

ISLE OF WIGHT SAFEGUARDING ADULTS BOARD

SAFEGUARDING ADULTS REVIEW CONCERNING MR R

OVERVIEW REPORT



INDEPENDENT REVIEWER - MARGARET SHEATHER

1. Introduction

- 1.1. This is the report of a Safeguarding Adults Review (SAR) that was commissioned by the Isle of Wight Safeguarding Adults Board (IWSAB) as a result of the death of Mr R on 19th March 2015 at the care home to which he had moved the previous day. The circumstances of his death raised safeguarding concerns and a safeguarding investigation was initiated. This took an unusually long time and when it was finally concluded in April 2016 the decision was then confirmed by the SAR Sub-group to commission this SAR.

2. The circumstances that led to a Safeguarding Adults Review being undertaken in this case

- 2.1. This section outlines the circumstances, and further detail about the processes involved follows in later sections.
- 2.2. Mr R was an 87 year old man who had been a resident of Holmdale House residential home since 8th October 2010, funded by the local authority. He had moved there following a hospital admission. Following inspection by the Care Quality Commission (CQC) in December 2014 and a review of incidents and deaths in the home there were serious safeguarding concerns about the care at Holmdale House. It was decided at a Safeguarding Adults Meeting on January 6th 2015 that the needs of all residents there should be reviewed, prioritising those at highest risk, and at a subsequent meeting on 9th January that consideration needed to be given to moving residents to alternative care if necessary, working with families where this was the case.
- 2.3. A review of Mr R's needs was carried out on 24th February 2015 in which his daughter (Ms G) was involved, a full assessment of needs completed and the family was asked to seek an alternative care home for him. They had great difficulty identifying a home that could meet his assessed needs and their enquiries got overtaken by the proprietor of Holmdale House issuing notice on 17th March that the home would close on 24th March. In view of the urgency of identifying an alternative placement, the local authority had also approached possible care homes for Mr R. Following an assessment on 16th March, Fallowfields felt that they could meet his needs.
- 2.4. Family members visited Fallowfields and chose their preferred room from the two offered for Mr R and he moved there on 18th March. The following morning he was taken to the toilet at 7.45am by a staff member who then responded to a call bell for another resident. She told Mr R to ring the call bell when he was ready. At 8.10am another staff member observed someone (who proved to be Mr R) lying at the bottom of the external fire escape stairs from a room adjacent to Mr R's and raised the alarm. It appeared that Mr R had left the toilet independently and walked into the room adjacent to his

own, from where he had left the building via the fire escape door and fallen down the short flight of steps. The ambulance service arrived quickly and notified his death at 8.24 am.

- 2.5. The cause of Mr R's death as given on the death certificate was: 1a subarachnoidal and intraventricular cerebral haemorrhage; 1b traumatic head injury with a fracture of the skull and fractures of the spinal column; Dementia in Alzheimer's disease
- 2.6. Under section 44 of the Care Act 2014, the Local Safeguarding Adults Board must arrange a safeguarding adult review 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. The purpose of a safeguarding adult review is to:
- Determine what might have been done differently that could have prevented harm or death
 - Identify lessons and apply these to future cases to prevent similar harm occurring again
 - Review the effectiveness of multi-agency safeguarding arrangements and procedures
 - Inform and improve future practice and partnership working
 - Improve practice by acting on learning (developing best practice)
 - Highlight any good practice identified
- 2.7. The SAR process is primarily one of learning rather than of formal investigation of conduct or possible criminal activity. Those latter activities are the responsibility of employing agencies, regulators and the criminal justice system. A number of methods are used to carry out SARs and on this occasion the IWSAB decided to commission an Independent Reviewer, Margaret Sheather, to review the available documentation and talk to the family. A draft report would then be considered by a multi-agency workshop and the independent report finalised following that discussion.

3. Terms of Reference and Process for the Safeguarding Adults Review

- 3.1. The Terms of Reference for the SAR were drafted by the IWSAB in August 2016 and shared with Mr R's family. They confirmed in October 2016 that they were content with the Terms of Reference and the final version is attached at Appendix 1.
- 3.2. The Independent Reviewer started work in September 2016. A range of relevant documents was reviewed, both via email and at the Isle of Wight Council offices, and on the CQC website. A meeting took place with a representative of Mr R's family in order to understand their experience of the

process of the move between care homes, the subsequent safeguarding investigation and its outcome. The Reviewer also developed a comprehensive chronology of the events from the less detailed one prepared for the safeguarding investigation report.

3.3. The original intention was to hold the multi-agency workshop in March 2017. Many of the individuals required for the meeting were also witnesses in a criminal prosecution case involving the home and following legal advice on the matter the meeting was postponed, and subsequently took place in August 2017.

3.4. As is usual in these kinds of reviews, a number of different agencies have been involved in the case as shown in the table below.

Isle of Wight Council: Adult social care Safeguarding Adults Commissioning Fire and Rescue Service	Isle of Wight NHS Trust: Ambulance Service Beacon Out of Hours Out patients Tower House GP Surgery
The Care Quality Commission	Hampshire Constabulary
Holmdale House (now closed)	Fallowfields

3.5. It would be usual in many reviews of this sort to involve the care provider organisation in the process. The legal action between the Council and Fallowfields in this case precluded direct involvement on their part, but they had already contributed to the safeguarding meetings after Mr R's death and the investigation (including the chronology), and so their account is represented to some extent through those routes. Holmdale had ceased operating by the time the review was started.

3.6. The following sections outline the events in the case and then address the various elements of the Terms of Reference.

4. Case Summary

Mr R's background

4.1. Mr R was an 87 year old man who had lived on the Isle of Wight for many years and had been a skilled carpenter in his working life. Once retired he continued very active, working sometimes as a driver's mate. He knew many people on the Island and was a sociable man who belonged to the Town Club and, among his interests, enjoyed horse racing. He had six children, two of whom were adopted, and one of whom shared her father's home until he had to sell it.

- 4.2. Mr R then went to live with his son and in due course moved into semi-sheltered accommodation. Signs of memory loss and confusion started to be evident in 2008 and eventually he was unable to continue in independent accommodation because he had started to wander at night. After a hospital admission in 2010 he moved into Holmdale House.
- 4.3. Mr R's family were very positive about the care offered at Holmdale during 2010-13 when it was run by its previous owners. When it was sold to the new owner in 2014 the staff stayed the same, but the family did not have the same confidence in the manager appointed by the new owner, and they noticed that the quality and quantity of food had reduced. Otherwise, they did not have concerns about their father's care.
- 4.4. The chronology of Mr R's case (see below - paragraph 4.6) shows that the main contact from professional agencies outside the care home during 2012-14 was with the NHS. This was mainly with the GP about infections and sleep difficulties, but some behaviour changes in 2014 prompted referral to old age psychiatry for a dementia assessment and treatment.

The sequence of events

- 4.5. The Isle of Wight Council staff member who prepared the report of the safeguarding investigation developed a merged chronology of the involvement of various agencies. I have added to that as I have worked through the document review, adding other events or communications that are relevant to the Terms of Reference of the SAR.
- 4.6. The chronology provides a lot of detail so the following table draws out what seem to be the key events before and after Mr R's death.

