In addition, he has experienced some dental issues, but these are largely historical.

6.3 During 2015 following a seizure and a neurology appointment, the records indicate he was diagnosed with small vessel disease following a CT scan, with no acute abnormality. The Review author was keen to ask if there was any connection between this and the recent sight loss. Medical opinion was that this occurred so long ago, without issues in the intervening period and that it was unlikely to be a factor causing any predisposition to visual problems nor a direct cause of recent issues. The past medical history is not considered relevant in the recent loss of sight.

a) Events surrounding the eye examination of Owen on the 24th May 2021

On the 24th May 2021 staff from the supported accommodation took Owen for an optician's appointment. The notes of this visit show some variation, between what was recorded by the carer and what is recorded by the optician. The standout discrepancy is that the carers notes record , that at this appointment Owen was given glasses and that advice was given relating to wearing those glasses while watching television. There is no reference to this is the optician records provided to the review, it simply records the eye test as being routine, records that no complaints were recorded with Owen's sight.
The records say that direct ophthalmoscopy performed to access the health of the eye, the recording of a grade one cataract was recorded in the left eye only, otherwise the rest of the eye was recorded as unremarkable. The optician's records suggest that the history given by the carer was vague.

In the practitioner session this was discussed in some detail. It is important to note that the optician performing this test was not present and that he had left the practice selling it to a new owner who took over in September 2022. The new owner was present at the practitioner session and was helpful and cooperative with enquiries, but the limitations of working with someone else's notes and the gaps in recording were evident.

The care provider was able to share at the practice session that this was a routine appointment, being a follow up from his last appointment on 15th April 2019. They described being able to support Owen on the visit and considered that they had given the optician an update on Owen's health and current status. They indicated that Owen often found it hard to cooperate but on this occasion the optician had examined him and suggested that all was well, as glasses were dispensed, Owen was offered a further routine eye appointment in two years.

It is a concern that the opticians notes provided to this Review, are not full and comprehensive, there is no evidence recorded of any consideration or adjustments being given for his learning disability, and no evidence of consideration of extra time and or support being offered. There is also no evidence regarding the giving of glasses, or the advice and support offered to the carer regarding the use of the glasses at home. The carers records show evidence that glasses were dispensed along with advice and guidance to the carer.

b) The eye examination on the 27th August 2021 and subsequent events

On the 23rd August 2021, care staff at the house where Owen lived had become increasingly concerned regarding his eyesight. They produced evidence to the Review process and raised issues within the practitioner group regarding the changes in Owen's behaviour, noted since the May visit to the optician. This included an inability to find his way to his ensuite bathroom at night, getting into his bed the wrong way round, and being unable to find his way around his home. The concern was such that they phoned the GP to discuss what they saw as increasing concern for Owen's health. They had begun to wonder if there might be another underlying reason for the difficulties Owen was experiencing. The GP suggested bringing forward the Annual Health Check to rule out possible causes.

On the 27th August 2021 the carers brought forward an appointment with the optician store and took Owen back, he was, on this occasion seen by a different optician. The carers reported concerns regarding Owen's sight and the incidents of concern that had occurred, records suggest that this included reference to the fact that Owen could no longer perform tasks which had been easy for him before. Due to the challenges in Owen being nonverbal, subjective responses could not be obtained for any of the tests. An eye examination was completed. The notes record that fundoscopy was unremarkable but that on ophthalmoscopy of the anterior eye dense nuclear sclerotic lens opacities were observed in both eyes. A routine referral was made to carry out cataract extraction, via the GP.

On 28th August 2021, the GP practice received the referral, and it was processed the same day. The referral was received by Moorfield Hospital on the 8th September 2021 and an outpatient appointment offered within the routine waiting timescales of 18 weeks. Owen was seen initially by general ophthalmology on the 19th October, and records indicate that there was raised intraocular pressures in both eyes in addition to the dense lens observation that was the primary reason for referral. On the 29th November 2021 carers accompanied Owen to a first outpatient appointment with the Glaucoma Service.

