

West Sussex Safeguarding Adults Board

Safeguarding Adult Review

In respect of

Matthew Bates and Gary Lewis

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Independent Author:

Brian Boxall
BDB Consultancy Ltd



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1 REASON FOR THE SAFEGUARDING ADULT REVIEW

Introduction

- 1.1. During the morning of 1st April 2015, two males Matthew Bates (30 years) and Gary Lewis (63 years) were taken to the Emergency Department of the local Hospital (East Surrey). They were residents of the same care home in West Sussex (different wings). Both have profound learning difficulties, cerebral palsy and suffer from osteoporosis (osteoporosis not diagnosed in Matthew until April 2015). They are non-ambulant and require assistance with every aspect of personal care.
- 1.2. Each was subsequently found to have suffered fractures to a femur, and were admitted to the hospital where they remained for several months before being resettled in different care homes.
- 1.3. Whilst the care home (Beech Lodge) was located in West Sussex, the placing authority for Gary was the London Borough of Camden and for Matthew it was Surrey County Council (Mole Valley).
- 1.4. The injuries were reported to West Sussex Adult Services Community Learning Disability Team (CLDT), and a Care Act 2014 Section 42¹ safeguarding enquiry was undertaken. This enquiry concluded that the injuries were **probably** caused as a result of single handed manual handling which was not in line with the guidelines in place at the care home.
- 1.5. The families subsequently (June 2015) requested that a police investigation consider possible criminal offences. It was concluded that there was insufficient evidence to reach a criminal threshold. Neither the safeguarding enquiry nor the police investigation were able to conclusively prove how the injuries occurred.
- 1.6. Matthew and Gary were vulnerable adults, and the West Sussex Safeguarding Adults Board commissioned a Safeguarding Adult Review in July 2016 in line with their West Sussex Adults at Risk Serious Case Review Protocol².
- 1.7. It is acknowledged that these are two individuals that could have been subject to separate Safeguarding Adult Reviews. Careful consideration was given by the Safeguarding Adults Board as to the most effective process to apply to gain the most from a review. It was agreed that on balance, given the similarity of the two cases (both resident in same location, both sustaining broken femurs around the same time frame), it would be more productive to undertake a joint Safeguarding Adult Review rather than two separate reviews.

¹ **Section 42 Care Act 2014 Enquiry by local authority**

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

(a) has needs for care and support (whether or not the authority is meeting any of those needs),

(b) is experiencing, or is at risk of, abuse or neglect, and

(c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

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

² *West Sussex Safeguarding Adults at Risk Serious Case Review Protocol (2013)*

The Review Process

- 1.8. The author of this report was commissioned to undertake a review in line with the guidance set out in the Care Act, 2014. The independent reviewer is Brian Boxall, a retired Detective Superintendent who served with Surrey Police for thirty years. Since his retirement in 2007 he has been an independent consultant, and has undertaken a number of serious case reviews, safeguarding adult reviews and domestic homicide reviews. He is currently the Independent Chair of a Safeguarding Children and Adults Board.

Methodology

- 1.9. Terms of Reference were produced and agreed (Appendix A). They set areas the review should consider:

1. Whether or not the injuries to both men could have been predicted or prevented.
2. Identify concerns/complaints recorded in respect of residents of Sussex Health Care Learning Disability specialist care homes over the scoping period, including incidents of physical injuries (including fractures).
3. Consider if there is any correlation between low level care incidents and increased level of safeguarding concerns. Were appropriate safeguarding referrals made to other identified incidents and were they responded to?
4. Did any of these incidents (if recorded) lead to a level of professional concern regarding Manual Handling?
5. Examine the response by agencies to these two incidents. Were safeguarding policies and procedures followed in a timely and proportionate manner, including a timely consideration of risk to others?
6. Were investigations, safeguarding and criminal, timely and thorough?
7. Were appropriate safeguarding referrals made to other incidents and how were they responded to?
8. How did the home ensure that their staff had the appropriate safeguarding knowledge, qualifications and skills? Were policy and procedures, including supervision, adhered to?
9. How did local and placing authorities ensure that the home continued to be a safe environment?
10. Were any of the statutory agencies aware of any concerns in respect of Sussex Health Care Learning Disability specialist care homes (including placing authorities or inspecting such as CQC)? How were concerns responded to? What was the outcome?
11. Are there wider lessons for any agencies involved regarding Sussex Health Care in relation to the way they are monitored and regulated?
12. To examine how identified areas of concern in respect of care homes within one local area are raised with placing local authorities or private placements, and vice versa.
13. Are there any issues, such as conflict of interest, in respect of the application of the safeguarding process when involving commissioned privately provided services?
14. To consider the impact of the Care Act post incident.
How were the families' concerns responded to post incident?

1.10. The following agencies were identified as having involvement with both Matthew and Gary.

- Sussex Health Care
- Sussex Police
- West Sussex Learning Disabilities Contract Team
- Care Quality Commission
- West Sussex Adult Services
- Surrey County Council
- London Borough of Camden
- Sussex Partnership NHS Foundation Trust
- Clinical Commissioning Group
- South East Coast Ambulance Service

Each organisation produced an Individual Management Review ³(IMR).

1.11. A Safeguarding Adult Review (SAR) panel was appointed to work with the reviewer, with representation from the following agencies:

- West Sussex Learning Disabilities: Operations Manager.
- Care Quality Commission: Inspection Manager.
- Sussex Police: Detective Chief Inspector
- Horsham & Mid Sussex CCG: Head of Quality and Nursing.
- Surrey & Sussex Healthcare NHS Trust.
- Surrey County Council.
- London Borough of Camden.
- Safeguarding Adults Board Manager.
- Sussex Partnership NHS Foundation Trust.

Review Period

1.12. The review panel identified the period that should be reviewed was April 2013 to March 2016. Relevant information outside this time span was also considered.

Parallel Process

1.13. Beech Lodge is one of a number of homes operated by a private company known as Sussex Health Care. During the period of this review, Sussex Police commenced a wide-ranging investigation into a number of serious incidents (deaths) which occurred across several care homes owned by Sussex Health Care. At the time of writing this report, Matthew and Gary's circumstances do not form part of that ongoing investigation.

1.14. The separate police investigation has focused on potential offences under the Criminal Justice and Courts Act 2015 Sections 20-25⁴ which came into force on 13th April 2015. Whilst the police timeline does not encompass the cases of

³ **Individual Management Review:** A report produced by individual agencies as part of the Serious Adult Review.

⁴ On 13 April 2015 the Criminal Justice and Courts Act 2015 Sections 20-25 came into force. These Sections create two new criminal offences of ill treatment or wilful neglect which apply both to individual care workers and care provider organisations.

Matthew and Gary, it will be considering the governance and culpability of Sussex Health Care. The final outcome of this investigation is not known at the time of writing this report.

Review Timings

- 1.15. The following provides a resume that explains why this review has been delayed.
- 1.16. The circumstances of this case were first considered by the Safeguarding Adults Board SAR subgroup in October 2015. In January 2016, the subgroup recommended that it did not fit the criteria for a SAR. The Independent Chair did not agree with the subgroup's conclusions, and it was agreed that it would be revisited once the then police investigation (commenced in June 2015) was concluded.
- 1.17. In July 2016 the Independent Chair made a decision to commission a SAR. In September 2016 authors for the SAR were identified, however in December 2016 these authors withdrew from the process. The current author was identified, and in February 2017, after meeting the families, agreed to author the report.
- 1.18. The review was planned to deliver a final report in July 2017, but there was a delay in completion as of some of the agency individual management reviews were not finalised and the author was unavailable for 6 weeks. At the same time (May 2017), Sussex Police commenced their investigation as per 1.13 above. The review was suspended at that time. The author met with the Senior Investigating Officer in August 2017 and following that meeting the review was recommenced.

Report Structure

- 1.19. At the request of family members, individuals have been named.
- 1.20. The analysis section of this report has been split into two main sections:

Section 1: Examination of period immediately before the injuries occurred and the subsequent safeguarding response by agencies.

Section 2: To examine care home concerns and monitoring pre April 2015.

2 INDIVIDUALS AND FAMILIES

- 2.1. As was highlighted in the introduction, injuries were sustained by two vulnerable individuals who were totally reliant on others for support. These two individuals must remain at the forefront of this review. The following is a brief pen picture of Matthew and Gary.
- 2.2. **Matthew Bates**
Matthew aged 30 years (at the time of the incident) has a severe learning disability, epilepsy, cerebral palsy in all 4 limbs and dystonia. He had a PEG⁵ fitted in 1999

⁵ A PEG (Percutaneous Endoscopic Gastrostomy) is a way of introducing food, fluids and medicines directly into the stomach by passing a thin tube through the skin and into the stomach.

and had a spinal fusion surgery in 2003. He was 19 years of age at the time. The surgery resulted in a change in his needs and an increased level of care was required. He is non-weight bearing and is dependent on a wheel chair for his mobility.

- 2.3. Matthew has difficulties communicating and has impaired cognitive skill, but is able to communicate through facial expression. His parents support him with communication. He loves football and is a supporter of Manchester United. His parents act as his advocate.

Gary Lewis

- 2.4. Gary aged 63 (at the time of the incident) has profound learning difficulties and multiple disabilities, with complex health needs associated with diagnoses of Osteoporosis and Dorsal Scoliosis. He lived for many years in a long stay learning disabilities hospital in Surrey. Camden Learning Disability Service became actively involved in his resettlement into the community in 1999. In 2003 Gary moved with friends to Beech Lodge. He has lost his parents, but his brother and sister have remained in very close contact with him and fully support and represent him.

Family Views

- 2.5. Whilst this review will examine the actions of various agencies, it is important to highlight how these injuries and the subsequent professionals' interaction with the families has impacted on the individuals. The author has spoken to Matthew's and Gary's family members on a number of occasions. He has also visited Matthew and Gary, with the support of family members.
- 2.6. The families of both Matthew and Gary emphasised that both men had sustained a traumatic and very painful event, and whilst both have settled down in new care homes, the families have explained that both Matthew and Gary are still suffering. Gary in particular, misses the friends that he made at Beech Lodge both having been residents since 2003. They had to endure great pain and long stays in hospital.
- 2.7. Both families have expressed concerns about how agencies have responded to the injuries. Despite the high level of contact they have had with a number of the agencies, neither family are satisfied with the outcomes and are sceptical about how impactful the Safeguarding Adult Review process will be in providing answers. One family member in particular has asked that 'sceptical' be changed to 'no confidence'.
- 2.8. They believe that agencies have not been open and honest with them and have genuine concerns that they are potentially colluding to hide the truth from them. Their main concern has been the influence that they believe the care home providers have had on the process, and they have continually highlighted the fact that the West Sussex County Council Cabinet Member for Adult Services (until recently) was a Director of the Care Home Company.
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- 2.9. The main questions they are seeking answers to are:
- How did injuries to their loved ones occur?
 - Why did they occur?
 - Who at a staff and corporate level is responsible?
 - Has there been collusion to hide the truth?
- 2.10. In order to gain answers, they have, and will continue to, take their concerns to whatever level is required. This includes legal advice and the use of the local and national press. To that end, they have already made a number of complaints and informed the Ombudsman. They have also asked for and received documents from various agencies and had meetings with individuals in senior positions.
- 2.11. Matthew's parents explained that they accept that accidents occur, and if individual agencies or organisations had accepted that they had made a mistake and fully explained how it happened, they may have accepted it. However, they do not believe that the system has done that. On a simple point, they expressed disappointment that the care home provider never sent a card or acknowledged Matthew's plight in the days after the injury occurred.
- 2.12. Gary's brother stated that he now has a total distrust of the agencies. He stated that he expected agencies to safeguard his brother, but he believes from what he has witnessed, that they are only supporting the agencies who harmed him.
- 2.13. The author has worked with the families to explain the function of the Safeguarding Adults Review. He has also made them aware that the review may not be able to obtain answers to all their questions, especially how the injuries occurred.

3 AGENCY CONTEXT AND GEOGRAPHICAL LOCATIONS

- 3.1 This review has considered services delivered across a number of geographical locations. It also examined various social care and hospital team structures. This section will summarise some of these location and structural issues, in order to provide a better understanding when considering the rest of the review report.
- 3.2 The following sets out the various geographical locations relevant to this review.
- Both Matthew and Gary were resident in Beech Lodge care home located in West Sussex.
 - The funding authority for Matthew was Surrey County Council
 - The funding authority for Gary was the London Borough of Camden.
 - The hospital they attended was located in East Surrey.
 - West Sussex County Council Adult Social Care is the safeguarding lead.

Due to the hospital's location staff were working to the Surrey Adult Safeguarding Procedures produced by the Surrey Safeguarding Adults Board. Once it was identified that the safeguarding incident had occurred in West Sussex the Pan Sussex procedures were applied.

3.3 **Sussex Health Care**

Sussex Health Care is the provider of the Care Home which is the subject of this review. Their website⁶ (as of 2017) describes the company as follows:

Sussex Health Care is an independent company providing care homes and support services based primarily in Sussex. The 20 homes run by the organisation offer a range of services focusing on care for older people (including people who are mentally frail with dementia or Alzheimer's Disease) and on specialist care for adults with physical or learning difficulties (including people with neurological disabilities).

3.4 Beech Lodge (where Matthew and Gary were resident) is registered to provide accommodation and nursing care for up to 40 people. The home is purpose built. It caters for young adults with physical and learning disabilities or autism.

Hospital Safeguarding Structures

3.5 The hospital has in place an in-house safeguarding team employed by the Hospital Trust. Its role is to provide advice and to support best practice around safeguarding in the hospital and to link with the Surrey and the West Sussex social care teams.

3.6 Whilst the hospital is located in Surrey, there is an even split of patients who are residents of Surrey and West Sussex. To facilitate this divide there are two separate social work teams based in the hospital, one from West Sussex County Council and one from Surrey County Council. Each team's role is to facilitate the discharge from hospital of people with social care needs (e.g. people who need a package of care set up before they return home, or people who may not be able to return home and need to go straight from hospital to a care home due to their level of frailty). The hospital's only involvement with the management of these teams is to provide an office, car parking permits and identification.

3.7 Due to the hospital's location, safeguarding concerns occurring within the hospital are investigated by the Surrey social work team. When the hospital becomes aware of a safeguarding concern that is likely to have occurred in the community, then the concern is passed to either the Surrey or the West Sussex hospital social work team to run the enquiry, depending on where the alleged abuse was thought to have occurred.

3.8 On receipt of a safeguarding concern assessed to have taken place in the West Sussex area, the West Sussex hospitals social work team's role is to ascertain the most appropriate social work team within West Sussex to undertake the enquiry in the community and forward the information to that team. The hospital team's function is not to run safeguarding enquiries as their role is specifically around hospital discharge, however they will assist in putting emergency safeguarding plans in place.

West Sussex Adult Social Care

3.9 In this case, once the safeguarding alert was referred from the hospital it was picked up by the West Sussex Adult Services Community Learning Disability Team

⁶ <http://www.sussexhealthcare.org/why-choose-sussex-health-care.html>

(Northern) - aka CLDT North.

- 3.10 This team works with adults with learning disabilities living in West Sussex, age 18 plus. Under normal circumstances it does not support adults located in West Sussex but placed and funded by other authorities. It does respond to safeguarding incidents occurring in West Sussex such as in the cases of Matthew and Gary.
- 3.11 The team has a structure of one team manager and two Senior Practitioners, then under these a multi-disciplinary team of social workers, assistant care managers, community nurses, occupational therapists, speech and language therapists and psychologists. The Team Manager, Senior Practitioners, social workers and assistant care managers are seconded to West Sussex County Council and the other health practitioners are all employed by Sussex Partnership Foundation Trust. The team manager has day-to-day accountability for the running of the team and workload management.
- 3.12 Within the Community Learning Disability Team North there is a "duty desk" which takes all "incoming" work including safeguarding. It is overseen by a team manager or a senior practitioner who take turns on a weekly rota to be "duty manager". Then there are 1-2 other workers from the team who also sit on the duty desk as the "duty worker." This is usually a full-time job for the day which takes them away from their day-to-day case load.
- 3.13 The duty desk deals with incoming queries, gathers initial information to support decision making, and can put in place immediate short term plans to manage risk, such as in a safeguarding scenario or, for example, if a carer goes into hospital and alternative arrangements need to be made urgently.
- 3.14 The duty desk can deal with a mixture of routine and complex/high risk enquiries on any one day. As soon as is feasible, the duty manager will allocate an enquiry manager and an enquiry officer to the case, usually in a day or two. This tends to be the case with most safeguarding work which meets the threshold for a section 42 enquiry. Until this handover occurs, the duty manager should be responsible for overseeing the work and the risk management plan. Referrals and allocations are reviewed by the team manager at a weekly meeting. The duty manager does have the discretion to allocate a case to a worker more urgently, if required, based on an assessment of risk.
- 3.15 For the purposes of this review the process will be referred to as 'Duty' pre-allocation and then Enquiry Manager and Enquiry Officer once allocated.