Date	Event/Activity
August 2014	The CQC carried out its first inspection of Fallowfields under its new assessment system. The report was published on 29 th December 2014 (see below).
3 rd October '14	Holmdale House manager emailed a Deprivation of Liberty Safeguards (DoLS) application to the Mental Health Act/Mental Capacity Act lead. This gives a broad indication that Mr R's general level of capacity was compromised at this time.
22 nd October '14	Letter sent from Fallowfields to the CQC reporting the incident where a resident had gone through a fire door and their intention to alarm all doors as a response. (NB this was a different door from the one Mr F subsequently left through)

12 th & 18 th December '14	<p>CQC inspected Holmdale for the first time since its change of ownership and since their new assessment system had been established. It was rated inadequate against all five categories of the assessment and warning notices were issued to the home related to medicines management, safeguarding people who used the service and failure to ensure that people had their care and welfare needs met. The local authority (LA) was alerted to this outcome on the day of the inspection.</p> <p>Work was immediately initiated by the Safeguarding team and continued intensively over Christmas and into the New Year.</p>
19 th December '14	<p>A safeguarding plan was agreed between the LA and the Holmdale management.</p>
29 th December '14	<p>CQC's inspection report on Fallowfields was published. It rated the home inadequate overall from the following findings against the five categories of assessment:</p> <ul style="list-style-type: none"> • inadequate on whether the home was safe and whether it was well-led • good on whether the home was caring • requiring improvement on whether the home was effective and responsive
6 th January '15	<p>First Safeguarding Strategy Meeting re Holmdale House arising from the CQC inspection. CQC had issued warning notices but not restricted admissions. The concerns included a higher number of expected deaths and falls notified to CQC in 2014, a number of safeguarding issues, concerns expressed by the GP and three deaths that had been referred to the coroner. The council had suspended placements at Holmdale immediately on hearing CQC's concerns and had started monitoring visits.</p> <p>In addition to the general concerns about quality of care, there were a significant number of specific safeguarding incidents related to various individual residents to consider. The meeting agreed the review arrangements for Holmdale residents and that a letter would be sent to families/representatives to inform them of the safeguarding investigation and seek their views.</p>
9 th January '15	<p>Second strategy meeting, which noted no improvement at Holmdale since the Safeguarding Plan had been put in place. A further management meeting was to be held by Adult Social Care to consider contacting clients' families/advocates again due to the seriousness of the situation and to consider removing residents from Holmdale. The IW Council agreed to take the lead</p>

	in liaison with residents' families. CQC intended to revisit the home on 26 th January to review action taken in response to the warning notices.
19 th January '15	Third strategy meeting mentions the possibility of the sale of Holmdale to a new owner. Reports were received from the monitoring visits, with continuing concern about quality of care and safety of residents. The position was discussed with the owner and manager and it was confirmed that the re-assessment process would continue and that some residents would need to move to alternative placements, whatever the immediate future of Holmdale.
30 th January '15	An article in the County Press drew attention to the CQC report on Fallowfields and its "Inadequate" rating
2 nd February '15	Fourth Strategy Meeting refers to the "programme of assessing all residents and liaising with family members" being ongoing. It appears by this time that numbers in the home are already reduced, with some residents having already moved or planning to do so. Two residents were noted to wish to remain at Holmdale and to have the capacity to make this choice. There had been no improvement in the overall standards of care.
2 nd February '15	Telephone call from the care manager completing reviews of the Holmdale residents to Mr R's daughter, Ms G to arrange a review. Ms G says there was no sense of urgency for the date of the meeting, nor was she informed that residents needed to move so, taking her work commitments into account, the meeting was fixed for 24 th February.
10 th February '15	Fire and Rescue Service wrote to Fallowfields , following a visit, about improvement required in the fire alarm system, structural fire precautions and safety training.
12 th February '15	Strategy meeting about Fallowfields following awareness of the CQC inspection outcome. The CQC representative was not able to attend but provided information that they had an action plan from Fallowfields in response to the inspection and would be following that up. Meeting concluded that no further action or investigation was required given the action already being taken by CQC but that the QA team would take up the issue of why the LA had not been informed about the inspection outcome.
20 th February '15	Fifth Strategy Meeting about Holmdale took place and noted extremely serious concerns remaining about the safety of the residents there. It was therefore agreed that the local authority

	would issue statements to all families to insist that all LA clients must be supported to move to alternative placements.
24 th February '15	<p>The review meeting for Mr R took place with Ms G also present. This was the first point at which she was informed that her father needed to move from Holmdale in two weeks and that the family needed to identify an alternative placement.</p> <p>The assessment completed on this occasion identified the following needs:</p> <p><i>“Mr R is able to access the toilet independently, providing he is aware where the toilet is positioned within walking distance of his room, and is aware of his surroundings.</i></p> <p><i>Mr R is unsafe to leave on his own; he requires 24 hour care to maintain safety. DoLS applied for 10/2014.</i></p> <p><i>Mr R has poor mobility and poor eyesight, he is at high risk of falls if not supervised when performing tasks and there is a high risk of Mr R attempting to leave the building which would make him high risk should he manage to leave.”</i></p>
10 th March '15	Holmdale inspection report published: inadequate overall and judged inadequate on all five areas of assessment.
25 th February - 12 th March '15	The family sought an alternative placement for Mr R but had considerable difficulty identifying one that they were satisfied could meet his needs.
12 th March '15	Care manager contacted Fallowfields to see if they had vacancies and could assess Mr R, which they agreed to do. The family members were informed about this option though it does not appear that the CQC inspection outcome was mentioned to them.
16 th March '15	Mr R assessed at Holmdale by the manager of Fallowfields and an offer of a placement was made
17 th March '15	Holmdale's owner issued a week's notice of the home's closure . This added to the urgency of moving any remaining residents, including Mr R.
18 th March '15	Mr R moved to Fallowfields , one of his daughters being there to see him in and Ms G visiting during the evening.
19 th March '15	<p>Mr R's death occurred as described in paragraph 2.4 above.</p> <p>Safeguarding referrals made by the manager at Fallowfields and by the ambulance crew that attended.</p>

26 th March '15	<p>First Safeguarding Adults meeting re Mr R, in two parts with the provider attending the second part.</p> <p><i>Part 1</i></p> <ul style="list-style-type: none"> • CQC inspection outcome confirmed • QA reviews had not previously identified concerns <p><i>Part 2</i></p> <p>Focus of discussion on</p> <ul style="list-style-type: none"> • the details of Mr R's admission to Fallowfields and the information available to them about his needs • the sequence of events on the morning of his death • the requirements about fire doors • impact on and support for staff • possible media interest <p>Actions:</p> <ul style="list-style-type: none"> • inter-agency timeline of involvement to be prepared • Fallowfields to provide plan of building • Police update • further meeting in 6 weeks and then consider whether an SAR was required • Chair to meet Mr R's family at an appropriate point
10 th April 2015	<p>Mr R's family made a formal complaint to the Council and response was sent acknowledging receipt and informing them that the safeguarding investigation takes precedence at this stage.</p>
9 th June 2015	<p>Second Safeguarding Adults meeting re Mr R, in two parts as before.</p> <p><i>Part 1</i></p> <ul style="list-style-type: none"> • Chair reported back on her visit to Mr R's family and that she would continue that contact. Complaint was noted. • No further action by the police • report from Environmental Health and discussion about home's management of health and safety generally, fire doors in particular • CQC about to carry out unannounced comprehensive inspection <p><i>Part 2</i></p>

	<ul style="list-style-type: none"> • update from Fallowfields on work done on fire safety systems include doors. • discussion of questions raised by family and what information available to Fallowfields • discussion of whether met criteria for SAR <p>Actions:</p> <ul style="list-style-type: none"> • Chair to feed back to Mr R's family with answer to their questions • Chair to make referral to SAR sub-group • meeting to reconvene in 6-8 weeks
Unknown	No further meeting notes have been provided until that on 19 th April 2016, though there is reference to a further meeting in August 2015. It is not clear what further stages there were to the safeguarding process and how the report was commissioned that was presented to the April 2016 meeting.
11 th January '16	Letter from Ms G to Head of Adult Social Care enquiring about follow up to the family's complaint.
28 th January '16	Response from Group Manager , Safeguarding explaining the process for completing the safeguarding investigation, and apologising for the long delay.
19 th April 2016	<p>Safeguarding Adults Meeting to receive the investigation report, and concluded that the allegation of neglect of Mr R was substantiated in relation to Fallowfields. Held in three parts: professionals only; professionals and provider; professionals and family members. Part 2 was cancelled as the provider could not attend.</p> <p>Actions: a large number of actions were agreed as shown at Appendix 2 and the investigation was closed.</p>
13 th June 2016	Further letter from Ms G to Head of Adult Social Care seeking response to complaint, and subsequent email to another staff member forwarding the letter as the original addressee had left the organisation.

