



**Bracknell Forest and
Windsor & Maidenhead**
Safeguarding Adults Board

BRACKNELL FOREST SAFEGUARDING ADULTS PARTNERSHIP BOARD

SAFEGUARDING ADULTS REVIEW REPORT

Mr EF – aged 71 years

This SAR was originally commissioned by Bracknell Forest Safeguarding Adults Partnership Board but was completed and published after the board had joined with Windsor & Maidenhead to form the Bracknell Forest and Windsor & Maidenhead Safeguarding Adults Board. For this reason, you may find references to both boards within this report.

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1. Introduction

- 1.1** The purpose of this report is to describe the process and outcomes of a Safeguarding Adult Review (SAR) carried out into the circumstances around the death of an individual, Mr. EF, who was receiving care, treatment and support from organizations in the Bracknell Forest area. Although Mr. EF's complex needs appear to have been met well during most of his lifetime, over his final months he experienced numerous episodes of ill health and falls which caused injury and required admission to hospital. Concerns were raised about the way in which services were provided to him and whether individual practitioners and organisations worked together effectively to ensure Mr. EF's safety and wellbeing. A Safeguarding Adults inquiry was held but the outcome was inconclusive due to lack of evidence. Whilst many good assessments were carried out and acted upon, there was a lack of co-ordination and the absence of a process for obtaining resources to meet additional identified needs, including those arising from end of life. This meant that Mr. EF may not have received the support he needed, nor was he cared for in the most appropriate setting, during his final months.
- 1.2** Bracknell Forest Safeguarding Partnership Board is responsible for considering whether the circumstances reported to them meet the criteria set out in the Care Act 2014 under Section 44 to hold a Safeguarding Adult Review. This states that 'Safeguarding Adult Boards must arrange a Safeguarding Adult Review when an adult in its area dies as a result of abuse or neglect or has not died, but the Safeguarding Adult Board knows or suspects that the adult has experienced abuse.' The decision was taken that the criteria were met. In this case, Mr. EF had died of natural causes but the circumstances gave rise to concerns that there may have been failures in the systems that supported him.
- 1.3** The Review must be carried out in accordance with Bracknell Forest Safeguarding Adult Partnership Board's Multi-Agency Safeguarding Adults Policy and Procedures <https://www.berkshiresafeguardingadults.co.uk/bracknell/> Each partner organization must co-operate in and contribute to the carrying out of the Safeguarding Adult Review. The aim is to identify the lessons learnt from the specific case and to apply these to future cases to prevent such circumstances occurring again.

2. Background Information to Safeguarding Adults Review

- 2.1** Mr. EF was 71 years old and had complex health and care needs, including a severe learning disability, severe challenging behavior and autism. He had many other physical health conditions, including a risk of choking, which required a high level of support to meet his needs from early childhood.
- 2.2** Mr. EF was able to make simple everyday decisions, such as choice of clothes or drinks, but had been assessed as lacking mental capacity for decisions on more significant matters. Bracknell Forest Council (BFC) was authorized by the Court of Protection to act as his Deputy for property and financial affairs in 2011 as he lacked the mental capacity for these decisions.
- 2.3** Mr. EF's parents died some years back and he had not been in contact with other family for many years.
- 2.4** Mr. EF was described as a great character with mischievous, emotional and sensitive qualities. He loved trips and festivities, especially ice cream, balloons, birthdays and Christmas. He understood basic words and commands and had some limited ways of communicating verbally and using his

own sign language. He formed close relationships with the staff looking after him and they were able to communicate with him, able to understand and meet his needs and to empower him to take decisions over daily matters.

2.5 This Review covers the time period from April 2015 until Mr. EF's death on 13 July 2016. During this time, his health deteriorated significantly. South Central Ambulance Service was called on 13 occasions and 10 admissions to hospital were made on an unplanned emergency basis. Following one of these admissions, South Central Ambulance Service raised a Safeguarding Adult Concern to the Local Authority that Mr. EF had an unexplained bruise to his right arm and was refusing to eat, drink or take his medication, leading to concerns about possible abuse and/or neglect. The Safeguarding Adult investigation process was concluded as unsubstantiated.

2.6 It was agreed to initiate the Review in March 2017 and to carry it out over a six-month period.

3. Terms of reference

3.1 The full Terms of Reference for this Review are attached (Appendix 1)

3.2 The guiding principles for a Safeguarding Adult Review are as follows:

- There should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice;
- The approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined;
- Reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed;
- Professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith and
- Families should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.

3.3 An Independent Facilitator was commissioned to lead the process and to write a short report. She had no previous involvement with health and social care organisations or individual practitioners in the Bracknell Forest area and has appropriate skills, experience and qualifications to carry out this process.

3.4 A Safeguarding Adult Review Panel was set up to oversee progress and conduct the work, with business support provided through Bracknell Forest Safeguarding Adult Partnership Board. This was chaired by the Independent Facilitator and included members from the key organizations involved:

Bracknell Forest Council Community Team, Physical and Learning Disabilities (CTPLD)
Berkshire Healthcare NHS Foundation Trust
Hightown Housing Association (Radian Support, prior to 1 July 2016) - the Provider
Bracknell Forest Council Adult Safeguarding Team.
Frimley Park Hospital
Continuing Healthcare Team, Bracknell and Ascot Clinical Commissioning Group
GP (supported by Clinical Commissioning Group)
South Central Ambulance NHS Foundation Trust
Bracknell Forest Adult Safeguarding Partnership Board

3.5 Methodology

There is a range of methods for conducting a Safeguarding Adult Review and it is the responsibility of the Panel to determine which method suits the case best, ensuring that it is proportionate and appropriate to the situation and makes effective use of resources. For the situation in respect of Mr EF, the Panel chose a modified version of a *significant event analysis*, with the additional requirement of an Individual Management Report and Chronology, or timeline, from each organisation. An Individual Management Report is a report of the organisation's involvement with the case, with identification of areas of concern and recommendations to improve. This methodology was selected in order to increase collaboration and bring agencies along with the Panel throughout the review.

The Chronologies, Individual Management Reports and recommendations for action were presented for discussion and analysis in a facilitated workshop style session, incorporating mutual challenge, and identifying learning at all levels and across all organisations.

The Individual Management Reports were written according to the principles set out in the standard terms of reference, Appendix 5 of the Bracknell Forest Adult Safeguarding Partnership Board Safeguarding Adult Review protocol, with the addition of specific lines of enquiry.

3.6 Specific Lines of Inquiry

These lines of inquiry were agreed by the Panel as points of focus and are used to structure the analysis of the case.

1. Facts of the case. Chronology of key events and relevant agency contacts to be submitted separately.
2. Mental Capacity.
3. Assessment, diagnosis and interventions.
4. Care Setting.
5. Inter-agency communication and roles.