Owen was uncooperative making examination of his eyes impossible; clinicians made the decision that he should be listed for bilateral examination under

anaesthetic (and possible right cataract surgery under general anaesthetic. Records from Moorfields confirm the decision was made in accordance with consideration of section 4 of the Mental Capacity Act as it was recognised that Owen required medical intervention as a result of his health needs. On the 7th December 2021 under general anaesthetic a right Brunescent cataract (leathery and fibrous) was removed as planned. Under anaesthetic the left eye was noted to be blind.
During surgery, an incident was recorded on the records seen, relating to the failure of blood pressure monitoring equipment. The surgery staff noted that they took appropriate action .

c) Ongoing treatment post-surgery under anaesthetic

Following surgery Moorfields hospital continued to see Owen as an outpatient for ongoing treatment. These appointments were documented in the reports submitted by Moorfields to this review. On the 13th December 2021 Owen was taken by his carers to an appointment with the Glaucoma service, views were taken of the inside back surface of both eyes. The left eye was clear, but in the right eye there was some clumps of vitreous haemorrhage on the right disc.
At a follow up appointment on the 10th January 2022, it was noted that there was right eye corneal abrasion after surgery, which was healing, and good eye pressures were noted in both eyes. Recording from Moorfields indicates further outpatient appointments, at which concern was expressed relating to Owen's vision. At the appointment with the Glaucoma service on the 7th February 2022, it was noted that he appeared to have no light perception in either eye. The notes record that medication would now be given to make Owens eyes comfortable rather than to preserve vision. At this appointment Owen was largely unable to cooperate, keeping his eyes shut.
At the outpatient appointment held on the 23rd May 2022, the record submitted to this review, notes –
Patient referred to Moorfields with no vision, and eye closure most of the time, and a Brunescent right cataract. Removing this cataract has not helped his vision. He has had vitreous in the front of his eyes suggesting historic oculodigital trauma: blindness characterized by repetitive rubbing of the eyes with fingers or the hands. It is likely that due to the high eye pressures (glaucoma) which were not treated and has taken away his vision also caused eye-rubbing (when Owen has tried to get some vision back by rubbing his eyes) that has caused the vitreous findings.

A further note records concern by Moorfields as to the circumstances of the referral being made to them, which was late presentation with a Brunescent cataract despite previous visits to external optometry services where normal findings took place.

d) When is a concern a safeguarding concern?

The Safeguarding Framework for protecting Adults and the requirements of the Care Act 2014 set out very clearly the responsibilities of all agencies in the protection of vulnerable adults. It requires those involved to make enquiries, gather information and to share information as a key strand of good practice. The case of Owen took a long time to come to the attention of the Safeguarding Adult Board. Two Safeguarding Enquiry meetings were set up by the Community Team for People with

Learning Disability – they are referred to in section 4 of this report. Neither meeting could proceed because of significant gaps in the information provided by the store that had dealt with Owen.

The Care Act emphasises the need to empower people, to balance choice and control for individual adults against the need to prevent harm and reduce risk, and to respond proportionately to safeguarding concerns. The Act, under section 45 sets out the responsibility of all professionals to comply with requests for information made by the Safeguarding Board for the purposes of conducting enquiries, and yet gathering information from the optician who saw Owen on this case has been impossible.

The situation of concern was not escalated to the person with responsibility for professional standards within the optician chain because it was not seen as a safeguarding matter.

Regulations under the Care Act also place a duty of candour on all service providers registered with the Care Quality commission The duty is designed to ensure transparency and honesty when things go wrong, this sits alongside the focus of this Review which is to learn when things do not go well and to improve practice as a result.

In this case there has been significant reliance on the contribution from people from the store attended by Owen and from those at Head Office for the chain, neither of which were involved and who have shared information from records that are at odds with other records, and which are in parts incomplete.

It is clear from evidence to the Review that the new Director/Practice Manager, recognised the seriousness of the correspondence sent to the practice on this case, and that he made attempts to discuss it with the previous owner. The Review has attempted to explore this further, and it is clear that despite a suggestion from the previous owner that he had responded to correspondence, there is no evidence to support this.

In considering the case of Owen the Board noted that Owen had very specific vulnerabilities as a consequence of his disability. We considered that neglect is not just an act of commission, but also omission, and that it is reasonable and proportionate to expect that the significant deterioration in Owen's sight between May and August 2021 would have triggered a safeguarding alert to have been raised.

7. Good practice identified

7.1 It is important to note that many practitioners offer a good level of service to their clients/patients and that they follow the policies and guidance that are provided to guide practice. Whilst recognising learning when things do not go well, Safeguarding Adult Reviews can also provide evidence of practice that goes over and above what is expected. Attendees at the practitioner review group were asked to contribute from their own and other agencies involvement areas that they considered had gone well.

7.2 The following was identified as areas to note.

- Owen was well settled in his accommodation since 2001, 22 years in the same accommodation was viewed as offering him considerable security and stability .
- The staff know him well, they describe his personality, his quirks and his behaviour with significant detail and records indicate a high level of person centered care.
- There was good continuity of nursing care within CTPLD.
- There was strong and vocal advocacy for Owen following his loss of sight.
- There was good communication between Moorfields Hospital and his carers.

