TELFORD & WREKIN SAFEGUARDING PARTNERSHIP

SAFEGUARDING ADULT REVIEW

LOU

Died November 2022

Age 40 years

OVERVIEW REPORT

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1. CIRCUMSTANCES LEADING TO THE REVIEW BEING ESTABLISHED

1.1 Lou had lived since 2013 in supported accommodation, a 3 bedroom house, managed by Hft, a charity that supports people with learning disabilities across England and Wales. Lou had severe learning disabilities resulting in significant impairment of behaviour, autism, moderate depressive episodes and generalised tonic-clonic epilepsy. Funding the care plan

1.2 At the time of her death, Lou was the sole occupant and had recently been moved to a ground floor bedroom which had been freed up following the departure of the other 2 people living there. Funding approved by the local authority provided for Lou to have 1-1 care throughout the day and a waking night carer.

1.3 Paramedics attended the unit at around 6.30 am on 19th November 2022 after the waking night carer had found Lou to be unresponsive and made a 999 call. On arrival paramedics found the night carer carrying out CPR compressions on her back as recommended by ambulance control because the carer was unable to turn Lou over. The paramedics quickly established that Lou was already deceased.

1.4 Police attendance was requested by the paramedics because the initial account provided by the carer suggested there might have been a failure to carry out the required hourly checks on Lou - the time gap being almost 2 hours since the last one at 4:30 am, and the initial accounts provided by the carer suggested that the carer may have fallen asleep.

1.5 Concerns had been raised previously about aspects of the care arrangements within the placement. These included concerns being raised about the potential problems of transfer and evacuation of Lou in the event of a fire or other emergency during the period when her bedroom was on the first floor.

1.6 Concerns had also been raised by Lou's family in December 2021 that there were problems in respect of the functioning of the assistive technology for detecting when Lou was having a seizure. In addition, the local authority's quality assurance team had identified some gaps in Hft's records and the application of its policies and procedures.

2. PARALLEL PROCESSES

2.1 A police investigation was carried out into whether there had been a breach of the provider's duty of care resulting in ill-treatment or neglect of Lou. The carer provided an account that Lou had been checked at 04.30 hours and 05.30, and denied falling asleep or listening to music – two explanations that the carer had allegedly made to the paramedics.

2.2 The conclusion from the investigation was that Lou's death was not preventable and was not as a result of negligent care as there was no evidence of a causational link between the care provided that morning and Lou's death.

2.3 In arriving at this conclusion, the police investigation took account of the findings of the forensic pathologist who carried out the post mortem that established that the cause of death was sudden death in epilepsy and coronary artery disease, and that Lou's death had not been preventable.

2.4 During the investigation, expert advice was sought from Care Quality Commission (CQC) on documents removed from Hft. Although CQC did identify some wider issues about the care provided by Hft, which are covered later in the report, CQC concluded that none of these would have ultimately affected events on the night of Lou's death. Therefore CQC made the decision that it would not be to using its powers to bring a prosecution but would instead carry out a follow up inspection to ensure that the issues identified are not found elsewhere in the service.

2.5 As part of the national LeDeR programme to improve healthcare for people with a learning disability and autistic people, a 'focused' LeDeR review [1] was also carried out into Lou's death. This review would gather information about Lou, and her healthcare, to identify what had gone well or less well and whether there was a reason for Lou dying at such a young age. GP notes form a large part of the review alongside input from family members, carers and healthcare professionals.

3. DECISION TO ESTABLISH THE SAFEGUARDING ADULTS REVIEW

3.1 Under Section 44 of the Care Act 2014, the Local Safeguarding Adult Board (SAB) must carry out a Safeguarding Adult Review (SAR) where an adult with care and support needs (whether or not those needs are met by the local authority) in the Safeguarding Adult Board's area:-

(i) has either died as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked together more effectively to protect the adult"

(ii) the adult has not died but the SAB knows or suspects that the adult has experienced serious abuse or neglect.

3.2 In December 2022, the Telford & Wrekin Safeguarding Partnership concluded that the criteria for carrying out a SAR were met. However, the decision was made to pause commencement of the SAR process until the parallel LeDeR review had been completed in order to avoid duplication of work. However, it was later established that the LeDeR review had been put on hold pending the coroner's inquest. Consequently, to avoid further delay, the decision was made on 5th June 2023 to proceed with the SAR process.

Purpose of the Safeguarding Adult Review

3.3 The approach to be adopted in carrying out this SAR reflects the safeguarding principles set out in the Statutory Guidance to the Care Act 2014:-

- to establish whether there are lessons to be learnt from the circumstances of the case about the way in which local professionals and agencies work together to safeguard adults at risk;

- to determine what agencies and individuals involved might have done differently to prevent the harm or death;

- to review the effectiveness of multi-agency safeguarding arrangements and procedures (both multi-agency and those of individual organisations);

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[1] *https://www.england.nhs.uk/learning-disabilities/improving-health/learning-from-lives-and-deaths/who-is-involved/*

- to identify the learning, including examples of good practice, and apply these to improve practice and partnership working to prevent similar harm occurring again in future cases.

Safeguarding Adult Reviews are not a means of reinvestigating safeguarding concerns, or to attribute blame, but a process to promote effective learning and improvement action.

4. TERMS OF REFERENCE

4.1 The scoping of the review agreed the following key lines of enquiry:-

1. The effectiveness of multi-agency working to ensure a co-ordinated approach to meeting Lou's physical and mental health needs, including:-

   (i) was there a shared understanding of each agency's role and responsibilities, and which agency had the lead role for co-ordinating and overseeing the multi-agency input?

   (ii) how any shared care arrangements were negotiated and agreed?

   (iii) did assessments and reviews seek, and take account of, contributions from other agencies involved and family members?

   (iv) whether there was prompt information sharing to enable other agencies to consider follow up action?

2. Did agencies provide appropriate support to Hft to assist them in delivering the care plan?

3. How appropriate and robust was the risk management plan given the risk of Sudden Unexpected Death in Epilepsy (SUDEP)?

4. Were there clear arrangements as to how appropriate assistive technology would be put in place, and did this technology prove fit for purpose?

5. Was there a shared understanding as to which agencies / teams held responsibility for applying quality assurance processes to check that Hft:-

   (i) had developed, and was applying effectively, relevant policies, procedures and guidance, including training, to meet Lou's complex needs;

   (ii) was adhering to all elements of the care plan and were applying effective risk management processes,

6. How robust were the quality assurance processes and risk assessments to check the information provided by Hft.

7. Was appropriate action taken promptly by agencies to respond to raised by Lou's parents about the assistive technology and the importance of Lou receiving care from known carers? Were Lou and her parents satisfied by the action taken?

Time period to be reviewed

4.3 It was agreed that the review would cover the period from 1st November 2021 to 21st November 2022 when the strategy meeting was held following Lou's death. This start date was agreed in order to enable exploration of the response to the issues raised by Lou's parents about assistive technology not being in place or being used, and the lack of consistency in the carers involved with Lou.

5. REVIEW PROCESS

Organisations contributing to the SAR

5.1 The following agencies contributed to the review through membership of the SAR Panel and submission of chronologies and agency reports covering their involvement:-

Midlands Partnership University NHS Foundation Trust
Royal Wolverhampton Hospital NHS Trust
Telford & Wrekin Council
- Adult Social Care
- Assistive Technology Team

West Mercia Police
Hft
Care Quality Commission

5.2 Information reports were also provided by:-

Shropshire and Telford Hospitals Trust
Shropshire Community Health NHS Trust
Ironbridge Medical Practice
West Midland Ambulance Service

5.3 Within the review process, a number of meetings were held involving the SAR Author, the LeDeR reviewer and the Safeguarding Adults Board Manager to review progress of the parallel reviews and share information that was emerging.

Timescales

5.4 A panel meeting to scope the review was held on 14th September 2023 with the follow up meeting held on 16th November agreeing the terms of reference and a deadline of 19th January 2024 for the submission of the agency reports.

5.5 However, despite frequent progress chasing, there was a 14 week delay before Hft submitted its chronology and report at the end of April after the delay had been brought to the attention of the Hft Chief Executive. It was explained that the delay was in part due to the difficulties in retrieving the paper records which had been archived following the closure of the unit where Lou lived. In addition, a major service redesign had resulted in many of the staff involved in Lou's care leaving Hft's employment with the consequent loss of their knowledge about Lou's care.

Family involvement

5.6 Lou's family responded quickly to the invitation to contribute to the review. At the initial meeting with Lou's sister and mother at the end of October 2023 when it was explained about the LeDer review, their preference was to delay having a full discussion until this could include both reviewers to avoid having to go through the process twice. Further email contact was maintained suggesting a meeting in January to avoid causing any upset over the Christmas period.

5.7 However, when a further approach was made, the family replied to say that they no longer felt able to have a meeting because they were still finding it difficult to come to terms with the loss of Lou but would be prepared to respond in writing to any questions.

5.8 In the light of this, although there were some issues that would have benefited from gaining the family's perspectives, including being able to reflect Lou's voice within the report in terms of how she experienced her life and the placement, the decision was made that no further approach would be made to the family. This was because the original letter sent to them had made it clear that their wishes regarding participation would be respected.

5.9 In addition, although the family's insights would have been beneficial in enabling the SAR to gain a more rounded view of Lou and her experiences, this gap did not affect the SAR Panel's ability to draw out the essential learning.

5.10 It was agreed however that at the conclusion of the review, an offer would be made to share the review findings.

Practitioner Reflection and Learning Events

5.11 Given that many positive changes have already taken place related to the SAR learning, and there had been a considerable turnover in staff across all agencies who were involved with Lou, it was agreed that practitioner events would not be the best way forward in this case. Instead, the following other means of rolling out the learning should be explored:·

- a 7 minute briefing will be produced to accompany the publication of the report that can be used across all agencies in training and team meetings;

- use of the ASC newsletter which has a section dedicated to SAR learning, and is discussed in all team meetings;

- holding workshops during the 'social work week';

6. TIMELINE OF KEY EVENTS AND AGENCY INVOLVEMENT DURING THE SAR REVIEW PERIOD

Explanatory Note

The report submitted by Hft included details of key episodes of care, including each occasion when Lou had a seizure which was helpful. These are not included within the timeline but will be covered in general terms later in the report.