3.7 Timescale for Review:

- a. Panel meeting to finalise process and timescales (15 May 2017)
- b. Chronologies to be submitted (19th June 2017)
- c. All Individual Management Reports to be submitted (26th June 2017 midday)
- d. Workshop to discuss Individual Management Reports (04th July 2017)
- e. Panel to discuss first draft report (8th August 2017)
- f. Final Draft Report submitted by Chair (30 September 2017)

3.8 Bracknell Forest Adult Safeguarding Partnership Board will publish the report and its recommendations in anonymous form once it has been agreed. The report will set out whether there are lessons to be learned about how practitioners and agencies worked together and individually, and how practice will change to improve outcomes for people. This will include identification of practice being shown to have a positive impact for Mr EF and of failings (at practice and organisational levels), which had a detrimental effect on his health and wellbeing.

3.9 The time period to be covered by the review is April 2015 to date of Mr EF's death on 13 July 2016.

3.10 Mr EF did not have contact with his family over recent years. His parents were both deceased and there was no contact with other relatives. Bracknell Forest Council located his sister in order to notify her of his death. Whilst it was understood at that time that she did not want to be involved further, the Panel decided that the Chair should write to her to inform her that a Safeguarding Adult Review had been commissioned and to invite her to participate according to her choice. No response was received to this correspondence and it was assumed that she did not wish to have any involvement.

Although Mr EF did not have family contact, he formed close relationships with his Support Workers in the organisation providing him with care and support. T Mr EF developed close emotional attachments to his support workers. The organisation has participated in this Review and concerns are explored as to whether sufficient credence was given to these relationships in making decisions as he approached the end of his life.

4. **Case Summary: The Facts**

4.1 This account has been collated from the Individual Management Reports and chronologies submitted by the organizations involved. The information provided is very detailed and this account attempts to identify the key events and issues arising.

4.2 Mr. EF was 71 years old with a very wide range of needs. He had a diagnosis of a significant learning disability, autism and severe challenging behavior. He had communication difficulties, being primarily non-verbal and was receiving help from Speech and Language Therapy. He had a risk of choking. He had childhood epilepsy but, apart from one seizure in 2007, he did not have any other seizures until the last few months of his life. He had other complex co-morbidities including congenital right talipes, cataracts, osteopenia, chronic anemia, vascular eczema, atrial hypertension and chronic atrial fibrillation.

4.3 Mr. EF needed help with every aspect of daily life, including all personal care. These needs had been met successfully in the same placement for ten years, although the nature of the care setting changed from residential care to Supported Living in 2010. Mr. EF held his own tenancy and shared the

property with three other residents with similar needs. The four residents shared 'core' staffing levels comprising two staff during the day from 07:00 to 22.00 and one waking night staff. Mr EF also received 42 hours per week one to one support to manage his behaviours. This included aggression towards others and self-injury. Accessing the community and going out in his car assisted by Support Staff decreased the behaviours. Mr EF had a particular bond with two of his support workers whom he had known for many years but related to other staff well as skills in understanding his communications and needs were shared within the team.

- 4.4** Mr. EF became eligible for Continuing Healthcare in March 2010 and the NHS Bracknell and Ascot Clinical Commissioning Group funded his care until he died. NHS Continuing Healthcare is the name given to a package of care arranged and funded solely by the NHS for individuals outside of hospital who have on-going health care needs. NHS Continuing Healthcare is free, unlike support provided by local authorities for which a financial charge may be made depending on income and savings. Those eligible for NHS Continuing Healthcare in their own home will be provided with health care (e.g. services from a community nurse or specialist therapist) and associated social care needs (e.g. personal care and domestic tasks, help with bathing, dressing, food preparation and shopping).
- 4.5** Mr. EF received a high level of support regarding his physical health needs. This included creams applied to the eczema on his legs, eye drops following his cataract surgery and administration of sixteen medications and creams. The Provider acted on warning signs that his health was deteriorating and contacted his GP and other health professionals appropriately. Examples included changes in his temperature, blood in his urine, concerns about his mobility and food and fluid intake. This needed specific vigilance as Mr. EF had polydipsia, excessive thirst. His daily routine and environment were considered carefully to maximize his quality of life in consultation with a behavior specialist. He also had regular appointments at four monthly intervals with a Learning Disability psychiatrist in a local clinic to review his health and medication. A Support Worker always accompanied him from the Provider at each medical appointment.
- 4.6** Mr. EF had access to the same range of health assessments and interventions as other people of the same age e.g. a podiatrist visited him at home regarding foot ailments; a routine optician's appointment on 10 March 2015 led to cataract surgery on 26 June 2015; he was given a flu jab on 19 November 2015 and vaccination against shingles was discussed with the nurse. He received timely and adequate responses from Primary Care; the GP showed sensitivity to Mr. EF's needs, seeing him in the car park on one occasion to allay his anxiety and made frequent visits to him when he was unwell. Timely onward referrals to specialists were made as required, chasing these up as necessary e.g. Urologist on 23 February 2016. Staff from CTPLD also visited regularly to review aspects of his care.
- 4.7** The Community Team for People with Learning Disabilities (CTPLD) is an integrated health and social care service employing both health and social services staff. It consists of social workers, nurses, Physiotherapists and Occupational Therapists. This team provide assessment, monitoring and review for people with a learning disability in the Bracknell Forest area. The Clinical Commissioning Group commissions their service to provide Case Management for identified individuals with a Learning Disability who are receiving continuing healthcare funding. There is evidence of very frequent contact and communication between Mr EF and the team on a wide range of matters regarding his wellbeing. It should be noted that this 'team' did not have access to a single information system which made working together problematical and caused difficulties in piecing together the sequence of interventions made by the team for the purposes of this Review.

- 4.8 Mr EF appears to have been supported to lead a fulfilling and independent a life within the significant constraints of his multiple conditions until his health started to decline over the last few months of his life. This led to increased difficulties for him in mobilizing as his health became frailer. The Community Team for People with Learning Disabilities made frequent visits to him at home, keeping him under constant review. Their physiotherapist assessed on 13 January 2016 that he was 'at high risk of falls' and ordered a Zimmer frame, commode and profiling bed for him. A joint visit with an Occupational Therapist was made on 18 January 2016 to assess his support and risks and to ensure that all necessary equipment was in place. A hoist was delivered in April 2016. His gait was described in April 2016 as slow and shuffling with difficulty in turning and frequent falls. These falls led to a number of admissions to A and E where several fractures were identified.
- 4.9 Mr. EF's long-term health conditions required medication and regular monitoring through specialist outpatients clinics at Frimley Park Hospital. This required five appointments during the period under review, to Dermatology, Haematology and Urology. He also had conditions associated with older age, notably cataracts in both eyes (which required five outpatient appointments, including one for surgery, between 14 April and 21 July 2016).
- 4.10 The chronology and report provided to this Review by South Central Ambulance Service provides evidence of many thorough assessments on which decisions to provide home treatment or conveyance to Frimley Park Hospital A and E were based. South Central Ambulance Service attended Mr. EF on 13 separate occasions between 11 January 2016 and his death on 13 July 2016. They transported him to Frimley Park Hospital Accident and Emergency ten times. On four of these occasions, he was assessed, treated and discharged home. On the other six occasions, he was admitted and spent more than 50 days as an inpatient. South Central Ambulance Service also assessed and treated Mr. EF at home themselves on three further occasions and provided support and advice to Provider Staff once by telephone after they called 111, a service operated by South Central Ambulance Service.
- 4.11 A brief summary of the reasons for his Accident and Emergency admissions follows, compiled from chronologies supplied by Frimley Park Hospital and South Central Ambulance Service Interventions at home by South Central Ambulance Service (SCAS) are in plain type; hospital admissions in **bold** and admissions with discharge the same day in *italics*.

