

# Learning Lessons Review

(Executive Summary)

# Mrs S

Published November 2019

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## Introduction

1. This Lessons Learned Review was commissioned by North Yorkshire’s Safeguarding Adults Board (SAB). The events that triggered the review were summarised in a briefing document and concern:
   1. A number of safeguarding referrals and complaints raised in respect of Mrs S[1](#_bookmark0) since 1 November 2013, both by her daughter[2](#_bookmark1) in relation to her care, and by The [Named], the Care Home in which she resided, in respect of her treatment by her daughter. The daughter had additionally made several complaints.
   2. The daughter’s dissatisfaction with the outcomes of the safeguarding and complaints’ processes that led her to install covert CCTV cameras in Mrs S’s room at the care home. Subsequently, the daughter contacted a number of agencies with footage[3](#_bookmark2) from the camera(s), including the Care Quality Commission (CQC), North Yorkshire County Council (NYCC) and North Yorkshire Police (NYP).
   3. A breakdown in the relationship between the care home and the daughter which created difficulties and tensions in the provision of care to Mrs S and led to the home serving notice on the placement.
   4. An application to the Court of Protection to ascertain whether it was in Mrs S’s best interests to continue to reside and receive care and treatment at The [Named] whilst continuing to maintain a relationship with her daughter.
   5. During an October 2016 safeguarding meeting it became apparent that the friend who had been supporting the daughter over a number of months at multi-agency meetings was a local Councillor, although not the daughter’s or Mrs S’s Councillor. The Councillor made public their lack of confidence in the state of care in care homes and belief that there was a lack of response by agencies to the abuse of vulnerable older people. These actions resulted in an unprecedented escalation within all agencies.
2. It was indicated in the briefing document that the Lessons Learned Review was being undertaken to consider how the safeguarding process and the subsequent escalation of the case was handled, both by the commissioning body, NHS Scarborough and Ryedale Clinical Commissioning Group (CCG), and the safeguarding body, North Yorkshire County Council, and what lessons could be learned to take forward into future cases.
3. The review considered the subsequent and unprecedented escalation of alerts and complaints concerning the home with the County Council, the Clinical Commissioning Group, the Care Quality Commission (CQC), North Yorkshire Police and the media between 1 November 2013 and 1 March 2017.
4. A Learning Lessons Review is a shared way of identifying lessons by considering and reflecting on what happened and asking why. As such it is part of being accountable. In commissioning

1 Mrs S’s two daughters were interviewed during the review and said that they found this acceptable nomenclature for their mother

2 Mrs S has three daughters and a son. This review report refers to the daughter named in the briefing note as daughter 1

3 It is understood as a point of factual accuracy that ‘Daughter 1 contacted the Police with the footage and this was shared by them with CQC and NYCC’

the review the Safeguarding Adults Board prepared terms of reference which show the aspects where they thought it most likely the multi-agency partners could learn. These included: hearing Mrs S’ view, pathways for linking safeguarding with other processes, the use of CCTV, leadership following escalation, arrangements for Councillors to raise concerns and responding to complaints.

1. The review method involved an extensive analysis and summary of documents, a series of written questions to the multi-agency partners about their roles and responsibilities, semi- structured interviews with key stakeholders and a viewing of CCTV footage. The review report addresses each of the nine main terms of reference in turn, then as requested undertakes a consideration and reflection on each and finally it identifies lessons for the Board to deliberate.

## Terms of Reference

1. The Independent Reviewers were asked to ‘consider and reflect’ on the specific areas of enquiry following:

How the safeguarding process was handled, with reference to the Multi-Agency Policy and Procedures in place at the time each safeguarding concern was raised – were policy and procedure followed appropriately by each agency?

1. Were Mrs S’s views heard throughout? Was there an appropriate process in place for ensuring Mrs S’s views were heard, including exercising her rights under the Mental Capacity Act. Was this process followed and was it adequate?
2. Is there a clear pathway in place that links the safeguarding process for individual concerns with other processes and was this followed? To include:
   * Collective Care
   * CQC inspection[4](#_bookmark3)
   * Commissioning and Contracting (both health and local authority)
3. Is there a clear pathway in place for individuals and/or their representatives (family members or advocates) to dispute the outcomes of safeguarding processes? Was this followed?
4. Is there a clear pathway in place for chairs of safeguarding meetings to escalate complex cases within NYCC and with multi-agency partners? Was this followed?
5. Is there a policy/procedure/guidance in place for staff in the use of CCTV by care providers and families as part of the assurance process which includes the rights and consent of those being filmed; appropriate use and storage of footage; who should view? If so, is this in line with relevant legislation and national published guidance?
6. Following escalation of the case – what action was taken by each agency individually and as a multi-agency partnership? Was there clear leadership and response to the situation in managing the following:
   * the care and treatment of Mrs S
   * the family members
   * the Councillor’s actions

4 CQC are the regulator which register and inspect care and nursing homes.

* + assurance about the care provider
  + the multi-agency partnership

1. Is there a clear mechanism for Councillors to raise concerns with North Yorkshire County Council and was this followed in this case?
2. What amendments, if any, should be made to the code of conduct for Councillors?
3. Is there a pathway for responding to complaints whilst safeguarding and other processes are in progress? Was this followed in this case and if no – give reasons?