6.1 On 16th November 2021 at the annual review with the Midlands Partnership Foundation Trust's (MPFT) Community Learning Disabilities Team, (CLD Team), Lou's mother raised her concerns that Hft (Hft), Lou's care provider, was no longer providing activities and trips out since Covid, and there was a lack of consistency in the care staff allocated to Lou. Communities Learning Disabilities Team passed these concerns on to Adult Social Care (ASC).

6.2 On 29th November 2021, Lou's mum raised concerns with the Adult Social Care social worker regarding how Hft was being managed as a service which led to agreement that the possibility of an alternative placement would be explored. Enquiries were subsequently made regarding a ground level bungalow that accommodated 4 people.

6.3 On 1st December 2021, Adult Social Care received calls from Lou's mother and sister raising safeguarding concerns that some of the assistive technology was not working and that Hft staff were not sure what equipment had been installed. After being screened by the ASC safeguarding team, these concerns were passed to the local authority's Assistive Technology Team (AT Team). 2 weeks later, on 14th December, Hft informed the AT team that the Alert Pulse Companion had not been successfully implemented and requested support to get it up and running properly.

6.4 On 10th December 2021, Lou and her mother attended the regular 3 monthly appointment with the epilepsy nurse to review the seizure activity to enable any necessary adjustment to be made to the Vagal Nerve Stimulator (VNS). [2] Further appointments took place on 11th March, 24th May and 27th September 2022.

6.5 At a site visit on 6th January 2022, an officer from the Assistive Technology Team met with 3 Hft staff and set up the pulse companion with the Hft duty mobile phone being used to download the app required to set the perimeters for heart rate monitoring. In addition to the on-site demonstration, full instructions were emailed later that day to Hft to be shared with other Hft staff.

6.6 However, 3 days later, Hft's technical support officer (Hft TSO) informed the Assistive Technology Team that Hft staff were still having problems as the Alert-It alarm kept going off when connected to the pager. The Hft TSO said a visit would be made to resolve the problem on 24th January and in the meantime staff had been advised to use Lou's tablet with the alarm until one could be provided.

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[2] *VNS therapy involves a small electrical device, like a pacemaker, which is implanted under the skin of the chest. The device sends electrical impulses to the brain through a nerve in the neck called the 'vagus nerve'. The aim is to abate the number of seizures the patient has, and to lessen the severity.*

6.7 During that subsequent site visit, it was found that the settings might have been changed inadvertently as these were too low. The software was installed on a tablet which enabled staff to more easily review the readings from the pulse companion and check the device settings were correctly set. A password was also installed to prevent Lou accidentally changing the settings which was shared with the Assistive Technology Team. The Hft TSO raised with the Assistive Technology Team that Lou now had 3 sensors in operation [3] and shared the hope that once it was established that the Alert-It was working well, the position could be reviewed so that just one was being used making it simpler for staff.

6.8 On 14th March 2022, Lou's mother informed Adult Social Care that she now wanted Lou to remain on the Hft site and not move into a bungalow. This had been an option that had been subject to ongoing exploration since June 2021 following a fire risk assessment had identified the challenges that staff would face in trying to evacuate Lou from her first floor bedroom. Two months later, on 23rd May, Lou's mother also informed Adult Social Care that she was now happier with the responses being received from Hft.

6.9 On 17th August 2022, Lou's mother told Adult Social Care that although things were better now at Hft, a review was required to ensure Lou received support from regular carers whom she knew, particularly as Lou was due to move soon to the downstairs bedroom. The case was allocated to a student social worker a week later to complete the reassessment with a qualified social worker.

6.10 The move to the ground floor bedroom took place in late September with Lou now being the sole occupant in the unit.

6.11 The review by Adult Social Care held on 13th October 2022 concluded that all risks were being managed at Hft and that the support provided, and the assistive technology installed, was the least restrictive possible and proportionate to the risks identified.

6.12 Lou's family confirmed that their preference was for the placement to continue and it was not in Lou's best interests for her to be moved. This was because Lou was happy there and benefited from the established routine and relationships with care staff. Although the family had previously raised some issues about her care, their recent experience was that the care arrangements had improved. It was agreed that Lou would receive more support to access the community. Accordingly, the risk assessments were updated and the case was subsequently closed on 11th November as the support plan had been updated and implemented.

6.13 On each of the 3 days between 4th and 6th November 2022, Lou was taken to hospital emergency departments because of continuing abdominal pain. However, no specific cause could be identified and it was concluded that Lou might be experiencing pre menstrual pain. She was prescribed paracetamol, buscopan and advised to arrange a follow up consultation with the GP to organise a scan. This consultation took place on 8th November 2022 when the GP advised that Lou should complete the course of Buscopan and await the results of the scan.

6.14 During week commencing 14th November 2022, Lou suffered with a bad cold which was accompanied by aching within her arms and legs. During a telephone call on the evening of 18th November, Lou told her mother that she was still feeling unwell with the cold - information that was relayed to the night carer at the start of the shift.

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3 *The pulse companion to the advanced pager, the epi-care going to the care assist and a medpage sensor that was by her bed.*

6.15 At 6.20 am on 19th November 2022, a 999 call was made by the waking night carer after Lou was found unresponsive when a check was made on her. According to the Hft waking night log this check had been made at 6.00 am. On arrival at 6.30 am, paramedics found the night carer carrying out CPR compressions on her back as recommended by ambulance control because the carer was unable to turn Lou over. The paramedics took over and turned Lou when it became evident she was deceased.

6.16 The paramedics requested police attendance because this was a sudden and unexplained death and because the initial accounts provided by the carer suggested that the previous hourly check that was due may have been missed. After taking Lou to the toilet at approximately 04:30hrs, the carer had returned to the lounge and was 'dozing off' but then changed this account to one of watching television prior to carrying out the check at 06:20hours. This meant there had been a gap of nearly 2 hours since the previous check.

6.17 Hft informed the ASC Emergency Duty Team (EDT) of Lou's death and explained that managers were on site ensuring that all protocols were being followed and all agencies had been informed other than the GP as it was a weekend. Discussion between EDT and the police confirmed that a strategy meeting would be held on Monday 21st November and in the meantime, EDT would request Safehands, who supplied the agency worker, to suspend the latter pending the police enquiries.

6.18 On 21st November 2022, the case was allocated by the ASC safeguarding adults team who informed Hft that they must cease its investigation and staff interviews as this was now a police investigation and further actions would be agreed at the strategy meeting.

PART 2 REVIEW FINDINGS

7. INTRODUCTION

7.1 The presentation of the review findings is organised within the following sections:-

- Oversight of Lou's learning disability;
- Oversight of Lou's epilepsy;
- Use of assistive technology;
- Care provided by Hft;
- Audits carried out by the Adult Social Care Quality Assurance Team;
- Review carried out by Adult Social Care;
- Application of the Mental Capacity Act;
- Issues around a possible deprivation of liberty;
- Multi-agency working

7.2 These findings are then followed by a section setting out the overall conclusions and the review recommendations.

7.3 First however, the report provides a brief profile of Lou to ensure she remains the central focus of the review.

8. LOU

8.1 Although the review was unable to obtain insights from Lou's family for the reasons explained previously, the review was provide with descriptions of Lou in Hft's report

plus the conversations the LeDeR reviewer had with Hft staff and professionals from other agencies.

8.2 The Hft manager described Lou as 'larger than life', 'playful', 'cheeky' with a 'contagious' laugh. Lou was able to communicate verbally and was described by professionals as chatting repetitively. Lou loved to tickle staff members and people she found to be 'fun'. However because of her size, this play could become a 'bit rough' although she was unable to recognise this.

8.3 Lou loved music especially listening to the singer Harry Styles who she was obsessed with – so much so that each morning the care staff would give her a letter from Harry Styles. Lou also liked jewellery making, doing artwork, and taking photographs with her phone. However, Lou sometimes lacked motivation which was said to be due to her autism and she needed lots of encouragement to complete activities – this encouragement being a core part of her 1:1 care and support plan.

8.4 Lou was able to wash and dress herself with support but preferred not to. She struggled with fasteners and ensuring things were not back to front. Lou's mother found supporting Lou increasingly difficult due to her own age and ill health and that of her husband, therefore sometimes it was easier to do things for Lou rather than cause behavioural issues by insisting she did things unsupported. Lou's mother was said to be aware that she possibly did 'too much' for Lou and stepped back from this when Lou moved into the Hft placement so she could support staff in encouraging Lou to be more independent.

8.5 Lou loved to go out for lunch and shopping with her mother each week and sometimes instead of shopping she enjoyed visiting local attractions such as museums, cinema and zoos. Sometimes she would take a photo of something she liked and send it to her mother who would then buy it for her if appropriate. Lou's bedroom was full of teddies, key rings and other toys - some that had never been taken out of their original packaging. Lou then found it difficult when Covid restrictions temporarily put an end to these shopping trips.

8.6 Lou was five foot ten and struggled with weight management. Although there was no record of Lou's weight in the Hft records, the review carried out by the Community Learning Disabilities Team in December 2020 established that Lou's BMI was 32 which placed her outside the accepted healthy range. Lou's mother kept records of her weight and staff were asked to keep records also, however this was not done.

8.7 One contributory factor for this was said to be that because of her autism Lou would never leave any food on her plate. Lou's mother therefore requested Hft staff to monitor Lou's food intake and supported staff in promoting healthy options and providing Lou with smaller portions. Lou loved to drink tea and coffee, always decaffeinated. According to the GP notes Lou drank tea and coffee excessively. Lack of exercise was also said to be an issue because Lou was not keen on walking unless it had a 'functional' purpose such as walking to a shop or cafe.

9. OVERSIGHT OF LOU'S LEARNING DISABILITY

9.1 Lou had a severe learning disability and Lou had been open to the Community Learning Disabilities (CLD) Services in the Midlands Partnership Foundation Trust (MPFT) since 2010 whose role was to monitor Lou's learning disability and any psychiatric issues. Lou had also been diagnosed as autistic in 2011 after exploration of the cause of some significant challenging behaviours.

9.2 The contact with Lou in later years was through the annual reviews where Lou was always accompanied by her mother and sometimes a Hft support worker. Both could seek advice or support from the team in the intervening period as necessary. Although Lou was assessed as lacking capacity to consent to her care and treatment, she was always encouraged to take as active a part in her reviews as possible.