7 Jan 2016	Treatment at home by SCAS after pushing staff member followed by fall and hitting head on door frame.
9 Jan 2016	Treatment at home by SCAS after legs buckling and bleed from mouth
11 Jan 2016	<i>SCAS transported to A and E following period of being unwell and painful elbow and head after fall. Same day discharge.</i>
22 Jan 2016	SCAS transported to A and E after seizure. 4 day admission
31 Jan 2016	SCAS transported to A and E following significant deterioration in health. Diagnosis of aspiration pneumonia. 4 day admission.
06 Feb 2016	SCAS transported to A and E following difficulty in waking – aspiration pneumonia and other conditions. 11 day admission.
19 Feb 2016	SCAS transported to A and E following reduced consciousness episode. Diagnosis urinary retention. 3 day admission.
27 Mar 2016	SCAS responded to 111 calls following missing medication (iron replacement)
16 April 2016	<i>SCAS transported to A and E with chest pain and increased respiratory rate. Diagnosis of fractured fourth rib. Same day discharge.</i>
17 April 2016	SCAS transported to A and E. Gradual decline, poor oral intake. Parkinson's symptoms, dehydration, healing rib fractures. 25 days admission.

17 May 2016	<i>SCAS transported to A and E as refusing medication, fluid and food. He was very agitated. Same day discharge.</i>
16 June 2016	Treatment at home by SCAS following trip and hitting head.
17 June 2016	SCAS treated Mr. EF at home following unwitnessed fall and cut to head. Transported to A and E as suffering from heart failure and atrial fibrillation. 5 day admission.
11th July 2016	SCAS transported to A and E following unwitnessed fall and eyebrow laceration. Fractured scapular, clavicle, multiple ribs and pleural effusion. Respiratory distress. 2 day admission prior to death.

4.12 South Central Ambulance Service considered 3 of the 13 incidents in which they were involved to be potential Safeguarding Adults concerns. On 7 January 2016, following a call from the Provider, a delay in obtaining information about medication out of hours caused concern about possible abuse. This did not lead to a Section 42 Safeguarding Adult Enquiry as the Designated Safeguarding Manager to whom it was reported worked with the Provider to resolve accessibility of this information.

A second concern arose on 27 March 2016 when the Provider reported a missed medication dose to the South Central Ambulance Service 111 service seeking advice. This did not lead to an Enquiry either as the missed medication was not deemed to be life threatening and the Provider contacted the GP for advice after speaking with South Central Ambulance Service. The Support Worker concerned was suspended from administering medications also.

The third concern did lead to a Safeguarding Adults Enquiry following a report on Monday 18 April 2016. The Provider to Mr EF, who was not eating, drinking or taking medication, called out the Ambulance crew on Saturday 16 April. Staff also suspected he was experiencing chest pains. The South Central Ambulance Service report stated that he had no 'oral and fluid intake and believed this may have been self-neglect and a sign of asking for help; concerned that he had a bruise on his right arm consistent with human handgrip.' They expressed concern that he was being manhandled.

An examination in Frimley Park Hospital Accident and Emergency Department showed that he also had a fractured left rib. The hospital did not raise this as a Safeguarding Adults matter to the Local Authority.

The hospital discharged Mr EF on the same day (16 April 2016). He remained unwell during 17 April. The out of hours GP was called and the ambulance service arranged to transport him back to Frimley Park Hospital once more on 17 April 2016

A Safeguarding Meeting was held on 22 April to consider allegations of physical abuse, the bruise and the fractured rib, and an allegation of discriminatory abuse, a perception that Mr EF's medical conditions were not being addressed in hospital.

The participants included the Chair, Local Authority Designated Safeguarding Manager and Safeguarding Assessor, Minute taker, Occupational Therapist and Community Nurse from Community Team for People with Learning Disabilities, Consultant Psychiatrist, Locality Manager and Service Manager for the Provider and Mr EF's Advocate.

Prior to the meeting, the Designated Safeguarding Manager and the Safeguarding Assessor had requested the home to carry out certain actions to look into the alleged physical abuse. The Provider Manager had scrutinised the reports provided and a body map dated 15 April, which showed a

small dark bruise noticed by the two staff supporting Mr EF with personal care. No reason could be identified for the bruise through a search of the home.

At the meeting, the Community Nurse queried whether the bruise resulted from thrombocytopenia, a condition with which Mr EF had been diagnosed. The Occupational Therapist, who had worked with him for some time, identified that his mobility started to deteriorate in August 2015 and that he had osteoporosis, which may have contributed to the left-rib fracture. They also stated that his mobility levels were variable throughout the day and that he could not use a walking aid but held on to staff when mobilising, making it possible that this type of contact may have caused the bruising.

The meeting participants agreed that it was not possible to reach a clear conclusion about whether abuse had occurred to Mr EF and expected that clarity on these issues would be provided at a multi-disciplinary meeting arranged at the hospital for 26 April 2016

In regard to the allegation of Discriminatory Abuse, concerns were made at the meeting about Mr EF's general health situation, the medications he was on and the hospital discharge procedures he experienced; it was acknowledged by the Community Nurse that he was probably discharged because there was no apparent medical reason to keep him in hospital. It appears that many people at the meeting felt that they did not have enough information about the causes of his poor health. It was expected that the meeting for 26 April would add clarity to these matters.

The meeting held on 26 April 2016 at Frimley Park Hospital was recorded as a Multi – Disciplinary Team meeting. The participants included the responsible Consultant, Ward Manager, Provider Managers, Community Nurse and Care Manager. The Consultant clarified the medical situation, but did not consider it was responsible for Mr EF's decline although further investigations would continue. He did not consider his blood condition would cause sensitivity to bruising. Mr EF was deemed fit for discharge and discussions about appropriate equipment and additional staffing took place to be pursued by the Community Team for People with Learning Disabilities.

There was discussion at the meeting about current medication and the historical medication background that Mr EF had experienced throughout his life; causing some side effects, which were affecting him holistically, way and which may be connected to his injuries and falls. The side effects of medications might also be interconnected with each other and affecting him. It appears that the Multi-Disciplinary Meeting did resolve some questions about the medications arising from the previous meeting but not about the reasons why Mr EF was becoming frailer. It did not provide any answers in terms of the safeguarding allegations raised either. The decision was made by the Designated Safeguarding Manager that, based on the information gathered by the home and the Safeguarding Assessor on looking into the allegations, on the balance of probabilities and acting proportionately, it was not possible to reach a conclusion about the bruise and the fractured rib therefore the Safeguarding Adults outcome was unsubstantiated.