Other Support Teams

- 3.16 Matthew and Gary were also supported within the hospital by the following teams:
- 3.17 **Learning Disability Health Team (LDHT)** is run by Sussex Partnership Foundation Trust. This team consists of a small number of health practitioners, physiotherapists, nurses, psychologists, speech and language therapists. The teams' remit is to provide a specialist health service to adults living in West Sussex placed by other authorities (because the Community Learning Disability Team do not work with them). This team had no involvement with Matthew or Gary prior to

April 2015.

- 3.18 **The Learning Disabilities Health Facilitation Team:** This is a team of nurses employed by Sussex Community NHS Foundation Trust. This team works to ensure adults with a learning disability are supported to access mainstream health services. The acute liaison nurse role is to support adults with learning disabilities and their family carers prior to, during, and after a hospital admission. Some of the nurses are based in the acute hospitals, including East Surrey Hospital, and some work in the community, helping with access to GP, dentist, etc.

4 CASE SUMMARY

- 4.1 As part of the review, individual agencies have produced chronologies covering the time period set for the review. The following is a brief summary of significant events only. For ease of reading it has been broken up into individual sections to cover the following:

- Matthew
- Gary
- The Care Home
- Multi agency interaction post 1st April 2015

The analysis section will set out in more detail events of 31st March and 1st April 2015.

Matthew

- 4.2 In June 2003 Matthew became a resident at Beech Lodge. In September 2009, the care home were informed that Matthew had a diagnosis of “pelvis obliquity” (this is when the pelvis is uneven).
- 4.3 In March 2013 a Surrey County Council reviewer from the Out of County Monitoring Team⁷ undertook a monitoring visit. No concerns were recorded regarding the placement or provider. Eight Surrey residents were visited at Beech Lodge on the same day. The visit was recorded in June 2013. There are no further recorded visits by Surrey County Council (the funding authority) until the incident in April 2015.
- 4.4 On the 24th March 2015 Matthew went home to stay with his parents. He returned to Beech Lodge on the 30th March 2015. No swelling or injuries were noted in his care notes upon his return.
- 4.5 During the evening of 31st March 2015, following Matthew being hoisted to his bed it was noted that his right thigh was swollen. The (early) registered nurse was called, they then requested that the deputy manager have a look at Matthew’s thigh. It was agreed that the thigh was swollen and a pillow was placed under his

⁷ The Out-of-County Monitoring Team was set up in February 2013 as part of the Public Value Review Project to undertake reviews of people in Out-of-County placements that had not been reviewed in the previous year. It was set up in response to the Winterbourne Serious Case Review. Team ended in June 2013 and responsibility for reviews handed back to local teams. Surrey IMR.

leg. It is recorded that he was in discomfort but the registered nurse recorded that Matthew did not appear to be in pain however, they did give Matthew Paracetamol.

4.6 There was a handover to night staff at 8pm, both registered nurses checked his right thigh and it was recorded as 'swollen but not right'. The following morning discomfort was recorded when personal care was given. During the morning handover both the day and night nurses checked Matthew. The day nurse thought his leg may be dislocated or fractured and felt he was in pain. ⁸NHS 111 were contacted, they advised to call the surgery. The GP was contacted and advised nurse to call an ambulance.

4.7 On 1st April 2015 Matthew was transferred to hospital by ambulance. On admission, it was noted that the patient was able to communicate "yes" with high pitched squeak. Consent to investigation and treatment form was completed. Section B assessed his capacity and Matthew was deemed to be lacking capacity to consent. The form was signed by a parent acting as his advocate.

4.8 On 2nd April 2015, Beech Lodge informed the Mole Valley Locality Team (by e-mail) about the suspected fracture and that Matthew had been taken to hospital.

Gary

4.9 In March 2003 Gary moved to Beech Lodge.

4.10 In February 2011 swelling and bruising was noted to Gary's left hand during a shower. It was x-rayed and it was confirmed that he had a fracture to the middle finger of his left hand. It was recorded that it was felt that he had damaged his hand when he knocked his hand on the headboard.

4.11 In December 2011, it was found that Gary had a fracture to his left ankle. The recorded explanation was that it was thought he had damaged his ankle when he repeatedly kicked the footplate of his wheelchair. The wheelchair was reviewed by the Chailey Heritage Foundation⁹.

4.12 In June 2013 Gary was allocated to a Camden Learning Disability Service worker for his annual review. A review was undertaken in September 2013 and this was informed by feedback from Gary's sister. She stated that she wanted him to continue to live at Beech Lodge. She did complain that she had not been informed about a blood test or results of the test on Gary.

4.13 On 23rd March 2014 a Mental Capacity Assessment was undertaken. This confirmed that Gary lacked capacity to make decisions around medication, clothes and food. His brother was acting as his representative and advocate.

⁸ NHS 111 is a free-to-call single non-emergency number medical helpline operating in England and Scotland. The service is part of each country's National Health Service and has replaced the telephone triage and advice services provided by NHS Direct, NHS24 and local GP out-of-hours services.

⁹ Chailey Heritage Foundation is a pioneering charity providing education, care and transition services for children and young people with complex physical disabilities and health needs.

- 4.14 On 4th October 2014 Gary's sister informed Camden that her brother had been admitted to hospital by the GP who had concerns about him being lethargic and sleepy. Camden had not been informed by the care home.
- 4.15 On 4th November 2014 Gary was admitted to hospital with aspirational pneumonia. There is no indication that Camden (the placing authority) were informed by the care home.
- 4.16 Gary's placement at Beech Lodge was reviewed by Camden Learning Disability Service in March 2015. It was recorded that Gary seemed happy with his placement, and that his family members were happy with the care he was receiving.
- 4.17 On the 29th March 2015, Beech Lodge night handover notes recorded that Gary had bruising on left outer side of eye and left outer side of lip. The carer reported the injuries and took photographs.
- 4.18 On the 30th March 2015 the care home handover day notes recorded that there was an appointment for x-ray of 'R hip'. It appears that Gary was taken to hospital for an x ray as a precaution. As no appointment had been made the hospital turned them away. It is not recorded which hospital was contacted. The x-ray was booked for 8th April 2015. The reason for this x ray is not recorded. It was also noted that the bruising to Gary's face was warm to touch.
- 4.19 On 31st March 2015 West Sussex Adult Social Care received an incident form from Beech Lodge stating that on 29th March 2015 at 20.30hrs minor bruising was noticed to left outer eye and lip (Gary). No action was being taken by the home. This was recorded in case notes as having been viewed by a senior practitioner and recorded as an 'incident/quality concern'. It was noted that Sussex Health Care had linked bruising to '*new T-bar and fidgeting in bed, family aware*'
- 4.20 On the morning of 1st April 2015 two allocated carers attended to Gary. They placed a sling under Gary ready to hoist him on to a shower trolley. One of the carers then left the room and the second carer carried on with the hoisting procedure alone. With both carers again present Gary was showered. Whilst he was being dressed it was noted that his breathing had altered, and a swelling to his upper left thigh was noted. The registered nurse was informed. They contacted the GP who advised them to call an ambulance.
- 4.21 Gary was transferred to hospital. He was accompanied by a carer who acted as his advocate. Consent to investigation and treatment form was completed, Section B assessed his capacity and Gary was deemed to be lacking capacity to consent.
- 4.22 On 2nd April 2015, Beech Lodge staff made phone contact with the Sussex Partnership Foundation Trust Learning Disability Health Team informing them that Gary had been admitted to hospital and a safeguarding alert had been raised. The same day a Learning Disabilities Health Facilitation Team worker visited Gary. Bruising to face was noted. Gary went to theatre the following day for a pin and plate operation on his left femur.

4.23 On 8th April 2015 the LD Health Facilitation Team contacted the West Sussex Adult Community Learning Disability Team duty to ensure that they were aware of the bruising on Gary's face. They were aware - see 4.19.

Beech Lodge

4.24 In February 2013 Sussex Health Care commissioned their own review of Beech Lodge. This highlighted a number of issues including the use of hoist slings, staff recruitment and the need for the home manager to register with the CQC.

4.25 In June 2013 and June 2014 CQC¹⁰ undertook inspections of Beech Lodge. The inspections (under a previous inspection methodology) found the home to be compliant with a standard of quality and safety that were reviewed at the inspection. The 2014 inspection identified that there was no registered manager in place at the time of the inspection. It was recorded that they had been without a registered manager for a month.

4.26 In October 2014 Sussex Health Care applied for change of registration with CQC to reflect a new company structure. No significant concerns were identified as part of the registration. The existing manager transferred as registered manager under the new legal entity and had day-to-day charge. The manager's position changed a short time after, and they were no longer in day-to-day charge. It was the duty of the provider to inform the CQC of the change. This they failed to do. This left the home operating without a registered manager. (This was identified during the CQC inspection in July 2015)

4.27 On 1st April 2015 Beech Lodge staff raised an incident form for Matthew and Gary. These were sent to West Sussex Adult Safeguarding Team, they also informed funding authorities and family members. They completed a RIDDOR report to the Health and Safety Executive and supplied a copy to the CQC.

4.28 The funding authority Camden recorded the following from Beech Lodge:

Morning staff member found (whilst trying to turn Gary to put him in his sling for personal care) a bruise on his leg and swelling. On site Physio was informed and (Gary's) GP. GP advised to be taken to hospital. At hospital found that Gary had a broken leg (left femur), which the consultant advised could not be explained by Gary's osteoporosis. Hospital raised safeguarding alert.

Two residents from Care Home admitted 1.4.15

Multi-agency Interaction Post 1st April 2015

4.29 The previous paragraphs have provided a basic chronology in respect of Matthew, Gary and Beech Lodge. The following will set out the events as recorded once Matthew and Gary arrived at the hospital. A detailed consideration of the safeguarding enquiry will be set out later in the report.

4.30 At 12.45 hrs on 1st April 2015 the Emergency Department (ED) consultant

¹⁰ The Care Quality Commission (CQC) regulates all health and social care services in England. The commission ensures the quality and safety of care in hospitals, dentists, ambulances, and care homes, and the care given in people's own homes.

documented their review and concerns in both patients' medical notes. It stated:

Whilst this could have been a coincidence it is of concern as these injuries are unusual in immobile patients and these two patients have relatively thick bone cortices despite one having a diagnosis of osteoporosis. I do not think these fractures would have occurred spontaneously and DO have concerns that they MAY have been sustained as a result of non-accidental injury.

Two Safeguarding Alerts, one for each adult, were created by the hospital.

- 4.31 The alerts were received by the West Sussex social worker based within the hospital, and forwarded to the West Sussex Adult Services Community Learning Disability Team 'duty' at 17.28 hrs on 1st April 2015. The e-mail stated:

There are concerns about the home as both customers are bed bound and it is not clear as to how they suffered the fracture.

Safeguarding alerts have been raised for both these cases and uploaded to the document section. Please could you follow up on these alerts as these have risen from incidents in the community.

- 4.32 West Sussex Adult Services Community Learning Disability Team 'duty' informed Camden on 2nd April 2015. Confirmation was sought by 'duty' from Sussex Health Care that only permanent nursing staff would be working at Beech Lodge over the Easter holiday weekend, and confirmed that manual handling techniques were in place. Sussex Health Care confirmed both. (It should be noted that this was Easter weekend 3rd to 6th).

- 4.33 A regulation¹¹ (18) 2 notification was sent to CQC on the 2nd April 2015.

- 4.34 West Sussex Adult Services Community Learning Disability Team 'duty' officer agreed a course of action with their operations manager.

Information gathering to take place and further decisions on 8/4/15 to determine if safeguarding meeting needed.

- 4.35 Documents were received from Sussex Health Care they included:

- CQC notification
- Action Plan
- 2x internal investigations
- Physiotherapy report
- Physio review report 26.3.15 updated 2.4.15.

¹¹ **Care Quality Commission (Registration) Regulations 2009: Regulation 18**: The intention of this regulation is to specify a range of events or occurrences that must be notified to CQC so that, where needed, CQC can take follow-up action. Providers must notify CQC of all incidents that affect the health, safety and welfare of people who use services. The full list of incidents is in the text of the regulation.

- 4.36 On 9th April 2015 the case was allocated to a West Sussex Adult Services Community Learning Disability Team Enquiry Manager and Enquiry Officer.
- 4.37 A safeguarding enquiry meeting was held on 10th April 2015. Present were representatives from Sussex Health Care, West Sussex Adult Social Care and Contracts, Sussex Partnership, Sussex Police and the London Borough of Camden. Gary's brother contacted the Enquiry Officer before the meeting, but was informed that he could not attend this meeting as it would be discussing two individuals so there were issues of confidentiality.
- 4.38 On the same day two West Sussex Council moving and handling advisors visited Beech Lodge.
- 4.39 On 13th April 2015 the Enquiry Officer requested that the Learning Disabilities Health Facilitation Team monitor both men for their physical wellbeing. Beech Lodge were informed that their staff should only visit for social interaction. They were not to be involved with direct care of either Matthew or Gary whilst they remained in hospital. (The monitoring visit took place on 14th April).
- 4.40 On the same day West Sussex County Contracts Team suspended the Sussex Health Care contract for new referrals from West Sussex CC.
- 4.41 On 16th April 2015 the Enquiry Officer was informed by the Enquiry Manager that during the monitoring visit on 14th, it was disclosed that a member of the care home staff had disclosed hoisting a customer on their own, and that the member of staff had been suspended.
- 4.42 On 17th April 2015 Surrey County Council received notes of the safeguarding meeting of the 10th. It is noted in the minutes that apologies were received from Mole Valley Duty Team, however they had no record that Surrey County Council had been invited. The Mole Valley team also stated they had not received an invitation.
- 4.43 On 20th April 2015, the Enquiry Officer received a report from the Moving and Handling advisor identifying a number of concerns.
- 4.44 On the 17th April 2015, the Sussex Adult Services Community Learning Disability Team contacted the LD Health Facilitation Team for an update, stating the safeguarding meeting was set for 23rd April 2015. The hospital Ward Manager stated that neither she nor the consultant had been invited.
- 4.45 A second safeguarding meeting took place on 23rd April 2015. There were separate meetings for both Matthew and Gary. Present were West Sussex Adult Services, Contracts, Sussex Police, SPFT, London Borough of Camden, CQC and the Moving and Handling advisor. Matthew's father and Gary's brother attended their respective meetings. At this meeting it was agreed that Gary would not return to Beech Lodge.
- 4.46 On 27th April 2015 the West Sussex Council moving and handling advisors visited the care home again.

- 4.47 On 11th May 2015 contact was made with all funding authorities with customers at the Care Home, to advise them they should prioritise reviews of their customers placed there.
- 4.48 In May 2015 the Learning Disabilities Health Facilitation Team were informed that neither family wished their relatives to be returned to Beech Lodge.
- 4.49 On 21st May 2015 the care home staff member who was supporting Matthew with personal care during the afternoon of 31st March, was interviewed by the Enquiry Officer and the Moving and Handling advisor.
- 4.50 On 8th June 2015 the care home nurses who had previously provided statements, were interviewed by Enquiry Officer and the Moving and Handling Advisor.
- 4.51 On 19th June 2015 a safeguarding meeting was held. Present were father of Matthew, the Independent Safeguarding Chair, Enquiry Officer and Enquiry Manager, the Contracts Commissioning Officer and Senior Practice Lead Surrey County Council. The aim of the meeting was to seek feedback on the draft safeguarding enquiry report.
- 4.52 On 24th June 2015, a safeguarding meeting was held. Present were brother of Gary, the Enquiry Officer and Enquiry Manager and the Independent Chair. Camden had been invited but did not attend. Both of these meetings were recorded as safeguarding meetings.
- 4.53 On the same day Gary's brother made a formal allegation to Sussex Police. On 3rd July 2015 Matthew's father made a formal allegation to Sussex Police.
- 4.54 On the 23rd July 2015 a Safeguarding Meeting was held. Present were West Sussex Adult Services, Sussex Health Care and CQC. There were apologies from police. Representatives of Matthew or Gary were not involved in this meeting.
- 4.55 The Enquiry Manager recorded of the safeguarding enquiry report that:
There are still some unanswered questions with regard to this enquiry and it is my recommendation that it remains open until the police have concluded their investigation.
- 4.56 A professional safeguarding meeting took place on 20th May 2016. Representatives of Matthew or Gary were not present. The meeting received updates in respect of the police investigation. The meeting was informed that files had been sent to the Crown Prosecution Service for a decision. The meeting also considered other concerns that had arisen in respect of other Sussex Health Care Homes.
- 4.57 In November 2016 letters were sent to families informing them that the police investigation had concluded and that the safeguarding enquiry would be closed. The enquiry is recorded as completed on 8th November 2016.

5 ANALYSIS OF EVENTS

SECTION ONE

Introduction

- 5.1 This section will examine the actions taken by Beech Lodge staff when injuries were identified, the agencies' response to safeguarding concerns, the role of the safeguarding meetings and the role of the police in the investigation.

Sussex Health Care Beech Lodge

- 5.2 The following information was taken from the interviews of the staff undertaken during the original safeguarding enquiry, the police investigation and the Sussex Health Care individual management review.

5.3 Matthew

During the evening of 31st March 2015 Matthew was taken to his room by a member of staff. It is stated that the member of staff said that he did not need any help. After a period of time this member of staff went to find a second member of staff to help hoist and transfer Matthew onto his bed. The second member of staff described Matthew as being red faced.