5. Analysis

5.1. The following sections are structured around the Terms of Reference, describing and analysing the information that has been identified in the course of the review. This came from:

- a range of documents
- the discussion at the inter-agency workshop held in August 2017 which considered a range of questions I had identified from the document review
- an interview with a representative of Mr R's family

5.2. It is worth noting at this point that because of the passage of time since the events that are the subject of the review, various changes have already been made to the relevant commissioning and safeguarding arrangements. In particular, the new DASS commissioned an Independent Review of safeguarding arrangements which reported to the Safeguarding Adults Partnership Board on September 22nd.

5.3. The issues in the various sections inevitably overlap at times so there is some cross-referencing in order to avoid too much repetition of the same point.

6. Identify the key events surrounding the decision to close Holmdale House and the decision making regarding the move to Fallowfields

6.1. The key events themselves are set out in the table at 4.6 above and the detail in the merged chronology. This section outlines some of the issues that emerge from those events, both positive points and those where improvement was needed. Each section concludes with a note of changes already made in response to the learning and any further work that needs to be done.

6.2. It is clear that, once the Council was alerted by CQC to the serious shortcomings their inspection had identified at Holmdale, appropriate actions were taken to support and monitor the care in the home and the relevant safeguarding processes were started. Placements at Holmdale were suspended and there was a significant commitment of resource from Adult Social Care throughout December 2015 and January 2016 to try and ensure the safe care of the residents. This included providing a staff member to support the manager of the home and supplying agency staff to supplement the existing staffing. There were also regular out of hours visits when numerous concerns were identified about the chaotic atmosphere during night shifts and inadequate night time staffing levels for the number and dependency of residents.

6.3. The series of safeguarding meetings that ran from January to March 2015 performed two related but distinct tasks:

- the identification and management of a range of specific safeguarding concerns about a number of individual residents at Holmdale and therefore the safety of the resident group as a whole

- the assessment of the viability of the home, and planning for the potential need to move all the residents if the necessary improvements in the standard of care weren't made
- 6.4. In some authorities, the issues relating to the performance of a care provider would be managed in a different forum from individual safeguarding concerns. This is often an inter-agency standing group such as a Care Governance Board or Quality Assurance group, which keeps an overview of the quality of care available across the authority area. It would usually have protocols in place to respond to reductions in standards and established expectations about communications with residents, families and other agencies. This kind of body was not in place on the Isle of Wight at this time.
- 6.5. The task of managing a possible home closure or any other reason for residents to move is always a complex one. It requires intensive involvement with the care home management itself as well as with residents and their families, to ensure they understand the thinking behind what is a serious and sometimes traumatic change for frail, older people. Families may not have experienced or perceived the shortcomings in care that are prompting the action, and therefore be reluctant to consider a move.
- 6.6. It is well-established that a change of this magnitude has a significant impact on frail older people and their level of functioning. Following a move such a person is likely to experience increased confusion and easily become lost, generally experience more difficulties than usual and is unlikely to remember instructions. Staff managing any transfer therefore need to be alert to this as a risk to be managed in the process of the move, ensuring all information about the person is fully communicated. It should be expected that staff in a care home, particularly one caring for people with dementia, should all be aware of the likely impact of the change on a new resident.
- 6.7. It was a demanding expectation for the Safeguarding Meetings to undertake both the safeguarding and care quality tasks. The first task was clearly pursued thoroughly through the appropriate procedures. It is also clear from the safeguarding meeting notes that the need to plan for the contingency that residents may need to move was rightly recognised from the start and actions were agreed about re-assessments of need and communications with families to make them aware of the situation. What is more difficult to track is the implementation of the communication with residents and their families in order to inform them about the situation and engage them in planning.
- 6.8. It appears that where a resident was the subject of individual safeguarding concerns their family was obviously aware of the problems identified at Holmdale and their possible need to move. This seems to explain why some residents had already started to move out of Holmdale before the final decision was taken at the meeting on 20th February that all residents would

need to move. Mr R was not one of the residents for whom there were specific safeguarding concerns, so this early individual communication did not take place with his family.

- 6.9. However, the 6th January safeguarding meeting agreed that a letter should go from the safeguarding team to all residents' families/representatives about the safeguarding investigation. This letter simply informed them of the investigation and sought their views about the care at Holmdale. A copy of the standard letter is available, but no individually addressed copy, so it has not been possible to confirm the date that it was sent to Mr R's family.
- 6.10. Later, a helpful statement was prepared for sharing with families about the need for moves to be considered. This stated *"As a result of initial and ongoing investigation into the operation of the Home, grave concerns have been raised to the extent that in order to ensure the health and safety of each resident, urgent steps are necessary for alternative placements for an indefinite period, pending the outcome of these investigations."* Staff were clear at the workshop that this statement was provided to families, but there is no record of how this happened.
- 6.11. This is not to say that the information was not shared at all, but certainly Mr R's family members state that they were not aware until his assessment on 24th February 2015 that there was a potential need for him to move. This would have been important for them to know, as they had generally been content with his care at Holmdale, so needed to understand the reasons for the proposed changes as early as possible. There is also on file a complaint from the daughter of another Holmdale resident about the lack of firm information about the process and the way some individual moves were handled.
- 6.12. The decision-making about the move to Fallowfields is covered in sections 7 and 8 below. This includes the issue of how the local authority kept itself informed about the quality of care in local care homes.

Lessons learned/changes made

- 6.13. There have been some significant changes in the local arrangements arising both from learning from this sequence of events and from national policy developments:
- the implementation of the national initiative "Making Safeguarding Personal" means that now there would be family representatives and advocates present at safeguarding meetings and so the service user and family voice will be heard more clearly
 - Adult Social Care (ASC) now has a protocol for responding to care home closure, and there is the separation of responsibility referred to in 6.4

above, with the Commissioning team leading on a home closure, a clear process to follow and named lead roles

- a commissioner now attends every safeguarding meeting in these cases
- There is now increased integration between ASC and the CCG, and the CCG has community support and advice in place to work alongside homes
- CCG and NHS now have safeguarding teams

Changes still to be made

6.14. Apart from this SAR, there have been several other audits and reviews of aspects of the work of the IW Council and its partners. These have provided additional actions, some of which are already underway, to ensure strong and effective safeguarding processes and to consolidate quality assurance and commissioning activity.

7. Clarify the actions and decision making by the CQC that informed the transfer of Mr R from one failing home to another failing home

7.1. The original Term of Reference referred to “...decision-making by the CQC regarding the transfer...” At the workshop the point was made that the CQC’s role was not to make the decisions about Mr R’s care, but to share information, so the Term of Reference has been slightly modified to reflect this.

7.2. The analysis of this section and section 8 below needs to be put in the context of a general statement about the inter-relationship between the roles and responsibilities of the local authority (and other commissioners of care) and the CQC as it affects registration, regulation, safeguarding and commissioning or de-commissioning. Some of the key points are:

- The CQC registers, regulates and rates care settings against a national set of standards that provide a clear benchmark for both individual purchasers and commissioning organisations to make their placement decisions and for providers to respond to.
- Commissioners of care can set their own standards in terms of what quality level they expect from a provider in order to contract with them. This might, for example, require the provider to have a “good” overall rating from the CQC, or it might accept “requires improvement” but want to check specific aspects of the rating to ensure client care and safety.
- It is therefore possible for a care setting to fall below the contracted quality level that commissioners require to make placements there, while still being registered.
- Where the CQC has inspected a care home and found areas of inadequacy or the need for improvement, the starting point is to seek

action from the provider, which the CQC then monitors. In extreme cases of failure they will alert the local authority immediately.