9.3 It was good practice that the concerns raised by Lou's mother at the last review in November 2021 were brought to the attention of Adult Social Care about the lack of consistency of staff at the Hft placement, and the ending of trips out since Covid. However, there was no evidence of the Community Learning Disabilities Team following this referral up when it did not receive any notification from Adult Social Care about how these concerns had been addressed.

9.4 Although it was planned to review Lou again in a year's time, this had not been arranged by the time of Lou's death.

10. OVERSIGHT OF LOU'S EPILEPSY

10.1 Lou had been diagnosed with epilepsy as a toddler, and experienced generalised tonic clonic seizures, [4] tonic seizures [5] and myoclonic seizures. [6] Lou's seizures would usually last for up to two minutes and were of such significance that she suffered learning delay. On occasions there would be up to twenty seizures per day. People familiar with Lou would usually know when she was about to have a seizure as she would become disengaged. Lou herself was totally unaware of any oncoming seizures. The volume of occurrences gradually declined once medical professionals controlled them to a degree effectively through medication. [7] and VNS implant, however seizures were occurring regularly throughout Lou's life from the age of three and a half.

10.2 The oversight of Lou's epilepsy was provided by the neurology team at New Cross Hospital in Wolverhampton, which is part of the Royal Wolverhampton NHS Trust (RWT), as this type of specialist service was not available in Telford.

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4 *Generalised Tonic-Clonic Seizures: Also known as grand mal seizures, involve unconsciousness and violent muscle contractions with both tonic (stiffening) and clonic (jerking) phases. They can also be accompanied loud vocal noises, drooling or frothing at the mouth and a loss of bladder control.*

5 *Tonic seizures cause sudden muscle stiffness and rigidity, often occurring during sleep and can last up to 2 minutes*

6 *Myoclonic Seizures: Characterised by brief, jerking spasms of a muscle or muscle group without loss of consciousness.*

7 *Lamotrigine 200mg 2 x daily, Topiramate 50mg at 4pm and 200mg at 8pm*
Levetiracetam 500mg – 3 x daily; Midazolam and Clobazam in the event of a seizure

10.3 Lou had an epilepsy care plan developed by the epilepsy specialist nurse which set out what the management should be for Lou's twitching, and what were the usual triggers might be. These were tiredness, stress, constipation, pain, before and after menstruation and when she was sleeping. It also explained what medication should be administered in the event of a seizure. The Vagal Nerve Stimulator (VNS), [8] which Lou referred to as her 'buddy', that had been inserted in 2019 at the QE hospital in Birmingham was not designed to provide alerts.

10.4 The care plan was reviewed at appointments every 3 months where Lou was accompanied by her mother with adjustments made to the VNS as required after studying the records of seizure activity during the intervening period. When the epilepsy nurse was reconfiguring the VNS, Lou would say 'buddy too strong' and the strength would be reduced accordingly.

10.5 The agency report provided by the Royal Wolverhampton Trust made the observation that throughout 2022, the seizure charts provided by Hft were well documented and showed evidence of improved seizure control and reduction of use of rescue medication which was encouraging.

10.6 During the SAR review period, 60 seizure episodes were recorded, many of which occurred around Lou's menstruation cycle, resulting in administration of Clobazam 10mg which Lou referred to as her 'Bluey'. There was no seizure activity that required buccal midazolam to be administered.

10.7 Lou had a protective helmet in the event of a fall during a seizure but this never occurred after the VNS was fitted. This led to Lou 's mother asking if Lou still needed to wear the helmet, but the nurse felt that Lou still liked putting the helmet on as it made her feel more secure particularly if she felt she may have a seizure.

10.8 The mental capacity assessments carried out by the Neurology Service concluded that Lou did not have capacity to understand, retain or weigh up the information relating to the management of her epilepsy. Consequently best interest decisions were made about her treatment and support. However, it is evident that Lou came to understand when she needed to ask her carers to swipe the (VNS) saying 'swipe buddy' or ask for a 'Bluey' (a clobazam tablet) if she needed one.

11. RISK MANAGEMENT - USE OF ASSISTIVE TECHNOLOGY

11.1 Lou had been provided with a Possum Epi Care Wrist sensor [9]in 2017 for the detection of convulsive seizures which had been privately funded via a grant. Although this was the only technical solution available at that time, by 2021 other technology had been developed. Therefore in April 2021, the local authority assistive technology team (AT Team) carried out an assessment which established that the Possum was not detecting all the various types of seizures experienced by Lou.

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8 *a 'pulse generator' which is connected to the left vagus nerve in the neck. This sends electrical stimulations through this nerve to calm irregular electrical activity within the brain that can lead to seizures.*

9 *The sensor detects tonic-clonic / grand mal seizures. When a seizure is detected, the alarm is activated and the base unit sends an alert to a mobile phone, tablet or pager*

11.2 It was identified therefore that provision of the Alert-It Pulse Companion would address this [10] which was set up in June 2021. Full instructions had been given to Hft staff on its use, with additional support and problem solving provided by 'Alert-It' technical support as well as the AT Team. A bed occupancy sensor [11] had also been provided to alert staff when Lou was up and about or if she had fallen from bed during a seizure.

11.3 Lou also had an audio monitor purchased by Hft after seeking advice from Hft's Personalised Technology Team so staff could listen for any seizure activity if the alarms did not activate. Lou consented to this and liked to turn it on and off. Lou also had bed rails in place to stop her falling out of bed.

Response to problems raised by Lou's family

11.4 When the problems were raised by Lou's family in December 2021 that Hft staff were struggling to set up the pulse companion, the Assistive Technology Team's action in resetting this and providing instructions to Hft staff did not prove completely successful as Hft staff continued to report difficulties using the equipment. These stemmed from the pulse companion alarming all the time because it was being triggered by Lou's low pulse rate.

11.5 The subsequent intervention by Hft's Technical Support Officer (Hft TSO) appears to have resolved the problem given that during the remainder of the SAR review period, there is no record of any further problems being raised regarding the operation of the technology. The Assistive Technology Team had no further involvement after the update provided by the Hft TSO on the outcome of the visit.

Arrangements for ongoing checks of the equipment

11.6 With regard to how ongoing checks were carried out as to whether the equipment was working, the review established that responsibility for these rests with the care provider who would then seek support from the Assistive Technology Team as necessary – the latter being reliant on any problems being reported by either the care provider or the family.

11.7 According to the Hft report, the monthly audits carried out by Hft managers established that daily checks were being carried out by staff. However, the Care Quality Commission's examination of Hft records noted that the checks were not consistently recorded, and the one due on the day before Lou's death had not been carried out.

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10 *This device is worn on the arm and monitors heart rate. A person's normal heart rate perimeters are set within an app. If the person's heart rate goes outside of the set perimeters, the device sends a message to a pager held by a carer on site.*

11 *This sits underneath the mattress and sends an alert to a pager when the bed is vacated.*

11.8 During the SAR, this finding was disputed by Hft who stated that the equipment had been checked on both the 17th and 18th November 2022 but the manner in which these were recorded was different – the former being entered on the electronic recording system and the latter on the paper record. [12] Hft speculated therefore that the use of these different recording methods might be the reason why CQC did not pick up that the 18th November check had been carried out. With regard to that observation, the author noted that CQC had been provided with all the paper records within which the 18th November check was said to have been recorded.

11.9 Notwithstanding the discrepancy in Hft's and the CQC's findings about that particular check, Hft did confirm during the review its own findings from a review of the daily records and seizure charts that completion of the daily checks were not consistent, not always contemporaneous and lacked some critical detail.

12. CARE PROVIDED BY Hft

12.1 During the review the author had the benefit if the perspectives gained by the LeDeR reviewer who had been able to talk with some of the care staff. It is evident from these conversations that there were many positives about the care provided by Hft and staff were very fond of Lou and always sought to go the extra mile to ensure she received the best possible care and this was provided in a way which Lou preferred and from staff she liked.

12.2 To support staff in providing this person centred care, a number of plans were in place following assessments:-

- a Care and Support Plan, which was updated in May 2022, was focused on supporting Lou to be as independent as possible. [13]

- a positive behaviour support (PBS) plan due to Lou's challenging behaviour at times where she could be verbally and physically aggressive towards staff. This was usually when Lou's routine was disrupted, perhaps by things or belongings being moved, the house being 'busy' or she was being supported by staff she did not know.

- The Hospital Passport, Health Action Plan and Emergency Information Grab Sheet were also updated in May 2022 – copies of these were passed to all professionals who had contact with Lou so they knew how to support Lou.

12.3 In addition to the appointments with the GP and the epilepsy nurse, Lou had regular appointments with the podiatrist, dental practice, and optometrist. Although short sighted, Lou was said not to require spectacles.

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12 *Hft explained that at the time it was in the process of switching from paper records to a fully digital system but in this transitional period, a mixture of paper and electronic record keeping systems was being used.*

13 *The support plan details health and social care contacts, diagnosis, what Lou likes and dislikes, how she wants to be communicated with and her activities of daily living and how she would like these carried out*

12.4 On a daily basis, staff would complete a chart with Lou to ensure Lou's wishes and feelings were taken into account to draw up activities and plan meals. Some days Lou did not want to complete this but staff encouraged her as it was an important part of Lou's behaviour support plan that she had some structure to her day - a change in routine being a known trigger for challenging behaviour which on occasions could lead to her striking out at staff. When this happened, staff would draw on the behaviour plan to manage her physical aggression and disengagement.

12.5 Hft also supported Lou to access the community using her motability vehicle, with 2 staff accompanying her due to her challenging behaviour and because it was difficult for her to use public transport. However, as outlined earlier in the report, at Lou's annual review with the MPFT Community Learning Disabilities Team in November 2021, her mother raised concerns that these trips out had not been resumed after the end of the Covid lockdown.

12.6 Support from carers she was familiar with was also important to Lou and she was able to verbalise if there were any particular staff she did not want to look after her. This became an issue that Lou's mother raised directly with Hft and also in the annual review with the MPFT Community Learning Disabilities Team. This resulted in the Hft management team working with staff, Lou and Lou's mother to identify which staff Lou liked, and devising rotas which Lou and her mother were happy with. In addition, Hft addressed the issue by recruiting new staff.

