Walsall Safeguarding Adults Board

Safeguarding Adults Review

Adult A

Author: Hayley Frame

Updated 21/9/18

1. Introduction

1.1 Criteria

A Local Safeguarding Adults Board (SAB) must undertake reviews of serious cases in specified circumstances. Section 44 of the Care Act 2014 sets out the criteria for a Safeguarding Adults Review (SAR):

An SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—

(a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

(b) condition 1 or 2 is met.

Condition 1 is met if—

(a) the adult has died, and

(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

Condition 2 is met if—

(a) the adult is still alive, and

(b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

An SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to—

(a) identifying the lessons to be learnt from the adult's case, and

(b) applying those lessons to future cases.

2. Decision to hold a Safeguarding Adults Review (SAR)

2.1. Following referral by Walsall Council to the Walsall Safeguarding Adults Board, a decision was made that the criteria for a SAR were met under condition 1 as set out above.

2.2. The circumstances of the referral were that Adult A had died in early 2016. A plastic glove was later found in her stomach. At the time of her death Adult A was placed in a residential care home.

3. Methodology

3.1. The methodology for this SAR has been developed to ensure the learning is gained in an effective and timely way, in line with the Care Act 2014 requirements. Key aspects of the process included:

- Consideration of multi-agency information submitted, including chronologies and individual management review reports.
- The formation of a SAR panel to consider agency information and agree Overview report
- Practitioners, including staff employed by the home, were not spoken to as part of the process due to on-going criminal enquiries.

3.2. Hayley Frame, Independent Author, has been appointed to write the SAR Overview report

4. Time period over which events should be reviewed

4.1. It was agreed that the review would focus upon events occurring from 1st October 2015 (when a whistle blower raised concerns about the residential care home but not in respect of Adult A) until the point of the home closure.

5. Organisations involved in the SAR

5.1. Organisations involved in the SAR were as follows:

- **Placing Local Authority**
- **Walsall CCG**
- **Walsall MBC:** Adult social care (the provision of social work, personal care, protection or social support services to adults in need or at risk, or adults with needs arising from illness, disability, old age or poverty)
  Commissioning (managing the market and development of services to meet demand and gaps in services)
  Procurement (tendering of services and contract compliance)
- **WMAS**
- **West Midlands Police**
- **Care Quality Commission**
- **Walsall Healthcare Trust**

IMR writers were asked to focus on the following questions in respect of Adult A:

a. Consider what lessons could be learned by your agency and identify any missed opportunities to safeguard the individual 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 individual and any background to engagement – to include how well it worked with the various agencies involved with this individual

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

In relation to the wider home, IMR writers were asked to focus on the following questions:

a. Consider the quality of your agency's work and the quality of your agency's care management.

b. Consider the quality and robustness of reviews

c. Consider the quality and robustness of information sharing between agencies

d. Establish the extent to which your agency adhered to local policies and procedures and its effectiveness of assessing quality of care.

6. Involvement of Family Members and Significant Others

6.1. The mother of Adult A was invited to contribute to the SAR. Although she felt unable to meet with the Independent Author due to personal circumstances, she did provide some thoughts via her Family Liaison Officer within the West Midlands Police.

6.2. Adult A's mother stated that Adult A appeared to be happy for the majority of her time at the residential care home, however in her last couple of visits to Adult A she did notice a change in her. She stated that when she came to leave she noticed a look in her eye that she had seen previously whilst Adult A was at a residential premises in another area. She stated that Adult A was not happy when she was in the previous placement.

6.3. With regard to the current placement, Adult A's mother stated that when she raised concerns staff always took action to deal with it, so this was an area she was very happy with. She said that overall she had an excellent service from the residential care home but she had noticed a change in the last 2 years. She felt this was because there was a significant amount of new staff.

6.4. With regard to social work services, Adult A's mother stated that there was no interaction with social care prior to the allocation of the social worker who undertook the more recent FACE review (see below). There was never a social worker at her annual review meeting prior to the allocation of this social worker from the placing Local Authority, of whom Adult A's mother spoke very highly.