- An “inadequate” rating from the CQC may not automatically trigger safeguarding concerns, depending on the reasons for the rating.
- Where there are safeguarding concerns they may relate to the overall provision of care and/or to specific shortcomings in the care of some individuals.
- Depending on local arrangements, even if there are no safeguarding concerns, an overall “inadequate” rating would usually be taken up by the commissioning team(s) and any inter-agency forum as mentioned in paragraph 6.4 above.

7.3. In this case the two homes concerned, Holmdale and Fallowfields, presented different levels of concern. Fallowfields was the first home on the Isle of Wight to be inspected under what was then a relatively new CQC regulatory framework. As a pilot inspection, the quality assurance process for the report took longer than usual so, although the inspection had taken place in August 2014, the report was not published until December of that year. In this case, although the overall rating was “inadequate” the concerns were not so serious as to lead the CQC to alert the local authority direct. There was not considered to be a direct risk to residents, and they were satisfied that the home had an appropriate improvement plan in place to address the shortcomings.

7.4. Holmdale, on the other hand, when inspected in December 2014, presented such serious failures that the local authority was alerted immediately. In this home there were individual safeguarding concerns that had to be addressed, as well as the overall care and safety of the whole resident group, and the actions noted in sections 4 and 6 above were put in place.

7.5. The CQC was not directly involved in the transfer arrangements for the residents from Holmdale House, but their inspection findings, communicated immediately the risk to residents was identified, enabled the local authority and its partners to take appropriate action. In relation to the less immediately severe problems at Fallowfields, changed approaches (see below) would now communicate the position earlier than in 2014/15 to ensure information sharing about the quality of care across the local market.

7.6. At that time the local authority had an unwritten “protocol” (i.e. custom and practice) that was used when a home was rated inadequate by the CQC. Immediate action would call for a safeguarding meeting to discuss the report and any other intelligence that they may be aware of. It was not unusual at this time for the new inspection regime to result in homes being rated as “inadequate” or “requires improvement”, when previously they had been

rated as “good”. At the meeting concerning Fallowfields the inspection report was examined and the content did not create any serious concern about continuing use of the home.

7.7. In 2014/15 the CQC had been seeking to establish quarterly meetings with the Director of Adult Social Services (DASS), in order to ensure regular communication about care provision in the authority. However, this had not proved possible because of the frequent senior management changes in the council at that time, with a number of interim appointments.

Lessons learned/changes made

7.8. Since the events under review there have been changes both in the CQC’s own processes and in local arrangements:

- The CQC process that was then relatively new is now fully embedded in practice and reports are published in a more timely way.
- The Quality Surveillance Group (QSG) is now established as part of a national initiative to bring together different parts of the social care and health system in a local area to share intelligence about risks to the quality of health and care provision. The QSG for the Isle of Wight meets bi-monthly and involves all the relevant agencies¹ in monitoring the quality of available care. This should mean that commissioners are alerted to potential failures at an earlier stage.
- The CQC would now alert the LA directly about negative inspection findings and there are general arrangements in place for CQC to share information more quickly through the Quality Surveillance Group.
- The CQC is now more focussed on fire exit arrangements in care homes with residents with dementia.
- ASC management structures are now in a far stronger state with a substantive appointment to the DASS post and to other key roles across safeguarding and commissioning. The CQC and DASS are in contact.
- The unwritten protocol in relation to “inadequate” inspection outcomes has now been formally approved and is called: The Isle of Wight Protocol for Suspending Placements in Residential and Nursing Homes and with Domiciliary Care Providers.
- In spring 2017, Adult Social Care redesigned its processes and approved a formal “Management of homes closure policy”. This specifies the discrete roles and responsibilities of the home owners, commissioners and social workers – and is explicit as to how residents, their families and staff are

¹ Organisations involved in a QSG include NHS England, CCG, CQC, NHS Improvement, the local authority, Public Health England, Health Education England and the local Healthwatch.

to be engaged in the closure process. At the time of writing this report, the new policy had already been deployed successfully three times.

8. Clarify the actions and decision making by the Local Authority regarding the transfer of Mr R from one failing home to another failing home

8.1. There are three related sets of local authority actions to consider here:

- how the LA kept itself informed about the quality and performance of its care market in general and individual homes in particular;
- how the decision making about the residents' moves from Holmdale were managed;
- how the decisions were made about Mr R's move in particular

Care market intelligence

8.2. It appears that, at the time of Mr R's move, the local authority and its commissioning partners did not have strong arrangements in place to gather intelligence about the care market and to respond to concerns or failures in the quality of care provision. As described above, while the direct alert from the CQC about Holmdale prompted a full response, there was no mechanism in place to pick up on the subsequent publication of the Fallowfields inspection report and its "inadequate" rating. There was not an established forum for the discussion of these kinds of issues if they fell short of an immediate safeguarding concern.

8.3. This in turn meant that it was not easy for care managers involved in advising individuals and their families about placement decisions to be briefed about changes in the quality of residential homes, whether a deterioration or an improvement.

8.4. Quality Assurance visits by the local authority had previously taken place at Fallowfields, with no problems being identified and it was considered to provide a good level of care. The impact of the new inspection regime mentioned in 7.6 above is also relevant to this.

Decision-making about residents' moves

8.5. The general issue of the decision-making about residents' moves from Holmdale has been covered in section 6 above, including the difficulty of tracking the detail of the process at this distance from the events themselves.

8.6. As noted above, there was an unwritten protocol at the time, so it has not been possible to establish whether the approach taken to decision making was in line with normal expectations or not.

Decisions about Mr R's move

- 8.7. Ms G was first contacted by phone on 2nd February 2015 to make arrangements for Mr R's review. She states that she was not given any information about the context for the review or about the possibility that her father may have to move. As there was no sense of urgency, she had no concern about the appointment not being until 24th February. If she had known the situation she would have made herself available earlier; as it was she did not understand until the meeting took place on 24th February that this would be a full assessment to inform the placement search. IW Council staff recollection is that there were conversations about the potential need for a move, but that Mr R's family wanted to wait for the outcome of the potential sale of Holmdale because, if possible, they wanted to avoid moving him. The chronology of the review doesn't provide sufficient detail to clarify this sequence of conversations any further.
- 8.8. On 12th February there was a Safeguarding Adults Meeting to discuss Fallowfields, following a report in the local paper of the outcome of the August 2014 inspection. As noted in para 7.3 above, the lack at that time of a system for the local authority to keep abreast of CQC inspection findings meant that it had not previously been aware of the "inadequate" rating. The CQC representative was not able to attend the meeting but provided information that the CQC was satisfied that the home had an appropriate Action Plan in place to address the findings of the inspection and that there was no "risk" to residents. The meeting therefore concluded that no further safeguarding action was needed.
- 8.9. As discussed in Sections 6 and 7 above, the conclusion that no specific safeguarding action was required does not deal with the question for commissioners about whether or not they wish to make placements in a home rated "inadequate". So, for example, the rating for Fallowfields published in December 2014 included the comment on the Safe element of the inspection²:
- "The service was not safe. Guidance was not followed in relation to infection control procedures. There were insufficient staff in the evenings to ensure people's safety and welfare. Measures needed to protect people from the risks of injuries caused by staying in one position for too long were not recorded in care plans."*
- 8.10. These are significant questions to raise about the quality of care in a home so the statement that they did not raise concerns about continued use of Fallowfields is a concern in itself. Discussion at the workshop included the view that an "inadequate" rating was a serious matter that required

² The CQC inspection is structured around five questions: Is the service Safe, Effective, Caring, Responsive and Well-led? The Fallowfields' "Safe" rating continued to be "requires improvement" in inspections in 2015, 2016 and 2017, though most recently the reference was only to medicines management.

attention beyond the safeguarding system. One might have looked for discussion by commissioners of whether they wished to continue to make placements while the improvements required by the CQC were put in place and alerts to staff about the raring. Commissioners might have asked the home to prioritise particular actions to provide assurance of residents' appropriate care and safety, and/or they might have offered support to the home in making the necessary changes. It does not appear that any such action was taken in this case, nor that the care manager and the family discussed this aspect of Fallowfields when the placement of Mr R was being considered.

