Cheshire West and Chester Safeguarding Adults Board

Safeguarding Adults Review re Gary

Overview Report

Concerning the care of Gary

Independent Reviewer

Pete Morgan BA, MA, MA & CQSW

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Appendix A

Terms of Reference for Safeguarding Adults Review SK

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Glossary

1. Introduction

1.1 For the purposes of this Overview Report and in accordance with his wishes, the subject will be known as Gary, his brothers as Ryan, David and Phil and their parents as Mum and Dad.

1.2 It is easy for Safeguarding Adults Reviews and Overview Reports to focus on events and the involvement and actions of a number of agencies; it is important that this Safeguarding Adults Review (SAR) and this Report recognise that, at their centre, is a human being, who should be treated with respect, and likewise their family members.

1.3 Gary was born in 1986 and was 35 years old and living with his Dad and brother Phil at the time of his hospitalisation in February 2022.

1.4 Gary was his parents' fourth and youngest son; his eldest brother, Ryan, died in 2002 of a brain tumour, his second eldest brother, David, moved into supportive living before the Review Period as did his Mum in May 2021.

1.5. Gary has a moderate learning disability; details of his education were not known to the SAR. No formal assessment of his care and support needs was completed until September 2021. His parents were never offered a carer's assessment.

1.6 When he left full-time education, Gary was accepted onto a college course, but left it in March 2007, in circumstances that are not clear. There was intermittent contact with the family by Adult Social Care (ASC) between 2014 and the Review Period, normally short-term in nature, and related to a specific incident or issue, often linked to Mum or Dad's health issues.

1.7. In March 2021, ASC became involved when dad was admitted to hospital; respite care was offered to Mum, Gary and Phil, but it was refused and Archangel Care were commissioned to provide support to the family in their home. There were concerns about the condition of the property and the care of all three of them while Dad, who was their main carer was in hospital.

1.8 Support continued from ASC and Cheshire and Wirral Partnership NHS Trust's Community Learning Disability Team, with the focus on improving the condition of the family home and the personal care of both sons, Mum having moved to supported living in May 2021.

1.9 On the 15th February 2022, a support worker from Archangel Care found Gary lying on the floor, having fallen down the stairs some thirty-six hours earlier. Dad had not called any assistance. An ambulance was called and Gary was taken to the Emergency Department at the Mid-Cheshire Hospital Foundation Trust. Safeguarding Concerns were raised by the North West Ambulance Service.

1.10 The case was referred to the Cheshire West and Chester Safeguarding Adults Board (the Board) for consideration for a Safeguarding Adults Review (SAR) on the 29thDecember 2023.

1.11 The referral was considered on the 26thJanuary 2023, when the Subgroup agreed the criteria for a Safeguarding Adults Review (SAR) had been met and therefore recommended to the Board's Independent Chair that a SAR be undertaken.

1.12 On the 27thMarch 2023, the Board's Independent Chair confirmed that an SAR should be undertaken in accordance with the multi-agency Safeguarding Adults Review.

1.13 This Report was authored on behalf of the Board by Mr Pete Morgan, an Independent Consultant.

1.14 This Review was commissioned under s44of the Care Act 2014; its commissioning was reported in the Board's Annual Report for 2022/23 and its findings and their implementation will be reported in the Annual Report for 2023/24 as required by the Act.

1.15 The Report was ratified by the Board at a specially convened meeting held on the 22nd September 2023.

2. The Safeguarding Adults Review's Terms of Reference

2.1 These are to be found in Appendix A

3. Family liaison and involvement

3.1 Contact was made with Gary through his allocated social worker. He was offered the opportunity to meet or speak to the Independent Reviewer, and to do so accompanied a supporter. He met with the Independent Reviewer, accompanied by his support worker on two occasions, the first time on the 9th January 2023 to discuss the purpose of the SAR and the second time on the 21st August to discuss the SAR's Findings.

3.2 Gary's parents and surviving brothers were contacted by Gary's allocated social worker to advise them of this Review, and to offer them the opportunity to meet with the Independent Author, and to do so with a supporter of their choice if they so wished. They all declined the offer.

3.3 They were advised they could change their mind about meeting either of the above at any time and that they would be given the opportunity to see and comment upon the findings and recommendations contained in the final draft of the Report before it was presented to the Board. This offer was also declined by all.

4. Key Events and Findings

4.1 Pre-Review Period – pre - 1st September 2019

4.1.1 The information provided to the Review gave no information on contact with his family prior to the 27th March 2007, when Gary was 19 years old.

4.1.2 Given Gary's assessment as having a moderate learning disability, it is a reasonable assumption that he would have attended a Special School following a Statement of his Educational Needs. He would therefore have been referred to the Transition process to ascertain his eligibility for services from Adult Social Care (ASC) on his 18th birthday in 2004.

4.1.3 This would have led, if appropriate, to his being offered an assessment of his care and support needs under the NHS and Community Care Act 1990. His parents would also have been eligible for an assessment of his care and support needs should have been offered an assessment of their care and support needs as his prime carers.

4.1.4 In principle. both Gary and his parents could have refused the offered assessments, though the legal position is not clear as to Gary's capacity to have made such a decision and, as this was prior to the Mental Capacity Act 2005, there was no statutory means of establishing who could have made such a decision.

Finding 1: No evidence was provided to the Review that Gary was referred to the Transition Process to establish his eligibility for support from ASC

Finding 2: No evidence was provided to the Review that Gary's parents were offered assessments of their care and support needs as carers for Gary or his brothers.

Finding 3: There is no evidence that the implications of the Mental Capacity Act 2005 was explained to the family as part of the Transition Process or options open to the local authority explored

4.1.5 Gary himself has advised the Review that, after he left school, he attended a local college for a couple of years before ceasing to attend due to being bullied by fellow students.

4.1.6 On the 27th March 2007, ASC record receipt of a referral from "Connexions" advising that Gary "had completed his college course. Advice given. NFA ASC Referral closed."

Finding 4: There is no evidence that the reason for Gary's dropping out of the college course was investigated and alternatives considered or that his assessment under the NHS and Community Care Act 1990 was annually reviewed at any stage.

Finding 5: There is no evidence that Gary's parents were offered assessments of their care and support needs as carers for Gary and his brothers as part of an annual review of his assessment under the NHS and Community Care Act 1990

4.1.7 It is of relevance here that the Care Act 2014 received the Royal Approval on the 14th May 2014, having been introduced in May 2013. Its contents were therefore known to all local authorities and its implementation deferred to the 1st April 2015 to allow sufficient time for local authorities and relevant partners to review and revise their relevant policies and procedures to be compliant.

4.1.8 In June 2014, ASC record that Gary's brother, Phil, had been admitted to Leighton Hospital (MCHFT) due to complications with a heart condition and his epilepsy. It was also recorded that another brother, David, had been admitted to hospital that May after a stroke.

4.1.9 On the 25th June 2014, ASC record receipt of a safeguarding referral from MCHFT due to concerns about Phil and David's safety on their discharge after their father (Dad) was verbally abusive while visiting Phil. On his discharge, Phil was provided with temporary respite care with a Shared Lives carer, where he continued to attend a day service provision in Northwich and have contact with his father.

Finding 6: There is no record of the outcome of the safeguarding referral nor of any follow-up by MCHFT to discover its outcome

Finding 7: There is no record of an assessment of Phil's care and support needs under the NHS and Community Care Act 1990 to establish his eligibility to respite care or of any capacity assessment to confirm his capacity to make decisions about where he lived or how his care and support needs should be met.

4.1.10 During July 2014, Phil's parents said they wanted Phil to return to live at home. On the 22nd July 2014, ASC record that Dad was admitted to hospital but do not specify which hospital or why. Gary's mother (Mum) went into respite care "as she wasn't coping." Dad discharged himself from hospital to care for Gary, who insisted on staying at home. On the 31st July 2014, ASC record completing a "Needs profile assessment" for Gary under

the NHS and Community Care Act 1990; it is noted that Gary was happy to be at home with Dad, and they "appear to be coping without added pressure of (Phil, David and Mum) being home."

Finding 8: There is no evidence of a capacity assessment being undertaken of Gary's capacity to make the decision to remain at home unsupported

4.1.11 In August 2014, ASC record that during August 2014, Phil returned to live at home with his parents and Gary, with support being offered by the Turner Fellowship twice daily, on the basis of the Needs profile assessment – see 4.1.10 above. There is no reference to David living at home.

4.1.12 In February 2015, ASC record that they have received notification that the chemists are going to stop dispensing medication for Gary and Phil as they hadn't attended their medication reviews. CWP Health Facilitation Team were asked to support the family and a GP home visit was requested, though it is noted that this is unlikely to happen, no reason is given and no resulting action is recorded.

Finding 9: It is of concern that neither Gary nor Phil, both of whom had a learning disability, had assessments of their capacity to decide whether to attend annual medication reviews with their GP

Finding 10: It is of concern that the GP Practice had not responded formally to the brothers not attending their medication reviews

Finding 11: While it has to be assumed that both Gary and Phil continued to be prescribed medication, there are no recorded outcomes to the requests for CWP Health Facilitation Team involvement or a GP visit.

Finding 12: It is of concern that the above didn't trigger a review of the care and support needs of the family, both individually and as a unit, under the NHS and Community Care Act 1990 or the soon to be implemented Care Act 2014

4.1.13 In February 2017, ASC record that Gary's benefits were stopped as he hadn't been to either the GP or his Department of Work and Pensions (DWP) review; Gary refused to go to the GP but did agree to go to his DWP appeal. A home visit from the Benefits Visiting team was requested. ASC also record a contact from the Turner Fellowship as Gary had asked them for support while they were supporting David – ASC agreed 2-3

hours support a week and the Turner Fellowship agreed to put together a support plan.

Finding 13: It is of concern that no formal assessment was undertaken of Gary's capacity to make decisions about his health or to manage his benefits

Finding 14: While a s9 assessment under the Care Act 2014 would have been required for ASC to fund Gary's support package from the Turner Fellowship, there is no evidence of this being completed, of it being holistic in nature or of it being subsequently reviewed at least annually

4.1.14 In March 2017 and January 2018, ASC record providing support to Gary re his benefits.

4.1.15 It is not clear when David left home; Cheshire Police record 9 instances of David being reported "Missing from home" between 2019 and 2022 and other incidents when he was missing from home, but it wasn't reported to them. At some stage after August 2014, he returned to live at home; by the 10th March 2021 he had moved to sheltered accommodation, presumably after an assessment of his care and support needs under section 9 of the Care At 2014, and he now lives in the same supported living accommodation as his Mum.

Finding 15: While David is not the subject of this SAR, it is of concern that, when a s9 assessment under the Care Act 2014 was undertaken to establish his eligibility for sheltered accommodation, no such assessment was offered or undertaken for his brothers or a s10 assessment offered or undertaken on his parents' care and support needs

4.1.16 There is no further recorded contact between ASC and the family until the 19th March 2021.

Finding 16: There is no record of the support package from the Turner Fellowship being implemented, reviewed or terminated though it is not referred to at the beginning of the Review Period

4,1.17 There is no assessment of any member of the family's care and support needs under either section 9 or 10 of the Care Act 2014 until 2021.

Finding 17: It is of concern that ASC record no contact with the family for some 3 years despite their need for care and support services and the duty to offer annual reviews of assessments under the Care Act 2014

4.2 The Review Period – 1st September 2019 – 31st May 2022

4.2.1 On the 12th March 2020, the GP Practice record that Gary was invited to attend for his annual Learning Disability Health Review (LDHR) but it is not recorded if he attended, whether this was followed up or what the outcome was.

Finding 18: It was good practice that the GP Practice invited Gary to his annual LDHR but of concern that there is no record of whether or not he attended or what its outcome was.

4.2.2 On the 29th December 2020, the GP Practice record ringing Gary three time to invite him to book an appointment for his LDHR but got no answer; the GP then tried three further times, also unsuccessfully, leaving a message on the answerphone. No further action is recorded.