- 5.4 The two staff members then hoisted Matthew from his chair to his bed. When his clothes were removed it was noted that his right thigh was swollen. The (early duty) registered nurse was called, they then requested that the deputy manager have a look at Gary's thigh. It was agreed that the thigh was swollen and a pillow was placed under his leg. It is recorded that he was in discomfort but the registered nurse recorded that Matthew did not appear to be in pain. However, they did give Matthew Paracetamol.

- 5.5 There was a handover to night staff at 8pm, both registered nurses checked his right thigh and it was recorded as 'swollen but not right'.

- 5.6 The police investigation identified a gap of either 15 minutes or 45minutes dependent on which version of events is correct, between the member of staff taking Matthew to his room and then requesting assistance. There is a lack of clarity as to what happened during the period that the member of staff was on their own with Matthew.

- 5.7 When interviewed, the registered nurse stated that she asked the agency nurse from the south wing and the nurse from Oak Lodge to come and assess the thigh. They thought it might be a pulled muscle. The police investigation identified that a broken leg was considered.

- 5.8 The post incident safeguarding enquiry failed to identify the exact point at which Matthew's injuries might have occurred. As will be highlighted later in the report, there are a number of discrepancies in the evidence provided by members of staff who were subsequently interviewed. This includes whether one of the staff members, on being asked to change Matthew's pads, indicated that he could do it on his own.

5.9 The following morning when personal care was given, Matthew was seen to be in discomfort. During the morning handover both the day and night nurses checked Matthew. The day nurse thought his leg may be dislocated or fractured and felt he was in pain. NHS 111¹² was contacted and they advised to call the surgery. The GP was contacted, they advised them to call an ambulance.

5.10 **Gary**

It is recorded that Gary's injuries were first identified when he was being hoisted during the morning of 1st April 2015. During her interview with the Moving and Handling advisor and the Occupational Therapist (on 30th April 2015). The first carer admitted that they were continuing to hoist Gary on their own when the second carer, who had been with them when they started to move Gary, had left the room.

5.11 When asked when they had first noted a problem, she stated that they (two staff) had to move Gary on the shower trolley back to the bedroom to dry him, as there was not enough room to dry him in the bathroom. When they rolled him on the shower trolley on to his left hand side they noticed his breathing had changed. She looked at Gary's leg and noticed an 'indent' on his leg below his hip.

5.12 It was at this point that the carer went to get the nurse in charge at the time. The nurse was not sure what was wrong, so she asked the staff to hoist Gary back onto the bed. The nurse went to get the manager and the physiotherapy assistant. It was the physiotherapy assistant who identified that there was a problem. As a result, the manager contacted the GP who advised calling an ambulance.

5.13 Moving and hoisting Gary on their own was against company procedure. However, the Moving and Handling Advisor and Occupational Therapist have commented upon the moving of Gary back onto the bed. Their report states:

This would mean rolling Gary to position his hoist sling. By rolling him this could have displaced the fracture. Displacement of the fracture was noted on the X-Ray report.

Observations

5.14 There are a number of issues that arise from these circumstances as recorded. Firstly, in relation to Matthew, the issue which has always been of concern to his family is the care home's staff response to the identification of possible injuries on 31st March 2015.

5.15 The action taken by the registered nurse was to provide Matthew with Paracetamol. It was a further 15 hours before an ambulance was called. Given the injuries that he was subsequently found to have sustained, the delay was significant and could have been avoided. His swollen thigh was also noted at handover at 8pm.

5.16 This specific issue was considered as part of the safeguarding enquiry and then the

¹² NHS 111 is a free-to-call single non-emergency number medical helpline operating in England and Scotland. The service is part of each country's National Health Service and has replaced the telephone triage and advice services provided by NHS Direct, NHS24 and local GP out-of-hours services.

later police investigation. A Consultant Orthopaedic Surgeon provided written opinion to the enquiry. They recorded the following:

The fractures would, or should, have been noticed straight away due to pain experienced by the patients, but also due to the deformities observed during nursing. The fact that the patients have limited ability of communication renders it somewhat difficult and relied on nursing acumen.

- 5.17 Given these professional observations about the anticipated level of pain it is surprising that the serious nature of the injury was not recognised (two registered nurses examined the leg) during the evening of the 31st and action taken immediately. The police investigation considered the actions of the nursing staff but found no evidence of criminal action. The review of the police investigation concluded that;

The decision made not to make immediate referral to hospital could be said to be made in good faith.

- 5.18 There is no evidence that any pain management /identification tool which identifies how individuals present when they are experiencing pain such as Disability Distress Assessment Tool (Dis DAT) was in use. For some people the signs can be very subtle hence the importance of using a tool such as a Dis DAT to help identify if someone is in pain.

- 5.19 The second issue highlighted is why an ambulance was not called immediately on the morning of 1st April 2015. The manager stated to the enquiry that due to the Care Act there is a requirement for staff to always call 111 first.

- 5.20 This statement is strange as there is no such requirement under the Care Act and as such, seems to be an excuse/justification for the action taken.

- 5.21 In respect of Gary there is clearer evidence that the injury to his leg might have been caused by manual handling, and (accepting that has not been definitively proved) at what point in time that it probably occurred. However, actions taken by staff at the nurse's instruction after Gary's leg was noticed to be swollen, the moving off the trolley back onto the bed has to be questioned.

- 5.22 Given that it was known that he suffered from osteoporosis, this additional action would probably have caused potentially more damage and distress to Gary.

Manual Handling and Osteoporosis

- 5.23 As it was known that Gary had a diagnosis of osteoporosis, manual handling procedures should have taken this into account. The Sussex Health Care (Jan 2018) review report identified the following:

From the limited information available it appears that the 'moving and handling' training at the time was general in its nature and application, there appears to be an assumption made that where service users had specific 'moving and handling' needs this would be addressed in the service. There is little evidence in the information available to me that this was happening prior to the incident in April

2015 at Beech Lodge.

- 5.24 The individual's care plan should highlight the specific requirements for Gary in respect of his osteoporosis. The Sussex Health Care report states:

. . . at the time being reviewed (2011- 2015) there is no evidence in the files available that osteoporosis was identified as an increased risk and therefore it would not have been picked up as necessarily requiring additional training. Where people are unaware of the risks or complications associated with a known condition, I would expect them to seek information and guidance from a known authority. This information should then be made available in the care plan documentation.

- 5.25 It is acknowledged by Sussex Health Care that their practice did not mitigate increased risk. They stated:

The risk of injury due to osteoporosis and any action required to mitigate the risk is not identified or detailed in care planning documentation. It is merely stated that this is a known condition.

A best practice approach would expect the risk that osteoporosis presented to be clearly highlighted at the front of the care folder and information on how to mitigate that risk fully detailed on 'moving and handing' care plans with a cross reference to that plan on every other relevant plan, e.g using T roll; pressure care'.

In particular, the 'frequency of turn' chart would benefit from a section that highlights any increased areas of risks and a cross reference for detailed plans.

- 5.26 This review highlights the additional risks associated with osteoporosis and the need for all staff to be aware of the risk the condition poses, and care plans taking into account these risks.

5.27 **Care Home Staffing**

Within Beech Lodge there was a mixture of staff, registered nurses and carers - some employed by Sussex Health Care and some supplied by a number of agencies.

- 5.28 In this case a number of staff who were on duty at the time of the incident were agency staff. When explored with the company, there was an expectation that the agency would ensure that the staff they supplied were checked, and that the skills and training that they were recorded to have were genuine. Agency staff when working, were expected to sign to confirm that they had read procedures and care plans. There was no system in place to confirm that staff were who they stated they were, or that they had read the required document. The Sussex Health Care report has recognised the risk of that process, they state:

It is not sufficient to say that staff are 'expected' to read individual care plans and sign to say they have done so. Checks should be made by Home Managers and Area Managers to ensure that this is the case, not only that they have read it but also understand the content. Best practice would also detail that care practice and

knowledge forms part of the supervision process and staff meetings.

The Agency Nurse Induction form makes no mention of safeguarding; it is however documented on the agency training profiles. Best practice would dictate that safeguarding expectations and processes were, as a minimum, summarised and displayed in a staffing area, so that they are fully accessible to all staff.

5.29 The failure of the system was highlighted in the June 2015 police investigation. An individual thought to be the agency carer who left the room before Gary was hoisted when interviewed by police denied being at the home. Beech Lodge staff were unable to identify him to confirm that he had been working. It is not clear if the individual interviewed was working and lied, or someone was using his identity to work illegally in his place. This raises a number of concerns, why would he lie, what has he to hide and if he is not lying, an unknown individual purporting to be someone else was working with vulnerable adults.

5.30 Care Homes use a significant number of agency staff. They should have in place systems to audit the fact that the agencies are undertaking robust checks on the staff they supply, and that the identity of staff reporting to work are confirmed.

5.31

West Sussex Adult Safeguarding Board to be assured that Sussex Health Care have systems in place to ensure:

- Within their care homes, any indication that an adult might have sustained a serious injury, should be responded to immediately by seeking medical assistance, including the option of calling 999.
- There is a process in place to ensure that the identification of agency staff working is confirmed.
- Care Plans for residents with osteoporosis should clearly identify the condition and the additional risks it poses, including a clear individual manual handling plan.
- They have in place a pain identification tool to assist staff to effectively respond to pain.

Safeguarding Response

Hospital

5.32 Matthew was taken to the local Hospital Emergency Department (ED) and was triaged at 11.04 am. Gary was also taken to the same hospital. He was triaged at 11.33 am. Concerns were immediately identified by the clerking Doctor who discussed their concerns with the duty consultant. The Emergency Department Doctor then discussed the cases with the Trust's Safeguarding Team. (The Hospital was located in Surrey and followed the Surrey Safeguarding Adults procedures).

5.33 The Emergency Department Consultant documented his concerns in both patients' medical notes at 12.45pm. He wrote:

“Whilst this could have been coincidence it is concerning as these injuries are unusual in immobile patients and these two patients have relatively thick bone cortices despite one having a diagnosis of osteoporosis. I do not think these fractures would have occurred spontaneously and DO have concerns that they MAY have been sustained as a result of non-accidental injury”.

- 5.34 This was an important entry that encapsulated the serious concerns of the Consultant and should have informed future action until further evidence became available.
- 5.35 The prompt identification of the safeguarding concerns by staff in the Emergency Department, which led to the consultation with the Trust Safeguarding Team and notification, was good practice and demonstrated the vigilance and awareness of staff to adult safeguarding issues.
- 5.36 A separate Safeguarding Alert Form ¹³(SVA1) was completed for each of the patients by different individuals. These were submitted to West Sussex Safeguarding Team Community Learning Disabilities Team via the hospital based West Sussex Social Worker who emailed the alerts at 17:28.
- 5.37 Both forms lacked detailed information. There is no explanation of the ‘safeguarding concerns,’ (Section 2 on both forms) this section was left blank. On both forms the question “*Are the police aware or involved? If yes give details:*” Were marked yes with no further details. It has now been established that the police had not been informed on the day by any agency, and did not become aware of the incidents until 9th of April 2015.

Observations

- 5.38 There were at that early stage a number of hypotheses as to how the injuries to Gary and Matthew could have occurred. They ranged from:
- Complete Accident
 - Avoidable Accident
 - Deliberate Act
- 5.39 The last two options could potentially have been criminal acts including assaults such as section 20¹⁴. Securing of evidence at an early stage was essential to establishing the facts.
- 5.40 The Consultant recorded their belief that the injuries sustained by both individuals were potentially non-accidental. This indicates a possible deliberate act and therefore a crime. The police should have been the lead agency and should have been involved at an early stage.

¹³ SVA1 West Sussex Safeguarding Alert Form.

¹⁴ [Offences Against the Person Act 1861](#) Section 20. Whosoever shall unlawfully and maliciously wound or inflict any grievous bodily harm upon any other person, either with or without any weapon or instrument, shall be guilty of a misdemeanour .

5.41 The Surrey and Sussex Health Care¹⁵ (SASH) individual management review states:

The Trust works to the Surrey Safeguarding Adults Board Multi-agency procedures, information and guidance document. In relation to contact with the police, the document states the following:

Criminal offences and safeguarding adults

“Everyone is entitled to the protection of the law and access to justice. Behaviour which amounts to abuse and neglect, for example physical or sexual assault or rape, psychological abuse or hate crime, wilful neglect, unlawful imprisonment, theft and fraud, and certain forms of discrimination also often constitute criminal offences. Although the local authority has the lead role in making enquiries, where criminal activity is suspected, then the early involvement of the police is essential.

A criminal investigation by the police takes priority over all other enquiries, although a multi-agency approach should be agreed to ensure that the interests and wishes of adults are considered throughout, even if they do not wish to provide any evidence or support a prosecution.

5.42 The individual management review confirmed the following:

In addition, the Trust safeguarding policy does in fact state as a duty for the Ward Manager/Matron:

Discuss allegation with Social Services and ensure any other agencies have been informed or involved e.g. Police. If necessary contact the Police directly.

5.43 Braye, Preston-Shoot¹⁶ (2017) report into learning from London SARs highlights the following:

The timing of information sharing was recognised as crucial too. One SAR emphasised the importance of early information sharing with Police by agencies such as the Ambulance Service, Adult Social Care and the Hospital, in order not to miss forensic opportunities relating to a possible crime scene.

5.44 The explanation as to why the police were not informed by the hospital, or why forms were not completed correctly appears to be one of communication failure between different teams, leading to confusion.

5.45 As set out at section 3 within the hospital there is an in-house Safeguarding Team. It was this team that the Consultant and Emergency Department staff liaised with, specifically the Named Nurse for Safeguarding Adults. The nurse believes that she contacted Surrey Social Services to inform them about Matthew and Gary. She

¹⁵ Surrey and Sussex Healthcare NHS Trust provides emergency and non-emergency services to the residents of east Surrey, north-east West Sussex, and South Croydon, including the major towns of Crawley, Horsham, Reigate and Redhill. They provide acute and complex services at to hospital (East Surrey Hospital) in Redhill.

¹⁶ [Braye, Preston-Shoot \(2017\); Learning from London SARs. Report for the London Safeguarding Adult Board.](#)

believed that they (Social Services) said that they would contact the police. There is no record of this conversation. There is however a note in the hospital safeguarding team note book.

It states that at 13.45 I handed over to X in WSSC the details of both patients as it was not completed on the form.

- 5.46 It is recorded in e-mails that the West Sussex hospital based social worker acknowledged the alerts at 17.23 hrs on 1st April 2015, and forwarded the alerts at 17.28 hrs to West Sussex Duty CTPLD north.
- 5.47 Given the serious concerns that were recorded by the consultant, there is no clear explanation as to why the police were not then contacted. It could be that having made a referral to West Sussex Hospital Adult Social Care Team, it was believed that they would then make the decision in respect of further action. It may be, as expressed by the safeguarding nurse, that they believed that social services from either Surrey or Sussex (it is not clear to which area team she spoke) stated they would inform police. There is no record of any such decision being made.
- 5.48 What this case highlights is the importance of accurate recording of both information on forms such as the safeguarding alerts, and to accurately record actions taken including who and when and the result of any conversation.
- 5.49 Agencies, including hospitals, should not be reliant on or make assumptions about how another agency will respond. As the Surrey Safeguarding Adult Policy highlights, they should have contacted the police directly.
- 5.50 The poor completion of both safeguarding forms containing partial or no information, and in regard to informing police incorrect information, hindered the initial decision making by the individual in receipt of the alert. It is of note that the forms were completed by different individuals within the Emergency Department. The fact that they lacked similar information, would indicate that this was common practice rather than a one off individual failing. It is also of note that the forms were completed by hand which limited the space for details of concern section 2.
- 5.51 The recently released Braye, Preston-Shoot report highlights the following:
- Records and recording
- Nineteen of the 27 SAR's identified learning about how practitioners record their work, or how the organisations provide them with recording systems and processes. The issues were diverse, but a common theme was an absence of key information in the case record.*
- 5.52 What has become evident during the review is the confusion that can arise when a hospital covers more than one area. In this case Surrey and West Sussex. The fact that there are two social care teams, one each from the areas is good practice, but as can be seen, in this case led to some confusion as to who was reporting to which team.

5.53 It is important to ensure that all staff are fully aware of the roles of the differing teams, and are clear as to what route is taken, dependent on the location at the time of the safeguarding concern.

5.54

Recommendations

West Sussex Adult Safeguarding Board to:

- *ensure that all agencies' staff recognise the need to report to police without delay, serious unexplained, potentially non-accidental injuries suffered by adults at risk.*
- *be assured (through audit) that adult safeguarding concern forms are being fully completed with all required information, in order that informed safeguarding assessments and decisions can be made.*
- *work with the Surrey Adult Safeguarding Board to ensure that East Surrey Hospital has in place policy and procedures that provide clarity about the geographical team split, and the reporting processes, including escalation policy.*

West Sussex Adult Community Learning Disabilities Team

5.55 The West Sussex Adult Community Learning Disabilities Team 'Duty' received a number of notifications in respect of Gary and Matthew.