- 4.13** The notes record considerable activity from the Community Team for People with Learning Disabilities around this period in connection with the deterioration in Mr. EF's health and his frustration around his inability to do what he wanted to do. Every day was different as his needs changed and fluctuated. Many concerns were expressed by the social worker in particular regarding Mr. EF's health, fears of early discharge and some lack of confidence in the hospital. He remained in hospital for more than three weeks on this occasion, as he was not deemed medically fit for discharge. A suitable wheelchair was delivered to him when he arrived home, after some delays. The Provider drew up a support plan to take account of his increasing needs. This was sent to the Community Team for People with Learning Disabilities and forwarded to the Clinical Commissioning Group in accordance with the expectations at the time.

- 4.14** Mr. EF was admitted to hospital again on 11 July 2016 via Accident and Emergency following a fall and was moved on to the Surgical Acute Dependency Unit at Frimley Park Hospital. He became increasingly unwell, requiring sedation to tolerate an oxygen mask. A 'Do Not Attempt Resuscitation' Order was put in place. A request for an Independent Mental Capacity Advocate was made, but not in time for one to attend. Provider staff attended the ward three times on 11 and 12 July 2016 to provide continuity of care for him and familiar faces. Sadly Mr. EF passed away at 15.35 on 13 July 2016. He passed peacefully, with someone with him at all times. His support workers were not aware of his imminent death and staff arrived after the event. It caused distress and concern to care staff that he died without people known to him by his side.
- 4.15** The Coroner recorded the causes of death as 1) a) Pneumonia with large pleural effusion b) Multiple rib fractures and 2) Cardiac failure, Atrial Fibrillation and Severe Learning Disabilities.

5. Analysis

The analysis was carried out under the headings for the Individual Management Reports as set out in the Terms of Reference. The specific issues and questions given for consideration are included under each heading.

5.1 Mental Capacity

Specific Line of Inquiry:

Was Mr. EF's mental capacity assessed in relation to specific decisions and documented in line with MCA 2005 and agency guidance?

What was the quality of the recorded assessments and responses to identified issues?

Were the needs, wishes and feelings of Mr. EF taken into account appropriately?

Were end of life decisions made appropriately, including DNAR?

Were care staff involved appropriately in decision making in view of absence of family?

- 5.2** The recording systems utilized by the Community Team for People with Learning Disabilities addressed Mr. EF's mental capacity in two Occupational Therapy reports dated 12 November 2015 and 16 May 2016 which state that he: 'lacks the mental capacity to make any decisions that are not concrete and based on the here and now. He can make simple choices e.g. between two types of drink. He will request what he wants through a mixture of signing, hand gestures, and single words understood by his staff team'.
- 5.3** Bracknell Borough Council assessed that Mr. EF did not have capacity to make decisions about property or finance when the residential home in which he lived de-registered. The Court of Protection in order for them to manage this on his behalf and to sign his tenancy agreement granted deputy status in 2011.
- 5.4** The GP surgery considered Mr. EF's mental capacity at key points in his care and treatment. Reviews of his capacity to make decisions around medicines and immunisations are recorded. In addition, a more formal capacity review was undertaken in 24 May 2016 by the Psychiatrist, concluding that he did not have the ability to understand the effects of his medication and that it needed to continue to be administered to him in his best interests.

- 5.5** The Provider reports that simple, every day decisions at home were managed by offering as much choice as possible. There were two significant decisions to be made regarding Mr. EF's health care and treatment during the review period where he did not have the capacity to consent.
- 5.6** The first related to the need for a general anaesthetic to undertake an eye examination prior to cataract surgery. On 8 May 2016, his Consultant signed the correct hospital form 4, for adults who lack the capacity to consent to treatment. The decision was discussed with the Support Worker accompanying Mr. EF and was documented. However, it was not decided to instruct an Independent Mental Capacity Advocate. This service is able to provide an independent safeguard to people who do not have capacity to make independent decisions, including decision for serious medical treatment, and who have no other person to support them apart from paid staff. The Mental Capacity Act Code of Practice does not give a definitive list of 'serious medical treatments' and it is up to the clinician responsible for the persons' treatment to consider the implications of what is proposed and to decide if the consequences are serious for that person. The Independent Mental Capacity Advocate can then support and represent the person who lacks capacity. Cataract operations are not considered by Frimley Park Hospital to be 'serious medical treatment' and an Advocate was not instructed to represent him. On reflection, the hospital considers this should have been done. However, there remains a view in the Individual Management Report that the cataract surgery would have taken place anyway as it was in his best interests and was successful when viewed retrospectively. However, this is not in the spirit of the Mental Capacity Act.
- 5.7** The second decision was the Do Not Attempt Resuscitate Decision taken on 11 July 2016. This sort of order is a record in the patients notes, shared with others as appropriate, that Cardiopulmonary Resuscitation should not be attempted. It is not a legal term and there can be confusion about it. In this case, it refers to a clinical decision made on behalf of a person who lacks capacity, made at the time in discussion with family if possible, and in the person's best interest. (It is not the same as an advance decision made by a person when they had capacity, which is binding on the clinicians involved). The legal position regarding of people without capacity is governed by the Mental Capacity Act and requires clinicians to assess what is in their best interests and act in accordance with that decision. In doing this, they need to consider what the person might have decided had they had capacity i.e. their past and present wishes, beliefs and values. In addition, if the decision is being made for a person who lacks capacity at the time the Do Not attempt Resuscitation order is being considered, the clinician must take into account 'anyone engaged in caring for the person or interested in his welfare'. The notes should describe the grounds on which the order is made. An Independent Mental Capacity Advocate was instructed in this situation as the decision to be made was clearly serious but it was too late for them to attend before Mr. EF died. This Service is not an emergency service and it is suggested that the referral should have been considered at an earlier stage in Mr. EF's treatment by medical staff.

According to the hospital, the decision with respect to Mr. EF was discussed by doctors from Accident and Emergency, Intensive Care Unit and Medicine and was signed by two doctors, noting that the decision had been discussed and agreed with his Provider during a telephone call. This process would appear to follow the requirements of the Mental Capacity Act. However, the Provider Manager does not agree that this was the content of the telephone discussion, who stated that she had provided clarification to the hospital about the process they needed to follow to make a best interests decision. The Providers' explanation to the hospital clarified that it was outside of their remit as a provider to give consent for a Do Not Attempt Resuscitation decision

The lack of consensus about this process is concerning, particularly as it led to inaccurate information being given in the referral to the Coroner, which stated that the Provider had been involved in this decision.