7.3 The above good practice is important to note and recognises the systems and practice improvements that the multi-disciplinary teams working in Learning Disability services have been driving forward.

8. Analysis of professional Practice

8.1 This Review has found that with the right support Owen had, prior to this incident been able to live a fulfilling and active social life, manage his physical health needs and live semi independently in his accommodation since 2001. While there have been concerns regarding Owen over the years, these have largely been resolved with the support and care of staff at his home and with the engagement of his brother.

8.2 Considering all of the reports submitted as part of the Review process, the discussion at the practitioner event and the interviews conducted in order to complete this Review, it is clear that this Review stems from the failures in care by his high street optician in his routine appointment on 24th May 2021. This date is critical.

8.3 There is no doubt that enquiries have been hampered by the sale of the high street store in question and despite the best efforts from the incoming owner/practice manager it has been hard to piece together a first-hand account from the optician in question. We are aware that by September 2021 the practice was sold, enquiries requesting information to support this Review to the previous owner went unanswered. Indeed, it was not until the new owner took up the business reins that any level of response was received, the Review understands that it was he, who alerted Head Office of the Boards involvement and interest in the case.

8.4 The patient records that were left, were incomplete and left out key information relating to matters such as the prescribing and dispensing of glasses, it is hard to have absolute clarity about the sequence of events being anything other than that described by contributing agencies, namely the carers for Owen and the specialist ophthalmologist who saw him.

8.5 Capacity to understand, and application of reasonable adjustments

8.5.1 The Government Guidance "Eye Care and people with Learning disability …" published 27th January 2020 recognises that people with learning disability are more likely to have serious sight problems, but less likely to be able to successfully access eye care services than the general population. There is a legal obligation for eye care services to make reasonable adjustments to ensure that people with learning disability can access services in the same way as other people. This might include making practical adjustments to the environment or changes in the process.

8.5.2 A sight test is not just about prescribing glasses, it is also about assessing eye health and identifying sight threatening conditions that with treatment can be resolved or the impact lessened. In this case the store in question was contracted to provide NHS services, requiring them to follow the Accessible Information Standard. This Review has been provided with no evidence that any consideration was given at the store to assessing the capacity of Owen to make decisions about the tests to be carried out, that the tests were explained to him in a way commensurate with his understanding or that the carers who had known Owen for many years were asked to assist in the process of encouraging Owen's awareness.

8.5.3 What the Review has seen as recorded from the optician, from events at the May appointment that suggest a lack of cooperativeness from Owen and, carers that appeared vague in providing information. The latter point is directly at odds with the carer records.

8.5.4 What is a concern for this Review is the apparent failure of the optician, in the face of being unable to complete a full eye test, to recognise when to hand on the baton of care to a more specialist service to complete a full examination.

8.5.5 If indeed there was any recognition on the part of the optician, that the eye test itself on the 24th May 2021 was less that satisfactory. While the notes indicate that ophthalmoscopy was performed which detected a grade 1 cataract in the left eye- there are gaps in information provided to this Review. There is no reference for example to the prescribing of glasses, evidenced in the carer notes, no reference to the full range of eye tests that would reasonably be expected when testing, including tests for visual acuity, visual fields, retinoscopy, eye pressure monitoring or a full ocular health assessment.

8.5.6 If these were completed, they are not recorded and if they were not – then the Review asks the question why the baton of care was not handed on to a specialist who might have been able to use other techniques to accurately assess eye health. The challenges of learning disability and the resulting behavioural issues do not justify leaving key tests incomplete, without key answers as to the health of Owen's eyes and recording a finding of unremarkable, routine appointment in 2 years.

8.5.7 By the time Owen returned to the store on the 27th August, his sight had deteriorated considerably. The records again show no evidence of adjustments being made, however Owen was examined by Volk and slit lamp, revealing dense cataracts in both eyes. A referral to specialist secondary care was completed the same day.

8.5.8 There is little evidence from the notes on either visit of any consideration of Owen's capacity and ability to cooperate with his eye appointment or any sense of a discussion as to how best an examination might be conducted to ensure that his eye health was ok. This includes any consideration of passing on the baton of care to others following the May appointment.

8.5.9 In the interview conducted with the professional standards lead the reviewer was reminded that this incident sits in a context of a 50% share of the market and yet only 10% of Fitness to practice referrals.