7. Parallel Investigations

7.1. An inquest in respect of Adult A has been opened and adjourned. Police enquires are ongoing.

8. Case Summary (author commentary in bold)

The following narrative relates to the home and other residents, as well as the subject of the SAR, Adult A.

8.1. Adult A was placed in a residential care home for adults with learning difficulties. She had been living there for 12 years prior to her death. Adult A was epileptic and received routine monitoring of her health needs. She was known to have learning disabilities combined with Rubenstein-Taybi syndrome[1], autism and epilepsy. Adult A had high levels of care needs, and was unable to complete tasks or self care independently.

8.2. On 7th October 2015, a whistle-blower contacted the Care Quality Commission to raise concerns at the residential care home. It was alleged that a care worker had mistreated two residents (neither of them Adult A), including the use of force and verbal abuse, and that the home manager was aware of this. Walsall MBC Adult Social Care were notified by the Care Quality Commission and Adult Social Care in turn notified the police. The matter proceeded to a section 42 enquiry (Care Act 2014) and initial planning discussion took place. The two residents in question were the responsibility of another local authority and discussions also took place with them.

8.3. The following day the residents within the home were seen by Walsall MBC Adult Social Care and the police. A police investigation commenced and it was requested that the acting home manager and care worker be suspended with immediate effect.

8.4. On 13th October 2015, agreement was sought from the police for Walsall MBC adult social care to complete safe and well visits to the residents. It was also agreed that reviews should take place in respect of the residents. The following day, the Walsall MBC Safeguarding Team Manager asked that a face to face multiagency planning meeting be arranged but this was delayed due to staff availability and could not be held until 5th November 2015.

[1] A condition characterised by short stature, moderate to severe learning difficulties and distinctive facial features

Records indicate that formal, statutory reviews were requested for 3 out of the 6 residents. The reviews completed were completed in a timely way (by 3rd December 2015).

There is no set timeframe for planning meetings being held as the timeliness is determined on a case by case basis by the social work manager with oversight of the safeguarding enquiry. The CQC were not invited to this meeting.

8.5. The CQC suspended the acting home team manager's application to become the registered manager on 3rd November 2015.

8.6. On 5th November 2015, the planning meeting was held. In attendance were representatives from Walsall Council, the placing local authority, the CQC and the police. The CQC decided that there was insufficient evidence to impose a condition on the provider's registration as the risk was being managed due to the staff members suspension and ongoing investigations. It was agreed within the meeting that all residents, regardless of the funding authority, would have weekly safe and well checks undertaken by Walsall MBC staff.

8.7. Adult A's social worker attended the meeting and completed a welfare check at the same time. It was recorded that Adult A appeared settled and was about to have lunch. A review/FACE meeting was scheduled for 7th January 2016 and Adult A's parents were invited.

8.8. Concerns were recorded by Walsall MBC Adult Social Care on 3rd December 2015 following a visit to the home. It was stated that staff were expected to do the cooking and cleaning. It was not clear how these concerns had been addressed. It was recorded by the procurement team that the complex care team would be investigating concerns in respect of staffing levels and rotas. As a result, Commissioners and Care Managers made unannounced visits checking rotas and the level of competency of staff on duty. Additional management and staffing support were provided by Walsall MBC from their In House Services.

It is of concern that the CQC were not notified of these developments.

8.9. A FACE assessments meeting convened by the placing local authority took place for Adult A on 8th January 2016. Her parents were in attendance. No concerns were raised and it was documented that there were risk assessments in place within the home with regard to 'use of electrical items', 'locking items away in cupboards', 'safety at mealtimes' and 'mouthing inappropriate items'. These were due to the risk of Adult A putting inappropriate items in her mouth plus the risk of choking whilst eating.

