Diogelu Gwent
Gwent Safeguarding

Adult Practice Review Report

Gwent Safeguarding Adults Board
Concise Adult Practice Review

Re: GWASB 2/2019

Brief outline of circumstances resulting in the Review

To include here: -

- *Legal context from guidance in relation to which review is being undertaken*
- *Circumstances resulting in the review*
- *Time period reviewed and why*
- *Summary timeline of significant events to be added as an annex*

A concise Adult Practice Review was commissioned by the chair of the Gwent Wide Adult Safeguarding Board on the recommendation of the Joint Practice Review Sub-Group in accordance with "Working Together to Safeguard People: Volume 3, Adult Practice Reviews, Social Services and Wellbeing (Wales) Act 2014, following the death of a 67 year old man who will be known hereafter as A.

Circumstances Resulting in the Review

A was an adult with learning disabilities who also suffered from a number of long-term conditions including Parkinson's Disease, epilepsy, lymphoedema and depression. He was described by people who knew him as a lovely person with an infectious laugh, a character and "you knew when he was in the room".

A had lived in his supported living placement since 2010, receiving one to one support from a registered domiciliary care provider commissioned by the local authority. During the week A attended a day centre.

In 2015 A was referred for an assessment around his ability to eat and drink safely and an Eating and Drinking Plan was produced. A's needs around eating and drinking comprised having his food cut up, close support and supervision, verbal

prompts and consistent staffing arrangements. This plan was included in the care arrangements both within the supported living placement and at the day centre.

As time passed this close support appears to have been replaced by less strict, but un-described, monitoring arrangements. A multi-disciplinary review of A's needs in July 2016 indicated that A is "feeding himself well…prefers staff not to sit with him". There is no record of a mental capacity assessment to support that A understood the implications of this action.

In March 2017, a choking episode occurred at a local supermarket restaurant. A was taken to his GP and the incident recorded within the care provider's records. There is no evidence of this information being communicated to other professionals.

Risk assessments around his care needs identified a risk of choking. In October 2017 a WARRN (Wales Applied Risk and Research Network) assessment identified the probability of choking as low as he is not left alone and the severity of choking as catastrophic.

On 17th December 2017 A experienced a further choking episode in the supported living placement which led to his death. A criminal investigation into the circumstances of his death is on-going.

The Adult Practice Review Panel decided to review the case for the 13 months prior to A's death. The review period was from 1st November 2016 to 17th December 2017. However, during the review it became necessary to consider some information as far back as March 2015.

Practice and organisational learning

Identify each individual learning point arising in this case (including highlighting effective practice) accompanied by a brief outline of the relevant circumstances

In undertaking this Review, we are grateful for the agency chronologies submitted. The family of A were informed of the review by the attached Police Case Officer and chose not to be involved. They will be informed about the outcome of the review. We would also like to thank the professionals who attended the Learning Event who, due to the length of time since A's death, had not necessarily contributed to A's care but were committed to agency learning opportunities. It was not appropriate to involve the care provider in the review because of the on-going criminal investigation.

From the information the following themes were identified:

1) Choking – Missed Opportunities

1.1 The possibility of A choking had been a key feature of assessments and care plans for many years by all agencies involved in his care The development of A's

Eating and Drinking Plan by an Occupational Therapist highlighted a number of key areas that staff involved in A's care needed to follow. This was re-enforced by the care plan produced by the social worker in November 2017 and the service delivery plans developed by care staff at the supported living placements in plans dated from June 2016.

1.2 There are a number of key events that impacted on A's care needs that represented missed opportunities to refocus the care provided on promoting safe eating and drinking practice:

- Service delivery plans written by the domiciliary care provider indicate that "where possible", staff should sit with A when he eats.
- The domiciliary care provider's manager informed the Memory Care Pathway Multidisciplinary Review on 25th November 2016 that "staff have found leaving (A) to eat was more acceptable to A. Staff monitor A without eating with him now". The Review concluded that no risks were identified. No review of the Eating and Drinking Plan arrangements was recommended and there appeared to be no consideration of A's mental capacity to evaluate the risks of the changes to the care provided. It has not been possible to find out exactly what supervision arrangements the care provider maintained at meal times; other than on the date of death his food had not been cut up and no one was present to provide supervision.
- A choking incident at a local supermarket restaurant in the presence of a member of care staff from the domiciliary care agency was reported within the supported living placement, A attended a cautionary GP appointment, but the incident was not reported by the care provider to commissioning or statutory agencies to trigger a review, or to the regulator as a notifiable event.