## Lessons Identified

1. All agencies recognised that some care practice identified on film – most notably moving and handling - was of enough concern to constitute possible physical abuse and resulted, with other concerns about the quality of some care delivery, in a programme of support to the home to improve care to all its residents. However, the overarching lesson hinged on **the want of expertise in working with a tenacious relative rather than about safeguarding an elderly woman with dementia**. There were two elements: (i) it appeared that the daughter had an expectation of the nursing home that was unrealistic

– for example, she sought and expected to receive detailed information about the minutiae of her mother’s day to day experiences – from a staff team responsible for 30 residents; and (ii) her information requirements and perceived behaviour created insurmountable barriers – for example, since the daughter believed that her mother was not eating or drinking enough, she fed her mother with high calorie food and drink which she conveyed to the home. This depressed her mother’s appetite and became the rationale for the daughter to persist in feeding her and challenging staff about nutrition and hydration.

### Homes should set out what prospective residents and their relatives may reasonably expect of care managed in group settings.

1. The complaints policy and procedure of both the local authority and the CCG address the response to “unreasonably persistent complainants”. The Safeguarding Board should draw from these to **adopt a consistent approach to habitual and persistent complainants across health and social care services**.

### The criteria for receiving and closing safeguarding alerts, most particularly repeat alerts, remain to be clarified. Further, how the safeguarding process is distinct from complaints should be made explicit.

1. The daughter exhausted the complaints route when the Local Government Ombudsman determined that her complaints were “out of time.” It also determined that “the Council followed the correct safeguarding procedures when concerns were raised…” Person to person meetings with the daughter to explain procedure, positions and decisions had no placatory effect. **Early on, a shared understanding of the problem between the family and the home might have constrained the emergence of a polarised and damaging position**. The home required access to advice on contractual matters when faced with the insistence of professionals that the resident could not be evicted. Care home providers and commissioners may find it useful to **undertake some joint work on fair**

**contracts, the terms of fair contract cancellation** and separately, on values reflecting Human Rights obligations.

1. **The *Safeguarding Adults West and North Yorkshire and York Multi-Agency Policy and Procedure* (2015) is long and detailed and yet does not address the interfaces** with safeguarding, complaints, commissioning, inspection, contract monitoring or “collective care” **and it does not consider the use of cameras in private spaces**. Although it honours the equal treatment of repeat allegations it does not take account of the persistent and excessive use of more than a single procedure. This created an unreasonable burden on the home and all agencies. For example, the daughter’s conviction that her mother was dehydrated and malnourished was contradicted by clinical tests and the medical judgment of her mother’s GP. The daughter was undeterred by the consistency of repeated medical opinion. **All Safeguarding Board partners should support medical opinion/clinical evidence.** The daughter’s tenacity in revisiting matters which had been considered and addressed was enabled by a want of clarity about which professional or organisation within the Safeguarding Board was to “hold the ring” in terms of problem- solving with the home and in dealing with the daughter’s communications. A proliferation of processes was invoked: safeguarding enquiries, safeguarding case conferences, safeguarding adults risk assessments, “collective care” meetings and safeguarding collective care multi-agency conferences – none of which feature in the *Policy and Procedure.* These processes involved many different professionals and managers with whom the daughter was on first-name terms. The daughter visited seven days a week, watched CCTV footage of her mother’s care during her evenings, and drafted detailed emails and letters citing what she had witnessed and/or viewed to senior managers across agencies. Although she was most exercised by her mother’s physical healthcare (her mother was ultimately fully funded by NHS Continuing Health Care), the **closure of safeguarding alerts and complaints which hinged on the patient’s health should have been advanced by clinical judgment, evidence and progress and led by the CCG rather than safeguarding**.
2. **There must be clarity about** (i) **what constitutes a** “**complex” case**. The mother’s care and support needs were not of themselves complex rather the circumstances in which professionals sought to meet those needs. (ii) **how “active case management” is manifest in the work of health practitioners**; and (iii) **the criteria for closing safeguarding alerts and complaints**.
3. Although immediate certainty and clarity are not always possible, decisions which are crafted through discussion and clinical judgment must be recorded as foundations for subsequent decisions. **A decision log may be a useful means of tracking** the evolution of responses and has an edge over the minutes of multiple meetings.
4. **Care management is the most appropriate vehicle for professional dialogue and engagement.** People making complaints or safeguarding referrals require clarity about processes and the potential outcomes.
5. There is a case for advancing a more muted approach to the continuing generation of safeguarding procedures and refinements since these cannot and should not direct the

discretion of all professionals in all circumstances. **Compliance with the Mental Capacity Act and the Care Act and a basic understanding of the law should be at the heart of professional practice**. The MCA provides for the appointment of IMCAs and among its various duties, the local authority and/or NHS bodies have a duty to appoint an IMCA if placement in a home is in question. If an IMCA is involved in a decision to remain in a home or move to an alternative placement, they should be involved in representing the person in subsequent reviews.