8.10. On 8th January 2016, an anonymous whistle-blower contacted the CQC. It was reported that one resident was biting another but that no action was being taken by the provider. It was also reported that staff members were providing bedding from

their own homes; that there was insufficient food and poor maintenance and that one staff members was taking alcohol on the premises. The concerns were passed on to Walsall MBC Adult Social Care and the police by the CQC. It was agreed that Walsall MBC Adult Social Care would commence unannounced visits and the CQC were informed of this. A visit was made by Walsall MBC Adult Social Care on the evening of 13th January 2016 by a social worker who reported no concerns.

The visit took place on the fourth working day following the concerns being raised. Whilst there is no agreed standard timeframe for visiting, practice expectations given the seriousness of the allegation would be a visit within 48 hours.

8.11. On 4th February 2016, Adult A was taken by home staff to the GP. She was seen to have a small scabbed wound on her right forearm which had been caused by another resident biting her on 31st January 2016. The GP was satisfied that there were no safeguarding concerns and Adult A's social worker informed her parents of the incident.

There is no evidence of the home having consulted with Adult Social Care or the police regarding Adult A having been bitten by another resident. The CQC were not notified. There is a clear delayed presentation to the GP although the reasons for this are unknown.

8.12. Also on 4th February 2016, the home submitted an incident report and a body map in respect of Adult A to Walsall MBC Adult Social Care. It was recorded by Walsall MBC Adult Social Care that the allocated workers for the perpetrator of the biting had been notified and that his risk assessment had been amended. This was not reflected in the records held by that Local Authority, who stated that there were no records to suggest that the social worker was made aware of the incident and no records to suggest that Adult A's social worker discussed the incident either. There are other records of other incidents on other dates but none on the date in question.

8.13. It was decided by Walsall MBC Adult Social Care not to progress to a section 42 enquiry on the basis that:

- The risk assessment had been amended for the alleged perpetrator
- Home staff had already made a referral to the dentist with regards to the alleged perpetrator and were following this up.
- Adult A had been seen by the GP
- Allocated workers had been made aware, as had Adult A's family

8.14. On 5th February 2016, the police informed the CQC that charges of ill treatment and neglect had been made against the suspended care worker. No charges were brought against the acting home team manager.

8.15. Adult A was seen again by the GP on 8th February 2016, her arm having swollen. It was felt to be a possible reaction and so antihistamines were prescribed.

8.16. A planning meeting was held on 10th February 2016. As the care worker was due to appear in court on 8th March 2016, the police enquiry had been concluded and the safeguarding enquiry was closed. It was agreed that the Walsall MBC commissioning team would engage the provider to monitor their action plan in respect of management and cultural issues within the home. Commissioners were dissatisfied with the content of the action plan.

8.17. On 1st March 2016, it was recorded by Walsall WBC adult social care that unannounced visits were continuing to one resident and there were some concerns which had been discussed with the home manager. The nature of the concerns was not recorded.

The CQC were not made aware of the concerns. It is not clear from the records why safe and well visits were continuing to be undertaken by Walsall MBC adult social care given the safeguarding enquiry had closed.

8.18. On 19th March 2016, the ambulance service was called to the home to attend to Adult A who was in cardiac arrest. Advanced life support was provided however Adult A remained a systolic throughout. She was taken to hospital and declared dead at 4.55am.

8.19. The police were notified and completed a Sudden Death Report which was forwarded to the Coroner. It was decided that the police would investigate Adult A's death on behalf of the Coroner's office.

8.20. Walsall MBC adult social care were not notified of Adult A's death until 22nd March 2016 although the placing authority were notified on the day of her death.

8.21. On 23rd March 2016 it became known that a glove had been found in Adult A's stomach and a forensic post mortem was to take place. It was also established from Adult A's relatives that she was known to put things in her mouth. All new placements were suspended following this development. In the interim it was agreed that a joint visit to the other residents by an advanced practitioner from the Walsall MBC safeguarding team would take place with the police. It was agreed that ongoing safe and well checks would continue rather than moving the other residents out of the home at that stage.