- 8.11. Once Mr R's review had been completed and his family was aware of the need for him to move they started to make enquiries with various alternative homes, but found it difficult to identify somewhere that could meet his full range of needs. Ms G took the lead for the family initially in this task. She has felt disappointed that the two-way conversation she had expected between family members and council staff to identify suitable places got overtaken by the, in her view, "vigorous" pursuit of the issue by council staff and managers. Given the level of concern, it is understandable that the council needed to move the decision-making on, but also understandable that the family might experience this as unwelcome pressure during a stressful time, particularly as they had been made aware of the need for a move relatively late in the process.
- 8.12. In the event, the family's search then got overtaken by Holmdale's owner's decision to close at short notice adding to the pressure on both the family and the local authority. It is not entirely clear why Fallowfields emerged as a possible choice for Mr R, though two other former Holmdale residents had already moved there. The care manager contacted the home on 12th March to enquire about possible vacancies and got a positive response. Contact with the family led to the placement being pursued.
- 8.13. The safeguarding investigation focussed a good deal on the information that was available to Fallowfields about Mr R's care and support needs and this also relates to the broader issues mentioned earlier about the need to manage the known risks of significant change for older, frail people. This is discussed further in section 9 below. Although the family had agreed to the move, Ms G was not confident, when she visited him on his first evening at Fallowfields, that the care staff were sufficiently well-informed about what he needed and when. It is not clear whether all the transfer arrangements, including full information about Mr R, conformed to expected good practice at the time.

Lessons learned/changes made

8.14. There have been a number of improvements in the intelligence gathering and other arrangements since the events that are the subject of this report. These aim to strengthen overall knowledge of the care market and ensure better information is available to care managers and to potential residents and their families when placements are being discussed. These changes and improvements include:

- commissioning would now lead on a home closure with named people and a definite process to follow, also involving social work
- if a home was rated inadequate now there would automatically be a meeting held to decide whether to place there
- any home with an inadequate rating would have support with their improvement plan from the CCG Care Support Manager
- the provider should have given 6 months' notice of closure and a provider would now be held to this
- the Quality Surveillance Group is in place and commissioners are signed up to receive CQC alerts when a report comes out
- The ASC Quality Assurance Leads have been conducting planned audits of care providers proactively since November 2016.
- There is a named person employed by the CCG, in their quality team, who supports providers in their quality improvement work. She works closely with the Local Authority via the ASC Quality Assurance Leads and a framework for further integration of quality assurance and support for Care Homes, Nursing Homes and Domiciliary Providers is being developed.
- The Business Continuity Plan for Care Home Closures now includes expectations on providers to notify and keep residents and families informed about the closure process. This would be via individual written communication and also through individual or group meetings, involving advocacy where required.

Changes still to be made

8.15. However, local organisations recognise there is still further work to do on these issues:

- ASC commissioners email information to managers who are expected to forward that to staff so assurance is needed that this happens promptly, including requests for staff to speak to commissioners regarding placements in homes

- Despite the alert arrangements re CQC inspection outcomes there are still potential gaps in information between CQC and commissioners about reports being issued so action is needed to address this
- The work to integrate the CCG support to care homes with the local authority's Quality Assurance function needs to be completed so that there is a coherent overall approach to care home quality. The ASC Quality Assurance Leads will be seconded to the CCG to work with the CCG Care Support Manager in the quality assurance integration.
- Fallowfields' most recent CQC inspection (February 2017, published in July 2017) still rates it as requiring improvement

9. Consider whether safeguarding concerns were recognised and responded to appropriately

9.1. There were two phases of safeguarding activity relevant to the Terms of Reference for this review:

- the safeguarding work at Holmdale arising mainly from the findings of the CQC inspection in December 2014
- the safeguarding process following Mr R's death

9.2. The first phase, as far as safeguarding processes themselves are concerned, appears to have been thorough and prompt, considering both specific individual issues and the wider implications for the home. The only significant difficulty was in aspects of communication about the investigation and its likely impact, which have been addressed in earlier sections. This section therefore focuses on the safeguarding process following Mr R's death.

9.3. As noted in the chronology, safeguarding referrals were made both by the manager at the care home and by the ambulance service following Mr R's death. The initial approach of the police was to assess whether there were any suspicious circumstances about the death. The officers attending at Fallowfields on the day didn't then give sufficient consideration to potential safeguarding issues.

9.4. Following the referrals, the safeguarding process was initiated and the first meeting held on 26th March 2015. There are a number of problematic aspects to the process that then took place over the following year and it has not been possible, this far from the events themselves, to establish a full account of what happened and why.

9.5. The problematic issues are:

- that there were two safeguarding meetings of which notes have been made available, held on 26th March and 9th June 2015 and one in August (for which I have not seen any notes), but then none appear to have

taken place until 19th April 2016. Such a long gap is unusual and in a safeguarding matter and, unless there was a clear stated reason, would be considered unacceptable.

- The actions at the March meeting did not include commissioning anyone to investigate the sequence of events, so the June meeting continued to focus on information gathering, mainly from the care home manager, rather than being able to analyse the situation and decide on further action.
- The discussion focussed entirely on the actions of Fallowfields, which was naturally a major issue, but did not extend to any consideration of the arrangements for Mr R's move from Holmdale and any influence they may have had on the outcome.
- Despite the focus on Fallowfields, the notes of the meetings do not record discussion of risks to any other residents and any action that should be taken about existing and future placements there, though the quality assurance lead from the commissioning team was present. This may have been an issue with the quality of the recording rather than the discussion, but either way needs to have been corrected.
- By the time of the August 2015 meeting it appears that possible neglect by Fallowfields had become the focus of the enquiry and a social services staff member was appointed to complete an investigation. It is difficult to match the process that this case followed with the procedures in place at the time, particularly in terms of expected timescales.
- The investigation and preparation of the resulting report took an unacceptably long time. The initial work was signed off by Adult Social Care but the DASS felt that further work was required and this was carried out by an independent person, as the original author had by then retired. The report was finally completed in February 2016. This was shared with the family, with some limited redactions, and discussed at the safeguarding meeting on 19th April 2016. By this time the report was referred to as a "review" rather than an "investigation" which blurs different stages of the process.
- The extended timescale in turn delayed the decision to undertake a Safeguarding Adults Review, contributing to some inevitable difficulties in putting together a full account at this late stage.

9.6. The participants in the workshop could not offer any further explanation of the extended process or why it had occurred and not been picked up by any monitoring of safeguarding activity. It was suggested that the vacancies in substantive appointments to senior management posts may have contributed

because of the consequent lack of continuity and support to middle managers and practitioners during that time.

- 9.7. It was also suggested that there were difficulties in identifying an independent chair for the safeguarding meetings. However, there is no reference in the notes of the meetings that did take place to this being an additional requirement over and above the current procedures' statement that the meeting *"should be chaired by an appropriate manager in adult social care/integrated care who will act in an impartial and objective way"*.
- 9.8. The investigation report, when finally completed, provided a detailed analysis of the events at Fallowfields itself, the information available to the staff at the home and therefore what could reasonably have been expected of them in that early stage of Mr R's care there. Fallowfields' managers sought to make the case that they had not had sufficient information about Mr R to be aware of the risk of leaving him alone in the toilet. However, the investigation report found that sufficiently specific information had been available to the home and therefore, in the light of the information provided, *"leaving Mr R alone in a strange setting, with his walking frame and within walking distance of his room (and therefore bedroom 7 and the fire door) was poor practice."* The report concluded *"In considering the contributory factors ... it has been demonstrated that there was a failure to take appropriate action and that too little attention was paid to Mr R's needs, amounting to neglect."*
- 9.9. This having been the case, it adds to the concern that a significant failing at the home had taken a year to be fully identified. Workshop participants agreed that the report preparation should have been managed much more tightly, and could only speculate as to the reasons for this. The process stands in contrast to the full sequence of regular meetings that had managed the Holmdale situation.
- 9.10. Discussion at the workshop indicated that there were problems with the quality of the notes made at safeguarding meetings at that time, which have contributed to the difficulty of tracking information sharing and decision making at this later stage.