5.8 The Mental Capacity Act 2005 (MCA) had been in place for over 11 years at the time of this situation. Although the requirements of the Act were considered and documented on a number of relevant occasions by the organisations looking after him, there is evidence from this Review that there were some shortfalls in making decisions of a significant nature. The needs, wishes and feelings of Mr. EF were not taken into account fully in decisions about his care, nor were end of life decisions made in discussion with appropriate people in the absence of family i.e. his support workers. An advocate would have added a voice for Mr. EF and ensured that his wishes were included in the decision making process. This could have been provided under the requirements of the Care Act 2014. A referral to the Independent Mental Capacity Advocacy service was not made in a timely way but was not actioned before Mr. EF died. It is concluded that the requirements of the Mental Capacity Act 2005 and related organisational policy are not fully understood or embedded in daily practice, especially in the acute hospital setting.

5.9 Assessment, Diagnosis and Intervention

Specific Line of Inquiry:

Were assessments carried out in a timely way to identify Mr. EF's changing needs?

Were they of sufficiently good quality to understand his needs, including risk?

Was monitoring and review in place?

Were his physical health needs correctly identified and robust responses provided and interventions delivered effectively in line with agency policy and practice guidance?

Were concerns escalated appropriately?

5.10 This section seeks to determine if the care plan, which was established originally to meet needs associated with Mr. EF's learning disability and behavioural needs primarily, was adjusted appropriately as he became more frail physically towards the end of his life. It will consider whether frequent emergency health interventions and hospital admissions would have been necessary if he had had different care plan or been placed in a different setting. During the Review period, the needs associated with his physical health and advancing age began to outweigh those associated with his severe learning disability

5.11 It is noted in Points 4.5 to 4.9 that Mr. EF received a high level of support within the Supported Living setting for his physical health. This appeared to meet his needs effectively until his health started to decline. He had access to the same range of health assessments and interventions as most other people of the same age, plus a good relationship with his GP who worked actively on his behalf. A social worker carried out an annual review on 20 April 2015 using the 'Supported Self-Assessment Questionnaire' in line with Care Act 2014 requirements. There was a good, trusting relationship between the provider, primary care and the Community Team for People with Learning Disabilities and there is evidence of a caring, professional approach and good assessments made by occupational therapists, physiotherapists, speech therapists and nurses.

5.12 It does not appear that the Community Team knew the information about the frequent interventions made by Southern Central Ambulance Service.

5.13 During the Review period, Mr. EF had 5 hospital appointments with respect to his cataracts, 5 specialist outpatient appointments and 10 emergency admissions to Accident and Emergency, of which 6 led to inpatient admissions lasting 52 days in total. In addition, Southern Central Ambulance

Service treated him at home on 3 occasions. Whilst it appears that all hospital assessments, diagnoses and interventions were timely and necessary, and they were carried out in accordance with the treatment pathways offered to any other patient, this pattern of hospital attendances and admissions would be disruptive and distressing for most people. It is likely to have been even more so for a man aged 71 who has a severe learning disability and autism which would cause him to have limited understanding and ability to adjust to the changes of environment and intrusive medical interventions. It is also noted that Mr. EF had numerous cuts, bruises and fractures resulting from his falls which must have caused considerable pain and discomfort on top of the symptoms of his other health conditions (urinary retention, breathing difficulties, tremors and a seizure) There are several references in the reports to Mr. EF being agitated, refusing food, drink and medication and exhibiting aggressive behaviour towards staff when they were providing care.

- 5.14** The Provider made their own assessment of Mr. EF's changing and fluctuating needs, which was sent to his social worker on 27 April 2016. The need to prevent falls was highlighted with a request for an increase in one to one funding to support his increased needs. Mr. EF was in hospital at this time. This request was forwarded to the Clinical Commissioning Group as they had held responsibility for funding under Continuing Healthcare since 2010. The last increase in funding was made in 2012. No recent reviews of his needs and level of support required had taken place recently and this referral was their first involvement for some time. The case management for NHS funded individuals was provided by the Community Team for People with Learning Disabilities on their behalf but assessments and reviews were not provided routinely to the Clinical Commissioning Group, who do not appear to have requested them. In order to improve co-ordination of Mr. EF's care, it was decided to hold a Multi-Agency Review prior to his discharge on 22 May 2016 to ensure that he could be discharged safely to the Provider. An Eligibility Review for Continuing Healthcare was to be included. However, it was decided later to hold it after he had been home for a month on 22 June 2016 to see how his needs were being managed in his home environment. Unfortunately Mr. EF was back in hospital again on that date and the Review did not take place before his death. These delays in reaching consensus about Mr. EF's needs on discharge meant that the funding requested by the Provider for additional one to one care was not put in place.
- 5.15** There was little evidence of multi-agency co-ordination or a holistic approach, or any indication of whose responsibility it was to provide such co-ordination.
- 5.16** It did not seem, in fact, that information about the root cause of Mr. EF's changing health was available to Community Team staff and this meant that planning appropriate care and support for his changing health needs was a challenge. He was not identified or assessed as approaching the end of his life and was not placed on the GP's End of Life Register despite the evidence that his health was deteriorating. This meant that a reactive approach to each new change in Mr. EF was needed as it happened rather than a planned approach to an expected deterioration as he approached the end of his life. This would have given him access to a range of services designed to meet needs at this stage of life.
- 5.17** In summary of this part of the analysis, it appears that there were no significant shortfalls in the assessment, diagnosis and interventions provided to Mr. EF until his health began to deteriorate from April 2016 onwards. However, from that time, the mass of evidence points to the fact that Mr. EF's health was declining but the assessments did not reflect this or identify that the end of Mr. EF's life was approaching. They were not shared across organisations to provide a coordinated view or assessment of his needs. Some of the risk around him was identified, e.g. mobility, and there were regular monitoring visits from the Community Team for People with Learning Disabilities. However, risk was not identified fully as evidenced by the increase in involvement from South Central Ambulance Service and the Frimley Park Hospital A and E Department in response to calls for assistance for Mr. EF by the Provider. There were several occasions when Mr. EF was very unwell and needed emergency transport to hospital. On at least 6 occasions, he fell and hurt himself badly. The Provider was unable to keep Mr. EF safe during this period with the facilities and staffing they had available.

5.18 It is of particular concern that there was no action taken by the funding authority to secure the additional one to one support hours required by the Provider to keep Mr. EF safe between the original request on 27 April 2016 and his death on 13 July 2016. Concerns were recorded by CHC about the suitability and sustainability of the placement in the longer term as Mr. EF's needs changed.

5.19 It is not likely that the above would have prevented the death of Mr. EF but identifying that he was approaching the end of his life would have enabled appropriate care planning and additional services. As greater numbers of people with learning disabilities and co-morbidities live longer in community settings, it is important for approaching end of life to be recognized. This might be at a younger age, and take a different form than is seen in the general population. It might have improved his quality of life significantly if he were provided with support to prevent at least some of the falls and subsequent admissions to hospital, which would have been distressing for him. It might also have met the Care Act criteria for wellbeing more effectively. "Well-being" is a broad concept relating particularly to personal dignity and being treated with respect; physical, mental health and emotional wellbeing; protection from abuse and neglect; control over day-to-day life and domestic and personal issues.