Finding 19: While it was good practice for the GP Practice to invite Gary to an annual LDHR, it is confusing that there is a gap of only 9 months from the previous invitation – see 4.2.1 above – and that the Practice's Did Not (DNA) Policy didn't result in a referral to ASC

4.2.3 On the 10th March 2021, ASC record that Dad was "unwell and was rushed to hospital". Respite care at The Loont was offered to Mum, Gary and Phil but this was refused. Support at home was arranged with Archangel Care.

Finding 20: It is of concern that no formal assessment was made of Gary's (or Phil's) capacity to make the decision to refuse respite care at the Loont.

4.2.4 Archangel Care's records describe the home as "in a terrible state of disorder": a large pile of rotting food waste on the kitchen floor with flies and visible maggots; in the bathroom, "the bath was of litter/waste (full of pop bottles, beer cans, food/takeaway containers), the toilet was full of dried on excrement and the floor and the area surrounding the toilet saturated in urine"; "the stairs and landing had countless bags of litter stored (beer cans, pop bottles, takeaway cartons). Each room had the same strong smell." The family address is not registered with the local authority and must therefore be rented from a private landlord, their identity is not known to the Review.

Finding 21: It is of concern that a safeguarding referral was not raised by Archangel Care on the basis of neglect/ self-neglect.

Finding 22: As the family home was rented, it is of concern that the private landlord had not been aware of the state of the property and the care and

support needs of the family and not raised a safeguarding concern with ASC

4.2.5 On the 11th March 2021, ASC record a Duty Worker contacting Mum's GP as there were concerns about her health. She was registered at the Witton Street Medical Centre where all the family except Dad was registered. He was registered at the Danebridge Medical Centre where he had been a patient for a long time. There was an oxygen tank provided by the Integrated Respiratory Team, Central Cheshire integrated Care Partnership (CCICP), in the home that she wasn't using. She initially refused to have an ambulance called as she didn't want to leave Gary and Phil, who were refusing to leave the house. She eventually agreed to one being called but then refused to go to hospital until she heard that Dad was returning from hospital to look after Gary and Phil.

Finding 23: It is of concern that an oxygen tank was present in a home with such obvious fire hazards, that Mum's use of the oxygen tank wasn't monitored and that an opportunity for health professionals to identify neglect or self-neglect was missed.

See Finding 20 above

4.2.6 A Social Worker stayed in the home throughout the above and raised concern about the state of the property which was cluttered with take-away food containers, out-of-date food in the fridge, Mum's soiled continence pads left around the house, faeces on and around the toilet and a lot of flies in the house which was generally dirty. On the basis of the above, safeguarding referrals were opened for Mum, Phil and Gary. Within ASC, options on Mum's discharge from hospital were discussed and it was noted that further assessments were required of all the family members.

Finding 24: On the basis that safeguarding referrals were opened for Mum and the brothers but not Dad, it is of concern that Dad was not identified as a potential perpetrator

Finding 25: It is of concern that the nature and purpose of the assessments required were not specified

4.2.7 On the 12th March 2021, the GP Practice record a letter was sent to Gary re his LDHR, followed up by a phone call from Reception that wasn't answered and three unsuccessful phone calls for the GP who again left a message on the answerphone.

See Finding 19 above

4.2.8 On the 12th March 2021, ASC record a discussion between Practice Manager and a Social Worker (SW1) about the home conditions and the “long history of non-engagement particularly by (Gary and Phil).” It was agreed that SW1 would be allocated to Mum, Gary and Phil and that ASC “will continue to assess/engage with the family and encourage package of care”.

Finding 26: it is of concern that the SAR saw no evidence of the “long history of non-engagement” referred to above or of any attempts to address this

4.2.9 On the 15th March 2021, ASC record that MCHFT had raised concerns about Mum being discharged home due to the home conditions. It was agreed that SW1 would be advised of any plans to discharge her so she could arrange respite care for Mum. SW1 visited the family at home; Gary was wearing the clothes he had been wearing the previous week. The house had been cleaned and some of the clutter had been removed. SW1 advised Dad of her concerns re the home conditions and Gary and Phil’s personal hygiene; he said that, as Mum would be going into respite care, he would concentrate on cleaning the house and Gary and Phil’s personal care. He agreed to SW1 asking what support Archangel Care could offer.

Finding 27: Given that the main factor in seeking to engage with the family was the neglect/self-neglect manifested in the state of the family home, it is of concern that the focus of input was on dealing with the symptoms rather than the causation of the neglect/self-neglect

Finding 28: It is of concern that the safeguarding referrals raised about Mum, Gary and Phil are not being followed through and that discharge plans are being made for Mum’s discharge from hospital without reference to them

4.2.10 On the 16th March 2021, the GP Practice recorded sending Gary a text message inviting him to attend for a covid vaccination.

See Finding 19 above

4.2.11 On the 17th March 2021, ASC record SW1 visiting the home to collect some items for Mum, who was to be discharged from hospital to The Loont. She only saw the hall and lounge, but these were in a better condition.

4.2.12 On the 18th March 2021, ASC record that a support package was offered from Archangel Care to help with cleaning the house, shopping, encouraging

Gary and Phil to shower and to help with meal preparation. This was rejected by Dad, who said he would accept support when Mum returned home.

Finding 29: It is not within Dad's remit to refuse services on behalf of Gary or Phil and any refusal by either brother should have resulted in an assessment of their capacity to make such a decision

4.2.13 On the 30th March 2021, SW1 visited the home; the conditions in the house had improved but Gary was wearing the same clothes as the last time she visited and they were now dirty and stained. SW1 explained the risks to his health of his poor personal hygiene and he agreed to have a shower and change his clothes before her next visit. Dad again refused to accept any help in the house.

See Findings 27 and 29 above

4.2.14 On the 6th April 2021, SW1 visited the home and Gary had changed his clothes and the home conditions "were much improved".

4.2.15 On the 26th April 2021, Mum's assessment under s9 of the Care Act 2014, originally completed while she was in The Loont in March 2021, was updated in hospital; she spoke of moving to a care home.

4.2.16 On the 26th April 2021, SW1 visited the home; she saw the kitchen, hall and lounge which were again in a better condition. Gary was again in clean clothes but still hadn't showered. Gary wasn't going out very much, though Phil was.

Finding 30: Gary's continued failure to comply with his agreed care plan should have led to a review of his capacity to make such decisions

4.2.17 On the 3rd May 2021, Mum transferred from her respite placement at The Loont to a permanent placement at Acorn Hollow, a residential care home.

4.2.18 On the 5th May 2021, Dad cancelled a home visit by SW1, but they did meet in Northwich to collect a tv for Mum in her new placement.

4.2.19 On the 25th May 2021, Cheshire and Wirral Partnership NHS Trust (CWP) record receipt of a referral for Gary by the Community Learning Disability Team (CLDT) from SW1. SW1 identified the following areas of concern: Gary had a long history of social isolation, was overweight – during the Pandemic he had put on some 6 stones - with an unhealthy diet and neglectful of his personal hygiene. The home environment, where he lived with Dad and Phil

who also had high support needs, was described as cluttered and poorly maintained.

Finding 31: It is of concern that the purpose of the above referral from SW1 is not clear – there are no identified desired outcomes – and no discussion with Gary about the referral being made is recorded

4.2.20 On the 2nd June 2021, ASC record a home visit by SW1; Gary was "well presented" and told SW1 he was taking his medication. He had not been out of the house since lockdown restrictions were lifted ad he didn't want to. Dad thought this would change once the football season started in August. SW1 described the house as a lot tidier than on previous visits – some empty food wrappers but no stale food or unpleasant smells. Gary was still not showering and didn't agree "to health referral", which means that the CWP Health Facilitation Team won't get directly involved with Gary though they did agree to attend any multi-disciplinary meeting SW1 set up.

See Findings 27 and 31 above

4.2.21 On the 14th June 2021, ASC record a s9 assessment under the Care Act 2014 is completed of Phil's care and support needs.

4.2.22 On the 15th June 2021, CWP record a conversation between a Specialist Practitioner, a Learning Disability Community Nurse (LDCN1), from the Community Learning Disability Team Cheshire West under Cheshire Wirral Partnership and SW1 in which SW1 provided background details of Gary's situation since March 2021. As a result, a joint home visit was arranged for the 22nd June 2021, but this was cancelled as Dad was unwell.

4.2.23 On the 23rd June 2021, ASC and CWP record SW1 making a home visit with LDCN1; they didn't see Gary or Phil who refused to come downstairs to meet them. The home conditions had worsened since SW1's previous visit with uneaten food on the floor, tables and chairs. Dad said he had been unwell and that his hoover had broken. SW1 offered assistance in the home but he refused it. Dad described Gary as now weighing 20 stone, having gained weight through eating takeaways and ready-made meals. It was agreed to make a further joint visit to review Gary's situation.

See Findings 27 and 29 above

4.2.24 On the 24th June 2021, CWP record raising a safeguarding concern, resulting in a multi-disciplinary meeting being convened.

4.2.25 On the 1st July 2021, CWP and ASC record a multi-disciplinary safeguarding meeting being held, attended by three members of the CLD a Community Learning Disability Nurse whose role is a Specialist Practitioner, Clinical Lead on the Intensive Support Team and LDCN1 who chaired - and SW1**.** The background details of the family's situation were discussed, including the fact that the CLDT had had no involvement with the family for over twenty years. The following actions were agreed: LDCN1 to continue to work with SW1 and visit the family; SW1 to continue to encourage dad to accept support in the home; SW1 to discuss with Dad a referral to the Fire and Rescue Service for a home visit and risk assessment; SW1 to seek Dad's agreement to his neighbour having her contact details in case he is unwell again and needs support; capacity assessments to be completed re Gary and Phil's capacity to make decision about their health needs, personal care and weight gain and assistive technology to be explored for Dad in case he should fall and need support. It was agreed to meet again on the 16th August 2021 to review progress. On the 2nd July 2021, CWP record sending Dad an email advising him of the above.

Finding 32: It is of concern that the precise status of the meeting within the multi-disciplinary safeguarding procedures is not stated

Finding 33: It is of concern that the family were not informed of the safeguarding procedures being implemented without the reason for not doing so being recorded

Finding 34: It is of concern that neither Gary or Phil were not informed of the outcome of the safeguarding meeting without the reason for not doing so being recorded

4.2.26 On the 8th July 2021, CWP record a phone conversation between Dad and LDCN1, having got no reply the previous day. Dad declined the offer of a home visit, saying Gary would be abusive and not stay. It was agreed CLDN1 would ring again "in a few weeks."

See Finding 29 above

4.2.27 On the 27th July 2021, ASC record a joint home visit between SW1 and CLDN1. The house was cluttered; it was discussed with dad getting "a skip to remove the large amount of unneeded items". Gary and Phil were upstairs but were persuaded to come down and did speak with CLDN1.

See Finding 27 above

4.2.28 On the 3rd August 2021, ASC and CWP record a joint home visit by SW1 and CLDN1; there were empty food wrappers, uneaten food and flies in the lounge as well as an unpleasant smell and the garden was cluttered. SW1 gave Dad the details of a skip hire company and he arranged for a skip to be delivered on the 9th August 2021. SW1 offered to visit on the 10th August 2021 to help with the skip and discussed support from a care agency and Dad agreed that she ask Archangel Care if they could restart their package of care.

See Finding 27 above

4.2.29 On the 10th August 2021, Dad cancelled SW1's visit as he had hurt his back putting a sofa into the skip; agreed that he visit the following week and he would continue to clear what he could.

See Finding 27 above

4.2.30 On the 17th August 2021, CWP and ASC record a joint home visit by SW1 and CLDN1. SW1 advised that Archangel Care will start a small support package on the 26th August 2021, when she will introduce the support worker to the family. Due to Covid and pressure on the social care sector, only one hour a week was possible, but that this would be increased when Archangel Care were able to do so. Agreed that SW1 and CLDN1 would also support Gary to attend appointments etc.

4.2.31 On the 18th August 2021, CWP record a discussion at the Resource Allocation Meeting (RAM**)** that agreed that Gary be allocated to Health Facilitation to continue health support to the family due to staffing changes.

See Finding 31 above

4.2.32 On the 26th and 31st August 2021, ASC record home visits by SW1, the first with staff from Archangel Care who will start support the following week. The house is described as no worse than previously on the 26th and "slightly cluttered" on the 31st, with some food items left out, but only recent ones.