Lessons learned/changes made

- 9.11. As with other sections, the passage of time since Mr R's death means that a number of changes have already been made:
- steps have now been taken to improve the quality of notes of safeguarding meetings
 - the focus of a safeguarding meeting would now be wider than the narrow concern with events at Fallowfields, and the process would involve the family more fully

- A representative of the commissioning team would be present at safeguarding meetings to discuss the communication arrangements about any investigation. Both then and now, however, there is an expectation for the home to communicate any incidents to family members and the CQC has seen evidence that this happened in this case.
- When the LA makes Quality Assurance Contract Monitoring visits they ask the provider about residents' meetings/communication to residents/families. They would expect that meetings are held at least every quarter and that the provider ensures that all resident views are sought, taking into consideration their individual communication needs and also if they do not wish to attend the meetings.

Changes still to be made

- it is proposed that there should be a clause in the LA contract with a care home to stipulate that the provider is required to communicate to all interested parties (residents/relatives/staff/Local Authority/CCG or relevant stakeholders) about their CQC inspection reports/ratings and that they would also communicate/provide an update to all parties of their action plan and outcomes. However, in cases when the provider is either rated 'Inadequate' or is subject to safeguarding processes the LA does hold regular meetings with the provider and is privy to their action plan and updates.

10. Consider how commissioners of services, adults, health and Social Care contracts, care management services, CQC and other adult safeguarding professionals interacted in this case.

10.1. A number of points about the interaction between the various professional agencies involved in this case have been picked up in the earlier sections of this report. Other than the points noted about different levels of communication between the CQC and the Council following inspections, interaction between safeguarding professionals is not a particularly significant feature of this case.

10.2. There was a strong focus in the safeguarding discussions and the investigation report on the quality and comprehensiveness of the information provided to Fallowfields when Mr R transferred there. It identified significant shortcomings in this process:

- The written Overview Assessment was not sent to Fallowfields or to Mr R's family
- Although the manager from Fallowfields had access to key documents about Mr R when she visited him at Holmdale to consider him for admission to the home, some of these were later identified as being out

of date in relation to the extent of his wandering at Holmdale, his tendency to navigate to his left and the general use in the home of a fire escape exit as an easy route to the garden. These would have been very relevant to managing his care appropriately at Fallowfields.

- the information transfer arrangements didn't meet expected standards

- 10.3. Although there were some necessary constraints on the sharing of information about police investigations relating to Holmdale, this did not prevent appropriate safeguarding action being taken.
- 10.4. Although this part of the Terms of Reference refers to safeguarding professionals, there are also inter-agency issues relating to Quality Assurance and Commissioning in relation to care providers which have been addressed in earlier sections of this report.
- 10.5. There is one additional element which is that on 10th February 2015 the Fire and Rescue service had written to Fallowfields raising concerns about a number of aspects of the fire safety arrangements. (See Appendix 3) The letter doesn't refer directly to the issue of the fire door being able to be opened but does give an indication of insufficient attention to fire safety arrangements generally. This raised the question of what obligation there might be on the fire service to inform any organisation other than the care home itself of concerns they identify.
- 10.6. Discussion at the workshop confirmed that fire inspections can issue various levels of enforcement notices to make improvements in their own right, but the CQC also has responsibilities in areas of safety. In this case the doors identified in the fire report are internal doors and not fire escapes such as the one through which Mr R left the building. While the fire service can make recommendations / enforcement, it is not usually considered a safeguarding matter, and in this case an improvement notice was issued and information was not shared with other agencies because it was assessed to be low level.
- 10.7. This is a similar issue to that discussed earlier, where concerns that fall short of safeguarding may still be of relevance to the authority responsible for the quality of the care market and commissioners of care placements. Incidents that are reportable to a particular agency need to be shared with others to ensure that intelligence about quality of care is comprehensive.

Lessons learned/changes made

- 10.8. CQC has evidence that the fire exit involved in this case now has a different and more secure opening method. Their more recent inspections at Fallowfields have not identified further concerns about fire safety arrangements.

- 10.9. There are new arrangements coming into place to remove barriers to data sharing and discussions at a strategic level to improve data sharing further. This all needs to be actively pursued to ensure coherent, well-coordinated inter-agency work.

Changes still to be made

- 10.10. Implementation of expected standards of information provision when a service user moves between care settings, whether from home or between residential settings, needs to be reinforced and monitored.
- 10.11. Potential shortcomings in information provision should be identified as a specific risk to be managed in the case of home closures or other complex/unplanned moves.

11. Provide the relatives of Mr R with an explanation of what happened and the steps taken to prevent any recurrence of events of a similar nature

- 11.1. There are two main elements to the family's concerns: firstly the way in which the need to move Mr R from Holmdale House was handled and secondly the actions taken following his death, including the response to their complaint to the Isle of Wight Council. Their key concern is to know that any necessary changes have been made to ensure that no other family has to go through the experience they have had. They particularly want assurance that all care homes that cater for people with dementia need to have the right security arrangements in place to prevent unsupervised exit from the building.

The move from Holmdale House to Fallowfields

- 11.2. I hope that the descriptions in the earlier sections go some way to clarifying for Mr R's family the overall process, where it worked as it should and where there were shortcomings. The actions outlined at the end of those sections indicate the steps that have already been taken to prevent such problems occurring again and some of the further work proposed.
- 11.3. It is regrettable that, despite the various work done in the course of this review, it's still not possible to provide a really comprehensive picture because of the gaps in the recorded account.
- 11.4. The majority of commissioners of care services are currently working in a context where the supply of affordable care has reduced and continues to do so because of funding and staffing pressures affecting the care market nationally and the impact of national reductions in local authority budgets. This will affect the Isle of Wight like anywhere else and the choice of home may therefore sometimes be limited, particularly to meet any special needs a potential resident may have. In that context local authorities will tend to work hard to try and support an established provider to improve their

performance so as to maintain continuity of care for their residents and continuity of supply in the local area. This is the context for the changes made since Mr R's death and those still needing to be achieved.

- 11.5. IWC will always work with residential homes to try and improve performance and bring them back up to required standards, so as to maintain the supply of good care and avoid the disruption of a move for the residents. This may mean that the possibility of closure is not immediately raised, but the council now makes clear its expectation that the provider will be open with families about CQC report outcomes.
- 11.6. Since Mr R's death the support arrangements for failing care homes have developed and a named person in the CCG leads on this work, assisting and advising the homes. This person has worked with Fallowfields and, as noted in 8.14 above already works closely with the local authority and further integration is planned.

Actions after Mr R's death

- 11.7. After Mr R's death a safeguarding investigation was appropriately started, in response to referrals from Fallowfields and the ambulance service. This has already been picked up in section 9 above in discussing how the investigation was handled, why it took so long and why it only addressed the issue of potential neglect by Fallowfields rather than looking at the whole process of decision-making about the move from Holmdale, the known shortcomings at Fallowfields and the safeguarding and commissioning issues that arise from those factors. The unacceptably long timescale of this work left the family in limbo for a long period waiting to know what view was taken of the cause of their father's death.
- 11.8. The family's experience of the safeguarding process has left them with low confidence in the effectiveness and accountability of the activity. This has arisen from several sources, I understand, in addition to the main process problem just mentioned.
- 11.9. Firstly, the evening before the Safeguarding Adults Meeting on 19th April 2016, to which family members were invited to hear the outcome of the safeguarding investigation, the chair of the meeting met the family members for a briefing. They found this a helpful and empathetic discussion. However, they found the meeting the following day very different in mood, feeling that there was some pressure for them not to take matters further and that those present were keen to get the meeting over. The family members were also aware that they had only seen a redacted version of the final safeguarding report, so were left wondering what they haven't seen.