12.7 Following this issue being raised, regular meetings were held with Lou's mother. Usually these were monthly but for a period they were taking place fortnightly. Although there were no formal minutes of these meetings, any concerns raised were recorded in the communications book.

12.8 Staff commitment to this was shown by Hft staff often working additional shifts, or swapping their shifts, in order to not cause any unnecessary distress to Lou. However, there were occasions when Lou's preference could not be accommodated because of staff unavailability and on occasions, support was provided by agency staff. However, Hft always tried to use agency staff Lou was familiar with, and on the morning when she died, the waking night staff was an experienced agency worker who was one of Lou's favoured staff having undertaken 2 or 3 shifts a week there for over 2 years.

12.9 Lou had close relationship with her family, particularly her mother, who had daily contact with Lou either through visits, telephone contact, trips out and visits to the family home. Lou's mother was a strong advocate for Lou, supported her with decision-making and attended medical appointments. This involvement was of huge benefit to Hft staff as Lou's mother would provide support in trying to encourage Lou when she was reluctant to engage with the care being provided. The strength of the relationships that developed between staff and Lou's family is evidenced by the fact that they have kept in touch since Lou's death.

Monitoring and response to seizures

12.10 The Hft agency report found that the records showed that staff demonstrated good practice in regularly checking on Lou both in the day and at night, and were responsive when they were concerned about Lou if she was sleepy, twitchy or unwell.

12.11 Night care staff were instructed to ensure that Lou must have her alert on at bedtime. On most nights, Lou went to bed between 9 and 10pm and slept until about 8am and some times later. Her average pattern over the year period was that she would often wake up between 2am and 4am to go to the toilet. On average, Lou would have two episodes of being incontinent which staff would then provide support, before going straight back off to sleep.

12.12 Due to the unpredictability of Lou's seizures, checks during the night were initially made every 30 minutes. However, this was felt it was too restrictive so an audio monitor was put in place and the checks changed to hourly. Lou slept with her bedroom door open and the hallway light on so that staff were able to keep a check on Lou without causing any disturbance. Staff were alerted to Lou's epileptic seizures either by Lou herself through shouting or through the monitoring equipment that was in place.

GAPS IN Hft'S ARRANGEMENTS FOR LOU'S SUPPORT

12.13 Although the foregoing paragraphs have identified many positives about the care provided, the review has identified a number of deficits. Some were identified by Hft and others through the visits by the Adult Social Care Quality Assurance Team (QA team) in July 2022, and others by the Care Quality Commission or the Adult Social Care Safeguarding Team during the police investigation and section 42 safeguarding enquiries carried out after Lou's death.

12.14 A major gap was that Hft did not have in place a robust moving and handling plan or a Personal Emergency Evacuation Plan (PEEP) to guide staff in the event of any emergency. Nor did Hft have a risk assessment or care plan in place in the event of seizure that might result in Lou requiring CPR as happened on the night she died. Both would have been essential given that Lou's height and weight, and her natural sleeping position face down, would make it difficult for a single member of staff to move her. Hft made the observation that managers should have liaised with its Health and Safety Team, or it's moving and handling specialist, to carry out risk assessments and draw up the necessary plans.

12.15 In response to these issues, Hft explained it does not routinely have moving and handling risk assessments for all people it supports. Whilst acknowledging there was a gap, there was a PEEP that was updated on 31st October 2022 after Lou moved to the ground floor bedroom. Hft did not have a specific risk assessment for CPR in the event of seizure at night, but made the point that advice had never been received from the Neurology team or the epilepsy nurse that this needed to be in place. In addition, Adult Social Care was aware of the risk in the event of a cardiac arrest but had not commissioned any additional care hours to mitigate this risk.

12.16 Hft also made the observation that as Lou was mobile and independent, the risk in the event of a seizure was that she might sustain a head injury if she fell to the floor – this being a key issue highlighted within all the various risk assessments.

12.17 A further finding in the Hft report was that although the Vagal Nerve Stimulator (VNS) Protocol was updated in May 2022, the protocols for responding to a Myoclonic Seizure, and for the administration of Buccal Midazolam had not been updated since 2020. The review noted that although Hft confirmed that it has an internal audit programme which includes health and safety checks, the Care Quality Commission had picked up that these seemed sporadic with much of the documentation relating to these ceasing in 2021.

12.18 In addition, the Section 42 enquiries identified that the review of the waking night risk assessment that was due by 31st August 2022 had not been carried out by the time of Lou's death. It also lacked detail about the support that staff might need to provide, and the information that Lou liked to sleep on her stomach, and staff would be able hear her breathing through the bedroom door which was kept ajar which was Lou's preference. This would have been important information for staff who were unfamiliar with Lou.

12.19 Hft confirmed that this was not an issue in respect of the night carer on duty on the morning Lou died as that agency worker had been working with Lou for over 2 years and was familiar with the contents of the risk assessment – an observation that applied to all the agency staff involved in Lou's care as there was a stable group of agency staff working regularly at Hft.

Quality of records

12.20 The Hft report concluded that generally record keeping was good, particularly in evidencing that Lou's voice had been heard and that staff had sought to promote her independence. However, there were a number of gaps regarding Lou's care which fell below the standard of recording keeping expected for a person with complex epilepsy. Reference was made to the seizure activity charts and daily records not always being contemporaneous and lacking some critical detail. They also indicated a lack of management oversight of these.

Training

12.21 On the issue of training for staff on supporting people with epilepsy, the Hft report stated that staff receive face to face first aid training every three years, with training on epilepsy and Buccal administration provided yearly. Hft confirmed that all staff were compliant with these training requirements at the time of Lou's death.

12.22 However, the Care Quality Commission (CQC) and Adult Social Care Safeguarding Team findings cast some doubt on these assurances from Hft. CQC found that the sheets for staff to sign that they have read and understood the various protocols were mostly incomplete, and the risk assessment for waking nights had not been signed by anyone.

12.23 The review received the explanation from Hft that although best practice would have been for these to be signed, there was no policy in force prior to Lou's death requiring this. Staff were expected however to be familiar with the all the relevant care plans and risk assessments.

12.24 From the examination of Hft's records, both the Care Quality Commission and the Adult Social Care Safeguarding Team raised the question of training for agency staff as to how well equipped agency or untrained staff were to provide effective support to Lou. One example was that the absence of guidance on what action they should take if medication needed to be administered given that the medication risk assessment confirmed that only staff who are competent and trained are allowed to administer medication.

12.25 During the SAR, Hft confirmed that there was no record of any agency worker completing Hft's internal training, and it is not their policy to provide training to agency staff. Instead Hft seeks assurance from the agency staff providers that their workers have the necessary skills and have undertaken relevant training.

12.26 Although there was no indication in the various assessment documents or protocols as to how the competency of agency staff would be checked, Hft informed the SAR that it did have an agency proforma that was introduced in July 2022. However, this had not been used with the agency worker on duty at the time of LC death because she had worked for Hft for over two years and Hft had received assurance from the employment agency that the worker was trained in epilepsy, first aid and handling of medication.

12.27 Hft also explained that it now has a Learning and Development training requirements form, agency supervision questionnaire, and an induction policy for agency staff which is completed at the start of the first shift.

12.28 In addition, the Care Quality Commission and the Adult Social Care Safeguarding Team identified that some of the risk assessments did not include any detail on what a seizure would look like for Lou, so it could be difficult for staff who were unfamiliar with Lou to identify when she was having a seizure and take immediate action. Both gaps had the potential to leave Lou vulnerable and lead to delays in Lou receiving the medical treatment she needed.

12.29 In response to this issue, Hft made the observation during the SAR that the Epilepsy Plan was written by the epilepsy specialist nurse who would have needed to ensure this level of detail was included being the practitioner with the clinical expertise and Hft staff not being registered health professionals. Although the plan did not describe what a seizure would look like, risk assessments did refer to what were the likely triggers for seizure activity.

Access to on call support

12.30 Questions were also identified by both the Section 42 enquiry report and the Care Quality Commission as to whether the arrangements for on call support from managers or qualified staff as set out in Hft's guidance was deliverable. This question was raised given the requirement in the waking night protocol that staff who are untrained in the use of Buccal Midazolam should contact the on call support immediately. Given that Lou's epilepsy management plan requires the first dose to be administered 5 minutes after a seizure has started, the question was raised as to whether on-call staff be able to provide a response within that 5 minute window.

12.31 The observation was also made that the guidance did not include any direction as to what staff should do if the on call staff were not immediately available – e.g. calling for an ambulance or contacting NHS 111. Similarly, within the protocol for Myoclonic seizures, there was no clear direction for staff as to what to do if Lou was unable to ask for her buddy to be swiped or was to refuse to have this done.

12.32 During the review, Hft confirmed that all staff at the neighbouring unit are trained in the administration of Buccal Midazolam and there were always two waking night staff and one sleep-in night carer on duty. As the unit was only 30-40 seconds away there would have never have been a delay if a night carer for Lou did not have the necessary training. Hft also made the observation that on the night Lou died, the administration of Buccal Midazolam would not have been appropriate as she was in cardiac arrest.

12.33 Hft also explained that as part of the assurance sought from the employment agency, a check would be made that the agency worker would know what to do in the event of a medical emergency.

Rota management issues

12.34 Given the initial possibility that the night care worker may have fallen asleep, the Care Quality Commission (CQC) suggested to the police that enquiries be made as to how many successive night shifts the agency worker had carried out prior to that night. In raising this, CQC noted that although the worker had only worked at Hft on 13th November during the week of Lou' death, [14] it would be worth checking with the employment agency what shifts had been worked elsewhere which may have contributed to any fatigue.

12.35 This question was also posed to Hft during the review given that it would be expected that Hft would also have checked this before making the decision to roster the worker for that night shift. However this was not initially addressed by Hft in its report which only cited the dates of shifts worked at Hft.

12.36 Hft subsequently explained that the duty of care for checking this rests with the employment agency – in this instance Safehands. Hft made the observation that the fact that some agency workers work with multiple agencies makes monitoring of shifts worked very difficult. Hft have since checked with the agency who advised that it does not routinely check if one of its workers is also carrying out work for another agency. However, the agency would check before placing a worker for any shifts that this would not result in them working beyond the working time directive. Hft also confirmed that it has its own policy to ensure compliance with this directive.