4.2.33 On the 2nd September 2021, ASC record a phone call between SW1 and Dad in which Dad confirmed the support worker from Archangel Care had started and had assisted to de-clutter the house and that he had some bags for the charity shop. Arranged for SW1 to visit on the 7th September 2021.

4.2.34 On the 7th September 2021, CWP and ASC record a joint home visit by SW1 and LDCN1**.** Gary was described as unkempt and with his hair matted at the back. It was suggested that he would need it cut before going out. SW1 described the home conditions as “OK” but LDCN1 described the house as being in “a poor condition” with Dad seen taking numerous bags of rubbish out of the kitchen. Dad confirmed that Gary still hadn’t bathed and hadn’t done so for eighteen months as he hadn’t gone out either.

See Finding 30 above

4.2.35 LDCN1 noted that Gary hadn’t engaged in “any health screening, bloods etc” and would therefore “require a gentle approach” and that Gary would benefit from some advice on exercise and health lifestyles and would benefit from some support and advice re food purchasing.

Finding 35: It is of concern that Gary’s lack of engagement in health screening etc had not produced an earlier response or a review of his capacity to make such decisions

4.2.36 On the 9th September 2021, CWP record that Gary’s case is officially transferred to Health Facilitation.

Finding 36: It is of concern that purpose of the transfer and its desired outcomes of Health Facilitation Service were not made explicit

4.2.37 On the 14th September 2021, CWP and ASC record a joint home visit by SW1 and the Learning Disability Community Nurse who was introduced to the family.

4.2.38 On the 15th September 2021, ASC record a home visit by SW1 to assist Dad with DWP paperwork; he advised that the washing machine had broken and that they were struggling for money. SW1 offers to apply to the Cheshire Carers Centre for assistance.

4.2.39 On the 24th September 2021, ASC record that Gary’s s9 assessment had been completed on the 22nd September 2021 as well as Dad’s s10 (Carer’s) assessment under the Care Act 2014.

Finding 37: It is of concern that neither the findings or outcomes of the assessments are recorded as aren’t any decisions by Dad or Gary re any offered support services. This is of particular concern as the input from Archangel Care would have been agreed on the basis of need and

eligibility identified in the assessments under s9 and/or 10 of the Care Act 2014 - see 4.2.41 below.

4.2.40 On the 5th October 2021, CWP and ASC record an unannounced joint home visit by SW1 and LDHF1. Gary was eventually persuaded to let SW1 cut his thick matted hair and Dad then shaved his head. Dad advised that Gary had showered since the last joint visit. SW1 described the house as “presentable”.

4.2.41 On the 19th October 2021, ASC record a home visit by SW1. The home conditions “were presentable” and the Archangel Care support worker had assisted in clearing the hall and kitchen and a number of bags were ready to go to the charity shops. The family were happy to continue to be supported by Archangel Care and SW1 agreed to see if a chiropodist would visit.

4.2.42 On the 2nd November 2021, ASC record a home visit by SW1. Home conditions were described as “acceptable”, the kitchen was a lot tidier with clear work surfaces and there was fresh food on the table. Gary is still going to his room when the Archangel Care support worker visits but he has stopped being abusive to her – there is no previous reference to any such behaviour by Gary. Gary was wearing a new football shirt and Dad had bought a new washing machine.

Finding 38: It is of concern that no work appears to have been done with Gary re his behaviour towards the Archangel Care support worker

4.2.43 On the 5th November 2021, ASWC record that Phil’s assessment under s9 of the Care Act 2014 was completed, using ASC’s Strengths Based Assessment process. The assessment identified the following needs:

- developing and maintaining family or other personal relationships
- maintaining a habitable home
- managing and maintaining nutrition and
- engaging in recreational activities

Services were refused by both Phil and Dad.

Finding 39: It is of concern that no reviews of Phil’s capacity to refuse support services was considered

4.2.44 On the 10th November 2021 ASC record that Archangel Care advised them that Dad had been admitted to MCHFT and that neighbours were supporting Gary and Phil at home awaiting a taxi to take them to The Loont for an overnight stay. In the event, Gary went to The Loont but Phil

refused to go. The Police record receiving a report that Phil was left at home alone but didn't respond having checked that ASC were dealing with the situation.

See Finding 39 above

4.2.45 On the 11th November 2021, SW1 visited Gary at The Loont, who confirmed he was comfortable and had slept well. He had had a shower and washed his hair; staff had completed a body map as they seen patches of dark, dry, flaky and mottled skin on his arms, feet and between his toes, possibly a fungal infection. Staff advised that he could stay another night.

4.2.45 On the 11th November 2021, SW1 visited Phil at home; he again refused to go to The Loont despite knowing Dad would be in hospital for another night. Archangel Care staff were present supporting Phil with his epilepsy medication. He was left with a mobile phone so he could be contacted and neighbours had a key to the house in case of an emergency.

See Finding 39 above

4.2.46 On the 16th November 2021, CWP record that SW1 had advised LDHF1 of the events of the 10th/11th November 2021 and that Gary and Dad had now returned home. LDHF1 requested a home visit from the GP due to Gary's history of not attending appointments. However, in accordance with a national recommendation at the time for keeping people safe due to Covid-19, the GP did not undertake a home visit but did agree to look at photos of the possible fungal infection. There is no record of any photos being sent to the GP or of any response from the GP. The GP Practice have no record of the above contact.

4.2.47 On the 19th November 2021, the GP Practice record sending Gary a letter inviting him to have the flu vaccine.

Finding 40: Given Gary's known Learning Disability and his history of non-engagement with health services, it is of concern that the GP Practice contacted him by letter and didn't follow up on his lack of response or advise other agencies of it

4.2.48 On the 23rd November 2021, ASC record a home visit by SW1 to assist Dad to apply for Universal Credit.

4.2.49 On the 6th December 2021, ASC record a home visit by SW1; she records that "Home conditions were OK". She saw Gary and Dad, discussing with

Dad increasing the input from Archangel Care. With some encouragement, he agreed to an increase to three hours a day, three days a week.

4.2.50 On the 15th December 2021, ASC record a home visit by SW1; she noted that the home conditions had improved thanks to the increase in support. Gary still spending much of his time in his bedroom but he has started to engage with the support worker.

4.2.51 On the 5th January 2022, ASC record being advised that Dad had collapsed in Northwich and had been taken to hospital by ambulance. After Gary and Phil refused to go The Loont, it was agreed with ASC's Learning Disability Team Practice Manager (LDTPM1) that if their neighbours were willing and able to keep a check on them, they could stay at home.

See Finding 20 above

4.2.52 On the 6th January 2022, ASC record being advised that Dad had returned home during the night but had tested positive for Covid-19.

4.2.53 On the 11th January 2022, ASC record checking with Archangel Care that they could provide a doorstep visit to the family; they agreed they would do so and also deliver some shopping.

Finding 41: It was good practice to ensure contact was maintained with the family during Dad's period of quarantine

4.2.54 On the 14t January 2022, the GP Practice record inviting Gary for his annual LDHR and a flu jab, though not how. The record does state "Text message also sent to patient on 14/01/22".

See Finding 40 above

4.2.55 On the 18th January 2022, ASC record a home visit by SW1; home conditions described as "OK". SW1 collected prescriptions for Gary and Phil, the latter was in bed unwell, but Dad advised he was still eating and drinking and taking his medication.

4.2.56 On the 26th January 2022, CWP record that SW1 advised LDHF that both Gary and Phil "had Corona virus and had been quite poorly". Archangel Care had been informed and provided "door-step visits until able to safely return to the support package.

4.2.57 On the 26th January 2022, ASC record a referral was made for assistive technology for Phil to support Dad in his carer's role and to enable him to attend respite in the future when an increased package of support would enable Gary and Phil to remain at home in his absence. There is no record of Phil or Dad agreeing to this referral being made.

4.2.58 On the 26th January 2022, ASC record a home visit by SW1 after a phone call from Archangel Care to advise of concerns about both Gary and Phil. Gary was still unwell, not engaging with Dad or the support worker, smelt of urine, hadn't changed his clothes for some time and had sores on his lips. Phil was still in bed but was eating and drinking and using a bucket in his bedroom to go to the toilet. When she visited, Phil was in his bedroom but let SW1 in; he appeared to have lost weight but was starting to use the bathroom again. Gary was reluctant to shower or change his clothes but was persuaded to do so. SW1 contacted LDHF by phone to ask she chase up the referral to the District Nurses to visit Gary, as it was thought he was more likely to engage with them.

4.2.59 On the 26th January 2022, the GP Practice record receipt of a letter from the LDHF raising the concern re a possible infection of Gary's lower legs - photos were included – and requesting a home visit. The GP assessed the photos to be consistent with haemosiderin deposits and didn't require an urgent visit but decided to "get further collateral history from Social Worker."

4.2.61 On the 27th January 2022, ASC record a series of phone calls by SW1: to Archangel Care to ask if support hours could be used to clear a backlog of dirty washing – it was agreed they could; to Dad, who confirmed that Gary had had a shower and changed his clothes. He was going to buy some sudocrem for the rashes on Gary's stomach and to the GP who agreed to try to arrange a joint visit with the Complex Care Practitioner, a nurse employed by CCICP, to provide a review of care needs, oversight and support to patients for a period of 6 weeks, though this can be extended if necessary.

4.2.62 On the 27th January 2022, the GP Practice records a phone call to SW1; concerns re Gary's hygiene, poor diet and his being increasingly isolated since the lockdowns were discussed. It was agreed to refer for a visit by the Complex Case Practitioner (CCP) as there was no acute need to be met.

4.2.63 On the 1st February 2022, ASC record a home visit by SW1; Gary had had a shower and was wearing clean clothes, but he was lethargic and not engaging well. Dad had been unable to get the Sudocrem and the rashes on his stomach were bleeding. SW1 agreed to contact the Complex Care

Nurse about the joint visit and Dad agreed to contact the GP for medicated cream for Gary.

4.2.64 On the 2nd February 2022, ASC record SW1 phoning the GP Practice and being advised the GP would ring her back re her concerns about Gary's physical and mental health.

4.2.65 On the 3rd February 2022, the GP Practice record referring Gary to the CCP – see 4.2.62 above

4.2.66 On the 4th February 2022, ASC record SW1 phoning Dad to ask if he had contacted the GP or the pharmacist re Gary's rash – he hadn't so SW1 offered and visited the pharmacist who suggested a cream to treat the dry skin and bleeding. SW1 then visited the home to give Dad the cream who agreed to assist Gary apply it after a shower later that day and to contact the GP Practice about a prescribed cream. Dad asked to reduce the support from Archangel Care, which SW1 advised against. The house was "clean and tidy overall" though there was a strong odour in the lounge for no apparent reason. SW1 spoke to Gary to discuss him having a shower and to Phil, who was in bed, and who advised that he was eating and drinking, Dad was supporting him with his medication but that his legs were still "quite shaky" when he got up.

4.2.67 On the 10th February 2022, ASC record SW1 receiving an email arranging an appointment for a key safe and epilepsy sensor to be installed in the home - see 4.2.57 above. They also record a phone call from the Archangel Care support worker advising that Phil had run out of epilepsy medication; she had contacted the GP Practice and arranged for an emergency prescription that SW1 agreed to pick up and deliver when she visited the next day.

Finding 42: Given Dad's failure to contact the GP or pharmacist as agreed – see 4.2.66 above) or ensure Phil had adequate medication, it is of concern that a further safeguarding referral wasn't considered.

4.2.68 On the 11th February 2022, ASC record SW1 contacting the GP Practice to ask if Gary and Phil's medication could be delivered to them rather than rely on Dad requesting repeat prescriptions, collecting them and getting them made up. It was conformed that the local chemist can re-order and deliver medication for free; SW1 agreed to assist Dad to arrange this with the chemist.

Finding 43: It was good practice to ensure the supply of Gary and Phil's medication though it is of concern that their agreement to the new

arrangements weren't sought or capacity assessments completed to enable Best Interest Decisions to be made.