5.20 Care Setting

Specific Line of Inquiry:

Were the care needs of Mr. EF fully identified and services commissioned to meet these?

Was care setting appropriate?

5.21 Mr. EF was fortunate in that he was provided with care and support in only three settings since he was nine years old. The shift from residential care to Supported Living in 2010, with its principle that everyone has a right to lead their own life and determine where and with whom they live and who provides their care, created an opportunity for Mr. EF to receive personalised care, tailored specifically to his needs rather than the more institutional setting of residential care. The Support Workers forged an excellent relationship with him over many years, with genuine feelings of love and respect between them. This could not have been easy given Mr. EF's changing moods and limited communication and they are to be congratulated on the quality of their service.

5.22 People with severe learning disabilities and complex conditions are living longer now, due to improved medical knowledge and greater awareness that older individuals need to access the health screening and support available to the general population. However, there is some evidence that adults with learning disabilities typically experience age-related difficulties at different ages, and at younger age than the general population (NICE consultation on 'The Care and Support of Older People with Learning Disabilities 2015.) This was recognized in part in that Mr. EF accessed age appropriate health care but more could have been done to identify the signs of his ageing and to plan in accordance with best practice.

- 5.23** During the last seven months of his life, Mr. EF had numerous falls, caused by poor mobility and failing health, resulting in injuries requiring hospital admission. The Provider had to call the Emergency Services thirteen times regarding their concerns for Mr. EF. This is neither a good use of resources nor a good existence for a frail, elderly man reaching the end of his life. Mr. EF had certainly reached a point at which professionals involved in his care were justified in their concerns regarding the ongoing suitability of the care setting to meet his needs. It was not possible to keep him safe in that environment with the agreed level of resources available.
- 5.24** Mr. EF appeared to feel safe, secure and settled in his care setting however. It had been his home for many years. His needs were understood there despite his limited communication. From the information gathered, it seems likely to have been the care setting to which he wanted to return after his various hospital admissions and where he would have chosen to live the rest of his life. In providing personalized care, this is an essential factor. Before considering a move to an alternative care setting, such as a home with nursing, all opportunities to meet his needs in the same familiar surroundings should be taken.
- 5.25** The Provider developed robust and holistic support plans taking Mr. EF's changing needs into account but these were not acknowledged or acted upon when planning for his discharge took place in April 2016. The assessment indicated the need for additional one to one hours to be agreed from Continuing Healthcare. This might have enabled them to have supported him effectively for longer but the process for authorization of this was not clear or understood. It must therefore be concluded that his care needs were not fully identified or granted by the commissioners.

5.26 Inter-agency communication and roles

Specific Line of Inquiry:

What evidence is there of communication and planning for Mr. EF's changing needs?

Was this adequate?

Was there clarity regarding the roles of all the professionals involved?

Was appropriate support available for hospital staff in providing personalised care to a person with a LD?

- 5.27** Mr. EF had significant health and care needs, each of which required input and intervention from different professionals and specialisms. It would, in fact, be difficult to imagine a more complex set of individual needs, making it praiseworthy that they were, on the whole, met effectively and in a personalized way in a community setting.
- 5.28** The volume of communication contained in the different organizations' recording systems indicate that there was no shortage of professional concern or interest in Mr. EF's changing needs. Communication was undoubtedly very complex because Mr. EF required many professionals from different teams and organizations to be involved and to communicate with each other. Commitment to work together was demonstrated repeatedly but it was never achieved effectively.
- 5.29** The GP had a good working relationship and communication with the Provider and ensured that medical support was effective in matching his needs and choices as far as possible. The frequency of Mr. EF's hospital admissions triggered an Admission Avoidance Care Planning meeting held by the

GP Practice, an initiative put in place to consider how the care of people with frequent hospital admissions can be managed to avoid these. However, key professionals were not invited to attend this meeting so it was of limited value. It is not clear whether other professionals were aware that the cumulative information about Mr. EF's frequent contacts with South Central Ambulance Service was available. The GP was not involved in any other multi-disciplinary forum for planning for Mr. EF either. These omissions could be seen as missed opportunities to plan Mr. EF's care holistically with everyone involved provided with all relevant information.

- 5.30** It has been mentioned previously in this Report that it is probable that Mr. EF experienced some distress whilst away from home in hospital. The Provider states that Mr. EF 'needed routine and he needed staff to understand his routines. By staff knowing him well they were able to determine his needs and guide others on how to support him'. Whilst they provided some information to ward staff, Mr. EF was transferred to different wards, which might have interrupted the flow of information. The Support Workers provided a high level of input, more than the hours for which they were contracted, during his time in hospital but for the majority of the time he would have been looked after by strangers. Busy hospital ward staff may not have had time to take full consideration of his specific needs and to provide a personalized service, although there is evidence that they tried to get extra support for him during his July admission. An Occupational Therapist recorded on 9 May that 'He did appear a bit tearful at times but that could be because he is finding hospital boring'. It may also have been because he was bewildered and frightened. An acute hospital setting may be appropriate for treating illness but patients with complex care needs and limited understanding is likely to find it difficult. It is sad that his Support Workers were not aware that his death was imminent and that they arrived after he had passed away. Mr. EF had a nurse to hold his hand in his final hours but he was denied the chance to have someone who knew him well by his side at this time.
- 5.31** When Mr. EF was admitted to hospital again on 17 June and 11 July 2016 after further unwitnessed falls with subsequent injuries, no Safeguarding Adults concerns were made, despite the fact that there had been a previous concern regarding the same sort of injury only three weeks before. In terms of Safeguarding Adults interventions, the concern was raised by South Central Ambulance Service regarding unexplained injury on 17 April 2016. Discussions were held in two meetings about the impact of his health conditions and medications, which were believed to cause unsteadiness and tendencies to fracture bones and bruise easily. However, the hospital consultant did not consider that this was the case. It should be noted that this Review has found no evidence to suggest that abuse or neglect did take place but it does suggest that a more robust investigation was warranted given that Mr. EF could not speak up for himself and that there were three other adults potentially at risk in the same placement. A further discovery of fractured ribs in A and E was not passed to Safeguarding Adults.
- 5.32** It is suggested that the hospital may not have understood the setting in which Mr. EF lived, its strengths and limitations, which may have impacted on their discharge plans following several admissions. Supported Living is a relatively new concept and it may be thought that individuals with such profound disabilities and health co-morbidities as Mr. EF would live in a home with nursing care. It does seem that hospital staff might have been supported to improve their service to Mr. EF through better information and guidance and reference has been made to a Learning Disabilities Liaison Nurse in post at the hospital but not accessible to patients from the East Berkshire area due to funding by the Clinical Commissioning Group. There is evidence that further consideration needs to be given to people with special needs to ensure their wellbeing and comfort both in hospital and on discharge.
- 5.33** There was a great deal of communication about Mr. EF's needs but there was little planning ahead or taking account of risk as professionals had insufficient shared information on which to make robust plans. End of life had not been identified so planning did not happen for that aspect of his

needs. Unfortunately, overall co-ordination and planning was not adequate as Mr. EF experienced many accidents and injuries, which may have been avoided. There was confusion regarding who should be a case coordinator across all organizations.