5.56 Firstly, on 31st March 2015 they received from Beech Lodge an incident of concern form relating to Gary. This reported minor bruising to his left eye and lip. It was recorded on Frameworki (local authority electronic recording system) AS008¹⁷ as an "an incident/quality concern" The WSCC form recorded:

A 'T' bar has been in place to support Gary. This has only been put in place this week. As Gary moves around in bed they feel it could be linked to fidgeting.

The information and advice section states:

On discussion with the staff nurse it appears that the family (siblings) have expressed concerns and advice was given that if Beech Lodge feel it relevant to find out what has happened then they can internally investigate but as far as safeguarding it has been logged as an incident.

5.57 The following day on 1st April 2015, they received a safeguarding alert form (SVA 1) from the hospital in respect of Matthew and Gary (previously discussed) and an incident form from Beech Lodge in respect of Gary. The latter form stated:

At 8.30am X notified Gary in pain when she went to support with personal care, nurse in charge and physio assistant were notified, GP called and Gary was

¹⁷ AS008 West Sussex Electronic Incident Device Quality Report

admitted to hospital.

5.58 AS009¹⁸ forms (one for each individual) were commenced by the West Sussex Adult Community Learning Disabilities Team 'Duty' on 1st April 2015. On entries dated 1st April 2015 (Matthew) and 2nd April 2015 (Gary), the Enquiry Manager¹⁹ recorded that the circumstances for both incidents required a section 42²⁰ enquiry to commence. These entries appear to have been entered retrospectively as the Enquiry Manager was not yet allocated to the case until 9th April 2015 and he was not working in 'Duty' during this period.

5.59 SCIE²¹ Adult Safeguarding Practice Questions states:

A Section 42 enquiry must take place if there is reason to believe that abuse or neglect is taking place or is at risk of taking place, and the local authority believes that an enquiry is needed to help it to decide what action to take to support and protect the person in question. The particular circumstances of each individual case will determine the scope of each enquiry, as well as who leads it and the form it takes.

5.60 It should be noted that the Care Act 2014 came into force on 1st April 2015.

5.61 A number of enquiries were commenced, including with Beech Lodge and with family members. Gary's brother raised a concern about the bruising, reported the previous day and it is recorded that:

Home Manager had been asked if bruising and fractures were linked and she said "didn't think so".

5.62 The placing local authorities - Surrey County Council and the London Borough of Camden - were informed on 2nd April 2015 along with the Care Quality Commission (CQC). It is recorded in respect of Matthew and Gary that:

Agreeing course of action with Ops Manager- information gathering to take place and further decisions on 8/4/15 to determine if Safeguarding meeting needed.

It should be noted that this incident took place just prior to the Easter Weekend. Risk reduction was considered, as there are a number of entries including:

¹⁸ AS009 I West Sussex Electronic Safeguarding report forms the West Sussex electronic safeguarding recording form.

¹⁹Role of the Enquiry Manager: At the point where the local authority's duty of enquiry is triggered ie. the three key tests are met, an Enquiry Manager will be appointed by the local authority. Every enquiry undertaken under Section 42 will have an Enquiry Manager appointed. Their overall role is to have responsibility for co-ordinating responses and decision making, and to ensure the local authority's duty under Section 42 of the Care Act is discharged appropriately. There may be an Enquiry Officer to support the Enquiry Manager. All Enquiry Managers must have appropriate training.

²⁰ An enquiry is any action that is taken (or instigated) by a local authority, under **Section 42** of the **Care Act 2014**, in response to indications of abuse or neglect in relation to an adult with **care** and support needs who is at risk and is unable to protect themselves because of those needs.

²¹ Social Care Institute for Excellence (SCIE) *Adult Safeguarding Practice Questions*: March 2015.

Copy of email to X requesting reassurance re manual handling techniques prior to Easter Break.

Copy of email from (home) confirming only permanent nursing staff will be on site over Easter Break.

5.63 There are then no further entries until 8th April 2015.

Observations

5.64 In respect of a Section 42 enquiry, SCIE²² comments:

The local authority may decide that another organisation should carry out the enquiry, but the local authority will retain overall accountability. The local authority must satisfy itself that the organisation will meet agreed timescales and follow-up actions. Whatever form the enquiry takes, the following must be recorded:

- *details of the safeguarding concern and who raised it.*
- *the views and wishes of the adult affected, at the beginning and over time. and where appropriate the views of their family.*
- *any immediate action agreed with the adult or their representative.*
- *the reasons for all actions and decisions.*
- *details of who else is consulted or the concern is discussed with any timescales agreed for actions.*
- *sign-off from a line manager and/or the local safeguarding lead or designated adult safeguarding manager.*

5.65 Whilst there were a number of enquiries being undertaken by the West Sussex Adult Services Community Learning Disability Team 'Duty' and then by the Enquiry Officer, the recorded entries raise a number of questions.

5.66 Firstly, given the serious nature of the injuries, what action was taken to safeguard the remaining residents still in the care home? There were clearly concerns as can be seen by the e-mails, which focused on agency staff and manual handling. But the reasoning behind these questions is not clear.

5.67 The West Sussex Adult Services individual management review highlights the following concerns:

This constitutes a safeguarding plan focusing on the risk of neglect to others (particularly through manual handling error) but is not clearly articulated as such and does not address other potential causes of risk which had not been ruled out at this time.

5.68 There appears from an early stage of the enquiry, to have been an assumption that manual handling was the probable cause of the injuries to both individuals. At that time, there was no evidence other than feedback from the care home management that this was the cause of the injuries.

²² www.scie.org.uk/care-act-2014/safeguarding-adults/adult-safeguarding-practice-questions/

- 5.69 There is no evidence that (prior to 8th April 2015) the police were informed of the incident. Whilst as highlighted at 5.62 a safeguarding meeting was to be considered, there is not recorded consideration of holding a 'planning' meeting (known as strategy meeting prior to the Care Act) to consider police involvement. Even if there had been an assumption that the police had, due to the entry of the hospital SVA 1, been informed, there is no indication in the notes that any individual in receipt of the alert in Duty contacted police to confirm if they were or were not undertaking an investigation.
- 5.70 There is no evidence recorded that Duty was aware of the recorded comments by the Emergency Department Consultant until a few days later. They were eventually recorded on the AS009 on the 9th April 2015, the day the case was allocated to an Enquiry Officer.
- 5.71 The serious nature of the injuries, the fact that they occurred at the same care home complex within a short period of time, and the fact that the Consultant strongly indicated that they were potentially non-accidental should have led to a police response. They were not made aware of the incidents until 9th April 2015, when they were invited to attend a safeguarding meeting arranged on 10th April 2015.
- 5.72 There is also no indication, other than the Easter Break staffing reassurances, that there was any risk assessment undertaken to consider the safety of the other residents. Other funding/placing authorities were not informed for a number of days.
- 5.73 *SCIE states:*
- Local policies and procedures should make clear the circumstances in which the police should be informed. In many cases it may be best to have an informal discussion with the police, together with the affected adult or their representative, to decide whether a police response is necessary.*
- It is essential to avoid a situation where a crime is effectively concealed by agencies carrying out their own enquiries. If a decision has been made to call in the police, they should be involved at the earliest opportunity. This is to ensure that key forensic evidence is not lost or damaged, and because a higher standard of proof is required in criminal proceedings than in disciplinary or regulatory proceedings. Early contact with the police may therefore help in obtaining and securing vital evidence and witness statements, leading to a successful prosecution.*
- Once the police are involved, their enquiries may take precedence over any others that may be in progress, and how these interact with matters such as internal disciplinary hearings will need to be coordinated locally.*
- 5.74 This explains the need for early contact with the police, and indicates the problems that occur when an agency, in this case the care home, starts to investigate themselves and starts to provide evidence.

5.75 This is also set out in ²³Department of Health guidance:

In other circumstances where the safeguarding concerns arise from abuse or neglect, then it would not only be necessary to immediately consider what steps are needed to protect the adult, but also whether to refer the matter to the police to consider whether a criminal investigation would be required or is appropriate. It should be remembered that abuse may consist of a single or repeated act. It may be physical, verbal or psychological, an act of neglect or an omission to act. Defining abuse can be complex but it can involve an intentional, reckless, deliberate or dishonest act by the perpetrator. In any case where you encounter abuse and you are uncertain about your next steps, you should contact the police for advice.

5.76 The SCIE and the Government guidance confirm the need for early contact with police when abuse is suspected. In this case there was no early contact. This led to an eight day delay, a delay partly caused by the fact that there was a four day holiday break. Such a break should not have led to a delay. This was not a case of just one individual with injuries, but involved two individuals sustaining the same type of serious injuries in the same time period, at the same location.

5.77 At that early stage all potential hypotheses (as previously listed) should have been under consideration. Manual handling appeared to be the favoured explanation. What was not being considered was whether the injuries could have been committed by the same individual within the care home deliberately. If this had been the case other residents may have been at risk.

5.78 Prior to the fracture there had been a notification of injuries to Gary's face. Whilst this was recorded as an incident, it is of note that the family members had expressed concerns. The incident report did not set out what those concerns were. Without that understanding of their concerns it is unclear how the decision to leave action to the home was reached. Once the fracture was reported the facial injury was dismissed as not being connected very early on in the enquiry. Whilst it formed part of the section 42 enquiry there is no clarity as to how the injuries to the face occurred.

5.79 The Sussex Health Care report prepared for this review makes the following comment:

In relation to the bruising/incident 31.03.2015; the conclusion of the investigation is ambiguous as to how the injury may have occurred. The original enquiry centred heavily on the care notes made at the time and possible injury from the T Roll. When this was ruled out, it was deemed to be 'cause unknown'. There does not appear to be any statements included from staff working at the time or a review of the equipment in the room. It would appear from the notes available that this investigation was not rigorous or robust, failing to take into account the opinion of x that this injury may have been intentional or consider any other cause apart from the T Roll.

²³ Department of Health: Care and support statutory guidance.
www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

5.80

Recommendation

West Sussex Safeguarding Adult Board to:

ensure that policy, procedure, and training, highlights the need, in potentially complex situations involving unexplained injuries to an adult at risk, for the police to be made aware as soon as possible.

West Sussex County Council Safeguarding Enquiry Meetings.

5.81

Safeguarding enquiry meetings were an opportunity to ensure enquires were focused and safeguarding plans appropriate. The following will consider the impact of the safeguarding meetings.

5.82

The Enquiry Manager confirmed that the injuries sustained by Matthew and Gary would be subject to a Section 42 enquiry on 2nd April 2015.

5.83

The initial safeguarding enquiry meeting was held on 10th April 2015, 10 days after the initial referral.

In attendance were:

- Enquiry Manager (Chair)
- Enquiry Officer
- Service Manager WSLDT
- WSCC Contracts Officer
- Service Manager Camden
- Sussex Police
- 2 x Sussex Health Care representatives

5.84

The meeting minutes note that family members had not been invited due to confidentiality. Gary's brother had asked to attend but was informed that he could not.

5.85

It is minuted that as well as the serious injuries to Matthew and Gary the bruising to Gary's face was also being considered.

5.86

It is evident that most enquiries, including staff interviews, up to the date of that first meeting, had been undertaken by Sussex Health Care staff, specifically the Care Home Manager. This is evidenced as the manager was providing updates to the meeting. This demonstrates a lack of direction having been given to Sussex Health Care by the Duty or the Enquiry Manager/Officer, as to exactly what actions they should have taken to support the safeguarding enquiry i.e. information gathering only (checking care records etc.), or, as they did, conduct staff interviews.

5.87

There was no clarity as to how the injuries, including the facial injury to Gary, had occurred. The police representative noted that it was imperative for someone to speak with Matthew. It was recorded that he:

Concluded that there are two unexplained injuries at this stage. Without more information, it was not possible to call whether there is a criminal element.

It was also recorded later in the minutes:

X confirmed that unless the Police receive evidence of a deliberate act, the investigation will remain with Social Services and Contracts who need to gather more information. The chronology to be supplied by Sussex Health Care may highlight a potential area of concern.

- 5.88 The injuries were unexplained and so criminal intent could not and should not have been ruled out. Police asked to be supplied with a chronology of events in order to allow an ongoing assessment, but did not agree to lead the investigation/enquiry at that stage. It is noted that at this meeting there was no representation from the hospital. They were not listed in the minutes as individuals invited but not attending so the assumption is that they were not invited, they should have been. The update given by the Enquiry Officer stated that the consultant was away on annual leave and the hospital was reluctant to give any information until his return.
- 5.89 Whilst this may be true in respect of any updated information, what the members of the meeting were not informed about was the statement recorded by the Consultant on the day Matthew and Gary attended the Emergency Department. The Enquiry Officer had recorded the statement on the IT system so was aware of it by the time of this meeting. This was an important statement as it was the most informative comment about the injuries available at that time. The fact that the meeting was not informed of this statement had a major impact on the effective decision making at the meeting.
- 5.90 A second Safeguarding enquiry meeting took place on 23rd April 2015. This meeting was split into two parts, one for each individual. Family members attended the appropriate meeting, as did the following:
- Independent Chair
 - Enquiry Manager
 - Enquiry Officer
 - Contract Commissioning Manager
 - Area Manager Provider
 - Quality Lead Provider
 - Service Manager Sussex Partnership Trust
 - CQC Inspector
 - Police
 - London Borough of Camden
- 5.91 It is recorded that there were a number of issues of concern having been identified in respect of Sussex Health Care, and as a result the West Sussex County Council Contracts team had suspended the Sussex Health Care contract. This suspension was only in relation to placements by West Sussex County Council. This did not impact on placements from other Local Authorities or self-funders. Any decision to suspend remained the responsibility of the placing authority.
- 5.92 Information received in a letter from an Orthopaedic Consultant and an email from the Emergency Department Consultant was discussed. The former letter stated:

the patients had fixed deformities and that in combination with the disused osteopenia, due to their immobility, these are factors that can precipitate fractures upon minimal manipulation (hoisting etc.)

In respect of the ED Consultant's e mail the meeting minutes recorded:

Dr X was not able to comment on the likely cause whether deliberate or accidental, but suggested that fractures could have been caused by bending force to the Femur. He thought it was highly unusual to see two of this kind of injury sustained by accident on the same day.

- 5.93 The differing opinions highlight that at that stage it was still unclear if the injuries were accidental, bad practice, or deliberate.
- 5.94 Further safeguarding enquiry meetings took place on 19th June 2015, for Matthew and on 24th June 2015 for Gary. It is noted that these meeting were recorded in different formats to the first two meetings.
- 5.95 The aim of these meetings was to review the draft safeguarding enquiry report. Sussex Health Care and CQC had not been invited as there was a further meeting on 30th June 2015. There is no evidence that this meeting took place.
- 5.96 Both families expressed concerns about the safeguarding report at their respective meetings. Matthew's family specifically in respect of the contradiction in the evidence, and Gary's family around the factual accuracy of the report and concern around what some witnesses had stated. Both believed the police should have led the investigation and were requesting the police should investigate.
- 5.97 A further safeguarding meeting was held on 23rd July 2015. In attendance were:
- Chair (Learning Disabilities Operations Manager)
 - Enquiry Manager
 - Area Manager Sussex Health Care
 - Deputy of Operations Sussex Health Care
 - Quality Lead Provider
 - 2 X CQC inspectors
 - Moving and handling Advisor
 - WSCC Contracts Manager.

Police sent apologies.

- 5.98 The minutes recorded the following:

The Chair outlined that the purpose of today's meeting was to come to a conclusion around the enquiry that has taken place into the two gentlemen who sustained similar fractures at Care Home.

It is of note that the family members were not involved with the meeting and there are no indications that they were invited.

5.99 Family views are noted in the minutes:

The families have given feedback that they are satisfied in how the enquiry has been looked into and that they are satisfied with the outcomes that X has identified within her report. They understand that the enquiry did not discover what actually happened but that lessons have been learnt.

5.100 This paragraph comes after it is recorded that the families are keen that the police consider undertaking an investigation around neglect. The enquiry manager had in the enquiry report recommended that the enquiry remain open until the police investigation had been concluded. This was not reflected in the minutes of this meeting.

5.101 The author has not been able to identify any strong evidence to support the statement about the families being satisfied. Their remaining significant concerns were not recorded.

5.102 A year later in May 2016 a further meeting, described as a professionals meeting, took place. Present were representatives from

- WSCC Learning Disabilities
- Enquiry officer and former Enquiry manager
- Police
- CQC Deputy Designated Adult Safeguarding Nurse CCG
- WSCC Contracts Commissioning Manager

5.103 Family representatives were not invited as it was declared a professionals meeting that would receive not only an update of the ongoing police investigation in respect of Matthew and Gary, but also to consider ongoing concerns about Sussex Health Care (identified post April 2015). The minutes note that the family would be updated - the author has no evidence that that took place.

Observations

5.104 The initial meeting took place ten days after the initial referral. The police were not informed for nine days after the initial incident, and there is no clarity as to the direction of the enquiry being led by West Sussex. It appears that it was believed that a Sussex Health Care Area Manager, not responsible for the specific home, was undertaking the investigation. What emerged was that the manager of the home undertook some of the investigation, removing any form of independence.