12.37 A wider issue was also raised with Hft as to what the usual arrangements are as to how many successive shifts a member of staff might be expected to work, both in respect of day and night staff.

12.38 Again, the Hft report did not initially provide a direct answer to the general query other than explaining that waking night staff are required to have an 11 hour break between shifts. Instead it cited the actual arrangements that were made during the last week of Lou's life. These were that there was one permanent member of waking night staff who worked 15th to 17th November with the remaining 4 shifts being covered by agency staff because at that time Hft was seeking to recruit an additional permanent member of staff.

12.39 Hft did subsequently provide a detailed summary of its working time policy which included coverage of the additional rules that apply to night workers to supplement those covering maximum weekly working hours and rest breaks. [15] The policy also includes a check to ensure that staff are fit for night work by offering a health assessment before they start a job involving nights, and which is repeated every two years if they take up the post.

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14 *The agency worker completed shifts for Hft at Lou's unit on 31/10/2022; 04/11/2022; 05/11/2022; 07/11/2022; 09/11/2022 (other unit); 11/11/2022; 12/11/2022; 13/11/2022, 18/11/2022.*

15 *In general, night workers must not work more than an average of eight hours in any 24-hour period over the 17-week reference period. Regular overtime is included in the average, but not occasional overtime. Night workers cannot opt out of the limit.*

12.40 The reliance on agency staff to provide some of the cover at night may have been a contributory factor for issues identified around the completion of the night time logs during November 2022 prior to Lou's death. In addition to 2 being missing, only 9 were entered on the official document created by Hft with 7 being recorded on lined paper. The evidence that this had been a recurring issue emerged from the Hft report which found around 20 instances between November 2021 and May 2022 where the night logs were missing.

12.41 In response to this finding, Hft explained during the SAR that it was going through an organisational transition from paper recording to utilising a digital recording system. During this transition period, a waking night folder continued to be used.

13. AUDITS CARRIED OUT BY THE LOCAL AUTHORITY QUALITY ASSURANCE TEAM

13.1 In the light of all the above findings by the Care Quality Commission and the safeguarding enquiries, the review considered the results of the routine proactive audit carried out by the Local Authority Quality Assurance Team in July 2022 [16] which identified the following areas where improvements and action were required:-

- the property was in need of updating;
- there were examples of poor recording, the daily log sheet needed to be audited daily, and the complaints procedure needing to be shared with residents;
- support plans needed to be updated and more person centred, risk assessments needed to be updated, and action taken to ensure staff were following Hft's medication policy;
- individuals should be supported to choose and access activities outside/inside the building – it was noted that Lou's access to the community had not been restarted since Covid;
- the need for recruitment to fill the gaps in staffing and the need for consistency in checking / exploring any gaps in employment history;
- Staff supervisions needed to be carried out regularly in line with policy.

No actions were identified in respect of policies and procedures, infection prevention control or health and safety.

16 *The areas covered by the audit were - Accommodation and Environment; Quality Assurance; Care Planning; Medication; Risk Assessments; Activities; Recruitment and Training; Staffing; Policies and Procedures; Infection Prevention Control; Health and Safety*

13.2 In the follow up visit on 28th September to review the action plan provided by Hft on 15th August 2022, [17] the Quality Assurance Team was satisfied that most of the actions had been completed. A request was made for a medication risk assessment to be completed for Lou which was returned 2 days later. [18] It was also noted that Lou was now the only person living in the unit, and that Hft was also going through a re-development programme at that time. The report provided by Adult Social Care for the SAR made the observation that it appeared things had improved and that there were no further concerns.

14. REVIEW CARRIED OUT BY ADULT SOCIAL CARE

14.1 Leading on from exploration of the Quality Assurance Team's involvement, the SAR considered how the review carried out by Adult Social Care (ASC) in October 2022 resulted in the conclusion that all risks were being managed and the placement continued to be appropriate.

14.2 The finding of the ASC agency report was that the social worker had not adopted the required evidence based approach by accepting Hft's assurances at face value and not checking any of the relevant documentation completed by Hft.

14.3 As a result, the review document did not include any detailed information around how the provider was monitoring Lou at night or that contingency plans had been discussed in the event of the assistive technology malfunctioning, or the arrangements for evacuation in the event of a fire or other emergency.

14.4 In addition, there was no evidence to suggest that the risk assessment was reviewed in consultation with other agencies involved - the Assistive Technology Team, the Epilepsy Nurse and the Quality Assurance Team.

15. APPLICATION OF THE MENTAL CAPACITY ACT

15.1 Although Lou was able to make some simple day to day decisions for example about activities and meals, Lou was assessed as lacking capacity in relation to decisions in respect of her health and support needs. However, she was supported to be involved in discussions around these by her mother, Hft staff or the professional assessing her. Lou was aware of the risks arising from her epilepsy and would often request her medication for her seizures if she felt unwell.

15.2 The Hft report explained that a review was carried out annually of how staff had approached the issue of mental capacity within which staff evidenced how they had supported Lou with decision making and who they had involved. The report also included the following decision specific assessments and best interest decisions:-

- September 2019 - Lou was deemed to have capacity to make the decision for the audio monitor to be used. Lou understood its purpose and she came to like being in control of when it was switched on and this became part of her routine;

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17 *Development of the Hft action plan was led by the Head of Service and Regional Area Manager with actions signed off and verified.*

18 *Hft confirmed that the Medication Policies have been updated for care and support delivered in registered properties and supported living environments.*

- May 2020 - it was concluded that Lou was able to consent to the daily care and support provided;

- January 2021 - administration of the Covid vaccination;

- July / August 2022 – Lou did not have capacity to manage medications and her finances.

15.3 The Hft report finding was that assessments were not completed to the standard expected and some were not updated yearly. In addition, there was no evidence of any discussion or assessment as to whether Lou had capacity to agree to the positive behaviour support plan (PBS). The plan itself was incomplete because it had not been signed by staff or Lou's family.

15.4 Hft also raised the issue that there was nothing within its records to show that a mental capacity assessment was carried out, and a best interest decision made when Lou had the Vagal Nerve Stimulator inserted in 2019 at the Queen Elizabeth Hospital in Birmingham as required by the Mental Capacity Act.

15.5 The author did make contact with the adult safeguarding team at the QE hospital who undertook to make enquiries with the relevant clinician. However, no further response was received. Given that the SAR panel had received assurance that locally there are robust arrangements in place for carrying out MCA assessments and making best interest decisions for these kind of medical issues, the panel agreed that there was nothing to be gained by pursuing the matter further.

16. ISSUES IN RESPECT OF DEPRIVATION OF LIBERTY

16.1 During the SAR, an important issue emerged as to whether Lou was the subject of an unauthorised deprivation of liberty having regard to the 'acid test' [19] set out by the Supreme Court in 2014 [20] which comprises two questions:-

(i) is the person subject to continuous supervision and control?
(ii) is the person free to leave?

16.2 Hft's view was that the acid test was met because Lou was under continuous 1:1 supervision and control, including the use of assistive technology, and was not free to leave the unit unaccompanied. Therefore Adult Social Care (ASC) should have sought the necessary authorisation given that it had commissioned these arrangements which were set out in Lou's care plan.

16.3 However, Hft had found no evidence that its own staff had alerted Adult Social Care that Lou met the 'acid test'. Nor had it found any evidence in its records, including the Adult Social Care assessment and care plan, that formal mental capacity assessments had been carried out, and best interest decisions made, in respect of any of these arrangements.

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19 *The term 'acid test' was used by the UK Supreme Court in its judgment in the case of P v Cheshire West & Chester Council; P & Q v Surrey County Council [2014] UKSC 19 to describe the 2 questions that need to be applied in determining if there is a deprivation of liberty.*

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16.4 The agency reports provided by Adult Social Care and the Assistive Technology Team did not address these issues and therefore further information was requested from the ASC panel representative who subsequently confirmed that there was no documented evidence of a mental capacity assessment being completed specifically regarding any of these arrangements.

16.5 In the light of this, the ASC lead officers for Deprivation of Liberty Safeguards (DoLS) were invited to attend the next panel meeting in September 2024 where an entirely different picture emerged. The DoLS lead officers provided full information about how the issue in respect of Lou had been considered, the decisions made, and the process for keeping these decisions under review.

16.6 It was explained that the issue was considered in June 2021 when a mental capacity assessment had been carried out which had established that Lou did not have capacity to make decisions about the restrictive arrangements, which were considered to be the least restrictive option, and therefore these had been applied through the making of a recorded best interests decision with Lou's family being consulted during that process.

16.7 In line with standard practice, legal advice had been sought and Lou's case had been considered and prioritised at the monthly legal gateway meeting. This had resulted in her case being placed in the medium priority category of cases that requiring a community DoLS application being made to the Court of Protection.

16.8 It was explained that the rationale for categorising Lou's case as medium priority was due to a combination of factors.

(i) there was a backlog of cases at that time being handled by the Court of Protection which was resulting in long delays before hearings were being held - a situation exacerbated by the impact of the Covid lockdown and an influx of new applications;

(ii) Lou and her family were happy with the restrictive elements of Lou's care plan and had raised no objections;

(iii) There were ongoing discussions about the possibility of Lou being moved to a different placement which would mean the whole community DoLS process, and application to the court, having to be repeated.

16.9 In respect of point (ii), it is important to clarify that the fact that Lou and her family do not appear to have objected to the arrangements would not have been a defensible argument that there was no necessity to seek the appropriate authorisation. Even if the family had held Lasting Powers of Attorney for health and welfare in respect of Lou, which they did not, this would not have been relevant because consent cannot be provided in respect of persons over the age of 18.

16.10 However, the statutory guidance emphasises the vital importance of involving family, friends and carers in the decision-making process, as happened in Lou's case, making the observation that a significant feature of a number of the cases that have come before the courts is a difference of opinion or communication issue between the commissioners or providers of care and family members and carers.

16.11 It was confirmed that the original decision was kept under review at the monthly DoLS meetings – although it was acknowledged that the outcomes could have been more clearly documented.