6 key Findings

6.1 Good Practice

This Review has been completed in partnership with representatives of the organisations who provided health and care services to Mr. EF over many years. They have been very willing to engage with the review process and have been honest, self-critical and open to challenge, keen to identify where learning may be identified to improve services in future. Indeed, steps have already been taken to improve the system based on the perceived issues arising from this case (6.2). There are some examples of excellent practice.

- Mr. EF had access to the range of primary and secondary health services available to the general population of his age.
- Mr. EF received a good, non-discriminatory service from his GP
- Mr. EF's complex health needs were managed without 'diagnostic overshadowing' (i.e. a tendency to attribute all problems to the major diagnosis, i.e. severe learning disabilities)
- Mr. EF received personalized care in a Supported Living environment, assisted by Support Workers to gain a good quality of life, despite difficult circumstances at times
- South Central Ambulance Service raised a concern with the Safeguarding Adult Team regarding unexplained injuries
- Staff involved carried out their roles professionally and showed interest in, and commitment to, improving Mr. EF's wellbeing.
- Staff from many organisations and in different roles had tried to work together but were impeded by the inadequacy of systems to support them.

6.2 Progress since the events leading to the Safeguarding Adults Review

A great deal has been achieved to make improvements where issues had been identified.

- A process for funding decisions was been put in place in June 2016 for the authorization of additional resources to meet the needs of people funded by Continuing Healthcare.
- A monthly liaison meeting between Bracknell Forest Council, including Community Team for People with Learning Disabilities, and Continuing Healthcare was been put in place in June 2016, with improved relationships and communication between organisations and professionals within the services. In these meetings, concerns and process issues are resolved. This meeting is replicated for the two other Local Authorities/Clinical Commissioning Groups, which the Continuing Healthcare Service covers.
- Bracknell Forest Council identified a Local Authority Lead for Continuing Healthcare.
- Continuing Healthcare introduced joint monthly training in early 2017. This is a regular forum for multi-agency staff to share information and liaise regarding people with a learning disability and other needs.

- The East Berkshire Continuing Healthcare Service is a Strategic Improvement Partner working with NHS England to improve access, outcomes and to reduce variation in health care.
- A Policy has been put in place regarding Care Pathways through hospital for People with a Learning Disability, including guidance on Best Interest Decisions and when to instruct an IMCA.

6.3 Themes

Bracknell Forest Health and Care services are not unique in finding that the systems in place are not always adequate to meet the changing needs of people with complex co-morbidities, nor do they always identify approaching end of life for these individuals. Similar concerns were also identified in two Serious Case Reviews carried out for Suffolk Safeguarding Adults Board in 2014, authored by Margaret Flynn, who also led the Winterbourne View Serious Case Review. An 'overhaul of structures supporting adults with learning disabilities was recommended which included the following actions, which are equally appropriate for Bracknell Forest to consider:

- A named Care Co-coordinator for health and social care for each individual
- An annual review, to include CHC
- A joined up system for record keeping and information sharing

6.4 At a national level, the Learning Disabilities Mortality Review (LeDeR) is a research programme commissioned on behalf of NHS England and run by Bristol University. Started in June 2015 and run over three years, it aims to clarify 'any potentially modifiable factors associated with a person's death and works to ensure they are not repeated elsewhere.' The LeDeR Programme will also collate and share the anonymised information about the deaths of people with learning disabilities so that common themes, learning points and recommendations can be identified and taken forward into policy and practice improvements. This is a programme in which Bracknell Forest Safeguarding Adult Partnership Board will be able to participate and benefit from the finding in any future revision of services.

The following main themes have emerged:

1. The requirements of the Mental Capacity Act are not yet fully embedded in practice, including the role of the Independent Mental Capacity Advocate, especially in hospital settings.
2. In Safeguarding Adults, when an individual lacks capacity and has very frail health conditions, care must be taken to avoid attributing unexplained physical injury to health conditions. In addition, concerns regarding people with injuries and limited communication who are admitted to hospital with unexplained injury should be reported.
3. Advocacy should be put in place for people with learning disabilities towards the end of life in order to ensure that needs and wishes are fully identified and taken into account when decisions about the future are made. Individuals without capacity have a right to this under both Mental Capacity Act and Care Act 2014.
4. It is important to recognize the life journey of any individual in assessment, in particular approaching end of life. Health conditions and medications may affect the time at which this occurs in people with complex co-morbidities but recognition of this life stage can enable the individual to receive the most appropriate care.

5. Vital lines of communication were not instigated between all key agencies and this did not enhance a full understanding of the situation by all involved. In turn this did not enhance opportunities to sustain his wellbeing.
6. Assessment and care planning was not coordinated between organisations and there was no clear process for approach for authorizing additional funding for people eligible for Continuing Healthcare. Clear processes for assessment, care planning and authorisation of service provision need to be in place and understood and shared by all staff involved in the care of a person receiving Continuing Healthcare so that needs can be met in a timely way. (This has now been addressed see 6.2)
7. Each person with entitlement to Continuing Healthcare who has learning disabilities and other co-morbidities should have an appropriate professional lead or case manager who is able to co-ordinate the convening of multi-agency meetings and planning of services. This may be the professional who has the most direct involvement and access to other service providers working with the individual.
8. People with learning disabilities may need additional support in hospital. This may be achieved by using support workers with whom the person is familiar on site during the admission to provide continuity of care and to assure their wellbeing and comfort. Hospital staff need information about the care needs of the person and the proposed discharge environment. Access to a Learning Disability Liaison Nurse has proved invaluable elsewhere.

References

Journal of the Royal Society of Medicine 2012 Jul: 105(7): 279-282

NICE The Care and Support of Older People with Learning Disabilities (draft – final version expected May 2018)

General Medical Council Guidance on Learning Disabilities

Suffolk Safeguarding Adults Board Serious Case Reviews 2014 (website)

Transforming Care – A National Response to Winterbourne View Hospital (Dept. of Health 2012)

Recommendations

1. Safeguarding Adult Board should receive assurance from Frimley Park Hospital that actions have arisen for the application of the MCA 2005 in relation to consent for treatment and DNAR have been embedded.
2. Safeguarding Adults Board should receive assurance from all agencies that when an individual who has deteriorating health and who experiences an unexplained fall or a significant number of falls in a short period of time that result in injury; the fall incident or incidents, will be reported to the local authority in order that any emerging pattern or emerging concern about the reason for the falls can receive an appropriate response.
3. Safeguarding Adults Board should be assured that people with LD who also have deteriorating comorbidities should have their needs related to approaching end of life included in their assessments and be considered for multi-agency advanced care planning, including advocacy.
4. Safeguarding Adult Board should be assured that key agencies are involved in the assessment and care planning for people with complex health conditions. Key agencies should all be involved in the decision regarding appropriate placement and support in line with multi agency guidance.
5. Safeguarding Adult Board should be assured that the agency who knows the person the most should be the professional organisation who takes responsibility to call a multi-agency meeting in line with the multi-agency guidance.
6. Safeguarding Adult Board will request that the local authority, CCG and Frimley Park Hospital will explore the possibility of additional support in hospital for people with LD. This may be achieved by using support workers with whom the person is familiar with on site during the admission to provide continuity of care and to assure their well-being and comfort. Decisions should be made on a case by case basis.
7. Safeguarding Adults Board should facilitate a multi-agency learning workshop.