2) Assessment, Identification & Management of Risk

2.1 A wide variety of needs assessments, risk assessments and review arrangements were undertaken in respect of A. Holistic assessments and reviews were undertaken and identified the choking as a risk in addition to other needs. It appears apparent from the documentation reviewed over time that although the severity of choking risk was considered to be catastrophic because of the implementation of the Eating and Drinking Plan and the close supervision assumed to be in place the probability or likelihood was considered as low.

2.2 In March 2015 an Occupational Therapist created an Eating and Drinking Plan which identified A:

- Needed to be provided with close support and supervision when eating and drinking,
- Needed to be verbally prompted and reminded not to overload his mouth with food,
- Should be supported by the same support worker throughout his meal.

This was identified as good practice.

2.3 A was seen by the Adult Speech and Language Therapy Service in May 2015 where appropriate positioning for eating and drinking was discussed. They

identified no negative signs and he appeared to be safe to continue a normal diet and fluids. Some general advice to maximise safe eating and drinking was provided and information about signs of dysphagia and when to re-refer was given.

2.4 WARRN (Wales Applied Risk and Research Network) risk assessments were undertaken and were updated and reviewed by the professionals involved regularly and shared with the provider. This was identified as good practice.

2.5 The WARRN stated that the risk of choking was catastrophic, however, the focus of the assessment dwelt more on other issues such as challenging behaviours, risks posed to staff, physical health including weight loss and manual handling. The other issues, whilst acknowledged as wholly relevant, seemed to shift the focus away from the potential catastrophic risk of choking. Given that potential consequences of choking there did not seem to be sufficient emphasis given to it within the WARRN.

2.6 The WARRN might have been strengthened if it gave a clear indication of what to do in the event of choking occurring or how such an event should be reported or managed. This could have been achieved through a stronger link between the WARRN risk assessment and the service delivery plan.

2.7 The WARRN assumed a risk of choking being 'low' based on certain activity and circumstances being in place and adhered to (e.g. A's food being chopped up and him being supervised). Overtime the environment altered to accommodate A's preferences and managing his behaviours rather than a rigorous focus on the primary risk – this over time appeared to be 'down-graded'.

2.8 It should be noted here that a significant incident of choking was not shared by the provider with the wider professional team and did not inform their practice; if this had been shared it might have triggered a further update and review of the risks and altered the view of the probability of choking being 'low'.

3) Care Plans, Risk Management Plans & Service Delivery Plans

3.1 In November 2016 a social worker from the local authority undertook a mental capacity assessment on A to determine whether he had the mental capacity to fully participate in the assessment of his wellbeing and care needs. The outcome was that he did not. This appears to be the only mental capacity assessment undertaken. The Integrated Assessment that followed highlighted A's needs for the care provider to follow the advice from Speech and Language Therapy and the Occupational Therapist around his food and fluid intake. The subsequent care and support plan highlighted the need to follow the same advice in relation to nutrition. Service Delivery Plans written by the care provider note that there was an awareness of the content of the Eating and Drinking Plan but includes the phrase "where possible" staff should sit with A.

3.2 The comprehensive Eating and Drinking Plan (March 2015) explicitly identifies the support that A needed to eat and drink safely. However, overtime adherence to the plan appeared to be comprised by other issues around A preferring to eat alone, management of his tremors, the need for A to get sufficient nutrition, and having access to a 'normal' diet. In addition there were varying and open interpretations of what was meant by 'close' supervision in the context of A's preferences. The WARRN risk formulation said that A was not left alone when eating, whereas the service delivery plan said supervision was where possible. What is known is that on the day he died, A was not supervised whilst he was eating. Adjustments and adaptations that were made to A's eating environment and levels of supervision / support which on the one hand could have promoted his independence and choice, but on the other hand served to compromise proper risk management. These adjustments and adaptations were made within a context of A having limited capacity to make informed decisions for himself about aspects of his care plan, and consequently should have triggered some detailed multi-agency discussions about what was appropriate to both maximise A's autonomy and preferences and ensuring his safety in the context of competing risks. Consequently, changes that were made appear to have been implemented without any evidence of authorisation.

3.3 There was a gap between what was written in care plans and what was actually delivered. The service delivery plan developed by the provider was not definitive about exactly what level of supervision was needed to keep A safe whilst eating. Neither was the service delivery plan shared widely across the professional network. There was some sense that arrangements for supervision at meal times were changed over time and this was not responded to by professionals or linked to the catastrophic risk of choking. There was a question mark around whether staff really did understand the consequence of not following the care plan. Even when a critical choking incident occurred, the significance of this did not appear to be fully understood by the care provider or trigger a review given the changed circumstances.