4.2.69 On the 11th February 2022, ASC record a home visit by SW1; Gary hadn't had a shower and didn't want to have one that day, but said the sore on his stomach was feeling better and had stopped bleeding. Phil was in his bedroom but had had a shower and was wearing clean clothes. He was still using a bucket in his bedroom to urinate but agreed to SW1 removing it. He said he would be happy to go out with the support worker and Dad agreed to an increase in support to facilitate this. The following day, SW1 contacted Archangel Care to set this up to start the following week and agreed that referral could be made to the Learning Disability Physiotherapy Service if required to assist Phil going out with the support worker.

Finding 44: It is not within Dad's remit to agree to any change in Gary or Phil's support package.

Finding 45: It is not clear what the trigger would have been for the referral to the Learning Disability Physiotherapy Service or if they had agreed to it.

4.2.70 On the 15th February 2022, ASC record the Duty Officer receiving a phone call from Archangel Care to report that the support worker had found Gary that morning at the bottom of the stairs "covered in faeces, teeth broken and his mouth all black." Gary had refused an ambulance. The Co-ordinator from Archangel Care (ACC1) had visited the home and Gary said he had been there since the night of the 13th February 2022. She told him she was calling an ambulance but when she did so was advised it might take five hours for one to arrive. A safeguarding referral was made to ASC and subsequently opened as a S42 Enquiry.

Finding 46: It was good practice for the support worker to contact the Co-ordinator, for her to overrule Gary's wishes and call the ambulance and to make a safeguarding referral

4.2.71 On the 15th February 2022, ASC record that the Duty Officer spoke to Dad on the phone, who said Gary had tripped going up the stairs, regained his balance then fallen backwards hallway up the stairs. Dad hadn't thought there was anything wrong as Gary was "gobbing off". When asked if he was aware that Gary had faeces all over him, he said he was. Dad then stated that Gary had managed to slide into the living room and had sat up against the sofa all night. On the night of the 14th February 2022, Gary had slept on a pillow on the floor. The ambulance attended and took Gary to MCHFT; the North West Ambulance Service (NWAS) raised a

safeguarding concern with ASC, including the information that Gary had a learning disability.

Finding 47: It was good practice of the NWAS to raise a safeguarding concern with ASC

4.2.71 On the 15th February 2022, Archangel Care record that Dad had said he hadn't called for any help as Gary had said he didn't want any.

4.2.72 On the 15th February 2022, the GP Practice record the above and that Gary, having been taken to the Emergency Department (ED) at MCHFT, was transferred to the Intensive Care Unit (ICU) having been found to be septic, dehydrated and with an extensive infective abdominal wound which was surgically debrided.

4.2.73 On the 15th February 2022, Cheshire Police record being contacted by NWAS to report concerns of Gary being left unattended by family members and having to be taken to hospital. The Police record contains no reference to Gary having a learning disability. A Police investigation into a possible assault or neglect commenced.

Finding 48: It was good practice for NWAS to contact the Police, but of concern that no other agency had done so.

4.2.74 On the 15th February 2022, MCHFT record that Gary was taken to ED after a "fall downstairs - long lie for 4 days. Septic, dehydrated. Extensive infected wounds requiring surgical debridement. Referred to surgical team. Post-operatively required Level 3 care on ICU." Gary was found to have a large wound to his right groin which required debridement and a course of intravenous antibiotics. During his admission, Gary was also found to have a Renal Vein Iliac Thrombus which was treated with blood thinners; he was also treated for Hospital Acquired Pneumonia and tested positive for Covid-19 while in hospital. where he had his first Covid vaccine. Staff at MCHFT recall though it is not detailed in the records, that the Police saw Gary in ED and that standard practice would be for treating clinicians to advise the Police of any issues that might affect his capacity or decision-making.

4.3 There is no suggestion that the medical treatment Gary received in MCHFT was in any way below standard, abusive or neglectful; this SAR will not therefore record its details or comment upon it.

4.2.75 On the 16th February 2022, the GP Practice record a phone call from the CCG's Designated Nurse Adult Safeguarding to advise them of Gary's

situation, that the Police and the MCHFT Safeguarding Team are involved and that a Strategy Meeting was happening that afternoon.

4.2.76 On the 16th February 2022, ASC record a Professionals/Strategy Meeting being held under the local multi-agency Safeguarding Adult Procedures re Gary. The Strategy Meeting was attended by:

- ASC Learning Disability Service Team Manager (LDSTM1) - Chair
- LDTPM1
- ASC Practice Manager Adult Learning Disability Team (LDTPM2)
- Cheshire CCG Designated Nurse (CCGDN1)
- ASC Adult Safeguarding Team Manager (ASTM1)
- ACC1
- Archangel Care Area Manager (ACAM1)
- Cheshire Police DS Child Protection Team (CPDS1)
- CWC Legal Team Officer (LTO1)
- MCHFT Dignity Matron (DM1)

The summary of actions from the meeting include:

- A safeguarding referral to be made re Phil due to concerns about Dad's capacity to care for him given his failure to seek assistance for Gary after his fall
- A decline in Phil's mobility was noted; he was very thin with ongoing concern re self-neglect; hoarding in Phil's bedroom making access difficult; use of a bucket in his bedroom as a toilet; no bed sheets or a light in his bedroom and ill-fitting clothes that were a trip hazard
- The CCG to request urgent visit by the District Nurse or GP to complete a health and risk assessment of Phil to determine next actions required; Archangel Care and ASC to support with a joint visit
- The CCG to obtain urgent GP update/information
- ASC to visit the home the next day and commence capacity assessments for Phil re "care/support/environmental risks/recent events"
- ASC to allocate Phil his own Social Worker
- "Advocacy referrals to be completed"
- Archangel Care to support daily while further assessments/ risk assessments are completed
- When Gary is well enough, his capacity to be assessed re care and support and a DoLS requested if required.
- A Legal Gateway Meeting to be requested
- Dad "to be offered a Care Act assessment again"
- ASC to "keep Police updated with outcomes"; they will await outcome of ASC enquiries before arranging to interview Dad.
- A further Strategy Meeting to be held on 21st February 2022

Finding 49: It is of concern that throughout the SAR there was inconsistency in the terminology used for the different stages of the local Safeguarding Adult Procedures

4.2.77 There is some confusion and a lack of clarity in the records available to the Review as to whether and when the Police were advised of Gary and Phil's learning disabilities and their potential lack of capacity re decisions relating to their health and welfare. The above demonstrates that they were aware of the need for capacity assessments of them both, that they were known to Learning Disability Services. DM1 recalls the Police seeing Gary in the ED on his admission to hospital.

Finding 50: It is of concern that the records of ASC, MCHFT and the Police do not provide a clear picture of the discussions and ensuing actions that took place when Gary was taken to and admitted to hospital on the 15th February 2022

Finding 51: It is of concern that the decision not to interview Dad was not challenged given the Strategy Meeting's knowledge of Gary's learning disability and potential lack of capacity

4.2.78 On the 17th February 2022, ASC record a home visit by a Duty Social Worker (SW2) to assess Phil's capacity re his health, care and support needs. Phil engaged well with the assessment, but it was assessed that he lacked capacity in all three areas of decision-making. The home conditions were described as poor. Phil was unable to walk downstairs without support, he looked unkempt and there was a strong smell of faeces. He'd had prawn crackers for his breakfast, he said Dad had been to the pub the night before. He wanted to go to Sainsburys, and later took himself there by taxi. The Archangel Care support worker and SW2 met Phil at Sainsburys with an ambulance and Phil eventually agreed to be taken to hospital. SW2 was later allocated to Phil.

4.2.79 On the 17th February 2022, MCHFT record that Phil attended the ED; he was "stable at triage … streamed to the falls service and discharged 17/2/22 at 18.29"

4.2.80 On the 18th February 2022, ASC record that they were informed that Phil "left hospital before assessment took place." This apparent contradiction with 2.80 above is due to inconsistent terminology: Phil was triaged but chose to leave the hospital rather than wait to be reviewed by a doctor. A home visit by DW1 and the GP; the GP assessed Phil as lacking capacity re his health and care needs and, as full health checks couldn't be completed at home, admission to hospital was necessary and an

ambulance was requested and Phil was taken to MCHFT. The GP contacted the hospital in advance to advise of Phil's arrival and the need to use the Mental Capacity Act 2005 (MCA) to ensure he doesn't return home without the relevant assessments being completed. ASC record receipt of a safeguarding referral from MCHFT on the basis of Gary being admitted to hospital following another safeguarding concern and Phil saying Dad drinks a lot and hits him and shouts at him.

Finding 52: It was good practice to assess Phil's capacity to make decisions re his health and care needs and to organise his admission to hospital

4.2.81 On the 19th February 2022, MCFT record Phil's attendance at ED and his admission to the Acute Medical Unit (AMU), part of MCFT's Emergency Care system for routine physical examinations, and a capacity assessment. A DoLS was put in place as Phil assessed as lacking capacity re his health and care needs.

Finding 53: It was good practice to put a DoLS in place for Phil but of concern that no DoLS was considered or put in place for Gary

4.2.82 On the 21st February 2022, CWP and MCHFT record a Professionals/Strategy Meeting being held under the local multi-agency Safeguarding Adult Procedures re both Gary and Phil and their recent hospital admissions. The meeting was attended by:

- ASC Senior Manager Learning Disability Services – (SMLDS1) - Chair
- LDTPM1
- SW1
- ASC Learning Disability Service Social Worker (SW2)
- DM1
- CCGDN1
- CWP Learning Disability Service Community Nurse (LDCN2)
- Cheshire Police DS Northwich CID (CIDDS1)
- CWC Legal Team Officer (LTO2)
- Student Social Workers ASC Learning Disability Services x 2

Archangel Care were not represented at the Strategy Meeting

4.2.83 In addition, concern was raised re locks on the outside of both brothers' bedroom doors; Dad advised that these had been put in place to stop the brothers going into one another's bedrooms, not to stop them getting out.

4.2.84 It was agreed that neither Gary or Phil should return to live at home and that long-term placements for them both, either together or separately, should be sought. Should they be fit for discharge from hospital before

these were identified, they were to be placed short-term at the Loont. ASC would complete capacity assessments re the decision as to where to live and their care needs for both brothers before their discharge from hospital to facilitate Best Interests Decisions if appropriate. There is no reference to a decision by the Police as to interviewing Dad or any consideration of whether an offence may have been committed under section 44 of the MCA. The outcome of the Safeguarding referral, either a section 42 Enquiry or its closure, is not stated. Given the nature of Gary's condition on admission to hospital – sepsis, a necrotic wound, anaemia, atrial fibrillation and bilateral pulmonary blood clots – and the length of time he was left on the floor by Dad after he fell, it was agreed that a referral for a Safeguarding Adults Review be made.

Finding 54: It is of concern that there is no reference to any member of the family being informed of or invited to attend the Strategy Meeting or of the decision not to do so being recorded

Finding 55: It is of concern that neither Gary or Phil, the latter having been assessed as lacking capacity to make decisions re his health and care needs, were represented by an advocate or Independent Mental Capacity Advocate at the Strategy Meeting.

Finding 56: Given the need for long-term decisions to be made about both Gary and Phil's health and support needs, including where they should live, it is of concern that no consideration was given to applying to the Court of Protection either for specific Orders or Deputies to be appointed

4.2.85 On the 21st February 2022, MCHFT record that Dad was admitted to hospital due to a deterioration in his Chronic Obstructive Pulmonary Disease. He was discharged home on the 28th February 2022.

4.2.86 On the 24th February 2022, MCHFT record that Phil was discharged from hospital to The Loont.

4.2.87 On the 21st March 2022, CWP record a discussion between the Community Learning Disability Nurse (CLDN) and SW1 as Gary had not had his Covid-19 vaccinations, despite being invited by the GP Practice. It was not clear if he had the capacity to consent to such treatment. The CLDN emailed MCHFT to ask if Gary and his brother had had the vaccinations while in hospital; it was confirmed that they hadn't. MCHFT agreed to investigate why not. The CLDN advised SW1 of the above.