8.6 The loss of sight experienced by Owen

This Review has had the benefit of seeing agency records and the reviewer has had an opportunity to speak to a consultant ophthalmologist as part of this Review. The referral was not marked urgent and was seen in the standard wait time of 18 weeks.

8.6.1 At the point of being seen by secondary specialist eye care general outpatients on the 19th October 2021 , it was noted that he had raised intraocular pressure in both eyes. He was referred to the glaucoma service where he was seen on 29th November and was listed for examination under general anaesthetic the following week , with the removal of a brunecent cataract on his right eye. This took place on the 7th December 2021 and while under surgery , surgeons noted that the left eye was already blind.

8.6.2 While under surgery blood pressure monitoring equipment failed and the hospital recorded a serious incident . The Review has considered the significance of this in relation to the onset of blindness for Owen . It is worth noting that before the incident occurred Owen had already lost sight in the left eye.

8.6.3 At the outpatient appointment on the 23rd May 2022, it was noted that despite surgery Owen's sight had not improved, and it was recognised that the constant rubbing of his eyes, possibly to improve his vision had caused oculodigital trauma.

8.6.4 They also found evidence that he had experienced high eye pressures which had been untreated which had likely exacerbated the constant eye rubbing. They also highlighted to this Review two other key issues , the pre surgery loss of sight in the left eye and the late referral relating to a brunecent cataract (which was thick and leathery).

8.6.5 This was unlikely to have developed in the right eye, (in which no cataract was observed at the May appointment in the local store) and where an appointment three months prior to referral had been documented as having normal findings .

8.6.6 What this Review has seen, is evidence that the appointment in May was not a full eye test or complete eye test in line with GOC standards and it is likely the right eye cataract was missed.

8.7 When is a concern a safeguarding referral?

8.7.1 It is clear from reading all of the evidence that this was not originally seen as a safeguarding matter. The report refers to the local optician not responding to requests for information, failing to alert the Head Office but it was not discussed with the safeguarding team or the secondary care provider either. To be fair these cases of neglect by omission, when someone has acute vulnerabilities are challenging, but they must be seen alongside both the existing needs for care and support and the impact that failure to act has on the individual's quality of life.

8.7.2 In this case it is profound, impacting on an individual who has lived successfully in semi-independent accommodation for 22 years in such a way that the ability for that arrangement to continue has been discussed and debated by those professionals working with him. Owen lost his confidence, his demeanour changed, he has needed additional care support losing aspects of his independence and his ability to do many of the things he did before.

8.7.3 This Review has highlighted the nature of safeguarding concerns in acts of omission, and it is the view that there is whole system learning – that needs to be reinforced with all agencies. All too often in safeguarding the focus is on something that has been 'done' to an individual as opposed to something being missed when it would reasonable be expected to have been done.

8.7.4 The Review has also highlighted that there was no 'Fitness to Practise' referral completed for the optician in this case. This was completed by the Review author rather than by any line manager or supervisor. The standards set by the GOC set out both behaviour and performance expected. It was the view of the author of this Review that this was a case that should as a minimum be investigated in view of the potential wider public interest and the need to ensure safety.

8.7.5 The expectation is that the head of professional standards would do this, when the safeguarding concern relates to a store manager/director who is also the professional in question relies on that individual reporting this. In this case that did not happen. The store was being sold, a new owner was coming in and, in that situation, safeguarding concerns, both to provide records and to share concerns was not acted upon diligently and as required by the guidance.

8.8 The model of care

8.8.1 The Review has seen significant evidence forwarded by the optician chain that there are clear procedures, guidance and policies in place that cover the aspects of this case. This includes.

- A clear policy framework on safeguarding both adults and children
- A clear policy on Mental Capacity and Deprivation of Liberty
- A framework to guide reasonable adjustments.

8.8.2 However, the success of a policy framework is only as successful as the ability of the professional user to apply them. The Review recognised the model of business and the responsibilities of the directors and store managers to implement a quality assurance framework that monitors day to day practice and ensure supervision to practice standards . However, the company information supplied to this Review states.