- 11.10. The Chair of the meeting was sorry to learn that the family had been left with these impressions as she certainly hadn't intended them to experience the meeting in that way. In the circumstances, the meeting was bound to be a sensitive one and the chair needed to ensure it fulfilled, but didn't exceed, its remit in the time available.
- 11.11. On legal advice, it was necessary to remove confidential information about Holmdale and any references to other residents there. That is the only change that was made and it may be helpful to the family to be aware that this was the reason for the redaction.
- 11.12. The second source of the family's lack of confidence is that there have been so many changes of personnel related to this case. They are aware that various people have retired, left or changed their job within the council and are inclined to see these changes as related to the actions taken in Mr R's case, but without that being acknowledged. They feel that nobody has been held to account for what happened.
- 11.13. This was a time of considerable change in the council's staffing, with a number of temporary appointments in addition to natural changes through retirement or people being appointed to new posts elsewhere. The workshop discussion, while recognising the impression that might be given, confirmed that the various changes would all have occurred independent of the events concerning Mr R. The matter of accountability is addressed in Section 12 below.
- 11.14. Finally, the family was surprised to hear that the police had reopened their investigation a year after their initial assessment of Mr R's death and they wondered what had prompted this. There is a more complex sequence of events that relates to this point.
- 11.15. After the police initial investigation had concluded that there was no evidence of corporate or gross negligence manslaughter the investigation passed to the Local Authority Environmental Health Department as the appropriate regulatory body. Under the Death at Work Protocol, if evidence comes to light which may establish that there is an element of gross negligence then the matter must be considered by the CPS. The Environmental Health investigation considered that it had identified such evidence and potential offences so duly referred the matter back to the CPS for consideration of gross negligence. So the re-opening of the case wasn't directly by the police, but resulted from the subsequent work of the Environmental Health Department.
- 11.16. It was agreed between the IW Council and the local police that a joint visit would be undertaken to the family to explain why the referral back to the CPS had been made. Unfortunately the police officer went ahead and

visited the family without the IW Council on 21st June 2016. Environmental Health services then made a separate phone call to the family.

The family's complaint

11.17. Ms G raised a formal complaint with the council shortly after Mr R's death and was informed in a letter from the Director of Adult Social Services (DASS) that "the issues and concerns that you raise in your complaint form are of such a high level that they are already being investigated under a level 4 safeguarding enquiry." She was assured that she would be kept informed about the enquiry's progress and told that her complaint would be put on hold pending the completion of the enquiry.

11.18. Ms G raised the matter with the DASS again in June 2016 after the completion of the safeguarding process, asking for an update on the examination of her complaint, and was told that he had left the authority. I cannot find that any formal decision was made in discussion with Ms G about whether there remained aspects of complaint to be investigated. My own enquiries about the outcome of the complaint investigation received a response from the relevant department that the matter had never been referred to them as a formal complaint so no action had been taken by them nor was due.

11.19. I would have expected a clearer distinction to be maintained between the safeguarding enquiry and the investigation of any complaint that was made. They are not the same process, and it is quite possible that a complainant may have concerns about how a safeguarding enquiry is conducted that should be objectively investigated. While it was reasonable in principle to ask for a complaint response to await the outcome of the safeguarding enquiry, it was not appropriate to regard the complaint as closed because the enquiry was. The two processes should have been understood to be separate and needing separate responses.

Lessons learned/Changes made

11.20. Many of the changes relating to the safeguarding investigation have been identified in earlier sections and will be picked up again in the conclusions below.

11.21. The Council's staff at the workshop recognised that the response the family received at the time about the complaint being handled through the safeguarding process was not appropriate and shouldn't have happened. The Council's complaints policy and processes were fully updated in October 2016 and there is a new complaints officer in post. This should ensure that there is no repetition of the response Mr R's family received.

11.22. The Chief Executive and Director of Adult Social Services have met Mr R's family personally to explore their concerns.

12. Conclusions

12.1. This section summarises finding from the preceding analysis.

Decision making about Holmdale House and the move to Fallowfields

12.2. There were a number of strengths in this phase of work.

- The CQC acted promptly to alert the local authority to their concerns about Holmdale. The local authority responded appropriately with intensive support and monitoring to the home and the sequence of safeguarding meetings that oversaw the whole process.
- The safeguarding work appears to have been timely and well-communicated where specific residents at high risk were concerned.
- The decision to move all the residents from Holmdale emerged logically from the work undertaken in and with the home.

12.3. However, there were also significant weaknesses.

- general communications to residents and their families about both the safeguarding process and the need to plan for a move do not seem to have worked consistently and certainly did not appear to have provided Mr R's family with timely and accurate information. It is difficult to understand why they were not informed about the reason for his reassessment when contacted in early February 2015. The process for him and them may have felt more positive if the situation had been clearly communicated as early as possible.
- It would have been preferable for the safeguarding activity and the quality assurance work in relation to Holmdale to be separately led, even if run through the same sequence of meetings. This would have shared the workload more evenly and might have improved the clarity of communication.
- It is not clear why the significant weaknesses at Holmdale that led to the CQC rating had not been picked up by the local authority's own Quality Assurance processes
- the relatively late point at which Mr R's family were made aware of the need to consider a move had an unhelpful impact on the subsequent work between the family and the local authority to try and identify an alternative for Mr R. With earlier information the search for an alternative placement would have started sooner with the potential to avoid the sense of pressure that developed.
- The lack of recognition that an "inadequate" rating for a home needed to be considered independently of whether any aspect of it met the safeguarding threshold.

- The “inadequate” rating at Fallowfields contained some serious concerns and these should have been taken up with the home from a quality assurance perspective, so the local authority could be assured about the care and safety of residents. The rating should certainly have been brought to the attention of Mr R’s family when the home was suggested to them.
- The incomplete information provided to Fallowfields at the time of Mr R’s transfer.

Were safeguarding concerns recognised and responded to appropriately?

- 12.4. As has been described earlier in the report, the safeguarding concerns at Holmdale were recognised and responded to thoroughly and promptly. However, the safeguarding process that followed Mr R’s death did not work effectively. It seemed to lose focus and momentum, and as a consequence became unacceptably prolonged, and there appeared to have been no monitoring process or sufficient senior managerial oversight that picked this up in order to bring it back within normal procedures. This is particularly striking given that the process related to a fatality.
- 12.5. The scope of the investigation was also too narrow, and should at that stage have taken into account the decision making process for Mr R’s placement as well as the events at Fallowfields.
- 12.6. This much-extended process had a significant impact on the family, and this was compounded by the inappropriate response to their complaint. Given that background, it was unfortunate that the chair of the safeguarding meeting that finally took place in April 2016 was in the position of needing to conclude the meeting to a deadline.
- 12.7. The complaints process should have been clearly separated from the safeguarding process and, even if it had to wait for the latter to be completed, should have addressed the points of complaint independently.

How commissioners of services, care management, CQC and other adult safeguarding professionals interacted in this case

- 12.8. Shortcomings in interaction between professionals were not as problematic in this case as it has proved in some other Safeguarding Adults Reviews. Much of it worked well, but there are two important points to note.
- As the safeguarding investigation found, Fallowfields had not been provided through professional channels with the full and current information they needed to ensure that all risks had been identified and that Mr R could be safely cared for. However, it also found that the family members who had visited the home had identified the specific risks about Mr R potentially wandering into the adjacent room.