4.2.88 On the 31st March 2022, CWP record that the CLDN noted that Gary is still in hospital; "he is walking more and using a stick……His wound is healing

but needs daily dressings. He wasn't chewing when eating and it was suggested that a Speech and Language Therapy assessment might be of benefit.

4.2.89 On the 5th April 2022, ASC record a Professionals/Strategy Meeting being held under the local multi-agency Safeguarding Adult Procedures re Gary. The meeting was attended by:

- LDSTM1 – Chair
- LDTPM1
- SW1
- SW2
- ACC1
- CCGDN1
- ACAM1
- DM1
- CAA1
- Registered Manager, Archangel Care (ACRM)
- Inspector, CQC
- Detective Sergeant, Northwich CID (CIDDS2)
- Tissue Viability Nurse MCFHT

with apologies from LDHF1, CIDDS1 and 2 members of CQC

4.2.90 The meeting noted that Gary had advised CAA1 that he didn't want to return home to live, but to live with Phil in a bungalow in Winsford; Phil felt the same but in Northwich. It was also noted that a capacity assessment had started of Gary but not which decisions this related to; that neither Gary or Phil had been spoken about the safeguarding investigation though Gary was aware of the meeting taking place; Dad was on a waiting list to have his care and support needs assessed under s9 of the Care Act 2014; ACRM advised the meeting that Dad would not call an ambulance "because every time he did, someone was taken away and they never came back"; DM1 advised the meeting that Gary was fit for discharge from hospital once nurses in the community could treat his wound – this would require some equipment that wasn't currently available and CIDDS2 advised the meeting that he would "update the lead officer for the case but it is likely they will conclude that is not in the public interest to prosecute Dad".

Finding 57: It is of concern that the Police weren't challenged over their not investigating any possible offence under s44 of the MCA, which applies to family members amongst others, as Gary lacked the capacity to safeguard himself and Dad failed to take the appropriate direct action or seek assistance

4.2.91 At the previous meeting held on the 21st February 2022, it had been agreed that all agencies would provide chronologies of their involvement with the family; these had not all been completed and it was agreed that those outstanding would be completed by the 29th April 2022, when a further meeting would be convened to consider any findings and whether the criteria for a Safeguarding Adult Review were met. While no statement is recorded as to whether abuse or neglect had occurred, it was noted that "Initial risks on admission have been mitigated" and "current risks can be managed by care planning and Best Interest process", that Care Act and capacity assessments were "ongoing" and that plans for Gary's discharge from hospital would investigate options including Intermediate Care and a possible short-term placement at The Loont pending identification of a long-term placement for both Gary and Phil.

4.2.92 In an Addendum to the minutes of the meeting, it was noted that Gary had another brother, Ryan, born in 1979. Ryan was registered as having a visual impairment in 1996. LDCN1 had supported the family when Ryan was diagnosed with a terminal brain tumour. Ryan moved to a care home in Leyland, Lancashire in December 2001, where he died in July 2002. LDCN1 advised the meeting that there had been no concerns about the care Ryan received from his family prior to his move to Leyland.

Finding 58: It is of concern that this information appears not to have been available to staff throughout the time that ASC were involved with the family, as it may have had an impact on the family's attitude to health services and hospital admissions in particular – see 4.2.92 above

4.2.93 On the 26th April 2022, CWP record a discussion with MCHFT might be discharged to The Loont for rehab on the 16th May 2022. He had improved physically and had his first Covid vaccination.

4.2.94 On the 28th April 2022, CWP record a discussion between the CLDN and SW1 that a discharge planning meeting would be required due to concerns re Gary's mobility and catheter care.

4.2.95 Between the 11th May 2022 and the 16th May 2022, CWP record a chain of emails between the CLDN, MCHFT, SW1, Archangel Care and Gary's Care Act Advocate (CAA1), commissioned by ASC from Disability Positive attempting unsuccessfully to arrange a discharge planning meeting. The CLDN liaised with The Loont to confirm a discharge plan for Gary; MCHFT liaised directly with The Loont around a referral to the District Nursing Service and agreed to arrange a visit once Gary was settled.

4.2.96 On the 16th May 2022, Gary was discharged from hospital to the Loont.

Finding 59: It is of concern that no formal discharge planning meeting was held for either Gary or Phil despite several attempts to convene one; however, the Strategy Meetings held under the local Safeguarding Adults Procedures on the 16th and 21st February 2022 and the 5th April 2022 had effectively fulfilled the purpose of agreeing their discharge plans

Finding 60: It is of concern that the local Safeguarding Adults Procedures appear to have terminated after the third Strategy Meeting with no conclusion as to whether abuse had occurred, no known outcome to the Police Investigation and no Safeguarding Plan for any member of the family

Finding 61: It is of concern that the SAR is not aware of the completion of Dad's assessment under s9 of the Care Act 2014 or its outcome

4.2.97 On the 26th May 2022, CWP record an email chain between the CLDN and SW1 re a referral to a dentist and a physiotherapy assessment due to steps at the property in Darhall School Lane which was the planned long-term placement for Gary and Phil.

4.2.98 On the 17th June 2022, Gary moved from the Loont to his current address in Darnhall School Lane, supported by a care package based on an assessment under s9 Care Act 2014 completed on the 22nd September 2021.

5. Analysis and Issues to be Addressed

5.1 The SAR needs to recognise that some of the events that impacted on Gary and his family pre-date the Review Period and even his 18th birthday. While the SAR neither saw nor requested information relating to these events, they are relevant and earning needs to be taken from them.

5.2 The SAR also needs to recognise the impact the Covid-19 Pandemic and the resulting Lockdowns will have had both directly on Gary and his family and on the staff working with them. This is not to excuse any short-comings in the quality of that care and support but to seek to understand how it occurred and the pressures that may have affected the behaviour and performance of agencies and staff involved.

5.3 This analysis and the Issues and Recommendations that result from it will assume that learning relevant to one agency will be transferable to partner agencies and across local authority boundaries.

5.4 The Findings identified in the Key Events above can be grouped under seven Themes, some of which are liked to specific agencies, some to generic areas of practice that apply across agencies.

5.6 Many of the Findings apply to more than one Theme, and it would be possible to group them under different themes. The Findings of Good Practice will be addressed as a whole; they will not be identified against each Theme.

5.7 These Themes are:

- Transition Services
- Adult Social Care/Care Act 2014
- The Mental Capacity Act 2005
- Adult Safeguarding
- Health Services
- Good Practice

5.8 Within each Theme, this Analysis will identify Issues to be Addressed; these will be brought together into Recommendations in the Conclusion.

5.7 While the subject of this SAR is Gary, the Findings often apply to Phil as well and sometimes just to Phil.

5.8 Transition Services:
Findings: 1, 3 and 58

5.8.1 The SAR saw no evidence that Gary – or any of his brothers – was referred into Transition Procedures prior to their 18th birthdays. This is despite both Gary and Phil having a learning disability. It is generally considered appropriate to initiate Transition Procedures from Children's to Adults' Services in the academic year that the young person has their 14th birthday. In Gary's case this would have been 2000/01 and in Phil's case 1989/90.

5.8.2 The importance of the Transition Procedures is three-fold: they enable Adult Services to identify those young people who are likely to be eligible for support services after their 18th birthday; they enable Adult Services to plan their future budgets to meet future needs and they enable young people and their families/carers to be prepared for their change from children to adults in the eyes of the law.

5.8.3 The NHS Community Care Act 1990 received the Royal Assent in June 1990. Although this is at the end of the academic year when Phil had his 14th birthday, the content and implications of the Act for services was well-known prior to that date.

5.8.4 Referring Gary and Phil into the Transition Procedures would have enabled their care and support needs to be assessed, their eligibility for services agreed and appropriate services identified and offered to them and their parents for when they became adults.

5.8.5 Of particular relevance to Gary, are the implications of the Mental Capacity Act 2005 for decisions about not only his finances but also his health and welfare. Until his 16th birthday, his parents were able to make all necessary decisions on his behalf, but from that time this power reduced until, on his 18th birthday, they lost all such decision-making powers. The Transition Procedures would have enabled these issues to be addressed with both Gary and his parents and decisions made as to the need for an application to the Court of protection either to make Orders re specific decisions or appoint a Deputy/Deputies if he was assessed to lack capacity re particular decisions.

5.8.6 Referral into the Transition Procedures would also have ensured that all agencies were aware of the death of Gary's elder brother, Ryan. This would have enabled consideration of its implications for the family and how they might interact with support agencies as well as any therapeutic support to assist them come to terms with their loss.

5.8.7 There is no evidence that Gary or his brothers had Hospital Passports agreed with their parents to ensure any attendance or admission to hospital was accompanied with all relevant medical and social information.

Issues to be addressed:

- **There was no evidence Gary being referred into the Transition Procedures to facilitate his transfer from Children and Families' Services to Adult Services on the basis of a holistic assessment under the NHS and Community Care Act 1990**
- **There is no evidence of any consideration being given to the need to assess whether Gary had the capacity to make decisions re his finances, health or welfare**
- **There is no evidence of Gary or his family being advised of the implications of the Mental Capacity Act 2005 for future decision-making**
- **There is no evidence of any consideration being given to the need to apply to the Court of Protection for any of the remedies at its disposal to ensure a process by which future decisions about Gary's finances, health or welfare would be made**
- **There is no evidence that Hospital Passports were agreed for Gary and his brothers as children despite their learning disabilities.**

5.9 Adult Social Care/Care Act 2014: Findings: 2, 4, 5, 7, 11, 12, 14, 15, 16, 17, 22, 25, 26, 27, 28, 31, 37, 38, 45, 59 and 61

5.9.1 This Theme includes those Findings that relate to the NHS and Community Care Act 1990 which has been replaced by the Care Act 2014.

5.9.2 Although they fall outside of the Review Period, there are a five Findings that relate to missed opportunities under the NHS and Community Care Act 1990 to assess Gary's care and support needs and those of his family. Had these opportunities been taken, along with the appropriate implementation of the Mental Capacity Act 2005 – see 5.10 below – some of the issues relating to the family's engagement with services might have been prevented.

5.9.3 There is no evidence that Gary was offered an assessment under the NHS and Community Care 1990 when he became an adult or that his parents were offered assessments if their care and support needs as his carers; there is no evidence that Phil's care and support needs were assessed under the NHS and Community Care Act 1990 when he was provided with a period of respite care in June 2014 or to support his attendance at a day centre at that time.

5.9.4 There is no evidence that Gary or Phil had Hospital Passports agreed with them and their family to accompany any attendance or admission to hospital. This ought to be standard practice for any child or adult with limited capacity, whether due to a learning disability, dementia or another cause of neurodiversity.

5.9.5 There is no evidence that the reasons for Gary's dropping out of his college course were investigated and that the support package of which it formed part being reviewed and revised to ensure it was fit for purpose. There is no evidence of any annual reviews being held of the support provided to Gary or being offered once he had withdrawn from the college course.

5.9.6 The first recording of Gary's care and support needs being assessed under the NHS and Community Care Act 1990 doesn't occur until July 2014, when no assessment of his parents' care and support needs as his carers was offered.

5.9.7 Despite their learning disabilities, both Gary and Phil did not have annual medication reviews with their GP, nor did the GP Practice at any time refer the family to ASC for any assessment under the NHS and Community Care Act 1990 or the Care Act 2014. However, there is no evidence of the GP Practice being contacted to provide health information as part of any assessment by ASC. When a home visit was requested from the GP and a referral made to the CWP Health Facilitation Team, there was no follow up when there was no response to the referrals.

5.9.8 When support was provided to the family by the Turner Fellowship in February 2017, there is no recorded assessment under the Care Act 2014 of any family member though the support was additional to support David was already receiving from the Fellowship. It has to be assumed that David had been assessed under the Care Act 2014 in order to receive support and that assessment should have identified Gary and Phil’s care and support neds and their parents’ eligibility for carers’ assessments. The same issue arises from the lack of a family assessments when Marl was assessed to establish his eligibility for sheltered accommodation.

5.9.9 There is no record of the care package from the Turner Fellowship, whether to David or the family being reviewed or terminated.