16.12 The SAR finding that Hft was unaware of this decision-making process, and the fact that prior to the involvement of the DoLS lead in the SAR process ASC representatives had not picked up that the issue had been considered, leads to important learning about the local arrangements for considering cases involving a possible deprivation of liberty which is covered later in the report. This learning includes coverage of the process for the provision of legal advice, how the cases are prioritised as regards making applications to the Court of Protection for approval, and how decisions are kept under review.

17. MULTI AGENCY WORKING

17.1 Although the reports showed that practitioners within individual agencies worked well with Hft and Lou's family to ensure Lou's health and care needs were met, there was little evidence of joint working and information sharing between the local authority, the MPFT Community Disabilities Team and the New Cross Hospital Epilepsy Service largely who instead largely carried out their role in isolation as evidenced by the following examples:-

- the MPFT Community Learning Disabilities (CLD) team did not seek information from Adult Social Care (ASC) or the New Cross Hospital Epilepsy Service to inform the annual reviews, and according to ASC and Hft they did not receive any documentation setting out the outcomes other than the specific issues raised by Lou's mother that were shared with ASC;

- there was no reference to any consultation with the epilepsy service by the Assistive Technology Team when new equipment was provided in 2021;

- ASC did not seek information from other services to inform the assessment / review carried out in October 2022.

17.2 There was also no multi-agency care plan that had been agreed by all agencies involved, nor had there been any discussion as to whether a lead professional should be designated to hold overall responsibility for overseeing and co-ordinating implementation.

17.3 The Adult Social Care (ASC) report made the observation that its understanding was that there were a series of lead roles for different elements of Lou's care – ASC for the care plan and funding for the placement, the epilepsy nurse for the management of Lou's seizures, MPFT for reviews of Lou's learning disability and any mental health issues, and the GP for monitoring Lou's health and prescribing.

18. CONCLUSIONS, LEARNING AND RECOMMENDATIONS

18.1 An important finding from the post mortem and outcome of the police investigation was that regardless of whether an hourly check was missed on the morning Lou died, her death was not preventable.

18.2 A further important overall finding is the evidence that all professionals worked hard to ensure Lou's health and care needs were met and all possible risks were mitigated. This is evidenced by the regular oversight by the epilepsy nurse and adjustments made to the Vagal Nerve System, the issues taken up by the MPFT Community Learning Disabilities (CLD) team with Adult Social Care (ASC) that had been raised by Lou's mother, and not least the dedicated care provided by staff at Hft. There was also evidence of agencies, individually, providing advice and support to Hft to enable the latter to deliver the health and care plans.

18.3 In addition, the previous assessments carried out by ASC had resulted in a care plan and the required funding to ensure Lou's assessed needs were met. Although Lou's mother did raise issues about aspects of the care arrangements both prior to, and during the SAR review period, her worries appear to have eased, and as 2022 went on she expressed her increasing satisfaction with Lou's placement.

18.4 This reflected the responsiveness of all agencies in addressing the concerns raised in respect of the assistive technology, ensuring Lou had carers she was happy with, and increasing the opportunities for Lou to have trips out into the community.

18.5 However, the SAR has identified a number of issues with regard to some of the key lines of enquiry, some of which led to agencies identifying actions to address these. These are described at relevant points in the remainder of this section.

Assessments and Reviews

18.6 With regard to the weaknesses in the review carried out by Adult Social Care in October 2022, the SAR panel was informed that the need for an evidential approach, and not accepting assurances provided at face value, is contained within the agency's policy and procedures covering assessments and reviews. As a result of this finding, the guidance has been reissued with a reminder of staff about the approach that needs to be taken. This is that when a review is due, a full reassessment needs to be carried out in order to ensure that all areas of a person's needs and the existing care plan are addressed.

18.7 With regard to the overdue review by the Community Learning Disabilities Team, MPFT established that an appointment letter was scheduled to be sent out within the next month. This finding led to 2 single agency recommendations, which have already been implemented:-

(i) follow-up with medics and medical secretaries to ensure current processes for scheduling medical reviews / follow up appointments are sufficiently robust to mitigate against the risk of over-due reviews.

(ii) discussion to take place with medics and medical secretaries to ensure clinic letters are being copied to all relevant parties (including the person and/or family as appropriate) and not just sent to GPs.

Multi agency working

18.8 There were significant gaps in multi-agency working with agencies working in isolation with little or no attempt to gain information and insights from other agencies to inform assessments or reviews. Nor were the outcomes of those shared with all those who needed to know so that these could be taken into account to shape their own work. There was no shared multi-agency plan setting out all Lou's needs, how these would be met, or agreement as to who would take on the lead professional role for overseeing and co-ordinating implementation.

18.9 Both Adult Social Care and MPFT considered that the development of a single multi-agency care plan would be beneficial to manage risks that are present in complex cases. This would include clear identification of the person's needs and inputs from all agencies involved together with the contingency arrangements in the event of emergencies. Careful thought would need to be given as to who would lead this process, how it would be populated, and how updates would be made and shared.

18.10 In addition, it is recommended that where multiple agencies are involved but each is holding separate review meetings, a copy of the review documentation and outcomes should be shared with the other agencies where they have not been part of the review process.

18.11 The Royal Wolverhampton Trust (RWT) report made the recommendation that there should be attendance by a representative of the care provider at clinic appointments as well as family members. This stemmed from Hft staff having never attending Lou's appointments.

18.12 With regard to Lou's case, Hft confirmed that it would be normal practice to attend all appointments. However HFT was very rarely to be able to provide a regular member of staff or manager to attend the appointments also. There was little benefit to taking bank or agency staff who had little knowledge of Lou's needs. Lou's mother attended these and provided feedback on the outcome to Hft staff to supplement that received from professionals. Very occasionally HFT provided a regular member of Lou's support team to attend these appointments.

Recommendation 1

The Telford and Wrekin Safeguarding Partnership should seek assurance that:-

(i) multi-agency procedures reinforce the need for a single multi-agency plan to be developed in complex cases to meet the service user's assessed needs and known risks, with clear arrangements as to who has the lead role for overseeing and co-ordinating implementation;

(ii) there is evidence from dip sampling and multi-agency audits of cases that the above requirements are being applied.

(iii) where agencies are holding single agency reviews, a copy of the review documentation and outcomes should be shared with other agencies who are involved with the service user.

RISK MANAGEMENT

18.13 The conclusion reached through the Adult Social Care review in October 2022 was that all risks were being managed. This was because of the personal emergency evacuation plan, the positive behaviour support plan, and the risk assessments which included guidance on managing Lou's seizures including the use of the assistive technology.

18.14 However the SAR has established that there were inconsistencies between the various protocols and risk assessments on the monitoring requirements, or action required in the event of a seizure or other emergency. In addition, risk assessments lacked sufficient detail to guide staff who were less familiar with Lou. There were also some gaps in Hft's records of the monitoring carried out but also in relation to the checks that needed to be completed routinely of the assistive technology and health and safety requirements.

18.15 The SAR panel noted that the report of the Section 42 enquiries included the following recommendations for action by Hft:-

- an audit of the night time records;

- the introduction of written handover notes to supplement the current practice of verbal handovers;

- Hft staff being reminded of the importance of dates, times and signatures being included in reports.

18.16 However, the SAR panel received no information as to whether these actions have been progressed although it noted that these had been mirrored to some degree in the Hft single agency learning that core training should include the importance of contemporaneous and factual record keeping. It is a concern that according to Hft, it was not made aware of these recommendations until 10th July 2024 by Adult Social Care, not has it been informed of the outcome of the Section 42 enquiries. In the light of this the following recommendation is made.

Recommendation 2

The Telford and Wrekin Safeguarding Partnership should seek assurance that the outcomes and recommendations from Section 42 enquiries are being shared at the earliest opportunity with all relevant organisations, including care providers.

SUITABILITY OF THE PLACEMENT

18.17 Leading on from the above gaps in the risk management arrangements is the more fundamental issue as to whether the care plan, and the placement itself, were appropriate in minimising any risks to Lou. This question stemmed from the circumstances of Lou's death where the night cover arrangements resulted in the challenges faced by the carer that morning of single-handedly trying to turn Lou over to carry out Cardiopulmonary Resuscitation (CPR).

18.18 Although this question was not addressed fully in the agency reports, within the panel discussions it was agreed that putting Lou in a situation when there was only one member of staff within the unit overnight was clearly a risk.

18.19 In reaching this view, the review noted that in June 2021 the suitability of the placement had been called into question because of the potential risks arising from the difficulty in evacuating Lou from the first floor in the event of a fire or other emergency. The outcome of the 2021 risk assessment was the exploration of a possible move to a bungalow or other ground floor accommodation.

18.20 This move was also something Lou's family had requested because additionally, they were concerned about the lack of effective assistive technology in place, and the lack of consistency in staff allocated to look after Lou. This resulted in Lou being looked after at times by carers who were familiar with her needs and routines.

18.21 The review also picked up on the observation made by the Care Quality Commission during the police investigation that although there were other Hft units close by, obtaining the assistance of other staff within the required response times could not be guaranteed in the event of a fire, or medication needing to be administered if the night carer did not have the necessary training.

18.22 As outlined earlier in paragraph 10.32, Hft did not accept this concern because of the proximity of the neighbouring unit, and because although not formally documented, it had been explained to all new members of staff or agency workers, what action to take in the event of an emergency.

18.23 Ultimately the plan to move Lou to an alternative placement was not progressed because in March 2022 Lou's family expressed their preference for the placement to continue as Lou was happy and settled there. The review acknowledged that in applying the Making Safeguarding Personal (MSP) approach, due weight was given to the views of Lou and her family, which was important.

18.24 Although a move to ground floor accommodation, which eventually happened at the Hft placement, was viewed as making evacuation less difficult, and an updated Peep Plan set out what action should be taken in the event of Lou having a seizure or any other emergency requiring evacuation, the risks would still have remained high unless the care plan included arrangements for 2 staff to be available quickly at night. This was because it would not be possible for Lou to be moved by just 1 person given her height and weight – as proved on the night she died. However, the possibility of funding being provided for 2 staff being on duty at night was not one that was ever proposed for Adult Social Care to consider.

18.25 The SAR Panel also heard from Hft that Lou was not always cooperative and that following a seizure it might have been difficult to move her regardless of the number of staff in situ. In addition, within the October 2022 review carried out by Adult Social Care, it was noted that Lou struggled to remember what to do during a fire drill and could put herself in danger by staying in her room.