Appendix 1

Bracknell Forest SAPB Safeguarding Adults Review: VEF

Terms of Reference Amended 17th May 2017

1. Overarching aim and principles of the Safeguarding Adult Review (SAR)

This SAR was commissioned by Bracknell Forest Safeguarding Adult Partnership Board following consideration and discussion of a referral outlining the circumstances of the case VEF. It was agreed that the circumstances met the criteria set out in the Care Act 2014.

The purpose and underpinning principles of this SAR are set out in section 2.9 of the Multi- Agency Safeguarding Adults Policy and Procedures. All Bracknell Forest Safeguarding Adult Partnership Board (BFSAPB) members and organisations involved in this SAR, and all SAR panel members, agree to work to these aims and underpinning principles. The SAR is about identifying lessons to be learned across the partnership and not about establishing blame or culpability.

The full Terms of Reference (ToR) are as set out in the SAR protocol for BFSAPB appendix 5 and reflect both the local Safeguarding Adults Policy and Procedures and the Care and Support Statutory Guidance, 2016. Aspects of this are reiterated and built upon below:

- The SAR will reflect the six safeguarding principles.
- These Terms of Reference may be published and openly available.
- All reports will be anonymised through redaction.
- The approach taken will be proportionate according to the scale and level of complexity of the issues being examined;
- This review will be led by a suitably experienced and qualified individual who is independent of the case under review and of the organisations whose actions are being reviewed;
- Professionals will be involved and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;
- Organisations will be responsible for the wellbeing of staff participating; the process can be demanding and upsetting.
- Families and friends will be invited to contribute. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.
- The review will takes steps to remove hindsight bias.

2. Methodology

The methodology for reviewing the situation in respect of VEF takes the form of a *significant event review*. This methodology has been selected in order to increase collaboration and bring agencies along with the Panel throughout the review, thus engaging all relevant professionals in the learning. A general outline of this methodology is set out in the SAR protocol. In this review this will require specifically that reports and recommendations are requested from involved organisations and these are discussed in a facilitated session, drawing out all of the learning and incorporating mutual challenge and learning at all levels and across all organisations. A short report will be produced to support ongoing actions from the learning. An independent facilitator will be commissioned to lead the process and to write the report.

g. Panel meets to finalise process and timescales (15 May 2017)

- h. Chronologies to be submitted (19th June 2017)
- i. All IMRs to be submitted (26th June 2017 midday)
- j. Panel meeting to discuss IMRs and workshop format (04th July 2017)
- k. Workshop to involve participants from all organisations (8th August 2017)
- l. Report published by Chair (mid-August 2017)
- m. Final panel meeting to agree report and recommendations (15th September 2017)

3. The Panel

- Julie Foster - Chair.
- Hannah Doherty, Head of Service - representing Bracknell Forest Council Community Team, Physical and Learning Disabilities(BFC CTPLD), and Berkshire Healthcare NHS Foundation Trust (BHFT).
- Gemma Richardson, Care Manager - representing Hightown (previously known as Radian) as the support provider.
- Frances Zvoma, Locality Manager - representing Hightown (previously known as Radian) as the support provider.
- Sarah Davies, Services Manager - representing Hightown (previously known as Radian) as the support provider.
- Abigail Simmons, Head of Adult Safeguarding - representing Bracknell Forest Council Adult Safeguarding.
- Mel Martin, Safeguarding Lead - representing Frimley Park Hospital
- Lorraine Charlton, Head of Continuing Healthcare and Placement Governance - representing Continuing Healthcare Team
- Blossom Godfrey – representing Continuing Healthcare Team
- Jennie Green; Named Professional – representing local CCG(who will support the GP in producing a report)
- Jane Fowler, Head of Safeguarding - representing Berkshire Healthcare NHS Foundation Trust
- Tony Heselton - Head of Safeguarding – representing South Central Ambulance NHS Foundation Trust.
- Dave Phillips – ASPB Manager – representing Bracknell Forest Council Adult Safeguarding Partnership Board.

The GP will be offered the opportunity to be a panel member; they will in any case be required to contribute a report to the review.

4. Time period

The time period to be covered by the review is April 2015 to date of death of VEF.

5. Specific Lines of Enquiry - Reports required for Workshop

It has been agreed that **the following organisations are to submit reports** based on the ToR and specific lines of enquiry to the SAR:

- Bracknell Forest Council Community Team, Physical and Learning Disabilities and Berkshire Healthcare NHS Foundation Trust (BHFT)
- Hightown (previously known as Radian) as the support provider
- Bracknell Forest Council safeguarding team
- Frimley Park Hospital
- CHC team
- GP (supported by the CCG as above)
- SCAS

The importance of including and involving front line care staff who knew VEF well is therefore underlined.

Reports will be written according to the principles set out in the standard terms of reference, appendix 5 of the BFSAPB SAR protocol, with the addition of **specific lines of enquiry as follows**. These lines of enquiry will be addressed/included in reports submitted for this review and in the facilitated discussion. They will be reflected in the summary report:

The review and all reports will consider: whether there are lessons to be learned about how individuals and agencies worked together and individually, and how these lessons will be acted upon/what is expected to change to improve outcomes for people. This will include identification and analysis of good and best practice which had a positive impact for VEF and of failings (at practice and organisational levels) which had a detrimental effect on Amy's health and wellbeing.

The review and reports (as relevant) will specifically:

6. **Facts of the case.** Chronology of key events and relevant agency contacts to be submitted separately.
7. **Mental Capacity.** Was VEF's mental capacity assessed in relation to specific decisions and documented in line with MCA 2005 and agency guidance? What was the quality of the recorded assessments and responses to identified issues? Were the needs, wishes and feelings of VEF taken into account appropriately? Were end of life decisions made appropriately, including DNAR? Were care staff involved appropriately in decision making in view of absence of family?
8. **Assessment, diagnosis and interventions:** Were assessments carried out in a timely way to identify VEF's changing needs? Were they of sufficiently good quality to understand his needs, including risk? Was monitoring and review in place? Were VEF's physical health needs correctly identified and robust responses provided and interventions delivered effectively in line with agency policy and practice guidance? Were concerns escalated appropriately?

9. **Care Setting** Were the care needs of VEF fully identified and services commissioned to meet these? (was care setting appropriate?).

10. **Inter-agency communication and roles** What evidence is there of communication and planning for VEF'S changing needs? Was this adequate? Was there clarity regarding the roles of all the professionals involved? Was appropriate support available for hospital staff in providing personalized care to a person with a LD?