5.9.10 There is a gap of some three years in contact between ASC and the family; under the Care Act 2014, the family had the right to refuse any offer of assessments or the provision of support, provided any refusal was compatible with the Mental Capacity Act 2005. However, the duty on the local authority to offer assessments or reviews on an annual basis remains. There is a reference to the family having a “long history of non-engagement”, but the onus is on the statutory services to engage with the service user and their family, not the other way round.

5.9.11 The family home was a privately rented property; the regulation of private landlords is a complicated issue and had the family home been rented from the local authority or an equivalent, annual checks could have led to referrals to ASC due to the state of the property. However, there is no evidence of the landlord being contacted as part of any assessment by ASC.

5.9.12 Once ASC have engaged with the family, a prime aim of their involvement was dealing with the state of the family home. This raised concerns due to issues of hoarding and its unhygienic condition but the focus was dealing with the symptoms rather than the cause of neglect/self-neglect that may have led to the deterioration in the condition of the home and of Gary and Phil. Given the death of Ryan and Dad’s later recorded comment about people going into hospital and not coming back, the potential link to loss and incomplete grieving is apparent.

5.9.13 The Hospital Discharge Planning to facilitate Mum's discharge from hospital to The Loont did not refer to the safeguarding concerns that had been raised about her and Gary and Phil. Any safe discharge plan should have contained measures to manage any ongoing risk to her from those safeguarding concerns.

5.9.14 In May 2021, ASC referred Gary to CWP's CLDT, detailing a number of areas of concern including his personal hygiene, diet and social isolation and the state of the family home. However, the purpose of the referral and any desired outcomes are not stated. Likewise, in February 2022, ASC suggested to the Archangel support worker that a referral could be made to the Learning Disability Physiotherapy Service for Phil without an agreed trigger for that referral or recording Phil's agreement to it.

5.9.15 In September 2021, assessments under the Care Act 2014 are completed for both Gary and his Dad, but neither the findings or outcomes of the assessments, such as the services to be offered, are recorded. When Gary doesn't cooperate with the support worker, no work is undertaken to either identify the reason for is behaviour or to remedy it.

5.9.16 These assessments were completed without any assessment of Gary or his Dad's capacity to make decisions relating to their care and support needs or any consideration of the need for Independent Advocacy under s 67 of the Care Act 214 to support Gary through the assessment process. The latter doesn't require the subject to lack capacity and there were grounds to consider Dad was not able to advocate effectively for Gary.

5.9.17 In an echo of their mum's discharge from hospital, Gary and Phil were discharged from hospital without any formal Hospital Discharge Planning meetings being held. The need for them was identified and attempts made to convene them without success. In the event, Gary was discharged with a care and support package based on a Care Act 2014 assessment from September 2021, some eight months prior to his discharge without it being reviewed.

5.9.18 It was acknowledged that Dad had his own care and support needs and their assessment under the Care Act 2014 was requested but had not taken place by the end of the Review Period.

Issues to be Addressed:

- **There is no evidence that Gary's Transition from Children's to Adult's Services did not include an assessment of his needs under the relevant Adult Social Care legislation**

- **There is no evidence that an assessment of Gary's capacity was part of his Transition from Children's to Adult's Services to identify any appropriate remedial actions**
- **There is no evidence that Gary's family were advised of the implications of the Mental Capacity Act 2005 on future decision-making re Gary**
- **There is no evidence of any annual reviews of Gary's care and support needs as an adult being offered or taking place**
- **There is no evidence that Gary's GP was contacted to provide health information to inform any assessment of his care and support needs or a Hospital Passport**
- **There is no evidence of the family's landlord being contacted to provide information to inform any assessment of Gary's care and support needs**
- **There is no evidence of an assessment of Gary's care and support needs being routinely completed before the provision of support services or of those services being regularly reviewed**
- **There is no evidence of support to the family having a focus on the causation of any hoarding/self-neglect as opposed to its symptoms**
- **There is no evidence that the Hospital Discharge Planning for Gary, Phil or Mum was holistic or addressed the safeguarding concerns previously identified.**
- **There is no evidence of the outcomes of the assessments of the family's care and support needs or the purpose and desired outcomes of resulting referrals to other services being clearly recorded**
- **There is no evidence of any consideration being given to commissioning an independent advocate for Gary under s67 of the Care Act 2014**
- **There was no evidence of an assessment of Dad's care and support needs being completed**

5.10 The Mental Capacity Act 2005:
Findings: 3, 7, 8, 9, 13, 20, 29, 30, 31, 35, 39, 43, 44, 45, 51, 53, 55, 56, 57 and 59

5.10.1 The Transition Procedures should facilitate a smooth move from Children and Families Services to Adult Services in both health and social care services. This is partially about establishing eligibility for services and identifying appropriate services when eligibility has been established as well as enabling long-term planning of services and resource allocation. It is also about preparing young people and their families or carers for their transition to adulthood.

5.10.2 A key facet of that preparation should be the impact of the Mental Capacity Act 2005 on decision-making post the young person's 18th birthday and, to a lesser extent, from their 16th birthday. This should include a consideration of the possible need for a capacity assessment as part of any assessment under section 9 of the Care Act 2014 and to inform any consideration of the need to apply to the Court of Protection fir either specific Orders or the appointment of a Deputy/Deputies of the young person lacks capacity.

5.10.3 There is no evidence of any consideration being given to the above in Gary's case or of any assessment of his capacity on his 18th birthday or as part of any assessment under the Care Act 2014 until February 2022. The same applies to Phil.

5.10.4 There is no evidence of any assessment being made of Gary's or Phil's capacity to make decisions relating to their health and welfare until February 2022, despite numerous decisions being made about accepting or refusing periods of respite care, attendance for medication reviews and health screenings, referrals for services and the provision of social care as well as the management of their benefits.

5.10.5 The above is compounded by Dad being allowed to make decisions on Gary's and Phil's behalf without any legal basis for doing so. This applies to their benefits as, although Dad had been appointed as Appointee for them both by the DWP, there was no assessment of their capacity to agree to this arrangement being out in place. On numerous occasions, Dad refused services without being challenged and without a Best Interests Decision being formally made.

5.10.6 Even if it was argued that Gary and Phil had capacity to make those decisions, their continued making of Unwise Decisions, which are permissible under the Mental Capacity Act 2005 and should not be taken as demonstrating that someone lacks capacity, should have led to a review of their capacity under 2.11 of the Code of Practice that supports the Mental Capacity Act 2005.

5.10.7 Despite initial concerns about Gary's capacity and one being applied for Phil, no DoLS was put in place for Gary throughout his period as an in-patient.

5.10.8 By February 2022, when the Safeguarding Procedures were initiated, Gary was not provided with an Independent Mental Capacity Advocate to support him through their implementation until after the second Professionals/Strategy Meeting on the 21st February 2022.

5.10.9 There is no evidence of the Police's decision not to interview Dad or to pursue a possible offence under s44 of the Mental Capacity Act 2005 being challenged despite the reasons given being incorrect – the section applies to family members, not just paid or registered carers. Equally, the concept of a "registered carer" was not challenged despite no such register existing.

Issues to be Addressed:

- **There is no evidence that the implications of the Mental Capacity Act 2005 were explained to Gary and his family as part of the Transition Procedures from Children's to Adults' Services**
- **There is no evidence that the Transition Procedures included a formal assessment of Gary's capacity**
- **There is no evidence that the Transition Procedures considered the need to apply to the Court of Protection for specific Orders or the appointment of a Deputy to facilitate decision-making for Gary as an adult**
- **There is no evidence that any agency challenged the legality of Dad making decisions relating to the health and welfare of both Gary and Phil or considered the need for Best Interest Decisions**
- **There is no evidence of any consideration of the need for a formal assessment of Gary's or Phil's capacity until the time of Gary's admission to hospital**
- **There is no evidence that the need for a DoLS to be applied for during Gary's hospitalisation was considered after the first Professionals/Strategy Meeting**
- **There is no evidence that consideration was given to commissioning an IMCA to support Gary until after the second Professionals/Strategy Meeting**
- **There is no evidence that the Police's decision not to pursue a possible offence under s44 of the MCA was challenged or the legal basis for it questioned**

5.11 Adult Safeguarding:
Findings: 6, 21, 24, 28, 32, 33, 34, 42, 49, 50, 51, 54, 55, 57, 58 and 60

5.11.1 The Findings can be considered in the order in which they reflect the implementation of the multi-agency Safeguarding Procedures.

5.11.2 There were several occasions when Safeguarding Concerns could and should have been raised about the care received by Gary and other members of the family including those relating: the condition of the

property, Dad's failure to ensure Gary and Phil had adequate medication, Dad's making decisions that weren't his to make and which weren't in Gary or Phil's Best Interests.

5.11.3 When a Safeguarding Referral was made by MCHFT, its outcome as not available to the SAR and there is no record of any feedback to the referrer of its outcome and the referrer didn't follow up on the Referral despite the subjects being discharged from hospital. The same situation arose when Safeguarding Referrals were raised about Gary, Phil and Mum, despite the Referrals relating to the condition of the home where Gary and Phil continued to live while Mum was discharged to a residential care home.

5.11.4 In the Safeguarding Referrals the adults at risk were identified as Gary, Phil and Mum. The Referrals related to the condition of the home and were therefore examples of either neglect or self-neglect, but at no stage was Dad identified as a possible perpetrator.

5.11.5 There is no record of the family being advised when the Safeguarding Procedures were implemented, being invited to attend any of the meetings held under the Safeguarding Procedures or being advised of their outcomes. This is contrary to the good practice identified in "Making Safeguarding Personal", a joint initiative between the \local Government Association and the Association of Directors of Adult Social Services in 2010 and subsequently revised, with the latest revision being in January 2020. There are circumstances when it may be appropriate not to advise the subject or their families of the Safeguarding Procedures being initiated, but if this should only happen as a conscious decision and the reasoning for it being recorded, it should not happen by default.

5.11.6 Despite both Gary and Phil being known to have a learning disability and, in Phil's case, having been assessed as lacking the capacity to make decisions re his health and welfare, neither was supported or presented by an advocate, whether under s68 of the Care Act 2014 or an IMCA under the Mental Capacity Act 2005 until the third Professionals/Strategy Meeting on the 5th April 2022.

5.11.7 The Professionals/Strategy Meetings held after Gary was admitted to hospital were chaired by managers from ASC's Learning Disability Services; the Meetings were therefore aware that Gary had a learning disability and that an assessment of his capacity to make decisions about his health and welfare was required. However, the Police's decision not to pursue any investigation into whether an offence had been committed by Dad in not getting any treatment for Gary after his fall was not challenged at any stage. While this might be understandable when Gary's wound was thought to be a knife wound, but once it became apparent how long he

had been left lying on the floor without any treatment, an offence under s44 of the Mental Capacity Act 2005 should have been pursued but wasn't, on the incorrect grounds that the offence didn't apply to a family member. A lack of legal literacy re the Mental Capacity Act 2005 might be understandable on the part of the Police, but not on the part of Learning Disability Service specialists.

5.11.8 The Professionals/Strategy Meeting held on the 5th April 2022 appears to have been the last Meeting held under the Safeguarding Procedures other than as part of the SAR procedures. A further meeting was to be convened after chronologies were received by a deadline of the 29th April 2022. There were other outstanding actions that were to be completed but the Procedures appear to have been closed without any conclusion being reached as to whether abuse had occurred, what the outcome was of the Police's deliberations and with no Safeguarding Plan in place for any family member.

5.11.9 Throughout the Review Period, there is a lack of consistency in the use of terminology relating to Safeguarding. "Safeguarding Referral" and Safeguarding Concern" are not differentiated, three Professionals/Strategy Meetings were held with no s42 Enquiry being initiated and no apparent progress through a Safeguarding process and no termination to the Procedure being recorded.