18.26 The learning from these findings is that where there are known risks of the type in this case, which could prove fatal, there has to be a process whereby a balancing act takes place that weighs up the known risks against the benefits of maintaining the placement, with the conclusions reached being recorded in detail. There is no evidence however in the Adult Social Care and Hft reports of this taking place, or that the explicit conversations that were required regarding these difficult choices were held with Lou's family.

18.27 One contributory factor for this not featuring in Lou's case is that the template used by Adult Social Care for Care Act reviews does not include a specific question or 'prompt' as to whether the placement continues to be suitable in managing all known risks.

18.28 Hft accepted that conversations with the local authority regarding the risk management of Lou's epilepsy were not recorded well. On reflection, Hft's view was that a multi-disciplinary meeting should have been arranged to review the risk and challenges associated with Lou's epilepsy – including those related to ensuring that Hft could provide staff that Lou was happy with in delivering her care.

18.29 The SAR noted that the Section 42 safeguarding report had directed the following 2 recommendations to Adult Social Care around this issue:-

- support plans need to include the rationale for close supervision, the monitoring and intervention required, and why these are proportionate – particularly where these place restrictions on a person's autonomy;

- reviews of the support plan and equipment would be beneficial to ensure these continue to meet the person's needs and are in the person's best interest. These reviews should be carried out in conjunction with the family or Lasting Power of Attorney (LPA) for health and welfare, the provider and any health professionals involved.

18.30 Again, the SAR panel did not receive any information as to whether these actions have been progressed. Therefore in the light of this and the other observation made about the approach that needs to be taken to ensure that placements minimise risks, the following recommendation is made.

Recommendation 3

Telford and Wrekin Adult Social Care should take the necessary steps to ensure that its guidance and templates on Care Act assessments / reviews require practitioners to address the issue of the suitability of the care plan, and / or a placement, taking account of any identified risks such as fire or possible medical emergency.

EFFECTIVENESS OF QUALITY ASSURANCE PROCESSES

18.31 The issues identified by Hft, the Care Quality Commission and the Section 42 enquiries raise questions about the robustness of the approach taken by the Adult Social Care Quality Assurance Team (QA team) given that some which pre-dated the July 2022 visit were not picked up.

18.32 The QA team's finding that there were no issues in respect of Hft's policies and procedures was in contrast to the findings of others who looked at these regarding either the absence, or lack of updating, of some key protocols that were crucial in underpinning risk management.

18.33 The QA team explained that only a small sample of policies would have been reviewed during the July visit. However, practice has now been changed so that providers are requested to submit all their policies along with the contract and quality questionnaire so that these can be examined in advance and form part of the discussions during the visit.

18.34 As well as the QA team, the social work team also had a role in providing quality assurance in respect of how the care was being delivered by Hft. However, as covered earlier, Adult Social Care's own review for the SAR found that the expected evidence based approach was lacking and the assurances provided by Hft that all risks were being managed effectively were taken at face value without any independent checks of relevant records.

18.35 Although the unit where Lou lived was closed after her death, the SAR panel was informed that Telford and Wrekin Council currently still have one service user in supported housing provided by Hft. In addition, it heard that Hft is redeveloping the existing site to provide more supported living units. It is essential therefore that appropriate action is taken to ensure that the issues about Hft's care arrangements that featured in this case are not replicated elsewhere.

18.36 During a discussion with the author about the Care Quality Commission's (CQC) involvement at the outset of the review, CQC explained that originally its plan was to carry out a follow up inspection of other local Hft provision quite quickly in the light if its findings during the police investigation. However, in the light of the departure of Hft's registered manager and approval of the replacement, CQC decided that it would be appropriate to delay the inspection to allow the new manager time to address the issues that had been identified.

18.37 In addition, since Lou's death and the change in manager, CQC had received feedback from a number of sources about the positive progress on action that had been taken by Hft. This included feedback from Hft on the full safeguarding review it had initiated across the organisation, and the visits made by the local authority's quality assurance team and its safeguarding adults team. Consequently, CQC confirmed that although an inspection would be carried out, this had now been afforded a lower priority.

18.38 During the SAR, Hft provided a summary of the action taken. Record keeping has transitioned onto a digital support planning system which provides managers with access to the daily records who log their monitoring activity. Hft's internal quality auditing and quality improvement processes have been reviewed with additional quality checks and audits implemented along with a performance review process which ensure that actions are taken in response to the audit findings. A policy review process has also been introduced which ensures that policies are kept up to date.

18.39 During the SAR process, information was provided by the Adult Social Care Quality Assurance Team (QA Team) of its ongoing involvement with Hft in respect of the latter's other units within Telford and Wrekin. Some of this activity also included the involvement of the adult safeguarding team in June 2023 and an organisational strategy meeting held in July 2023 that was also attended by the Care Quality Commission.

18.40 The QA team subsequently carried out 3 further visits during 2023 and 6 visits during 2024 at the point that this overview report was finalised in September 2024. This included a full audit of one of the Hft units in April 2024. This was immediately followed by a meeting with the local authority commissioning team to share the QA team's findings.

18.41 Notwithstanding the evidence of this proactive involvement, which received positive acknowledgement from the SAR panel, it remains the author's view that given the specific findings from this SAR in respect of Hft, the following recommendation should still be made.

Recommendation 4

The Care Quality Commission and Telford and Wrekin Adult Social Care should take into account the findings from this SAR to review its plans for future quality assurance checks in respect of Hft's supported housing provision in the Telford and Wrekin area, particularly in respect of the robustness of Hft's policies and procedures, the quality of Hft's record keeping, and risk management arrangements for individual service users.

PROVISION OF ASSISTIVE TECHNOLOGY

18.42 Appropriate assistive solutions were identified and installed that best increased the chances of Lou's seizures being detected which were unpredictable. Both the local authority's Assistive Technology Team, and Hft's technical support officer responded quickly to resolve the problems raised by either Lou's family or Hft staff.

18.43 However, in the light of this case, the Assistive Technology Team (AT Team) has reviewed its procedures in relation to assistive technology that can experience variables, both in terms of the individual (ie varying seizures) and the technology itself (signal, connectivity etc.) As a result 2 new documents have been introduced to be utilised during the provision of seizure detection equipment:

18.44 The first is a checklist that encourages assistive technology officers to consider all of the variables, roles and responsibilities relating to the piece of equipment. This also supports the conversations with the individual, their family and support network around the equipment's limitations and contingencies. This checklist is signed by all parties and uploaded to the client record.

18.45 The second is a responsibility letter which is sent out to the service user, or their representative, to outline the equipment that has been provided, the limitations and the importance of utilising the kit alongside their existing support network. It also guides people back to the Assistive Technology Team with a telephone number and email address for future enquiries or to report problems.

18.46 In addition the team has introduced a peer review involving weekly meetings within the team to discuss new assessments and possible assistive technology solutions. This will provide an opportunity to discuss cases and provide challenge regarding suitable solutions and also check that processes are being followed.

18.47 Finally, the service is in the process of considering how to implement a more formal system for carrying out annual reviews of cases involving more complex assistive technology solutions with service users and their carers to capture any issues about the operation of the equipment previously supplied. This might be through a documented review / conversation or an annual letter being sent out with a reminder of the team's contact details in case of any issues arising.

18.48 This formal review process is considered to be important because at the time of Lou's case there was none in place and the Assistive Technology was reliant on reports from users/carers/family as to whether there were any problems with the technology.

18.49 In addition, as part of the drive to ensure that all non professionally qualified workers complete mandatory Mental Capacity Act (MCA) training, all members of the Assistive Technology Team are in the process of completing this which will enable them to complete non-complex MCA assessments when assistive technology equipment is being provided and consider whether this raises an issue that needs to be considered in respect of a possible deprivation of liberty.

18.50 Notwithstanding these positive developments, there remains an issue that was included in the key lines of enquiry as to whether there were clear arrangements as to how appropriate assistive technology would be put in place. On this issue, it would appear that the involvement of both the local authority's Assistive Technology Team and the Hft's technical officer resulted in a lack of clarity about where ultimate responsibility rested for checking that the technology was fit for purpose ad working effectively.

18.51 This was evident from events after the Assistive Technology Team's (AT team) visit in January 2022 to reinstall the equipment which resulted in the Hft technical officer unilaterally taking the decision that he would visit to resolve the continuing problems. When he informed the AT Team both of his plan to visit, and later how he had resolved the problem, it does not appear that the AT Team considered whether there was a need for them to carry out a further check before ending its involvement. Nor does it appear that the plan for the allocated social worker to monitor any issues in respect of the equipment was carried out.

18.52 This finding would suggest a need for the Assistive Technology Team's protocols to be updated to include coverage of roles and responsibilities in situations where care providers have their own technical support staff.

18.53 In addition, the panel identified that when assistive technology is provided, there needs to be a contingency plan in the event of a technology failure which details what steps providers can take to mitigate any consequential risks. The panel was informed that providers have also been asked not to accept transfers from hospitals until the assistive technology is in place to ensure there are no gaps in meeting assessed needs.

Recommendation 5

The Local Authority's Assistive Technology Team should ensure that:-

(i) where care providers have their own technical support team, the Assistive Technology Team's protocols provide clarity on the respective roles and responsibilities for approving the provision of any assistive technology and for resolving any issues that arise in respect of the functioning of the equipment.

(ii) there is always an agreed contingency plan for care providers to follow in the event of a technology failure.

ISSUES AROUND DEPRIVATION OF LIBERTY

18.54 During the SAR, the lead officers for Deprivation of Liberty Safeguards (DoLS) within Adult Social Care provided a detailed explanation of the process for decision-making and review through monthly legal gateway meetings of cases which appear to meet the Community DoLS criteria. Helpfully, copies of all the relevant guidance documents were provided. These included:-

- the Community DoLS toolkit which includes guidance on how cases are prioritised as low, medium and high in respect of applications to be made to the Court of Protection;

- the terms of reference for the Legal Gateway meetings that involve the lead DoLS officers, legal services and Adult Social Care (ASC) team leaders;

- the Community DoLS user guide which provides a new process map for staff to explain how to move through each stage of the process in the electronic case recording system.

18.55 It is important to highlight the observation made by the lead officers that the introduction of these documents is fairly recent and they were not available to professionals at the time the DoLS issues were being considered in respect of Lou.