The Company will:

f) Ensure that all practice staff are familiar with the guidance (https://www.abdo.org.uk/regulation-and-policy/advice-and-guidelines/regulatory/oc-guidance-on-safeguarding-g-mental-capacity-deprivation-of-liberties-and-the-prevent-strategy/) and know what to do if they suspect and observe signs or symptoms of suspected abuse or neglect, so that they are compliant with Level 1 Intercollegiate Guidance for Safeguarding adults (2018) and Children (2019).

g) Ensure each optometrist has completed the DOCET Level 2 accredited[1] 'Safeguarding Children and Safeguarding Vulnerable Adults' training modules (funded by the Department of Health via the College of Optometrists) and submitted evidence to the Company.

h) *Comply with local safeguarding, mental capacity and deprivation of liberty policies including any updates required in line with multi-agency policies and the commissioner's safeguarding requirements.*
i) *Ensure all optometrists are aware of and adhere to the relevant College of Optometrists and Optical Confederation guidelines.*

The Company's Safeguarding, Mental Capacity Act and Deprivation of Liberties Policy will be reviewed annually and amended in order to comply with evolving local multi-agency policies and commissioner safeguarding requirements.

8.8.3 What is clear in completing this Review is that the company has no mechanism to **ensure,** compliance. The model of business - where there is a director and store owner who can measure the effectiveness of their staff, falls short when the director and store manager is also the practicing optician.

9. Conclusions and Learning

9.1 This SAR Report is the Ealing Safeguarding Adults Board's response to the loss of sight for Owen, to share learning that will improve the way agencies work individually and together.

9.2 Owen has a range of complex issues linked to his learning disability, all of which he has weathered and has achieved a positive quality of life in a very stable home environment.

9.3 The situation changed dramatically following the visit to a routine eye appointment on the 24th May 2021. That appointment resulted in Owen being offered a follow up in two years it me and was recorded as normal.

9.4 Some three months later on the 27th August 2021 he returned to the opticians having experienced significant difficulties with his sight. As a result of seeing a different optician he was referred to secondary care. On the 7th December 2021 under anaesthetic his left eye was noted to be blind and despite the removal of a cataract on his right eye, Owen was eventually registered blind on the 23rd February 2022.

9.5 In the months between his operation in December and being registered blind in February Owen experienced a confusing and distressing time. The impact on his quality of life has been significant.

9.6 The findings of this Review are that if Owen had received a more thorough examination on the 24th May 2021, or if the optician had recognised that completing such an examination was impossible given Owens behaviour and that he needed to involve secondary care the outcome may have been different. Access to a timely intervention to assess both eye pressures, and the development of cataracts may have facilitated an improved quality of life or a different outcome.

9.7 It is hopeful that the outcomes from this Review will enhance and sustain support for people with learning disabilities and their carers. The findings and recommendations should be monitored for compliance, implementation, and assurance by the Safeguarding Adult Board and a clear action plan drawn up to implement the changes proposed. This should be led by the Practice Review and Audit group.

9.8 Advocacy for Owen is an issue in any discussions to compensate for the changes in his quality of life as a result of these events. This should be taken forward by those working closest to him and discussed with the family .

10. Points to initiate change for consideration.

1. **Consideration should be given to improving the quality of information made available to health practitioners on an individual with Learning Disability's health. SeeAbility produce a range of information that is helpful.**
2. **Recording that is accurate, complete, dated and signed by the practitioner should be a standard in recording in ALL health records and in this case the private provider should remind store directors and practitioners of their responsibilities and of the standards set by the GOC.**
3. **The provider should complete a learning session with providers in the group on this case in order to recognise and explore.**
    a. **How reasonable adjustments should be made in order to complete an eye examination of an individual with Learning Difficulties**
    b. **How steps should be taken to engage carers**
    c. **At what point they should recognise the limitations they have in conducting an eye examination of an individual with Learning difficulty and how they pass on the baton of care safely**

    The aim of this session should be to develop learning resources that can be rolled out across the chain.

4. **The Board should receive assurance that this has been done and of the outcomes and actions taken**
5. **The ESAB may wish to remind all practitioners that safeguarding concerns are not just acts of commission but encompass acts of omission also.**
6. **The provider needs to consider the use of the word 'ensure' in relation to its policies and compliance, with particular reference to how it can exercise that role effectively and diligently when there is a concern regarding the practice of a store director.**
7. **The Board should consider making this report available to the GOC to assist with their enquiries.**
8. **The Board should also make this report available to the Commissioning Team for optical services at NHSE so that they are fully aware of the concerns**

Appendix 1 Glossary and explanation of terms

TERM	EXPLANATION
ASC	Adult Social Care
GP	General Practitioner
CTPLD	Community Team People with Learning Difficulties
GOC	General Optical Council
ICB	Integrated Care Board
LNWH NHS	London North-West Hospital NHS Trust
MCA	Mental Capacity Act
MDT	Multi-Disciplinary Team
ESAB	Ealing Safeguarding Adults Board
SAR	Safeguarding Adult Review
WLNHST	West London NHS Trust