Issues to be addressed:

- **Throughout the Review Period, there were inconsistencies in the terminology used to refer to activity within and the different stages of the Safeguarding Procedures**
- **There were numerous opportunities to raise safeguarding concerns about the care and support Gary received from Dad and the condition of the family home that were missed**
- **When Safeguarding Concerns were raised, these were not always clearly triaged and addressed**
- **Feedback of the outcome of Safeguarding Concerns was not routinely provided to referrers or chased up by them**
- **Despite both Gary and Phil being known to have learning disabilities, there is no evidence of any consideration being given to the commissioning of an independent advocate under s68 of the Care Act 2014 or an IMCA until after the second Professionals/Strategy Meeting**
- **Despite the Professionals/Strategy Meetings being chaired by senior members of ASC's Learning Disability Service, there is no evidence of any challenge to the Police's decision to not pursue a possible offence under s44 of the MCA or any questioning of its legal basis**

- **There is no evidence that the Safeguarding Procedures were formally progressed through or closed with any conclusion as to whether abuse had occurred, a safeguarding plan being in place for any family member or the outcome of the Police's deliberation being known**

5.12 Health Services:
Findings: 9, 10, 11, 12, 18, 19, 23, 36 and 40

5.12.1 Neither Gary or Phil, both of whom were on long-term medication, were routinely invited to medication reviews though Gary was, as an adult with a learning disability, invited to annual LDHRs during the Review Period.

5.12.2 There is reference to neither young men attending medication reviews prior to the Review period, which resulted in the chemists advising that further prescription would not be dispensed, but this didn't result in either an assessment of their capacity to decide not to attend the reviews or a Safeguarding Referral on the basis of self-neglect if they had capacity or neglect if they didn't. The same applies to Gary's not attending his LDHRs.

5.12.3 The GP Practice's normal means of communication with Gary would appear to be either by letter or text message; the failure to respond to these or to messages left on his voicemail by contacting ASC leads to concerns as to the robustness and effectiveness of the Practice's Did Not Attend procedures, particularly with respect to adults known to have a learning disability.

5.12.4 At no stage did the GP Practice contact ASC about the family, either individually or collectively, for assessments under the NHS and Community Care Act 1990 or, subsequently, the Care Act 2014.

5.12.5 In February 2015, ASC requested support for the family from the CWP Health Facilitation Team and a home visit by the GP. There is no record of either request being met or responded to or of them being chased up by ASC.

5.12.6 There was present in the family home, an oxygen tank for Mum's use. It was not clear to the SAR why this had been provided or who had initially prescribed it. However, as she was registered with them, the GP Practice would have been responsible for monitoring its usage and the on-going need for it. They would also have been responsible for ensuring the safety of the conditions in which it was kept, including arranging the assessment of any fire risk. It is accepted that this responsibility would have been shared with the CCICP, but by not meeting this responsibility, both

agencies missed opportunities to identify and respond to a situation of possible neglect or self-neglect.

5.12.7 In September 2021, responsibility for Gary's case is transferred from CLDT to the Health Facilitation Team "to continue the role due to staff changes" but without a clear statement of what the role was, its focus or what the desired outcomes from their input was.

Issues to be addressed:

- **There was no evidence that either Gary or Phil being routinely invited to medication reviews prior to the Review Period or of their failure to attend during the Review Period led to referrals to ASC, Safeguarding Concerns being raised or their capacity to make health and welfare decisions being assessed.**
- **The normal medium of communication between the GP Practice and Gary was by text or letter**
- **There is no evidence of the GP Practice's Did Not Attend Procedure being implemented despite Gary's lack of response to texts or letters inviting him to make and attend appointments**
- **There is evidence of gaps and lack of clarity in the Health records of contacts and referrals relating to Gary**
- **There is no evidence of any monitoring of Mum's use or on-going need for oxygen at home or of any pre-provision safety checks**

5.13 Good Practice:
Findings: 18, 19, 41, 43, 46, 47, 48, 52 and 53

5.13.1 There is a total of sixty one Findings identified in the Key Events; of these, only four identified just good practice; the remaining fifty seven were linked to examples of practice that were of concern.

5.13.2 For example, it was good practice that Gary's GP Practice invited him for his annual LDHR, but of concern that there was no record of whether he attended or not, what the outcome was if he did or what action was taken if he didn't. It was also of concern that the GP Practice's prime means of communicating with Gary required him to read either a text message or a letter.

5.13.3 When Gary was found after his fall, it was good practice that the Archangel staff responded quickly and overruled his wishes that the NWAS be called; equally it was good practice that the NWAS staff both raised a safeguarding concern with ASC and contacted the Police due to their concerns about the circumstances in which Gary sustained his injury and Dad's lack of response to it.

5.13.4 It was good practice on the part of the GP who attended Phil on the 18th February 2022, on the basis of his assessment that he lacked the necessary capacity, to arrange his transport to hospital and to advise the hospital of the need to ensure he didn't take his own discharge inappropriately. As a result, a DoLS was put in place for Phil.

5.13.5 While there are concerns about some of the practice and procedures identified in the Key Events, what is also apparent from the evidence provided to the SAR is the commitment of staff, particularly but not exclusively, SW1 and LDCN1 to supporting Gary and his family. In this, they were ably assisted by the staff from Archangel, who worked with the family despite their lack of co-operation and sometimes being rude or offensive and maintained appropriate contact during the periods of Lockdown and when the family were in quarantine.

6. Conclusions and Recommendations

6.1 Although the focus of this SAR has been the period between the 1st September 2019 and the 31st May 2022, some of the issues that were major factors in the events leading to Gary's hospitalisation in February 2022 can be seen as originating prior to the Review Period.

6.2 In particular, the process by which Gary moved from Children's to Adult Services set the scene for much of what happened later. Transition Procedures should be initiated in the academic year in which the young person has their 14th birthday; this allows appropriate assessments of the young person's care and support needs to be carried out and planning to take place to put in place appropriate services and for Adult Services, both health and social care, to manage the financial implications of so doing.

6.3 While the Mental Capacity Act 2005 does start to apply to young people after their 16th birthday, it is only fully applied once they are 18 years old; the Transition Procedures therefore need to include a formal assessment of the young person's capacity to make decisions about their health and welfare – care and support – needs and to put in place any appropriate measures via the Court of Protection, such as specific Orders or Deputyships. As well as preparing the young person for life after their 18th birthday, the Transition Procedures also need to prepare their parents/carers.

6.4 Given his health issues in addition to his learning disability, Gary should have had a Hospital Passport agreed, initially with his parents and later

with himself and, if he lacked capacity, the person legally responsible for such decisions.

6.5 It would appear that Gary was not referred into the Transition Procedures at any stage prior to his 18th birthday and appropriate planning and assessments did not take place to ensure his care and support needs were identified and, if appropriate, met as an adult.

Recommendation 1:

That the SAB seek assurance from the Safeguarding Children's Board that the Cheshire West and Chester Transition Procedures have been reviewed and revised as necessary in response to the Issues to be Addressed identified in 5.8 of the Analysis above

Recommendation 2:

That the SAB seek assurance from ASC that the Cheshire West and Chester Transition Procedures have been reviewed and revised as necessary in response to the Issues to be Addressed identified in 5.8 of the Analysis above

6.6 Although any capacitated adult has the right to refuse an assessment under s9 of the Care Act 2014 – other than in specified circumstances – and the right to refuse any services offered as a result of such an assessment, this does not remove the duty on the local authority to continue to offer such an assessment or a review at least annually. The emphasis here is on the "capacitated adult"; at no stage was Dad's right or power to make decisions on behalf of Gary and Phil as to whether or not to receive care and support services questioned. This despite both young men were known to have a learning disability.

6.7 Any assessment completed under s9 of the Care Act 2014 should be holistic and gather information from a wide range of sources, but particularly health and housing colleagues, unless a capacitated adult refuses permission for a named agency or individual to be contacted. There is no evidence of Gary's GP or the family's landlord being invited to contribute to any assessment of the care and support needs of any family member.

6.8 The above points apply equally to assessments competed under s10 of the Care Act 2014 of a carer's support needs.

6.9 The Care Act 2014 requires local authorities to commission independent advocates in specific circumstances; there is no evidence of any

consideration being given to Gary needing an independent advocate despite the numerous examples of Dad not acting in his Best Interests.

6.10 In April 2022, Dad was waiting for an assessment of his care and support needs under s9 of the Care Act 2014; there was no evidence that this had occurred some months later.

Recommendation 3:

That the SAB seek assurance from ASC that its Assessment Policies and Procedures have been reviewed and revised as necessary in response to the Issues to be Addressed identified in 5.9 of the Analysis above

6.11 There had been concerns about the condition of the family home for some time, but no work had been undertaken to identify and address the underlying causes of the hoarding and self-neglect that was apparent. Research has demonstrated the need to identify and address these causes if any lasting impact is to be made on such behaviour; dealing with the presenting issues or symptoms will inevitably result in the behaviour returning.

Recommendation 4:

That the SAB seek assurance that the multi-agency Hoarding and Self-neglect Procedures have been reviewed and revised as necessary in response to the Issues to be Addressed identified in 5.9 of the Analysis above

6.12 There is no record of any formal Hospital Discharge Procedure being implemented when Mum, Gary and Phil were discharged from hospital. This resulted in potentially unsafe discharges as specific safeguarding concerns were not formally identified or addressed prior to their discharge or on their return to the community.

Recommendation 5:

That the SAB seek assurance from ASC and MCHFT that their Hospital Discharge procedures have been reviewed and revised as necessary in response to the Issues to be Addressed identified in 5.9 of the Analysis above

6.13 There were examples of services being provided without any assessment of a family member's care and support needs and therefore without clear desired outcomes from the service. They were also examples of referrals to other agencies without a clear purpose or desired outcome.

Recommendation 6:

That the SAB seek assurance from ASC that its Policies and Procedures for agreeing and commissioning services have been reviewed and revised as necessary in response to the Issues to be Addressed identified in 5.9 of the Analysis above

6.14 A common thread through all the Themes identified in the Analysis is the failure to recognise the implications of the Mental Capacity Act 2005 for Gary and his family.

6.15 Despite both Gary and Phil having a known learning disability and making repeated Unwise Decisions, no assessment, formal or informal, of their capacity was made, with the result that Dad continued to make decisions that he had no legal authority to make. There is no suggestion that he was aware of this, as the implications of the Mental Capacity Act 2005 were never explained to him or any other member of the family.

6.16 While a DoLS was put in place when Phil was admitted to hospital, this never happened at any stage during Gary's admission.

6.17 When the first Professionals/Strategy Meeting was held under the Safeguarding Procedures, the need for Gary to have an advocate should have been apparent and likewise his entitlement to the support of an IMCA, given that Dad could not be considered able to advocate on his behalf.

6.18 While it may be understandable and reasonable that the majority of police officers are not fully conversant with some of the details of the Mental Capacity Act 2005, particularly offences under s44 of the Act, the failure of the Police to recognise that s44 does apply to family members and of learning disability specialists to challenge could lead to any adult with a cognitive disability, be it a learning disability or a dementia, being denied access to the criminal justice system through a lack of legal literacy. It may well be that it would have been decided that there was no public interest in pursuing such a prosecution in this case.

Recommendation 7:

That the SAB seek assurance from all partner agencies, but particularly ASC, that they have reviewed and revised their internal policies and procedures relating to direct service provision as necessary in response to the Issues to be Addressed identified in 5.10 of the Analysis above

Recommendation 8:

That the SAB seek assurance from ASC, the Police and CWP that they have reviewed and revised their staff development programmes as necessary to ensure that operational staff and their managers are legally literate with regard to the Mental Capacity Act 2005 in response to the Issues to be Addressed identified in 5.10 of the Analysis above.

6.19 There were examples during throughout the Review Period of inconsistent usage of terminology with regard to the Safeguarding Procedures and their implementation, including the lack of a clear process for moving from a safeguarding concern to the closure of the Procedures.

6.20 This lack of clarity may partially account for the number of missed opportunities to raise safeguarding concerns about the family, the quality of the triaging and addressing of those concerns that were raised and the lack of feedback to referring agencies or follow up from those agencies when no feedback was received. Some of these missed opportunities etc are historical and might not happen now and the difficulties posed for agencies that have to work with more than one set of multi-agency procedures such as hospitals also needs to be acknowledged.