18.56 It was explained that by April 2025, all mental capacity assessments, best interest decisions and DoLS decisions will be on the ASC electronic recording system which will enable application of quality assurance processes to be much more robust.

18.57 The toolkit and legal gateway terms of reference explain the factors that are taken into account in arriving at decisions on prioritisation of cases for application to the Court of Protection.

18.58 Low priority cases are those where there is a settled placement, there is no evidence of any objection, and no additional restraints or restrictions are being used above those described in the 'acid test'. In addition, end of life situations are classed as low priority as there is no benefit to be gained from authorisation being sought.

18.59 Medium priority cases include those where:-

- there is regular 1:1 care during the day and / or night;
- 2:1 supervision is required within the community;

- the person is asking to leave but not consistently showing behaviours which push this or making active attempts to leave;

- the person appears to be unsettled some of the time but responds to reassurance;

· the use of chemical restraint or medication (PRN) is used infrequently.

18.60 High priority cases which will result in a legal gateway review, and decision for an application to the Court of Protection, are those where, in addition to the medium priority factors:-

- restraint is used regularly, for example to physically prevent someone from leaving their property, medical sedation, confinement to a place of safety as opposed to use of a lap belt to support posture and remove risk of injury;

- the person, or relevant person on his / her behalf, is actively objecting to the care or accommodation arrangements, which may include evidence of frequent attempts at leaving the property and / or stating clear refusal of care;

- there are safeguarding concerns which may be impacting on the care and support that the person is receiving;

- where there is an existing DoLS authorisation which is due to expire;

- there is an existing DoLS authorisation and the person is moving from residential or hospital care to supported living.

18.61 A further development is that the assistive technology team will seek to be included in any mental capacity assessment to provide advice on any assistive technology being proposed, and the implications in respect of any possible deprivation of liberty. It was also confirmed that a new protocol has been implemented that describes best practice in the use of assistive technology for supporting people with epilepsy.

18.62 The guidance on the community DoLS criteria and decision-making arrangements are supported by a comprehensive training programme comprising 3 sessions that cover in detail the principles underpinning the Mental Capacity Act and how these need to be applied in carrying out assessments. Session 2 includes a particular focus on assessing executive function, and session 3 focuses on the identification and decision making process in respect of community DoLS.

18.63 The terms of reference for the legal gateway meetings explain that before a referral is made to Legal Services, these will check that all the necessary assessments and documents have been completed satisfactorily that are required to enable an application to the Court of Protection to be made.

18.64 It is evident that the decision-making and review arrangements are clearly very robust. However, during the SAR panel discussions, it emerged that other agencies, particularly care providers, may not be aware of these arrangements. The fact Hft representatives could find no reference to the DoLS decision in Lou's case, also suggested that there are issues about how decisions made through the legal gateway meetings are disseminated.

18.65 It was agreed therefore that the ASC DoLS lead officer would liaise with the Adult Social Care Quality Assurance Team to organise a presentation to the care provider forum to explain the DoLS process, the approach to prioritising applications to the Court of Protection, and the action that providers need to take to raise cases where a DoLS application appears to be required.

18.66 Although this SAR related to a person living in supported housing, the panel noted that there may be other community settings where a possible deprivation of liberty issue arises. It will be important therefore that the Safeguarding Adults Board seeks assurance that other professionals who are working in community settings, other than Adult Social Care (ASC) staff, are aware of the arrangements for considering whether the community DoLS criteria apply and their responsibilities for bringing this to the attention of either ASC or the safeguarding team in the Integrated Care Board.

18.67 In making this recommendation, it was noted that the comprehensive training modules provided by Adult Social Care covering the Mental Capacity Act and community DoLS are only delivered to its own staff.

18.68 In respect of private providers, the SAR panel was told that most have their own internal arrangements for accessing relevant training, with the ASC Quality Assurance Team picking up any gaps in these during its audits. The ASC DoLS team does try to offer some support for providers, including signposting them to training they can access. In some circumstances, the DoLS team has also supported providers with informal training on DoLS if this has been identified as an area that requires improvement. However, this is not something that it can commit to doing across the board due to its limited staff capacity.

Recommendation 6

The Telford and Wrekin Safeguarding Partnership should seek assurance that all care providers and other professionals working within the community are aware of the 'acid test' as to whether the Community DoLS criteria apply, and the process which needs to be followed when possible cases are identified.

ARRANGEMENTS FOR INVESTIGATIONS FOLLOWING A SUSPICIOUS DEATH

18.69 The final area of learning stems from the action taken by Hft and the Safehands agency immediately after Lou's death which could have undermined the integrity of the police investigation. Although aware of the police being on site because the death was potentially suspicious, an Hft manager on arrival at the unit immediately took the night carer into a private room to debrief her and make a written account of the carer's description of events.

18.70 The resulting account added to the difficulty faced by the police in establishing the timing and sequence of events because the manager did not include the information later provided by the carer to the police that a check had been carried out on Lou at 5.30 am. The difficulty arising from this was that the manager was clear that the carer did not share this information, but the carer was insistent that it had been shared but for some reason the manager had not recorded it.

18.71 That version of events provided by the carer was markedly different to that initially provided to the paramedics – the carer later denying that these comments had been made and that the paramedics had misheard or misunderstood what had been said.

18.72 As soon as it was discovered after the safeguarding enquiries commenced that Hft was continuing with its own investigation and carrying out interviews, they were told to cease this immediately as this was now a police investigation.

18.73 During the SAR process, Hft denied that the manager had debriefed the carer but had just taken some basic details to complete an incident report in line with Hft's policy in order to comply with its duties to notify all the relevant people as quickly as possible. This included the family, the Care Quality Commission, Adult Social Care, and the GP. Hft explained it had not commenced an investigation and no statements were taken. Instead it was the manager from the Safehands agency who had provided support to the carer in a private space. Having rechecked the records, Hft confirmed that the investigation tab within Hft's incident recording system was only updated on 21.07.24, the day of the subsequent strategy meeting and not prior to the initial police enquiries.

18.74 However, that assertion from Hft does not accord with the information in the agency report provided by West Mercia Police nor the record of the Section 42 enquiries. The latter document included details of the initial conversation with the Hft manager who reported Lou's death. The manager explained that the death was being treated as suspicious and further investigations were being made, and that managers were taking witness statements having begun their own internal investigations in line with Hft procedures.

18.75 The view of Hft's representatives on the SAR panel in respect of this account was that the Hft manager had misunderstood what was taking place and had mistakenly perceived the initial fact finding for statutory reporting purposes as amounting to the commencement of a full investigation which was not the case.

18.76 Ultimately, given the marked differences in the contemporaneous accounts, and that provided by Hft representatives during the SAR process, it was not possible for the SAR to reach a clear finding as to what action was taken by Hft immediately after Lou's death.

18.77 Notwithstanding this, in the author's view, there is possible learning from this aspect of the case which requires further exploration following this SAR to ensure there is a shared understanding of action that can be taken by care providers and employment agencies to fulfil their duties around notification to relevant agencies, and provide immediate support to staff involved, while ensuring that the integrity of any police investigation is not compromised.

18.78 With regard to the latter, it is important that providers are aware of how and when there needs to be any immediate consultation with the police, and the role of the strategy meeting in making decisions as to how any criminal investigation and safeguarding enquiries are to be progressed.

18.79 The reason for the author's view is that regardless of the nature and extent of the initial enquiries carried out by Hft to establish the facts immediately after Lou's death, these appear to have been carried out without any consultation with the police.

Recommendation 7

The Telford and Wrekin Safeguarding Partnership should request Adult Social Care, Shropshire, Telford and Wrekin Integrated Care Board and West Mercia Police, in consultation with the Care Quality Commission and the Care Provider Forum, to issue further guidance as necessary to care providers which explains what action they can take to gather information to discharge their duties to notify the appropriate organisations of a suspicious death, and to support staff, where there is, or likely to be, police enquiries.

19. FULL LIST OF RECOMMENDATIONS

1. The Telford and Wrekin Safeguarding Partnership should seek assurance that:-

   (i) multi-agency procedures reinforce the need for a single multi-agency plan to be developed in complex cases to meet the service user's assessed needs and known risks, with clear arrangements as to who has the lead role for overseeing and co-ordinating implementation;

   (ii) there is evidence from dip sampling and multi-agency audits of cases that the above requirements are being applied.

   (iii) where agencies are holding single agency reviews, a copy of the review documentation and outcomes should be shared with other agencies who are involved with the service user.

2. The Telford and Wrekin Safeguarding Partnership should seek assurance that the outcomes and recommendations from Section 42 enquiries are being shared at the earliest opportunity with all relevant organisations, including care providers.

3. Telford and Wrekin Adult Social Care should take the necessary steps to ensure that its guidance and templates on assessments / reviews require practitioners to address the issue of the suitability of the care plan, and / or a placement, taking account of any identified risks such as fire or possible medical emergency.

4. The Care Quality Commission and Telford and Wrekin Adult Social Care should take into account the findings from this SAR to review its plans for future quality assurance checks in respect of Hft's supported housing provision in the Telford and Wrekin area, particularly in respect of the robustness of Hft's policies and procedures, the quality of Hft's record keeping, and risk management arrangements for individual service users.

5. The Local Authority's Assistive Technology Team should ensure that:-

   (i) where care providers have their own technical support team, the Assistive Technology Team's protocols provide clarity on the respective roles and responsibilities for approving the provision of any assistive technology and for resolving any issues that arise in respect of the functioning of the equipment.

   (ii) there is always an agreed contingency plan for care providers to follow in the event of a technology failure.

6. The Telford and Wrekin Safeguarding Partnership should seek assurance that all care providers and other professionals working within the community are aware of the 'acid test' as to whether the Community DoLS criteria apply, and the process which needs to be followed when possible cases are identified.

7. The Telford and Wrekin Safeguarding Partnership should request Adult Social Care, Shropshire, Telford and Wrekin Integrated Care Board and West Mercia Police, in consultation with the Care Quality Commission and the Care Provider Forum, to issue further guidance as necessary to care providers which explains what action they can take to gather information to discharge their duties to notify the appropriate organisations of a suspicious death, and to support staff, where there is, or likely to be, police enquiries.