- There was no formal inter-agency group at that time that shared intelligence about quality of care, monitored and responded to care home difficulties and addressed the outcome of CQC inspections. This would have picked up sooner on the inspection outcome at Fallowfields and also provided the structure for the response to Holmdale

Accountability

- 12.9. One of the issues usually addressed in a SAR is whether it is possible to identify any particular action or omission that significantly affected the course of events. In this case, the investigation that concluded in 2016 had already reached a clear view about this in relation to Mr R's death. Having examined in some detail the issues of information provision and fire safety arrangements in Fallowfields, it identified neglect at the care home as the immediate contributory factor. Leaving Mr R alone so early in his stay to find his way back to his room was found to be poor practice (see paragraph 9.8 above).
- 12.10. This review identifies other less immediate but nonetheless contributory issues, in particular:
- the time pressure on the decision making about Mr R's move from Holmdale, arising from the late notification to the family about the need for a move
 - the lack of recognition that an "inadequate" inspection outcome presents serious questions about a care provider that need investigation by commissioners, regardless of whether any specific safeguarding issues are raised
 - the fact that the Fallowfields rating was not brought to the family's attention, which may have influenced their view about proceeding with the placement
- 12.11. In relation to the unacceptable delays in the process following Mr R's death, it is still not clear why this was not picked up and corrected. The assumption has been that the very unsettled management arrangements at the time were a key contributory factor.
- 12.12. The local authority has recognised the shortcomings in process and practice that affected this case and they have been and continue to be addressed through programmes of change and development both in safeguarding and commissioning. This is in partnership with other key agencies. The issues have needed to be addressed at this system and practice level, rather than in relation to individual staff members' actions.

13.Recommendations

13.1. In the two and a half years since Mr R's death a number of audit and review activities have been carried out. These were initially internal, then with independent input and most recently were commissioned by the new DASS. Between them they cover much of the same ground as this review has needed to address. A process of change and improvement started during 2016 (as noted in some of the changes listed in earlier sections) and is still very active now with a detailed Action Plan arising from the most recent independent review, overseen by the DASS and the Safeguarding Adults Board.

13.2. I therefore propose to limit the recommendations from this review as, in my view, many of the process and practice issues that need to be addressed are covered in the outcomes of these other audit and review activities.

Recommendation 1

13.3. The Safeguarding Adults Board ensures that the actions in place and proposed for safeguarding systems from the range of audit and review activity already undertaken are co-ordinated and as far as possible consolidated into a single process that is well managed, with clear accountability for the actions to an agreed timescale;

Recommendation 2

13.4. The findings from this review that focus on safeguarding issues are linked in to that co-ordinated plan

Recommendation 3

13.5. The local authority and IoW CCG, notwithstanding progress already made, ensure that their quality assurance and care governance functions are well-established and their role understood by all parties. This needs to include:

- clarity between the CQC and local authority and CCG about how their roles and responsibilities interact to respond in a timely manner to provider deterioration or failure;
- that standard contractual arrangements state clearly what standards are expected of care providers and what action will be taken where those standards are not met;
- consider including in individual service user contracts an explanation of the contractual position and care governance arrangements that are in place, which can assist discussions when commissioners need to take action in response to deterioration or failure
- clarity that inadequate standards of care require investigation, even when they fall short of the safeguarding threshold, followed by agreed

action to mitigate shortcomings and clear information to any relevant parties about the standing of the care provider while improvements are made

Recommendation 4

13.6. This will be assisted by the IoW local authority ensuring that information available to service users and their families about safe, good quality care:

- is easily available in a range of formats and signposted from all appropriate locations
- supports their decision-making with clear information about the quality they are entitled to expect and how to assess whether places they are considering meet these standards
- is clear about their right to raise concerns, to whom to take them and how they will be responded to

Margaret Sheather, Independent Reviewer

3rd October 2017

ADDENDUM:

A Coroner inquest was held in 2020. During the hearing, a previously unseen bundle of papers which included social care assessments on Mr R's needs were submitted by Adult Social Care. These papers had been in the possession of Adult Social Care but had not previously been disclosed during the safeguarding investigation, through the criminal proceedings, or to the Coroner, or during the course of the inquest.

Following the inquest, the Coroner drew the additional, new information to the attention of the Safeguarding Adults Board, so that the new information could be examined, and consideration given to the new information to inform this review. The new information includes 6 pre-Care Act assessments of Mr R's needs dating from 2009 to 2014. All of the assessments provided acknowledge Mr R's mobility and record different levels of concerns. The first assessment (2009) shows Mr R having a more independent life, living in a flat under a supportive living scheme. The last assessment (2014) indicates Mr R's risk of falling and leaving the building whilst living at Holmdale House residential care home. The documentation indicated that the staff at Holmdale House worked with the risks by having sensory pads to act as an alarm for staff should Mr R mobilise. Although the additional assessments (which were dated between February 2009 and February 2014) were outside the scoping period of the review, the Coroner wished to raise that Adult Social Care were aware of risks associated with Mr R prior to the 24th February 2015 report referenced within this Review. The information provided was considered against the Terms of

Reference for this review, and specifically the focus on the decision to move residents from a failing care home, deemed to be inadequate by the Care Quality Commission, to another care home which was also subsequently found to be inadequate under the Care Quality Commissions new inspection regime.

The additional information provided by the Coroner is important to note. Whilst the focus of this specific review is the reason for the move, not the process by which this happened nor information sharing between professionals the failure to share relevant information could have led to a different outcome for Mr R. Had Fallowfield's had access to the information which confirmed the level of Mr R's mobility and his tendency to wander, that was in the possession of Adult Social Care, they may have felt that they were unable to meet Mr R's care and support needs or may have assessed the risk associated with caring for him differently. Whilst the information provided does not change the findings in the review relating to the Terms of Reference, nor the recommendations contained with the review itself it is essential to acknowledge that when arranging care and support the local authority Adult Social Care department must ensure that a care provider has access to all relevant information in a timely way if they are to be able to make informed decisions about whether they can support an individual and ensure that in doing so they can mitigate any areas of potential risk.

Appendix 1

Terms of Reference Mr R SAR

1. To clarify the actions and decision making by the CQC regarding³ the transfer of Mr R from one failing home to another failing home.
2. To clarify the actions and decision making by the Local Authority regarding the transfer of Mr R from one failing home to another failing home.
3. To provide the relatives of Mr R with explanation of what happened and the steps taken to prevent any reoccurrence of events of a similar nature

Process

1. The reviewer will be asked to undertake an independent review of the existing documentation in this case, including the final safeguarding report.
2. The reviewer will be asked to consider the following:
 - 2.1 The key events surrounding the decision to close Holmdale House and the decision making regarding the move to Fallowfields.
 - 2.2 Were safeguarding concerns recognised and responded to appropriately?
 - 2.3 How commissioners of services, adults, health and Social Care contracts, care management services, CQC and other adult safeguarding professionals interacted in this case.

³ Amended to "...that informed the transfer..." (See paragraph 7.1)
Mr R Safeguarding Adults Review 2017

Appendix 2

Actions agreed at Safeguarding Adults Meeting 19th April 2016

Part 1

- safeguarding investigation closed
- Service Manager to update Practice Guidance Paper stating that the full assessment must be shared with providers
- Chair to write to proprietor following up the meeting with a copy of the report
- meeting minutes to be sent to the police
- Service Manager to share the action plan implemented by Adult Services to reflect the learning following this case

Part 3

- Family members to identify to the report author any amendments of inaccuracies in the report and any further statements
- Group Manager to check details on Swift re whether a previous incident at the home when a resident had left unobserved was reported to safeguarding
- Group Manager to provide family with a copy of the overview assessment
- Chair to share copy of the report with the provider asking them to respond
- QA lead to check whether the home has been visited since the negative CQC report
- Group Manager to check whether Care Manager visited the home before Mr F was placed there

Appendix 3

Issues raised by Fire and Rescue Service

Fire alarm system is inappropriate to provide effective early warning for the existing fire evacuation strategy. New system needed.

Structural fire precautions are inadequately maintained. An assessment of the effectiveness of all existing fire resistant and self closing doors should be carried out. All doors leading onto escape routes should be improved if required to a more modern 30 minute fire resisting self-closing door incorporating intumescent strips and cold smoke seals.

Inadequate safety training of fire evacuation and fire awareness is provided to employees.

Recommends immediate call to fire service if alarm goes at night before any investigation, due to minimal number of staff on duty.