Recommendation 9:

That the SAB seek assurance from partner agencies that they have reviewed and revised as necessary their internal safeguarding policies, procedures and staff development programmes to ensure that terminology is consistent with the Cheshire West and Chester multi-agency Safeguarding Procedures in response to the Issues to be Addressed identified in 5.11 of the Analysis above

6.21 While Gary was contacted annually by his GP Practice to arrange his LDHRs, this was by letters and texts, mediums of communication that are likely to be inaccessible to someone with a moderate learning disability. When he did not respond, there was no follow-up with Gary, or contact made with ASC either to raise safeguarding concerns to suggest a review of his care and support needs. This also means that Gary did not routinely have his medication reviewed.

6.22 There was a lack of any evidence of the routine monitoring of Mum’s need for or use of the oxygen prescribed for her or of any assessment of the health and safety risks its provision may have raised in a household where there were concerns about hoarding and self-neglect.

Recommendation 10:

That the SAB seek assurance from the Cheshire and Merseyside ICB that GP Practices and specialist health services have reviewed and revised their internal policies and procedures to respond to the Issues to be Addressed identified in 5.12 of the Analysis above

6.23 Despite the Issues to be Addressed that have been identified in this SAR, there was also evidence of high-quality support being provided to Gary and his family and of staff who demonstrated great commitment to doing so. This should be recognised.

Recommendation 11:

That the SAB seek assurance from partner agencies that the relevant staff have their good practice acknowledged as identified in 5.13 of the Analysis above

6.24 There is always a debate to be had between an Interventionist and an Autonomist approach to social and health care provision, particularly to those with a learning disability or another disability that impacts on the adult's capacity. A key component of professional practice for Social Workers and Health colleagues is the requirement to respect an individual's right to make choices and, if necessary, to take the least restrictive option when making decisions on behalf of another when exercising their Duty of Care. To maintain this balance requires high quality professional supervision – not just caseload management – and the opportunity for reflective practice in a safe environment.

6.25 Given the commitment demonstrated by health and social care staff to support and work with Gary and his family, a question has to be asked of the quality of the professional and peer support that was available to them. It should be recognised that the Review Period overlapped with the periods of Lockdown imposed during the Pandemic, and this will have impacted not only on the availability of staff and on their ability to have direct contact with Gary and his family, but also on the practicality of providing high quality and regular professional supervision. However, it can also be argued that Lockdown made the need for such supervision even greater than ever.

Recommendation 12:

That the SAB seek assurance from partner agencies that they, and the services they commission, have reviewed and revised their Supervision Policies and Procedures to ensure staff have access to Reflective Practice both within their line management structure and with multi-agency peers

7. Recommendations:

Recommendation 1:

That the SAB seek assurance from the Safeguarding Children's Board that the Cheshire West and Chester Transition Procedures have been reviewed and revised as necessary in response to the Issues to be Addressed identified in 5.8 of the Analysis above

Recommendation 2:
That the SAB seek assurance from ASC that the Cheshire West and Chester Transition Procedures have been reviewed and revised as necessary in response to the Issues to be Addressed identified in 5.8 of the Analysis above

Recommendation 3:
That the SAB seek assurance from ASC that its Assessment Policies and Procedures have been reviewed and revised as necessary in response to the Issues to be Addressed identified in 5.9 of the Analysis above

Recommendation 4:
That the SAB seek assurance that the multi-agency Hoarding and Self-neglect Procedures have been reviewed and revised as necessary in response to the Issues to be Addressed identified in 5.9 of the Analysis above

Recommendation 5:
That the SAB seek assurance from ASC and MCHFT that their Hospital Discharge procedures have been reviewed and revised as necessary in response to the Issues to be Addressed identified in 5.9 of the Analysis above

Recommendation 6:
That the SAB seek assurance from ASC that its Policies and Procedures for agreeing and commissioning services have been reviewed and revised as necessary in response to the Issues to be Addressed identified in 5.9 of the Analysis above

Recommendation 7:
That the SAB seek assurance from all partner agencies, but particularly ASC, that they have reviewed and revised their internal policies and procedures relating to direct service provision as necessary in response to the Issues to be Addressed identified in 5.10 of the Analysis above

Recommendation 8:
That the SAB seek assurance from ASC, the Police and CWP that they have reviewed and revised their staff development programmes as necessary to ensure that operational staff and their managers are legally literate with regard to the Mental Capacity Act 2005 in response to the Issues to be Addressed identified in 5.10 of the Analysis above

Recommendation 9:
That the SAB seek assurance from partner agencies that they have reviewed and revised as necessary their internal safeguarding policies, procedures and staff development programmes to ensure that terminology is consistent with the Cheshire West and Chester multi-agency Safeguarding Procedures in response to the Issues to be Addressed identified in 5.11 of the Analysis above

Recommendation 10:
That the SAB seek assurance from the Cheshire and Merseyside ICB that GP Practices and specialist health services have reviewed and revised their internal policies and procedures to respond to the Issues to be Addressed identified in 5.12 of the Analysis above

Recommendation 11:
That the SAB seek assurance from partner agencies that the relevant staff have their good practice acknowledged as identified in 5.13 of the Analysis above

Recommendation 12:
That the SAB seek assurance from partner agencies that they, and the services they commission, have reviewed and revised their Supervision Policies and Procedures to ensure staff have access to Reflective Practice both within their line management structure and with multi-agency peers

Appendices

Appendix A

Terms of Reference for Safeguarding Adults Review

SAFEGUARDING ADULTS REVIEW

SAR CASE Gary

TERMS OF REFERENCE

Introduction:

1. The purpose of SAR Case Gary is to:

    a. Establish whether there are lessons to be learnt from the circumstances and the context of Gary and his family about the way in which local professionals and agencies work together to safeguard vulnerable adults.

    b. Review the effectiveness of procedures (both multi-agency and those of individual organisations).

    c. Inform and improve local inter-agency practice.

    d. Improve practice by acting on learning (developing best practice).

    e. Commission an overview report which brings together and analyses the findings of the various reports from agencies to make recommendations for future action.

2. The Safeguarding Adult Review (SCR) Subgroup will consider any lessons learnt by each agency in conjunction with the findings of SAR Case Gary to develop a single inter-agency action plan for implementation. Responsibility for driving through any required process improvements will sit with the chair of the Cheshire West and Chester Safeguarding Adults Board (CWaCSAB).

Terms of Reference for the Safeguarding Adults Review Panel

3. The Panel will comprise of:
    - CWaC Adults Social Care (Jennifer Harrison, Team Manager for Adult Safeguarding Unit)
    - Cheshire and Merseyside Integrated Care Board (Jackie Goodall, Designated Nurse)
    - Cheshire Police (Serious Case Review Team)
    - LSAB Board Manager, Dawn Lewis

Substitutes are acceptable, provided they are of equivalent seniority.

4. The SAR Panel is responsible for:

   a) Ensuring the review is completed within the agreed timescales.

   b) Finalising the Terms of Reference of the Review.

   c) Ensuring that relevant agencies are informed of the requirement to complete an Individual Management Report (IMR) and Chronology.

   d) Quality assuring the IMRs and Chronologies and identifying any need to commission further IMRs or obtain expert legal advice.

   e) The Panel Chair will ensure that the Overview Author has all the completed documents.

   f) Ensuring that each organisation is aware of its own responsibility to implement single agency lessons to be learned, in accordance with their internal quality assurance and governance arrangements, to ensure vulnerable adults are safeguarded.

   g) The Panel will make recommendations to the SAR Subgroup for a multi-agency Action Plan, ensuring that there is no delay in the implementation of actions which will safeguard vulnerable adults.

   h) The Panel will make decisions on if/how to involve any wider family in the review, in particular, Gary's parents and both his siblings.

   i) The Panel will ensure the SAR Quality Markers are followed.

   j) The Overview Report, an Executive Summary and Action Plan will be presented to the CWaCSAB for ratification.

   k) Legal advice, when and if necessary, will be provided by CWaC Legal Services.

Terms of Reference for the Safeguarding Adults Review

Scope

5. The SAR will cover the period 01.09.2019 to 31.05.2022.

6. The SAR will specifically consider the following issues:
   - The impact of Covid-19 and Lockdown on the management of the case

- The implementation of the Mental Capacity Act 2005
- The effectiveness and timeliness of joint working, information-sharing and communication
- The degree to which staff demonstrated “professional curiosity” and challenge?
- The implementation of the Care Act 2014 - in particular, the offering and completing of assessments under s 9 & 10 and the use of Independent Advocacy
- The timeliness and effectiveness of Review processes for adults potentially eligible for services including annual health checks
- The responses to and outcomes of any Safeguarding Concerns raised
- The effectiveness of management supervision structures and processes in the management of the family as a whole

Timetable

7. The SAR will follow the following timetable:

• Initial SAR Panel Meeting to set ToR etc	05/08.22
• Trawl of agencies involved with Gary and his family	19.08.22
• Meeting With IMR Authors	TBC
• Second Panel Meeting	09.09.22
• Third Panel Meeting	08.11.22
• IMR writers to submit revised chronologies and IMRs	02.12.22
• Consideration of IMRs and draft Key Events by SAR Panel	31.03.23
• IMR authors to submit revised IMRs or clarification*	21.04.23
• Panel to consider key events, findings and analysis	15.05.23
• Overview Report Author to submit first draft	18.05.2023
• Consideration of draft Overview Report by SAR Panel	25.05.2023
• Overview Report Author to submit Overview Report and Executive Summary final draft	06.2023
• SAR Panel to agree Overview Report and Executive Summary and write multi-agency Action Plan	08.2023
• Submission of Overview Report, Executive Summary and Action Plan to SCR Subgroup	20.08.2023
• Sign off of the Overview Report, Executive Summary and Action Plan at the CWaCSAB	22.09.2023

*If necessary

Terms of Reference for IMR authors

Individual Management Reports

8. The following agencies have been requested to submit an IMR. Each IMR will include a chronology of the agency’s involvement and brief synopsis of any relevant involvement prior to the Review period:

- *To be completed after trawl of agencies completed*

9. IMRs must be completed by an individual who has had no direct, or line management involvement with this case.

10. Guidance will be provided to IMR writers as required.

11. IMR writers will be asked to focus on the following in the context of 6) above:

    a. Consider what lessons could be learned by your agency and identify any missed opportunities to safeguard the individuals during the time period (include areas of good practice).

    b. Consider the role and purpose of your agency's involvement and how well you shared information.

    c. Consider the effectiveness of the work of your agency with the individuals and any background to engagement – to include how well it worked with the various agencies involved with these individuals.

    d. Consider how well your organisation understood, documented and responded to risks associated with this case.

    e. Consider the quality of your agency's work and the quality of your agency's management of the case.

    f. Establish how well Mental Capacity Act was understood within your agency at each point of contact and whether a Best Interest's decision was considered at any point of contact.

    g. Establish the extent to which your agency adhered to local policies and procedures relevant to this case.

Scope

12. The IMRs will cover the following period: 01.09.2019 to 31.05.2022 with a brief synopsis of any relevant prior involvement.

Timetable

13. IMR writers will observe the following deadlines for the completion of :

    a) Chronologies 31.09.22
    b) IMRs 02.12.22

14. All chronologies and IMRs are to be submitted electronically to the Safeguarding Boards Business Office via secure email by the deadline dates.

Terms of Reference for Overview Author

15. The Overview Author will be asked to focus on the following in the context of 6) above:

    a. What were the lessons learnt by each agency?

    b. Consider the effectiveness of the work of the various agencies involved with both the individuals.

    c. Consider the role and purpose of each agency's involvement and how well the agencies shared information.

    d. Consider the quality of the work of different agencies and the quality of their management of the case.

    e. Establish how well Mental Capacity was understood by the various agencies at each point of contact and whether a Best Interests decision was considered at any point.

    f. Establish the extent to which the involved agencies adhered to local policies and procedures relevant to this case.

    g. Explore the quality of risk assessments and how these were undertaken.

Scope

16. The overview report will cover the following period: 01.09.2019 to 31.05.2022.

Timetable

17. The Overview Report Author will observe the following deadlines:

- Submission of first draft w/c 19.12.22
- Submission of final draft w/c 15.08.2023

18. The Overview Report is to be submitted electronically to the Safeguarding Boards Business Office via secure email by the deadline date.

Appendix B?

Glossary