5.105 Immediate safeguarding actions were put in place i.e. confirmation that all staff over the Easter period were trained in manual handling and there would be no agency staff. This plan was based on the acceptance that the safeguarding risk was the application of manual handling procedures.

5.106 CQC did not attend the initial meeting. The CQC individual management review explains the reasoning behind this decision as follows:

The decision, by the lead inspector, not to attend the first safeguarding meeting on

the 10 April 2015 was in line with guidance provided to inspectors at the time in relation to the criteria for attending safeguarding meetings. This was because the limited information received did not indicate a potential breach of Regulations, or that concerns were being raised regarding registered person(s) or provider-wide concerns. Appropriate decisions were made about CQC's attendance at the future safeguarding meetings as by this time information received highlighted potential breaches of the Regulations.

- 5.107 The author accepts that the actions by the lead inspector were in line with CQC guidance at the time. He believes however, that given the serious nature of the injuries to two individuals, that first meeting was essential in deciding the future direction of the enquiry and that CQC representation would have added an extra layer of knowledge and guidance.
- 5.108 At a meeting of the individual management review authors and Safeguarding Adult Review panel members the hospital Consultant's recorded comments were discussed. To many agencies, including the police, the existence of this strong comment came as a surprise, and with hindsight changed their perception of what they were dealing with. Had the hospital representative attended the first safeguarding enquiry meeting then they may have been able to raise this issue, it was known but not raised.
- 5.109 It was a major failing not to have presented the Consultant's recorded comments. The information being presented at the time potentially led to a wrong perception of what had occurred, diluting the serious nature of the injuries and their potential cause.
- 5.110 There are indications in the minutes that manual handling was becoming the main focus for the potential cause of the injuries. This had already started to appear to provide an explanation for the injuries, without the conclusive evidence to support such a conclusion.
- 5.111 The Chair's comments sum up the issues as follows:
- The Chair concluded that at the present time there are lots of unknowns. It was not clear whether there is any abuse. It could be a variety of things from neglect or failure to follow guidelines through to non-accidental injury.*
- 5.112 Taking what was known at that moment in time, not what subsequently came to light, there should have been a significant concern that an individual may have inflicted the injuries or that there were potential institutional failings which might constitute criminal offences.
- 5.113 Gary's brother did make a request to attend. He was informed that because the meeting was considering personal information about residents other than his brother, he could not attend. The reason for their exclusion from the meeting was undermined when the families subsequently received copies of the minutes. They expected that they would be redacted so information about the other party were not devolved. This was not the case, they received full minutes.

- 5.114 The Care Act 2014 focuses on the involvement of the adult at all stages. The Sussex Safeguarding Adult procedures states the following:

*The adult and/or their representative must always be involved from the outset to the completion of the enquiry.*²⁴

- 5.115 The reason given for them not to be invited ‘confidentiality,’ was not sufficient to have excluded them. As occurred at later meetings, this initial meeting could have been split to involve the different representatives at the appropriate times. It was this exclusion from the initial meeting that fuelled the families suspicion that there was possible collusion to hide the truth. The families believed that this meeting was to consider future lines of enquiry. They were shocked to become aware that Sussex Health Care was involved in this initial meeting. It is from this point that the families’ strongly held belief that the enquiry was being directed by Sussex Health Care commenced.

- 5.116 Sussex Health Care involvement was also questioned by the police representative.

The Sussex Police report highlights that the DS when interviewed said:

He clearly recalls making representations to X, the Enquiry Manager, that he felt it was inappropriate for them to be in the meetings, but X felt that they should be, and they were included in the meeting(s). DS X did not wish for them not to be part of the meeting for any reason other than he felt there would be a more open discussion amongst professionals. He explained that when an investigation is at such an early stage facts are often unclear, and can even be wrong when examined more closely. He felt that giving such information to non-professional and involved parties at such an early stage could cause issues further into the investigation if that information proved to be inaccurate or misleading.

- 5.117 There is no record of this concern contained in the minutes of the safeguarding meeting. There is no evidence that the minutes were challenged by any of the agencies, including police. This also indicates a level of concern by police, however, this did not lead them to commencing an investigation.

- 5.118 It is important that when meeting minutes are published attendees should take the time to read them and challenge if necessary to ensure that their comments are accurately reflected.

- 5.119 Department of Health Care and Support Statutory Guidance²⁵ provides the following advice:

Responding to abuse and neglect in a regulated care setting

14.70 The employer should investigate any concern (and provide any additional support that the adult may need) unless there is compelling reason why it is

²⁴ Sussex Safeguarding Adults Policy and Procedures Edition 3 July 2016

²⁵ Department of Health (Updated Aug 2017) Guidance and support statutory guidance; www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

inappropriate or unsafe to do this. For example, this could be a serious conflict of interest on the part of the employer, concerns having been raised about non-effective past enquiries or serious, multiple concerns, or a matter that requires investigation by the police.

5.120 At that early stage an explanation for the serious injuries had not been established. Sussex Health Care were the private enterprise responsible for the effective running of the home, and possible culpability of the company or their staff had still to be established, so involvement of the Sussex Health Care staff (prior to the initial meeting) should have been minimal. As will be seen later, they were involved to a significant level in the enquiry. The author is not making any judgement about Sussex Health Care.

5.121 As has been previously indicated, given the circumstances and the serious nature of the injuries, the author believes that there was a need for a meeting to plan who should be involved, and to what level, be held prior to the first safeguarding enquiry meeting. If this had taken place between police and adult social care, then clarity of action could have been considered, and any concerns about the involvement of family and Sussex Health Care could have been explored.

Impact of the Care Act 2014

5.122 The date of the alerts for Matthew and Gary of 1st April 2015 coincided with the introduction of the Care Act 2014. The wider impact of the Care Act will be considered later in this report, but it must be acknowledged that the Act has had an impact on adult safeguarding enquiries as it introduced a different approach.

5.123 The pre Care Act investigation procedures were quite prescriptive, there were four “levels,” so when a concern was raised the allocated investigation manager decided whether to proceed under level 1, 2, 3 or 4. The different levels prescribed the approach and also gave an indication of timescales.

Level 1 was for a minor concern and the investigation was delegated to a provider, to report back to the investigation manager in 14 days.

Level 2 are minor incidents subject to a social care review process.

Levels 3 and 4 were more serious concerns, level 3 on an individual level and level 4 was for organisational abuse.

5.124 The procedures set out that a strategy discussion or meeting should occur to plan the investigation, and that a case conference chaired by an independent chair should take place to discuss the investigation officer’s report and recommendation and close the investigation off. The old procedures also set out that there were two outcomes at the end of the enquiry, firstly a decision about whether the allegation was substantiated, unsubstantiated or inconclusive and secondly to set out a safeguarding plan.

5.125 The Care Act introduced ‘Making Safeguarding Personal’. This meant that there were no set “levels” and timescales to guide enquiry managers. Instead in planning and organising the enquiry, they were to be guided by the outcomes desired by the individual at the centre of the enquiry (or, if they didn’t have capacity, the outcomes their representatives stated or the outcomes that would be in their best interest).

Likewise, the timescales could be more flexible and proportionate for the individual. There are no set expectations about when meetings should take place and they became “safeguarding meetings” rather than strategy discussions/meetings and case conferences.

- 5.126 The role of the independent chair became less prescribed, no longer having a role in chairing case conferences (as there was no longer such a thing). It remained possible to delegate the enquiry officer role but not the management/decision making function, and the manager had more autonomy to decide when to delegate an enquiry, rather than this being governed by the “level” as it was under the previous procedures.
- 5.127 Agencies should have been prepared for the Care Act, West Sussex County Council staff did receive 2 days training around the Act.
- 5.128 Whilst there is in place a Pan Sussex Safeguarding policy and procedure which covers all aspects of safeguarding, it does not provide strong guidance or advice contained within other areas policy and procedures. The Pan London policy being an example. This provides simple and easy to follow charts and guidance. West Sussex may wish to consider if it would provide better guidance.
- 5.129 This case was probably the first case to come under the requirement of the Care Act. Whilst preparations had been made by agencies for the Act’s implementation, there would inevitably still be a certain level of uncertainty.
- 5.130 Whilst under the Care Act 2014 there is less prescription and more flexibility as to how an enquiry should be undertaken, including the meeting structure, given the circumstances of the injuries the author believes that a planning meeting to consider the ‘investigative strategy’ should still have taken place between the police, West Sussex, possibly the CQC and Health to review the circumstances and set out a clear plan of enquiry. This should have been undertaken prior to the Easter Break.

West Sussex County Council Safeguarding Enquiry

- 5.131 As has been highlighted, the police were not leading the investigation into the cause of the injuries to Matthew and Gary. The oversight of the enquiry was led by the Enquiry Manager and Enquiry Officer, and it was the outcome of their enquiry that formed the basis of the enquiry report considered at the June 2015 meetings. It is therefore relevant to examine how the enquiry was conducted in order to consider the strength of the final outcome.
- 5.132 As it was agreed that the local authority should undertake the Section 42 enquiries (given that the police were not directly involved in the investigation), it was important that it should be well directed and controlled, to ensure that the facts could be uncovered and verified in an organised and timely way. The information obtained could then be pulled together to form the basis of the safeguarding enquiry report.

5.133 The safeguarding enquiry report reviewed at the safeguarding enquiry meetings of 19th June 2015 for Matthew and 24th June 2015 for Gary, highlights a number of issues. The first being the inconsistency of the evidence obtained from the care home staff. The report relied on a number of information sources.

5.134 **Matthew's case**

- Staff were interviewed by Sussex Health Care managers.
- Interviews of staff conducted over the telephone by the Enquiry Officer.
- Some staff were subject to a second interview by the Enquiry Officer and the Moving and Handling advisor.

5.135 **Gary's case**

- Interview and statements obtained by Sussex Health Care managers.
- Interviews by Enquiry Officer and the Moving and Handling advisor.
- Interviews conducted over telephone by Enquiry Officer with one agency worker declining to meet and who produced their own written statement.

5.136 The following paragraph evidences the lack of continuity and a lack of information.

Re Bruising to Gary's face there again is contradiction in the evidence - a staff nurse stated that she asked the staff member who had noted the bruising on the 29th March why he had not reported it. She states that he replied that he forgot. When the staff member who no longer worked for SHC supplied a statement he stated that he noted the bruising and reported it to the agency nurse on shift.

5.137 There are a number of other contradictions also present in the Matthew report:

Staff member A goes on to say that he asked Matthew if he was hurt and he said yes, at which point staff member A asked staff member B to call nurse 2. In her interview nurse 2 stated that when she was called to see Matthew and asked him if he was in pain his response was no.

It is of note that staff member B no longer works for Sussex Health Care and was not interviewed.

It is also of note that interviews were still being undertaken in May/June 2015, over a month after the initial incidents.

5.138 The Adult Social Care individual management review highlighted the confusion:

I cannot find what instructions were given to SHC regarding interviewing of staff and gathering of staff statements on file. Some of the statements appear to have been gathered by home manager. Some of the reports provided do not leave a clear audit trail- eg not named dated and signed- so it is unclear who completed them. The quality of many of the reports provided by SHC and on file are poor quality.

.....My conclusion is that this is an area of the enquiry which would have benefited

from more direction and oversight if it was to be delegated.

There are also notes of interviews with registered nurses on file but the records are unclear as to who the nurses are, who conducted the interviews and when.

- 5.139 These comments encapsulate the problems with the enquiry that was uncoordinated, contradictory and was supported by badly recorded information.
- 5.140 It was from this information that the Enquiry Officer reached the following conclusion, as recorded in the safeguarding report.
- 5.141 **Matthew**
As the enquiry officer in this case, having considered all the information gathered and discussed them with Manual Handling Advisor and Enquiry Manager, it is my professional opinion that the reported injury sustained to Matthew's leg, although cannot be proven either way, was highly likely not self-inflicted/spontaneous and that most likely the injury was sustained was during a manual handling episode.
- Gary**
The Enquiry Officer conclusions are exactly the same as for Matthew.
- 5.142 The Enquiry Manager's section 42 recorded outcomes were more detailed.
- Matthew's Enquiry Manager Summary:
- Although it cannot be clearly stated as to how or when the injuries to Matthew occurred, the recommendations from X's manual handling report states that they were likely to have been caused by moving and handling techniques used when rolling/turning.*
- The report states that Sussex Health Care were aware of the increased risk of potential fracture occurring to Matthew.*
- The enquiry found that Sussex Health Care and the staff at Beech Lodge had not effectively reduced the risk of sustaining a potential fracture to the lowest point possible. This is evidenced in training, equipment, documentation and auditing systems used within the company as a whole.*
- The outcome section then sets out evidence for this conclusion.
- 5.143 The Enquiry Manager's Summary for Gary is the same.
- 5.144 In neither case was the exact time the injuries occurred established and by whom they were inflicted. One member of staff was disciplined and given a final written warning as a result of confirming that they moved Gary on their own contrary to care home policy. It was not conclusively confirmed that the injury resulted from that movement.
- 5.145 Both families challenged the findings, highlighting the contradictions and the lack of certainty that they require to help the victims understand why they were injured.

- 5.146 What came out of the police investigation and highlights the impact of not having a thorough investigation at the time, was the fact that when interviewed the agency worker who was believed to have been present with Gary, denied when interviewed that he had been at the care home on that date. The police were unable to establish if he was or was not. Whilst there is no evidence to indicate that this individual was responsible for any injuries, the fact that the home or the police were unable to confirm who was working is very disturbing and must raise concerns about how Sussex Health Care employ their agency staff.
- 5.147 **Observation**
Matthew and Gary were vulnerable individuals who had suffered very serious injuries. They and their families expected the safeguarding process to help them find out how and why the injuries were sustained. It is evident from the brief overview of the enquiry that it was confused with no clear recording, lead or enquiry action plan. This resulted in the confusion and the ultimate conclusion that the time and reasons for the injuries could not be identified, and assumptions made that they had occurred due to moving and handling errors.
- 5.148 The fact, as known at the initial stages, was that two individuals suffered similar injuries over a very short period of time, with a hospital consultant strongly expressing an opinion that they were non-accidental injuries.
- 5.149 There is no evidence presented in the Safeguarding Enquiry that indicates what enquiries were undertaken to ascertain if these two incidents were linked. Could the same individual have inflicted the injuries? Manual handling was being considered as the probable cause at a very early stage, and subsequent enquiries sought to examine that scenario, with minimal evidence to indicate that other options were actively being considered.
- 5.150 It might be the case that handling was the cause. A thorough safeguarding enquiry/police investigation may have provided the conclusive evidence to substantiate that hypothesis. This safeguarding enquiry did not.
- 5.151 There is also evidence of lack of control. Whilst the representatives for Sussex Health Care at the meetings were not directly involved in the care of either of these individuals, it appears that the area manager who was tasked with making enquiries, delegated some of the work to the home manager.
- 5.152 This has been acknowledged by Sussex Health Care. Their report has the following observations.

At the time, the initial investigation into the fractures sustained by both residents was undertaken by the Home Manager. As the cause of the fractures at the time was unknown, I would expect the investigation to be undertaken by a member of senior management team. It would now be completed by the Safeguarding Lead who is part of the Quality Team, which sits separately to the Operational Team. The documents that I have viewed in relation to the internal initial investigation evidence little more than a chronology of events.

5.153 It is apparent from what was done and what was recorded that the enquiry itself lacked focus and control. As highlighted, pre Care Act (1st April 2015) the policy and procedures with regard to investigations was prescriptive. Post Care Act policy and procedures provide little advice as to how to undertake enquiries, especially those that have the complexity of this case, and others may be at risk. The author has considered the current policy and procedure and would agree that it lacks specific guidance. The Pan – London Adult Policy and Procedures would appear to have more direction in respect of enquiries.

5.154 The pre Care Act 2015 No Secrets²⁶ Department of Health 2000 guidance provides the following guidance in respect of investigations:

Investigation

A properly co-ordinated joint investigation will achieve more than a series of separate investigations. It will ensure that evidence is shared, repeated interviewing is avoided and will cause less distress for the person who may have suffered abuse. Good co-ordination will also take into account the different methods of gathering and presenting evidence and the different requirements with regard to standard of proof.

This paragraph highlights good practice and explains how an enquiry should be coordinated. This principal should still be considered for enquiries post Care Act. This case demonstrates the problems that arise if this approach is not taken.