1. **The CCTV footage did not provide the evidence to pursue allegations of “neglect” or “willful neglect.”** It does evidence personal care being undertaken by a single nurse when assessments had determined that there should be two nurses. If the home had not trained the worker concerned or supplied the correct protective clothing, then it would have been in breach of regulations. If this was deliberate and applied across the home, then a charge of neglect may have had traction. Although this was not the case, the resident’s care did evidence a need to improve management and the professional oversight of staff. The extent to which care home staff have a sense of teamwork, can access training opportunities to improve residents’ experiences, are mutually supportive and supported by the manager and owner tend not to be known by commissioners. **North Yorkshire’s commissioners might involve Skills for Care and provider organisations in addressing different responses to the circumstances which are the focus of this review**.
2. Since the resulting “**Collective Care” process** was experienced as punitive by the home, a **re-consideration is merited**. This should involve care providers, residents and the families of residents to ensure that the investment of professional effort is of lasting benefit in terms of improving the quality of care and eradicating poor practice.
3. The scrutiny of practice at the home was wholly disproportionate to the risk of the identified resident being harmed. **The principle of proportionality was given no expression**. The home did not become a better home as a result of the intense scrutiny to which it was subjected.
4. The CCG and the local authority accepted the need to reinforce and enhance care management and quality surveillance practice. **There was a disconnection between a care provider’s quality as determined by the CQC and its performance**. The CQC did not detect poor care in relation to the mother’s care or any other resident until *after* the film footage was revealed. **Regular dialogue between the Safeguarding Board partners including the CQC is merited about safeguarding referrals, most particularly concerning notifications from homes and the lessons arising from North Yorkshire reviews** – not least to develop a working knowledge of their respective remit, powers, investigation and enforcement resources of all agencies, including North Yorkshire Police. The home was suspended from the “Care Homes Provider List” as a result of “ongoing safeguarding concerns…” and its resulting action plan was micro-managed with “meetings about meetings.” Undue deference was paid to the aggrieved daughter and Councillor. **An action plan should bring together the requirements of commissioning, inspection and safeguarding to aid coordination and communication**.
5. The Councillor secured media attention to the case. **The home resident’s nutritional status – confirmed by clinical tests - did not merit the Councillor’s symbolic hunger strike**. There are several mechanisms available to assist Councillors with concerns and advise them of the implications of any actions. Matters relating to the conduct of Councillors are the subject of a code and the circumstances warranted use of these mechanisms. The chief officers involved, including the Council's Monitoring Officer, should utilise the learning from this case to review guidance, induction and training available to Councillors - both generally as well as specifically related to adult safeguarding.
6. The use of cameras in the public spaces of homes is likely to become commonplace and may be helpful in training and supervision, for example. **It is covert filming in private spaces that enters an ethical twilight zone**. Although the daughter’s camera did confirm some poor practice, filming the personal care of people who do not have capacity to consent to such filming should be the subject of best interests’ decision-making. Safeguarding Boards are well-placed to consider law and regulations in preparing local procedures and practical guidance concerning the use of CCTV in care homes and group living settings. This is pertinent to commissioning, contracting and inspection as well as to safeguarding. It should reference matters of consent, choice, rights, privacy and security.

## Conclusions and recommendations

1. The context was a nursing home with a positive regulatory track record and a demanding daughter who visited most days. Her allegations were far reaching and because the home was unable to circumscribe the challenges arising from her perceived behaviour, their impact expanded outwards and upwards for many years. From receiving little assistance, then disproportionate scrutiny through to receiving substantial assistance[5](#_bookmark4) the home was overwhelmed one way or another both by daughter 1’s presence and in dealing with her demands as well as the attentions of agencies. There was no across agency agreement on managing the daughter’s voluminous correspondence. The home’s practice suffered as a result of the cumulative impact of this state of affairs.
2. It is recommended that the circumstances that led to this review form the basis of a strengths- based approach to partnership working - and that the lessons negotiated with North Yorkshire SAB partners serve to highlight the benefits that accrue from setting aside process-driven approaches.

5 The home received direct support to alleviate the pressures including the offer of mediation funded by the CCG, and the CCG additionally paid for an individual to supervise daughter 1’s visits to enable the continued contact between her and her mother. The home was given support by bespoke staff training which the CCG commissioned and monitored focused on improving their record keeping and defensible documentation – this was specifically to assist them in providing better quality records of the care they were providing. The CCG initiated the Best Interests Court proceedings in part because of concern over the impact of the filming on the morale of the staff and of the homes ability to recruit staff. Finally the CCG made regular contact with the care home manager to look at what support could be put in, including a meeting in the CCG offices along with the home owner to look at support through the Court of Protection processes.