4) Mental Capacity & the Wishes of the Individual

4.1 The documentation reviewed indicated that during this period only one mental capacity assessment was undertaken. Changes to the support provided to A when eating was changed supposedly to accommodate A's wishes. Although an individual's mental capacity is issue and time specific, given the other information reviewed it appears un-likely that A would have had sufficient mental capacity to evaluate the implications of making such a decision. The decision to amend these care arrangements was shared by the care provider at a Memory Care Pathway Multidisciplinary Review on 25th November 2016. The sharing of this information did not appear to be challenged or trigger a review of the Eating and Drinking Plan.

5) Ensuring Care is Provided

5.1 The responsibility for providing A with safe levels of care within the supported living placement lay with the domiciliary care provider commissioned under contract

by the local authority. This care is regulated under domiciliary care standards by Care Inspectorate Wales.

5.2 There were many professionals from a number of agencies involved in providing, assessing and monitoring A's care needs and risks to his wellbeing. The quality assurance roles of these different bodies needs to be clearly understood and communicated. The overall assurance for any provider environment depends on the good sharing and exchange of information of all those involved in an individual's care. Equally, that assurance needs to happen at both the higher level and on the ground – the *reality testing*. There needs to be clarity around who is doing what to assure the quality of the care delivered, including identification of any gaps. Opportunities for the scrutiny of A's care should have been built in to the monitoring arrangements and these should have informed any review of the quality and quantity of A's care contained in the care plan and the provider's service delivery plan.

5.3 Although the system of reviews by social care and health professionals, contract monitoring by the local authority, regulatory visits by the Regulator and feedback from family members provides a degree of assurance of the quality of care provided, the current system relies on a degree of trust that contracted care providers will provide quality and safe levels of care, informed by care and risk management plans. In respect of A, the Eating and Drinking Plan and the social worker's assessment and care plan were specific in relation to the close support that was required when A was eating. The WARRN risk assessments indicated that the risk formulation was based on the assumption that A was not left alone when eating and the consequences if not could be catastrophic. However, the provider's service delivery plan highlighted that this support was provided "wherever possible". There is no indication that the monitoring of A's care picked up on this change. Feedback from the care provider to a Memory Care Pathway Multidisciplinary Review highlighted that A was no longer provided with close support to eat and there is no evidence that the professionals present challenged this information given their knowledge of both the social worker's assessment and care plan, and the Eating and Drinking plan. The risk management section of the review is not completed inferring that there were no risks identified. In addition, the choking incident in March 2017 in the presence of the care provider's staff was not reported to the local authority, Health Board or the Regulator.

5.4 There were regular multi-disciplinary meetings which is positive, but there is a concern that these were more along the lines of confirming that things were ok based on verbal feedback from of the provider, rather than the opportunity for any deeper checks, challenges around A's current condition, identifying changes or a deterioration in his condition which might trigger a wider review of his care needs or referrals to other services. There did not appear to be a professional curiosity to identify whether care arrangements were being followed, whether the provider's stated practice changed the identified risks and whether overall it was a good enough care environment for A.

6) Sudden Deaths in Care Environments

6.1 Police attended A's address where he was discovered deceased. The attending officer treated the incident as a sudden death and the coroner was duly notified.

6.2 The report highlighted that A had been to hospital the previous day as staff had noticed bruising under his arm which was believed to have been the result of a fall, A was examined and no fractures were identified.

6.3 Staff informed the officer that they had brought him his cooked dinner. The officer was told that A didn't like staff sitting with him when he was eating so they leave the room and check him every 5-10 minutes, when they returned to check him 10 minutes later they discover that he wasn't breathing they rang 999 and commenced CPR.

6.4 The attending officer checked A for injuries but did not consider checking the care plan. Had the officer checked the care plan they would have seen that he was at risk of choking and should be supervised whilst eating. This omission resulted in the death initially being treated as a sudden death as opposed to a suspicious death where a Detective resource would have been allocated.

Improving Systems and Practice

In order to promote the learning from this case the review identified the following actions for the SAB and its member agencies and anticipated improvement outcomes:-

Learning Theme 1: Assessments, Monitoring & Review of Individuals (cross referenced with themes in previous section - 1, 2, 3, 4, 5)

All agencies to ensure there are stronger links between assessments, risk management plans, and service delivery plans. The monitoring of care arrangements needs to inform when reviews are required outside of statutory timescales, and focus on how care is actually delivered.

All professionals involved with an individual's delivery of care should apprise themselves of the contents of the care provider's service delivery plan.

WARRN risk assessments need to give equal weighting to physical, mental health and behavioural risks.