5.155

Recommendations

West Sussex Adult Safeguarding Board to:

- *be assured that all Enquiry Officers and Enquiry Managers have received specific training for the role of leading/coordinating effective enquiries, taking into account the evidence gathering requirements of organisations such as the police and the CQC, also taking into account the Person Centred approach of the Care Act.*
- *review the current Pan Sussex Adult Safeguarding policy and procedures to ensure it provides sufficient clarity for staff undertaking complex safeguarding enquiries. To include issues raised in the review, such as planning meetings, clarity of action plans, consideration of involvement of private providers and the involvement of the adult or representative. (Consider if policies and procedures produced by other authorities may be more user friendly).*
- *be assured (through audit) that section 42 enquiries are supported by clear action plans which record action owner’s timings and results.*
- *be assured (through audit) that the adult or their representatives are fully engaged in a safeguarding enquiry as per policy and procedures.*

²⁶ No Secrets:

Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse

- *emphasise the need to ensure that staff attending meetings review minutes to ensure that they accurately represent the meeting and the individuals input, and challenge if they are not accurate*

Police Response

5.156 As has been previously established, the police were not informed of the incidents until 9th April 2015. It is therefore not possible to state what level of response they would have provided if they had been informed by the hospital or the West Sussex Adult Services Community Learning Disabilities Team on 1st or 2nd of April 2015. However, it is the expectation of Sussex Police that they would take the lead in such circumstances and the changes they have made to their Safeguarding Units in October 2015 to amalgamate Child and Adult Protection have led to a more robust structure.

5.157 The author has been supplied with a report produced as a result of a complaint made by the two individuals' relatives to the Sussex Police Crime Commissioner, and a secondary report produced in response to questions being posed by the author.

5.158 The enquiry meeting of 10th April 2015 was attended by a Detective Sergeant from the Adult Protection Team. He also attended the meeting of 23rd April 2015.

The Chair queried whether police interest will depend on the medical view awaited from the hospital. His minuted response was:

DS agreed in part, and added that it was imperative for someone to speak to Matthew. He can communicate and may be able to inform when he first felt the pain. It was about looking at the chronology of care given to him - was there opportunity for someone on their own to have been with Matthew. He concluded that there are two unexplained injuries at this stage. Without more information, it was not possible to call whether there is a criminal element.

5.159 His comments are reasonable and his direction advice correct, but there was also no information available at that stage to suggest that it was not a criminal act. In the subsequent complaint report:

He advised WSCC to continue their enquiries as it was believed that this was an unexplained injury to each service user and that information was still being gathered. He asked that all documents be sent to him.

5.160 His responses provided some oversight and advice but he was still leaving the investigation to be led by the West Sussex Adult Social Care.

When spoken to by the police report author, the DS stated:

Whilst the initial decision was that there was not enough evidence to suggest injuries were as a result of a criminal act, he kept an open mind, and asked for all documentation to be sent to him, in order that if that situation changed he could instigate a criminal investigation.

- 5.161 In the conclusion section of the police review of initial response, investigation and supervision report it states:
- In conclusion, the main issues in the case are that officers that initially dealt with this did not consider there was any criminal offence committed and this decision was made relying on the information supplied by West Sussex County Council and staff from Sussex Health Care. There should be an independent review by the police to assess whether or not offences may have taken place rather than rely on other views.*
- 5.162 The author agrees with this conclusion and believes that given the unusual circumstances, the serious nature of the injuries and the location (a care home occupied by very vulnerable individuals) that the police should have led the investigation as soon as they became aware. By allowing others to investigate a complex set of circumstances, the end result was unsatisfactory. As a result, the families made complaints of criminal offences in June 2015 and Sussex Police had to commence an investigation, albeit several months after the incident when the evidence and the witnesses had been contaminated.
- 5.163 The police report sets out some of the enquiries that they had to undertake during their lengthy investigation. These included:
- Obtaining all medical records
 - Analysis of medical records by experts
 - Consultation with the National Injuries database
 - Specialist interpretation of x rays
 - Consultation with a Moving and Handling expert
 - Statements from witnesses
 - Interviews under caution with relevant staff
 - Examination of training records
 - Face to face meeting with CPS to discuss early investigation advice
 - Linked fraud aspect to case - it was discovered that a member of staff had provided fraudulent records to obtain employment
- 5.164 This is a good outline of the level of investigation undertaken. However, it was taking place following the safeguarding enquiry.
- 5.165 The police have learnt over the years that early investigation provides increased opportunities to gather evidence and therefore improve chances that are appropriate to secure a conviction. The College of Policing have provided the following description of the Golden Hour:
- 5.166 *The golden hour is the term used for the period immediately after an offence has been committed, when material is readily available in high volumes to the police. Positive action in the period immediately after the report of a crime minimises the amount of material that could be lost to the investigation, and maximises the chance of securing the material that will be admissible in court.*
- 5.167 This principle should also apply to cases of potential adult abuse, especially where

the victim is unable to communicate how they received injuries.

- 5.168 The investigation was subject to review by a Detective Inspector. He concluded that the threshold for criminal charges was not met. Within his report he highlighted how the safeguarding enquiry might have impacted on any subsequent criminal charges if the threshold had been met:

There is undermining evidence from WSCC which states there is no indication of criminal conduct by the staff and this would immediately be disclosed to the defence if charges were considered.

Whilst this was one of many areas considered by the Detective Inspector, the author has included it to highlight the potential impact 'any' safeguarding enquiry might have when criminal charges are considered. Had a proportionate investigation been undertaken from day one led by evidence, then the conclusion would have been more informed and more defensible than the conclusions reached by the Enquiry Officer in June 2015.

Observation

- 5.169 The decision not to undertake a criminal investigation at an early stage has had a significant impact on the outcome for Matthew and Gary and their families. It is important to try and establish why, when they became aware of the injuries, that the police did not take the lead.
- 5.170 A factor in this case was, it appears, the situation work circumstances that the DS was in at the time. He was running the Adult Protection Team and it is recorded that his team's workload was high which meant that his workload as the supervisor was also high. This included 100 rapes and 40-50 domestic violence incidents.
- 5.171 The delay in informing the police, the lack of strong challenge from others to his stance of waiting until evidence of criminal offences, and the early assumptions that the explanation was probably manual handling, just enabled this response to take place. When placed against his team's workload it would not have been a priority.
- 5.172 What was missing was a lack of 'professional curiosity' that should be applied in such circumstances.
- 5.173 Had these injuries been sustained by children, then the author is certain that the response from all agencies would have been significantly different. What this case highlights is that injuries to adults with learning disabilities do not receive the same response. There is a reluctance to consider that injuries may have been deliberately inflicted.
- 5.174 There is a need for officers to better understand the complexity of investigating incidents involving vulnerable adults.
- 5.175 Sussex Police have since this incident amalgamated their Adult Protection Teams and Child Protection Teams into one Safeguarding Investigations Team, and have increased their team numbers to provided better officer resilience.

5.176

**Recommendation
Sussex Police:**

Should ensure that they undertake/lead investigations, in cases of complex unexplained injuries sustained by vulnerable adults resident in a care home setting. This is to ensure that evidence gathering opportunities are not missed or compromised.

6

SECTION TWO

CARE HOME CONCERNS AND MONITORING

- 6.1 One of the roles of the review is to consider if the injuries suffered by Matthew and Gary could have been predicted and thereby prevented. In order to do this, it needed to establish if there were opportunities to identify any concerns in respect of both the home (Beech Lodge) or across the organisation (Sussex Health Care) prior to April 1st 2015, and specifically in respect of manual handling.
- 6.2 As a result of the safeguarding enquiry and the subsequent police investigation, a number of issues in respect of Beech Lodge were identified. These included monitoring concerns around person centred planning, particularly in relation to risk assessment and manual handling, records and equipment issues.
- 6.3 It was also reported that:
- *Incident and accident forms were not cross-referenced with body map: they also do not link into safeguarding and they should, especially as the external audits ask if safeguarding has been raised from these reports.*
 - *Customers had goals and aspirations recorded. However, it was noted that these were the same for 3 customers and some not realistic.*
 - *Some care plan areas could be more detailed and include more information about how to support customers, particular around mobility.*
- 6.4 The subsequent police investigation highlighted the issue of staff failing to follow procedure in respect of manual handling, and identified serious concerns about staffing issues following their inability to identify an agency staff member, who when questioned denied being at the home. The July 2015 CQC inspection highlighted the home's failure to have in place a registered manager.
- The Home: Beech Lodge**
- 6.5 In respect of the specific home, a number of recording processes have been examined, including internally recorded incidents, recorded safeguarding enquiries and issues raised by placing authorities or as a result of CQC inspections.

External Inspections

6.6 In February 2013²⁷ Sussex Health Care commissioned an independent assessment of Beech Lodge, to review compliance using CQC essential standards and outcomes. A number of the report's recommendations have links with issues highlighted after 1st April 2015. They include:

- *The use of hoist slings should be reviewed to ensure that all slings are named for individual residents. This is to minimise the potential risk of cross contamination during use.*
- *Staff recruitment and selection procedures should be followed according to policy. All of the necessary pre- and post-employment information should be obtained and held on file for each member of staff. This should be consistent across all staff files and include records of interviews and evidence of attendance at induction training.*
- *The home manager should submit an application to the CQC to be recognised as the Registered Manager and also prepare for the CQC fit person interview.*

It appears that this assessment was commissioned to assist the home to prepare for the CQC inspection. It is not clear what action was taken by Sussex Health Care in response to the report's recommendations.

6.7 A CQC inspection took place in June 2013. They inspected the following standards as part of a routine inspection:

- Consent to care and treatment
- Care and welfare of people who use services
- Cleanliness and infection control
- Requirements relating to workers
- Records.

6.8 The home met the required standard in each of the categories.

6.9 There was a further CQC inspection a year later in June 2014. The following standards were inspected on this occasion:

- Respecting and involving people who use services
- Consent to care and treatment
- Care and welfare of people who use services
- Management of medicines
- Safety and suitability of premises
- Staffing assessing and monitoring the quality of service provision

The home met the required standard in each of the categories, but it was again recorded that the home had been without a registered manager for a month.

²⁷ Kenny: (2013) *Independent assessment and review of compliance with CQC essential standards and outcomes*, Health Care Regulation Solutions

However, observations confirmed that the home was well led.

6.10 The one issue that was continually being highlighted within the CQC published reports was the lack of a registered manager. This was again identified at the July 2015 CQC inspection. The author has been informed that in July 2015 there was in place a registered manager but they were an area manager not in daily charge of Beech Lodge.

6.11 **Reported incidents**

The second source of information that might have provided an opportunity to highlight potential issues within the care home, was the internally recorded concerns, and the safeguarding concerns referred to West Sussex.

6.12 Sussex Health Care have provided an overview list of incidents/concerns that were recorded internally within Beech Lodge between February 2013 and 31st December 2014.

79 incidents were recorded over this period, these were generally categorised as:

- Falls
- Minor Injuries
- Violence/ Aggression towards staff

There was an increase in recording in 2014 mainly in the category of minor injury and violence.

6.13 Between March 2013 and 1st April 2015 four incidents were reported by the home as incidents of concern to West Sussex Social Care. Three in 2013, two were dealt with as incidents 1) Swelling on eye. 2) Slip from shower chair. One was an enquiry (fractured tibia). This enquiry was inconclusive, previous fractures had been reported due to osteoporosis. Due to the enquiry not establishing how the injury occurred, it is not possible to confirm if manual handling was an issue. One report was received in 2014 (fall from a toilet); this was dealt with as an incident.

6.14 This level of referrals did not lead West Sussex Social Care to consider that there were any ongoing safeguarding concerns with Beech Lodge. The families, until April 2015, had not expressed any significant concerns about the home.

6.15 The reviewer of the police investigation (Detective Inspector) stated in their conclusions that:

The number of referrals to CQC and WSCC are proportionate to the number of beds and they are not deemed to be an outlier by CQC.

6.16 Whilst there is no evidence that there were any flags that would have highlighted a significant concern, it is clear that the Sussex Health Care system of internal review analysis of incidents was not strong.

6.17 The section 42 outcome, as well as setting out issues with documentation and training, also highlighted auditing, commenting;

It is clear that self-regulation is the method for ensuring standards are met. This is fundamental to providing a good/excellent service, and is embedded by putting new knowledge into practice and reflecting on incidents as a method of prevention. This is lacking and holding back standards with SHC.

- 6.18 This lack of internal review was again highlighted in the recent CQC inspection 2017²⁸:

The provider and manager reacted positively in response to risks and quality issues raised by outside agencies. However, the provider had not always identified issues without outside agencies interventions. Therefore improvements were needed to ensure their monitoring systems were consistent and effective to ensure continuous improvement.

- 6.19 They had in place a recording process not a review process. They would identify concerns and thereby consider actions to reduce the impact on the individual or other residents.

- 6.20 Sussex Health Care have created a new position, Director of Quality Compliance & Service improvements. The new Director commenced in January 2018. The author has discussed the recorded incidents with the new Director, and she in her new position produced an updated individual management review.

In her report she states the following:

It is evident that internal oversight and scrutiny was limited in the time leading up to incident. There is little evidence available to demonstrate that incident reviews were taking place, that the effectiveness of training was being monitored or that care planning was being scrutinised. Alongside this, there is little evidence that action plans from audits were being monitored with progress on actions being tracked or themes being identified.

- 6.21 This lack of scrutiny within the organisation was a weakness and a risk to residents. Whilst there were a significant number of incidents recorded as minor injuries, due to the lack of scrutiny in is not possible to identify how many of these minor injuries were as a result of incorrect manual handling. The function of the new Director is to have an analytical oversight across all homes, to challenge and to ensure that potential safeguarding concerns are identified and an early intervention is taken.

Governance: Sussex Health Care

- 6.22 Sussex Health Care are the providers of a number of care homes across West Sussex. The review has sought to establish if there were any concerns expressed about the Sussex Health Care estate and the governance of homes in West Sussex.

- 6.23 The CQC were asked to examine their records and they concluded:
In August 2015 CQC's data management teams were asked for an Accident and Incident analysis for Sussex Health Care by the Inspection Manager. This was to

²⁸ CQC Beech Lodge Inspection report Nov 2017. www.cqc.org.uk/sites/default/files/new_reports/INS2-2473803415.pdf

be able to identify if any of the locations operated by Sussex Health Care were an outlier for incidents. Although this information was noted as difficult to analyse due to its complexity it did not ultimately show any obvious outliers. As part of this review a retrospective report was initiated using new data analysis systems introduced since the incidents. This again confirmed that Sussex Health Care was not an outlier for accidents and incidents being reported.

(It is important to clarify that this analysis was in respect of numbers only, not about the content of the notifications).

Local Authority

- 6.24 The West Sussex Learning Disabilities Contracts Team were, prior to the commencement of the Care Act, responsible for monitoring visits to contracted residential care services in West Sussex. Beech Lodge was one of the monitored homes. It is of note they only had one place funded by West Sussex. The site had 40 registered beds; 20 were funded by other local authorities.
- 6.25 This limited usage of the Sussex Health Care services by West Sussex was (it is recorded) because the commissioners did not consider the model of care provided by Sussex Health Care to be truly person-centred, and had some concerns about the scale and remoteness of some of the locations. This was an individual authority's decision based on what they wanted for their customers. It was not considered to be an issue of safeguarding concern and did not impact on other authorities using placements.
- 6.26 The West Sussex Contracts individual management review stated that they had no recorded indications of any significant concerns about Sussex Health Care homes or Beech Lodge in respect of safeguarding pre 1st April 2015. There had been two recorded suspensions of Sussex Health Care learning disabilities facilities in 2014 and 2009. Neither were Beech Lodge.
- 6.27 Whilst the individual management reviews did not highlight any specific known concerns about Sussex Health Care, when the author explored the issue of concerns further with the panel members he was provided with a copy of draft minutes of a meeting held in April 2014.
- 6.28 This meeting took place following concerns raised about the Sussex Health Care learning disability services. Present at the meeting was:
- WSCC Contracts Manager Adults
 - WSCC Contracts Manager L&D
 - Rep CCG
 - Principal Manager, Adults Safeguarding

The purpose of the meeting as recorded in the minutes was:
Concerns raised by X following meeting in SHC learning and disability services regarding apparent ongoing issues/ safeguarding concerns that appear to have continued over a prolonged period of time.

- 6.29 Other issues highlighted in the minutes included:

SHC has historically appeared quite defensive in approach to alerts either advising they had taken action/ the issue has been rectified, however the same issues appear to recur.

SHC tend to employ nurses to work/manage though don't tend to employ staff with direct knowledge of the care group e.g. LD- where communication skills can be lacking.

It was also recorded that there was movement of home managers from good homes to homes with issues. This resulted in the good home starting to decline.

6.30 The following actions were recorded:

- Pressing need for information/intel system.
- NHS rep to be invited to next meeting as they hold CHC funding intelligence.
- Contracts spreadsheet of all registered services to be used to aid understanding of any patterns and management arrangements in SCH. Relationship map also to be used to aid understanding of connectivity and relationship and accountability.
- SHC to be contacted and a meeting requested with senior managers and CQC.
- Safeguarding leads in Hants, Surrey, and Sussex to be contacted informally re SHC services in those areas that might be of relevance re understanding wider context of issues.
- Follow up meeting to be held once the SHC, CQC non-compliance meeting had taken place.

6.31 As a result of this meeting an analysis report of issues across the organisations' homes was produced. It identified the following:

- Unexplained injuries/bruising alongside absence/poor incident reporting
- Unexplained fractures
- Absence of pressure area management
- Managing challenging behaviour
- Staff Shortages/Skills
- Manual Handling concerns
- Paperwork- fit for purpose, not adequately detailed, not complete, illegible.

6.32 Whilst manual handling had not been highlighted within West Sussex County Council as of specific concern within Beech Lodge (was identified in the Sussex Health Care commissioned review), it was when the whole of the group's care homes were reviewed. The analysis report stated:

Concerns appear widespread, ranging from poor care plans, carers not following care plans when transferring residents, to residents falling from hoists, and another sustaining facial injuries whilst assisted by carer in the shower. Further training has been identified as an issue that needs immediate and on-going action

- 6.33 These comments are significant given the issues around care planning and manual handling in respect of the care of Matthew and Gary. Concerns about unexplained fractures was equally concerning.
- 6.34 A further meeting was held in April 2014 between West Sussex County Council Contracts, CQC and Sussex Health Care. This meeting was a non-compliance meeting in relation to a specific home (not Beech Lodge), that had failed 4 out of 5 areas of a CQC inspection. The analysis report was referred to and it is also recorded that analysis of CQC reports had identified that there were common themes of non-compliance issues around outcomes 4,13, 21 focuses on care and welfare, staffing and records. At that meeting Sussex Health Care set out their improvement plan and there was an agreement that there would be regular meetings.
- 6.35 The meeting held in April 2014 and the resultant analysis report provides evidence that significant concerns were being raised about homes run by Sussex Health Care. The meeting was good practice and the recorded actions which focused on recorded systems analysis were appropriate. West Sussex County Council have been asked by the author to provide any evidence of follow up meetings, as indicated as an action in the minutes. They have not been able to do so. CCG have not been able to locate any further reports or minutes which appear to address the issues raised in the April meeting.
- 6.36 In the absence of any further information, the author believes that the April non-compliance meeting was used to raise issues with Sussex Health Care. Their action plan and commitment to regular meetings, would appear to have been the end outcome.
- 6.37 There is no evidence of follow up action taken by West Sussex Contracts to start to address these issues or to undertake any monitoring or audit over the coming year. There is no information that indicates if other authorities were spoken to and what action they may have taken as a result. Given the concerns about previous Sussex Health Care responses to issues raised, the lack of any follow up is surprising.
- 6.38 Having identified a number of significant concerns across Sussex Health Care homes in West Sussex, the local authority failed to put in place a robust plan to work with Sussex Health Care, other funding authorities or self-funders to raise awareness of and reduce concerns. They did not put in place a regular monitoring oversight process to ensure that Sussex Health Care continued to work with the local authority to over a period of time. This was a missed opportunity to have put in place a strong oversight.
- 6.39 The professionals meeting held in May 2016 minutes a number of concerns identified across several of Sussex Health Care Homes. The author has been informed that these concerns were post April 2015 and the meeting was to examine if police needed to respond. (This report will not comment on these additional concerns). This appears to evidence the lack of any significant progress to address the concerns highlighted in April 2014.
- 6.40 **West Sussex Safeguarding Adults Board**
Given the level of concern, it would have been good practice to have brought to the

attention of the Board concerns about a major care home provider in the West Sussex area. The multi-agency board could then have placed it on a risk register and then regularly provided challenge/oversight to ensure improvements and reduce risk. There is also no evidence that the concerns were highlighted at the Board.

6.41 This is surprising as June 2014 saw the publication of the Orchid View Serious Case Review. The oversight of care homes should have been high on the Board's agenda and as a multi-agency board, members who were aware of concerns should have raised them.

6.42

Recommendation
West Sussex Safeguarding Board to:
receive regular reporting of concerns being raised about West Sussex care homes. This is in order to monitor the response to ensure improvement or contractual action is taken.

West Sussex County Council:
should review the way it discharges its market management duty under the Care Act to ensure that it understands the quality of care being delivered in West Sussex and is able to support providers to improve where it identifies weaknesses.

Funding Authorities

6.43 Another source of information highlighting possible concerns were the funding local authorities. They have a duty to ensure that they review placements, and the reviews should consider safety of the home. They would also be in receipt of concerns raised.

Many of the residents within Beech Lodge were being funded by authorities other than West Sussex. In this case there were two different placing/funding authorities - Surrey County Council and the London Borough of Camden. Both have been involved in the review. These authorities were responsible for the oversight of the care they were funding, so had the opportunity to have identified any concerns. It is important to see what action they took to be assured of the safety of the placements.

Matthew

6.44 Matthew was placed in Beech Lodge in 2003 and was an open case to the Mole Valley Locality Team, Surrey County Council. This team was responsible for the assessment and review of Matthew's care needs, and had been since he moved to Care Home1 in 2003. Prior to 2013 the last recorded review was in 2010.

6.45 In February 2013, as a direct result of the Winterbourne Serious Case Review, the authority set up an Out of County Monitoring Team. In March 2013, this team undertook a review at Beech Lodge. The review manager of the care team has stated that these were not comprehensive reviews. The individual management review describes the visit as follows:

They did not involve a review meeting with the different professionals and Care Home, and talking with staff and residents if possible and reviewing care plans and risk assessments. There were no concerns or issues identified by this visit in relation to Matthew, with a recommendation for a further visit to be undertaken in the next 12 months.

- 6.46 Matthew was one of eight Surrey residents at the care home at the time. The visit reviewed all eight residents on the one day. It is not clear if Matthew was seen, but the review clearly did not involve any detailed conversation with Matthew or his parents. Despite the recommendation, no further review visits were recorded before 1st April 2015.
- 6.47. The authority assumed that due to the lack of any information to suggest otherwise, there were no issues in respect of the care being provided to Matthew. This included the lack of any negative feedback from Matthew's parents when they were contacted by the authority in respect of financial considerations. It is fair to state that Matthew's parents had no concerns prior to the injury. When the author discussed this with them, they did point out that they are not professionals and so would not be in a position to challenge issues such as handling and lifting.
- 6.48. The Surrey County Council individual management review concludes:
- Overall, the failure to undertake any reviews during this period appears to have compromised the ability of the placing authority to gain a view of the quality of care being provided to Matthew and identify any concerns or issues.*
- 6.49. The individual management review author explored why regular reviews were not undertaken by the authority. The conclusion is that there were staffing pressures that led to prioritising on the levels of urgency and risk. This was a particular problem to the Mole Valley area. Another area in Surrey also had residents at Beech Lodge and they did undertake reviews.

Gary

- 6.50. Camden Learning Disability Service was involved with planning and settlement of Gary from 1999. He was moved with friends to the community placement Beech Lodge in 2003.
- 6.51. In respect of the review period, Gary was subject to a review by a Camden Learning Disability Service worker in September 2013.
- The Camden individual management review states:
- Gary has significant health needs. It is not clear that the Social Worker or care home understood how complex these were. It does not appear that the local learning and disability team were invited to contribute to this review, so the review was not able to consider how Gary's health needs interacted with his social care needs.*
- 6.52. This is an important point. Any review to be effective must consider both health and social care needs, otherwise a review will not be holistic and is very reliant on

family or an advocate providing information. The level of knowledge of the individuals undertaking reviews will impact on whether the review is person-centred non generic.

- 6.53. Gary was also reviewed by Camden Learning Disability Service social worker on 26th March 2015, a few days prior to the incident.
- 6.54. The review confirmed that Gary was happy in his placement and that his family members were happy with the care he was receiving. The individual management review confirms that it was not recorded if the reviewer:
- *Saw Gary in his room*
 - *Checked the equipment in that room*
 - *Checked if the risk assessments for moving and handling were up to date and reflected in the care plan*
 - *Had access to up to date health assessments*

The reviewer recorded that they spoke to the Care Home

- *Home Manager*
 - *In House RGN*
 - *Physiotherapist*
- 6.55. From a placing/funding authority's position this highlights a couple of issues. Firstly, the failure by Surrey County Council to undertake regular reviews, and secondly the standard of the reviews which appear to have been reliant on providers and family members, and with little understanding of current health needs of the individuals. There is no evidence of any involvement of the local learning disability health team being involved in reviews. The author has been informed that Sussex Health Care had their own arrangements in respect of learning disability support (own Physiotherapist, Speech and Language Therapist – for eating and drinking support, and nursing support) and that the local Learning Disability Health Team did not routinely receive referrals requesting specialist support for people with a learning disability living within Sussex Health Care homes. Requests were usually received from the allocated GP and generally for psychiatric support or a medication review. Given the number of residents across Sussex Health Care homes, the team would have expected a larger volume of referrals.
- 6.56. Both Matthew and Gary had been resident at the home since 2003, and it is fair to comment that neither family had any significant concerns in respect of care prior to 1st April 2015. With hindsight, they have now identified areas that they consider to have been evidence of possible poor care. What this case highlights is that whilst families views need to be sought, it must be remembered by professionals reviewing care provision that most families are not fully aware of what 'good care' looks like, especially in respect of specific care plans, equipment, staff experience and training etc.

6.57. As was identified at the post-incident monitoring visits, failings in handling and lifting i.e. lacking individual focused care plans and equipment may have contributed to the injuries. These issues, if the Camden and Surrey reviews had been focused on the needs of the individual and not on just generic issues, should have been identified before the incident, and if addressed, may have reduced the opportunity for injuries to have occurred.

6.58. As has been highlighted, a significant number of individuals within Beech Lodge were placed from other local authorities. There is no indication that any of these authorities had raised concerns with West Sussex.

6.59. **Recommendation**
Surrey County Council to ensure:
that out of area care home placements reviews are undertaken within required time scales,

London Borough of Camden, Surrey County Council to ensure:
reviewers consider all the needs of the individual and ensure care plans are personal. A full record of how the review reached its conclusions should be made.

7 OTHER ISSUES

Recording of Information

7.1. What has become an issue with a number of agencies is the standard of recording. The completion of the initial SVA alert form by the Hospital staff has already been highlighted. The level of information was very limited, and did not provide a full picture of the level of concern raised by the Consultant, which initially led to the requirement for an alert.

7.2. The completion of the electronic form (A0009) by social care was limited. As the individual management review highlighted there was:

- *No capacity assessment found in the file*
- *No evidence found on social work file of the communication being sent out to other funding authorities*

7.3. And the CQC also highlighted the lack of documented decision making. It is when investigations like the SAR are undertaken, that these deficiencies in recording are identified.

7.4. The poor recording also impacted on the families, as when they sought information, they also identified the poor or incorrect recording. This then can lead to assumptions as to why this is taking place, and it is very hard to defend decisions when there is no clarity as to why they were reached and when.

7.5.

Recommendation

West Sussex Adult Safeguarding Board to:

ensure that multi-agency or individual agency training emphasises the need to ensure that forms (electronic or otherwise) are completed to a high standard, to enable the best level of information sharing or review.

Post Incident Care

7.6.

It is important to acknowledge that post-incident treatment for Matthew and Gary was good. This was provided at East Surrey Hospital by the Sussex Community NHS Foundation Trust Learning Disabilities Health Facilitation Team, which provided acute liaison services for both Matthew and Gary and their families during their stay at the hospital. This team identified that the wheelchair that Gary had when they attended hospital was not suitable for him and they organised best interest meetings with Gary's family to discuss the feeding arrangements. This was good practice and their involvement assisted both adults to resettle into their new Care Homes.

Family Concerns

7.7.

As was highlighted at the start of the report, the families of Matthew and Gary have expressed major concerns about many aspects of the various enquiries, including this review.

7.8.

Firstly, they are still not satisfied that they know how the injuries to Matthew and Gary occurred. This has been fully explored in this review.

7.9.

Secondly, they believed at the time, and continue to believe, that all actions taken by agencies have deliberately undermined the safeguarding enquiry from the start as a result of collusion.

7.10.

It is important to appreciate why the families hold such strong views that there has been collusion and a conflict of interest. Their main and remaining concern is in respect of the Council's Cabinet Member²⁹ (at the time) for Adult Services and Health and their links with the Care Home Company Sussex Health Care. This individual was a paid advisor for Sussex Health Care.

7.11.

Given the position of Sussex Health Care as a significant provider of care home places within the Sussex area, the family questioned the ability of the Cabinet member to be impartial when it comes to issues in respect of Sussex Health Care.

²⁹ Each cabinet member is the spokesperson for the policy area or 'portfolio' they are responsible for. They also:

- lead on developing council policy and make recommendations to the Cabinet
- provide guidance to the Cabinet on running activities
- give guidance to the Cabinet on budget priorities
- monitor performance and make sure policy is delivered
- lead on improving council services
- make sure that activities meet the council's overall vision, core values and guiding principles

This includes the possible influencing of the safeguarding enquiry.

7.12. This review has not examined the role of the individual Cabinet Member. However, the author, with the information provided to the review, has not identified any direct or indirect involvement of the Cabinet Member. The author understands that the previous Safeguarding Adult Board chair had raised this issue with the Council Chief Executive, and was reassured that he was not involved with the decision making in respect of Matthew and Gary. It is of note the Cabinet Member has since stepped down following the commencement of the ongoing police investigation.

7.13. What this case highlights is the need for a Local Authority to ensure that there is no conflict or perceived potential conflict when considering Cabinet Member positions. The requirements of the Nolan Principles,³⁰ the 7 principals of public life need to be carefully considered.

1. Selflessness
2. Integrity
3. Objectivity
4. Accountability
5. Openness
6. Honesty
7. Leadership

7.14.

Recommendation

West Sussex County Council to:

ensure that current governance arrangements in West Sussex County Council in respect of Members' and Officers' outside interests are consistent with Nolan Principles, and that safeguarding Lead Members should not hold outside interests with local provider organisations, that might appear to raise a conflict of interest with the post they hold.

Structure/Procedural Changes

7.15. The injuries suffered by Matthew and Gary occurred in 2015. Since that time there have been a number of changes in structure and process that will impact on how services respond today. Some of these changes have been previously set out in the review but others have not, so this section will just highlight changes.

7.16. **Sussex Police**

Sussex Police have since this incident amalgamated their Adult Protection Teams and Child Protection Teams into a Safeguarding Investigations Unit (SIU), and have increased their team numbers to provide better officer resilience.

7.17. **West Sussex Learning Disabilities Contracts Team**

Prior to the commencement of the Care Act, they were responsible for monitoring visits to contracted residential care services in West Sussex. Post-Care Act the contracts team have taken on the role of market oversight. WSCC now work with all providers based in West Sussex, not just those they have contractual relationships

³⁰ Committee on Standards in Public Life (May 1995) Guidance The 7 principles of public life: Gov UK

with.

7.18. **Sussex Health Care**

The company have (since January 2018), implemented the following structure changes with the introduction of:

- New CEO (Responsible Individual)
- New Director of Quality, Compliance and Service Improvement
- New Safeguarding Lead
- New Quality team (sitting separately to Operations in order to provide critical oversight and best practice support)

New Governance and Quality Assurance policy and processes, including:

- Changing the process relating to the development of policies
- Central collection and analysis of governance data
- Untoward Event Reporting policy
- Introducing a robust quality audit with oversight of action plan completion through Watchlist process
- Improved communication to share lessons learnt and trend analysis
- Initiating a care planning development project
- Developing positive relationships with external organisations

7.19. The introduction of the Compliance and Service improvement should strengthen the safeguarding oversight and governance and enable closer working with West Sussex County Council and other placing authorities.

7.20. The changes within Sussex Health Care are to be welcomed and if implemented should change the culture of the organisation to be more responsive to concerns and willingness to work with other organisations and improve relationships.

7.21.

Recommendation

West Sussex Safeguarding Adults Board to:

be assured that the new Sussex Health Care structure improves the organisation, reducing concerns and introducing a culture of openness and willingness to work with other agencies.

Orchid View Review

7.22. Another change that should have an impact on the oversight of care homes is the West Sussex Orchid View Serious Case review³¹ published in June 2014. It was commissioned following a Coroner's Inquest into a death at the home in 2011. It was a comprehensive review which produced 34 recommendations.

7.23. Orchid View was a care home that accommodated persons in the category of old age and dementia. It was raised by the review panel members that the Orchid View findings may not have been considered across the whole care home environment including those for individuals with learning disabilities, which as can be seen in this case, have a wide-ranging age category.

³¹ *Orchid View Serious Case Review (June 2014) West Sussex Adults Safeguarding Board*

- 7.24. A number of issues raised in the Orchid View review are relevant to this review, the major one being the issues around registered managers. The Orchid View review highlighted a regular change of home manager. This review has highlighted that Beech Lodge when inspected in 2014, 2015 and 2017 did not have in place a registered manager at the time of the inspection. This was highlighted in the CQC reports.
- 7.25. The West Sussex Safeguarding Board published a one year on review³² in July 2015.
- 7.26. It is important that the Orchid View recommendations are reviewed. As the review considered factors pre-Care Act, it is important to see what impact (if any) the Act has had on some of the original recommendations.

7.27.

Recommendation

West Sussex Safeguarding Adults Board to:

ensure that the Orchid View recommendations are being monitored for compliance across the whole sector, including homes specialising in care for individuals with learning disabilities.