WARRN risk assessments should prioritise catastrophic risks even when the probability of these occurring is low.

Where it is deemed that an individual may lack mental capacity, Mental Capacity assessments should be considered when major changes to care arrangements are being proposed, particularly where the individual may lack insight into the implications of the proposed changes on their safety.

Learning Theme 2: Contract Monitoring & Inspection (cross referenced with themes in previous section - 1, 2, 3, 5)

All agencies need to assure themselves that the care that is recommended, contracted for, and that they are monitoring, is the care that is being delivered to meet the individual's assessed needs and mitigate identified risks, and is compliant with the Regulations.

The efficacy of the current system relies on the trust that care providers are undertaking their roles in compliance with care plans and the regulations.

There should be opportunities for care staff to have direct contact with other professionals, and to be directly involved in the feedback around a person's care. Professionals involved in the monitoring of care arrangements speak directly to the individuals who are delivering the care.

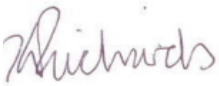
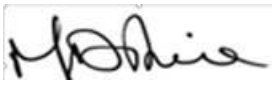
Learning Theme 3: Training (cross referenced with themes in previous section - 1, 2, 3, 5)

Care providers to ensure that their staff have access to training specific to the needs of the individuals they care for and their needs are reviewed annually

Commissioners and Regulators to ensure that care staff have sufficient skills and experience to meet the specific needs and risks of the individuals they care for. This would include compliance with any risk management plans.

Learning Theme 4 – Police Response to an Unexpected Death (cross referenced with theme in previous section - 6)

In the event of an unexpected death of an individual who resides in a supported living placement or care home, a public protection supervisor should be notified and in their absence the duty Detective Sergeant. The Detective Sergeant will decide based on the circumstances of the death whether attendance of a Detective resource is necessary. Guidance will be provided to officers and Force Control room in relation to this.

Statement by Reviewer(s)			
REVIEWER 1	Stephen Howells	**REVIEWER 2 *(as appropriate)***	DCI Mark Johnson
Statement of independence from the case *Quality Assurance statement of qualification*		**Statement of independence from the case** *Quality Assurance statement of qualification*	
I make the following statement that prior to my involvement with this learning review:- • I have not been directly concerned with the individual or family, or have given professional advice on the case • I have had no immediate line management of the practitioner(s) involved. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference		I make the following statement that prior to my involvement with this learning review:- • I have not been directly concerned with the individual or family, or have given professional advice on the case • I have had no immediate line management of the practitioner(s) involved. • I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review • The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference	
Reviewer 1 *(Signature)*	p.p 	**Reviewer 2** *(Signature)*	p.p 
Name *(Print)*	Stephen Howells	**Name** *(Print)*	DCI Mark Johnson
Date	23.03.2021	**Date**	23.03.2021

Chair of Review Panel (Signature)	
Name *(Print)*	Jane Rodgers
Date	18.03.2021

Appendix 1: Terms of reference
Appendix 2: Summary timeline

Adult Practice Review process

To include here in brief:

- *The process followed by the SAB and the services represented on the Review Panel*
- *A learning event was held and the services that attended*
- *Family members had been informed, their views sought and represented throughout the learning event and feedback had been provided to them.*

Adult Practice Review Process

The Gwent Wide Adult Safeguarding Board (GwASB) Chair notified Welsh Government on 25th June 2019 that it was commissioning a Concise Adult Practice Review.

Reviewer: Stephen Howells, Service Manager, Caerphilly Local Authority

Reviewer: Mark Johnson, DCI, Gwent Police

Chair of Panel: Jane Rodgers, Head of Children Services, Monmouthshire County Borough Council

The services represented on the panel consisted of:

- Gwent Police
- Adults Services
- Aneurin Bevan University Health Board
- Welsh Ambulance Service Trust

The Panel met regularly from August 2019 in order to review the multi-agency information and provide analysis to support the development of the report.

Learning Event

A Learning Event took place in September 2019 and was attended by the following agencies:

- Gwent Police
- Adults Services
- Aneurin Bevan University Health Board
- Welsh Ambulance Service Trust

Family Members
Family members were informed that the review was taking place but did not wish to meet with the reviewers.
☒ Family declined involvement

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Date information received ……..

Date acknowledgment letter sent to SAB Chair ……

Date circulated to relevant inspectorates/Policy Leads …….

Agencies	Yes	No	Reason
CSSIW	☐	☐	
Estyn	☐	☐	
HIW	☐	☐	
HMI Constabulary	☐	☐	
HMI Probation	☐	☐	