8 CONCLUSION

- 8.1. The major lesson that comes from this Safeguarding Adults Review is the impact that failure to undertake a co-ordinated, evidence led safeguarding and or criminal enquiry, has on the Adults who suffered the injuries, their families and in the long term to the reputation of agencies.
- 8.2. Matthew and Gary and their families should have been confident that when their loved ones suffered serious injuries, the subsequent safeguarding enquiry should have been able to provide an explanation as to how and why the injuries occurred. The conclusion reached by the safeguarding enquiry in this case was not conclusive, and left the families spending many hours seeking answers on behalf of Matthew and Gary.
- 8.3. This has led them to believe that there has been some form of collusion between agencies to suppress the truth. This belief is difficult if not impossible to rebut. Whilst one of the aims of a Safeguarding Adult Review must be to help provide the adults and their families with some form of explanation and therefore closure, in this case the families have expressed strong opinions that they have no trust in the process.
- 8.4. Whilst the hospital's initial identification of safeguarding concerns, resulting in a clear statement by the Emergency Department Consultant, was good practice, this

³² ORCHID VIEW **ONE YEAR ON** 07.2015 West Sussex Safeguarding Adult Board

was then undermined by poor completion of the safeguarding alert forms, including the false indication that the police had been contacted. Whilst there is confusion as to why the form indicated that the police had been informed, the circumstances of these injuries and the Consultant's strong recorded statement, should have led to police being contacted directly by the hospital. Had the injuries occurred to two children, the author has no doubt that police would have been contacted very early on. This case demonstrates how the approach to injuries inflicted on vulnerable adults still has a different more cautious approach, leaving adults at risk.

- 8.5. This failure to inform police could have been rectified upon receipt by the West Sussex Adult Safeguarding 'Duty' Team of the alerts. There was no contact with police at this point to either confirm their involvement, or a planning meeting with police, prior to the first meeting, to consider the incidents and a way forward for the enquiry. At an early stage handling and moving was the emerging explanation, and this was never strongly challenged. 'Confirmation basis' appears to have reduced 'professional curiosity' leading to the lack of consideration of other possibilities.
- 8.6. The impact of failing to undertake a quality safeguarding enquiry, manifested itself in the resultant safeguarding enquiry report. This highlighted the deficiencies in the enquiry, the lack of focus, consistency of evidence gathering and a failure to consider and evidence hypotheses other than manual handling. The conclusion is not clearly evidenced and based on assumptions rather than fact. The conclusions were challenged by the families, and as a result they requested that the police undertake a criminal investigation.
- 8.7. Whilst there is no evidence that would have indicated that Beech Lodge residents were at risk prior to April 2015 there is evidence that there were concerns about the governance of Sussex Health Care across their homes in West Sussex, raised in April 2014. This initial meeting was not followed up and no robust plan to monitor and challenge Sussex Health Care appears to have been created as a result of the concerns. This was a missed opportunity to introduce some oversight.
- 8.8. If the placing authority of Matthew had undertaken timely reviews and had Gary's placing authority review (undertaken a few days before the injury) been thorough, taking into consideration all aspects of health needs, they might have identified some of the concerns highlighted after the injuries occurred.
- 8.9. This review has examined a number of issues, and it must be concluded that the serious traumatic injuries that were sustained by two vulnerable adults within what should have been a safe environment - a care home - probably could not have been predicted. The author has been presented with no evidence that indicates collusion to influence the safeguarding enquiry, it was the failings identified that influenced the enquiry outcomes.
- 8.10. Failing to investigate the injuries suffered by Matthew and Gary in a thorough and timely manner, led to a confused enquiry which was led at an early stage, by the assumption that the injuries were caused by manual handling, and reached a conclusion that is not certain and not supported by clear evidence. This has let Matthew and Gary down and has led families not to have any trust in what agencies have said in response to their many questions.

9 RECOMMENDATIONS

West Sussex Adult Safeguarding Board to:

- R1 be assured that Sussex Health Care have systems in place to ensure:
- Within their care homes, any indication that a vulnerable adult might have sustained a serious injury, should be responded to immediately by seeking medical assistance, including the option of calling 999.
 - There is a process in place to ensure that the identification of agency staff working is confirmed.
 - Care Plans for residents with osteoporosis should clearly identify the condition and the additional risks it poses, including a clear individual manual handling plan.
 - They have in place a pain identification tool to assist staff to effectively respond to pain.
- (Page 22)
- R2 ensure that all agencies' staff recognise the need to report to police without delay, serious unexplained, potentially non-accidental injuries suffered by adults at risk.
- (Page 26)
- R3 be assured (through audit) that adult safeguarding concern forms are being fully completed with all required information, in order that informed safeguarding assessments and decisions can be made.
- (Page 26)
- R4 work with the Surrey Adult Safeguarding Board to ensure that East Surrey Hospital has in place policy and procedures that provide clarity about the geographical team split, and the reporting processes, including escalation policy.
- (Page 26)
- R5 ensure that policy, procedure, and training, highlights the need in potentially complex situations involving unexplained injuries to an adult at risk, that the police should be made aware as soon as possible.
- (Page 31)
- R6 be assured that all Enquiry Officers and Enquiry Managers have received specific training for the role of leading/coordinating effective enquiries, taking into account the evidence gathering requirements of organisations such as the police and the CQC, also taking into account the Person-Centred approach of the Care Act.
- (Page 42)

R7 review the current Pan Sussex Adult Safeguarding policy and procedures, to ensure it provides sufficient clarity for staff undertaking complex safeguarding enquires. To include issues raised in the review, such as planning meetings, clarity of action plans, consideration of involvement of private providers and the involvement of the adult or representative. (Consider if policies and procedures produced by other authorities may be more user friendly).

(Page 42)

R8 be assured (through audit) that Section 42 enquiries are supported by clear action plans, which record action owner's timings and results.

(Page 42)

R9 be assured (through audit) that the adult or their representatives are fully engaged in a safeguarding enquiry as per policy and procedures.

(Page 42)

R10 *emphasise the need to ensure that staff attending meetings review minutes to ensure that they accurately represent the meeting and the individuals input and challenge if they are not accurate.*

(Page 42)

R11 receive regular reporting of concerns being raised about West Sussex care homes. This is in order to monitor the response to ensure improvement or contractual action is taken.

(Page 53)

R12 ensure that multi-agency or individual agency training emphasises the need to ensure that forms (electronic or otherwise) are completed to a high standard, to enable the best level of information sharing or review.

(Page 56)

R13 be assured that the new Sussex Health Care structure improves the organisation, reducing concerns and introducing a culture of openness and willingness to work with other agencies.

(Page 59)

R14 ensure that the Orchid View recommendations are being monitored for compliance across the whole sector, including homes specialising in care for individuals with learning disabilities.

(Page 60)

- R15 **Sussex Police:**
should ensure that they undertake/lead investigations, in cases of complex unexplained injuries sustained by vulnerable adults' resident in a care home setting. This is to ensure that evidence gathering opportunities are not missed or compromised.
- (Page 46)
- R16 **West Sussex County Council:**
should review the way it discharges its market management duty under the Care Act to ensure that it understands the quality of care being delivered in West Sussex and is able to support providers to improve where it identifies weaknesses.
- (Page 53)
- R17
to ensure that current governance arrangements in West Sussex County Council in respect of Members' and Officers' outside interests are consistent with Nolan Principles, and that safeguarding Lead Members should not hold outside interests with local provider organisations, that might appear to raise a conflict of interest with the post they hold.
- (Page 58)
- R18 **Surrey County Council to ensure:**
that out of area care home placements reviews are undertaken within required time scales.
- (Page 56)
- R19 **London Borough of Camden, Surrey County Council to ensure:**
reviewers consider all the needs of the individual and ensure care plans are personal. A full record of how the review reached its conclusions should be made.
- (Page 56)

1. Introduction:

1.1. This Safeguarding Adult Review is commissioned by West Sussex Safeguarding Adults Board in response to the injuries sustained by XX and YY in April 2015 whilst living at Beech Lodge Residential Care Home. The review is being conducted in accordance with the West Sussex Safeguarding Adults Board Safeguarding Adult Review Policies and Procedures. The aim being to establish if there are any lessons to be learnt about the way in which local professionals and agencies worked together to prevent and reduce the abuse and neglect of adults.

1.2. The two gentlemen both sustained fractured femurs. Both men have severe learning disabilities and physical disabilities; they are both non-ambulant and require assistance with every aspect of personal care. Both men were admitted to hospital on the same day. In neither case was it clear exactly how the injury occurred. Although the fractures were not fatal, they were serious injuries that have had a lasting impact on both gentlemen. Both men have moved to a new care home after living at Beech Lodge for a long period of time.

1.3 Although both men's injuries are similar, the SAR process will consider both men separately where appropriate, recognising that there are two individuals involved in this SAR.

1.4 In YY case a swelling was noted which corresponded with the site of the fracture the previous evening but the nurses on duty made the judgement that there was no need to call an ambulance. YY is funded by Surrey County Council.

1.5 In XX case XX sustained injuries to his leg and face and the enquiry was not able to ascertain exactly how the injuries were sustained to his leg or face or even if they were related. XX is funded by Camden Local Authority.

1.6 A safeguarding concern was raised in early April 2015. The enquiry concluded that the injuries were caused as a result of single handed manual handling which was not in line with the guidelines in place.

1.7 Sussex Police took the view initially that there was no evidence to support an investigation into wilful neglect. The Enquiry Manager recommended that this should be investigated. XX brother also had contact with the police and this resulted in them undertaking an investigation. This has now been completed and the thresholds were not met for a criminal prosecution.

2. Legal Framework:

2.1 The Care Act 2014 states that Safeguarding Adults Boards (SABs) must arrange a Safeguarding Adults Review (SAR) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is

concern that partner agencies could have worked more effectively to protect the adult. SABs must also arrange a SAR if an adult in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect.

In addition to the above SABs might select cases for either of the reasons noted in the statutory guidance:

1. Where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults
 2. To explore examples of good practice where this is likely to identify lessons that can be applied to future cases
- 2.2 The purpose of the SAR is to promote effective learning and improvement action to prevent future deaths or serious harm occurring again. The aim is that lessons can be learned from the case and for those lessons to be applied to future cases to prevent similar harm re-occurring.

3. Methodology:

- 3.1. This Safeguarding Adult Review will be conducted using Individual Management Reviews, which will reflect on multi-agency work systemically and aim to answer the question; why things happened.? The review will recognise good practice and strengths that can be built on, as well as things that need to be done differently to encourage improvements. This review will be a proportionate, collaborative and an analytical process, which will actively engage all agencies involved in the SAR.

4. Scope of Case Review:

- 4.1. XX Date of Birth:
YY Date of Birth:
- 4.2. Scoping period: from April 2013 to March 2016.

5. Individual Management Reviews (IMR)

- 5.1. IMR's will be requested from:
- WSCC Adult Social Care
 - Hospital (SASH)
 - Care Quality Commission
 - WSCC Contracts/Commissioning
 - CCG
 - Sussex Police
 - Sussex Healthcare
 - Camden Adult Social Care
 - Surrey Adult Social Care

- Mental Health Services (SPFT)
- GP

*The Safeguarding Adult Case Review Subgroup has requested there is input from a specialist manual handling adviser

6. Safeguarding Adult Review Panel

6.1 A panel will be established to oversee the progress of the SAR and final report. The Panel will include a senior manager from:

- WSCC
- CCG
- Sussex Police

7. Areas for consideration:

- 7.1 Whether or not the injuries to both men could have been **predicted** or **prevented**.
- 7.2 Identify concerns/complaints recorded in respect of residents of Sussex Healthcare LD homes over the scoping period, including incidents of physical injuries (including fractures).
- 7.3 Consider if there is any correlation between low-level care incidents and increased level of safeguarding concerns.
- 7.4 Did any of these incidents (if recorded) lead to a level of professional concern regarding Manual Handling?
- 7.5 Examine the response by agencies to these two incidents. Were safeguarding policies and procedures followed in a timely and proportionate manner, including consideration of risk to others?
- 7.6 Were investigations; safeguarding and criminal, timely and thorough?
- 7.7 Were appropriate safeguarding referrals made to other identified incidents and how were they responded to?
- 7.8 How did the home ensure that their staff had the appropriate safeguarding knowledge, qualifications and skills? Were policy and procedures, including supervision, adhered to?
- 7.9 How did local and placing authorities ensure that the home continued to be a safe environment?
- 7.10 Were any of the statutory agencies aware of any concerns in respect of Sussex Health Care LD homes (including placing authorities or inspecting authorities such as CQC?) How were concerns responded to? What was the outcome?

- 7.11 Are there wider lessons for any agencies involved regarding Sussex Health Care in relation to the way they are monitored and regulated?
- 7.12 To examine how identified areas of concerns in respect of care homes within one local area are raised with placing local authorities or private placements, and vice versa.
- 7.13 Are there any issues, such as conflict of interest, in respect of the application of the safeguarding process when involving commissioned privately provided services?
- 7.14 To consider the impact of the Care Act post incident.
- 7.15 How were the families concerns responded to post incident?

8. Engagement with the family

- 8.1 A vital part of this process is to engage with the family members, giving them the opportunity to be involved in the SAR process and share their experiences and concerns with the Independent Author. Lots of opportunities will be built into the process to ensure family members are updated on the progress made with the overview report and feedback on the final report.

APPENDIX B**Glossary**

AS009	Form used by West Sussex County Council
Aspirational pneumonia	Aspiration pneumonia is caused by breathing in vomit, a foreign object, such as a peanut, or a harmful substance, such as smoke or a chemical
Care Act 2014	The Care Act 2014, came into effect from 1st April 2015, the Care Act changes many aspects of how support is arranged and aims to give greater control and influence to those in need of support.
Cerebral Palsy	Cerebral palsy is the name for a group of lifelong conditions that affect movement and co-ordination, caused by a problem with the brain that occurs before, during or soon after birth.
CCG	Clinical Commissioning Group
CPS	Crown Prosecution Service
CQC	Care Quality Commission
CLDT	Community Learning Disability Team
DisDAT	A process that: identifies distress, rather than pain; documents signs and behaviours manifest from that distress and provide a checklist that outlines possible causes of distress.
Dorsal Scoliosis	The term dorsal scoliosis refers to any such curvature of the spine that occurs between the bottom of the neck and the top of the pelvis.
DS	Detective Sergeant
Dystonia	Dystonia is the name for uncontrolled and sometimes painful muscle movements (spasms).
ED	Emergency Department
Golden Hour	The first hour after a traumatic injury, when emergency treatment is most likely to be successful.
IMR	Individual Management Review
Independent Safeguarding Chair	Chairs the Safeguarding Adults Board

LDHT	Learning Disabilities Health Team is a small team of health practitioners, physiotherapists, nurses, psychology and speech and language therapists.
MSP	Making Safeguarding Personal
MCA	Mental Capacity Assessment
Mole Valley Team	Surrey County Council
NHS 111	NHS 111 is a free-to-call single non-emergency number medical helpline operating in England and Scotland. The service is part of each country's National Health Service and has replaced the telephone triage and advice services provided by NHS Direct, NHS24 and local GP out-of-hours services.
No Secrets	'No Secrets' set out a code of practice for the protection of vulnerable adults. It explains how commissioners and providers of health and social care services should work together to produce and implement local policies and procedures. 'No Secrets' was repealed by the Care Act 2014 on 1 April 2015. The act contains replacement and mandatory requirements around adult safeguarding.
Nolan Principles	Seven principles of Public Life as defined by the Committee for Standards in Public Life.
Orchid View	In June 2014, West Sussex Safeguarding Adults Board published the findings of the Serious Case Review regarding Orchid View Care Home in Copthorne.
Osteoporosis	Is a condition that weakens bones, making them fragile and more likely to break.
Pan Sussex Policy and Procedures	The Pan Sussex Safeguarding Adults Policy and Procedures includes changes introduced by the revised Care and Support Statutory Guidance published in March 2016 which replaces the Care Act statutory guidance published in November 2014.
PEG	Percutaneous Endoscopic Gastronomy = a way of introducing foods, fluids and medicines directly into the stomach by passing a thin tube through the skin and into the stomach.
PCC	Police Crime Commissioner
Pelvis obliquity	Pelvic obliquity can be caused by leg length inequality, contractures about the hips, as part of a structural scoliosis or as a combination of two or more of these causes.
Post Care Act	The Care Act 2014 came into effect from April 2015 so

	post Care Act is from that date.
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 – the duties on employers and people in control of work premises to report certain workplace accidents, occupational diseases and specified dangerous occurrences (near misses).
Safeguarding Enquiry	An enquiry is any action that is taken (or instigated) by a local authority, under Section 42 of the Care Act 2014, in response to indications of abuse or neglect in relation to an adult with care and support needs who is at risk and is unable to protect themselves because of those needs.
SAB	Safeguarding Adults Board
SAR	Safeguarding Adults Review
SASH	Surrey and Sussex Healthcare NHS Trust
SCFT	Sussex Community Foundation Trust
Section 42 Enquiry	See safeguarding enquiry above.
SHC	Sussex Health Care
SIU	Safeguarding Investigations Unit
SPFT	Sussex Partnership NHS Foundation Trust
Spinal Fusion Surgery	Spinal fusion is an operation that causes the vertebrae (bones of the spine) in the back to grow together.
SVA1	West Sussex Safeguarding Alert Form
SCR	Serious Case Reviews
SCIE	Social Care Institute for Excellence
T Roll	T rolls are used primarily, but not exclusively, to control posture and position of the body.