8.22. An urgent meeting was held on 24th March 2016, chaired by the interim head of community care from Walsall MBC and attended by Walsall MBC staff from commissioning, the complex cases team, contract monitoring and learning disabilities services as well as the designated adult safeguarding manager. It was agreed that the contracts monitoring team would suspend the home with immediate effect. Arrangements were made for safe and well checks to be undertaken by the learning disability team plus visits by the Emergency Duty Team over the weekend.

8.23. On both 29th and 30th March 2016, the police contacted the CQC requesting an urgent inspection. On 30th March 2016, the CQC held an urgent internal management review meeting where it was agreed that an urgent comprehensive full ratings inspection would be completed. Given the other agency involvement and unclear details of the issues surrounding the potential criminal investigation given the post mortem findings, the CQC wanted to ascertain what were the current risks to inform inspection planning.

8.24. On 31st March 2016, an unannounced evening visit was completed by commissioning managers (Walsall Council and CCG). The visit raised concerns regarding the nutritional value and balance of weekly food menus, concerns regarding induction, supervision and training levels of staff, generalised risk assessments and behaviour support plans and no communication passports or communication plans for residents. An action plan was agreed. A further visit took place on 1st April 2016.

8.25. On 1st April 2016, the CQC initiated a meeting with the police to gather further information. As a result the CQC had a clearer understanding of the circumstances surrounding Adult A's death and as such an urgent inspection was arranged.

8.26. A comprehensive CQC inspection commenced on 4th April 2016 and concluded on 8th April 2016. As part of the inspection it became apparent that there had been other occasions where the perpetrator of the biting had attempted to harm Adult A but that her worker in the placing authority had not been informed of this. The inspection established 6 breaches of statutory regulations. The provider had not completed statutory notifications of abuse to the CQC.

8.27. Walsall MBC held an urgent meeting with the provider on 5th April 2016 and agreed that they would provide support staff, including learning disabilities managers, to the home before consideration was given to move residents. It was also agreed that Learning Disability Community Nurses would review all of the residents.

8.28. On 13th April 2016, the CQC held an internal management review meeting chaired by a Head of Inspection. This meeting was to discuss the home and agree the most appropriate level of enforcement action. A Notice of Proposal to cancel registration was agreed and thisdecision was subsequently discussed and agreed with the Deputy Chief Inspector of the CQC on 15th April 2016.

8.29. Also on 13th April 2016, a section 42 enquiry commenced as the perpetrator of the biting had bitten another resident. On 15th April 2016, the CQC were informed that a resident identified as being at risk during the inspection had fallen and suffered a fracture. The provider on this occasion did inform the CQC via statutory notification. This notification stated that the Local Authority had been made aware. The CQC discussed the injury with the provider to establish the circumstances of what had happened.

8.30. On 19th April 2016, the police informed the CQC of concerns that a resident at a sister home was believed to have toe nails that had grown so long that they had become infected. Walsall MBC adult social care were informed and the resident had a fungal nail infection. No further action was taken by Walsall MBC. At this stage the CQC were drafting legal notices in respect of the home.

8.31. Concerns also came to light that day regarding the perpetrator of the biting, who was shredding his bedding and may wrap this around his neck. The provider confirmed that the risk had not been managed but that he would address this immediately. The same assurances were given by the provider to the CQC.

8.32. The next day a whistle-blower contacted the CQC to state that residents were at risk of harm. The CQC, who were initiating enforcement action, passed this information on to both the police and Walsall MBC.

8.33. On 20th April 2016, staff from the placing authority visited the home and shared concerns with Walsall MBC about staffing levels and one resident being observed to eat dandelions in the garden. These concerns were shared with the CQC.

8.34. An urgent meeting was called by Walsall MBC on 21st April 2016. In attendance were the CQC as well as the management team that Walsall MBC had put into the home. They reported that they did not feel that the provider was taking on board the advice being provided to them. It was discussed how residents may be at increasing risk of harm and that measures put in place to manage the risk were not having the required effect. The CQC became increasingly concerned listening to the feedback from managers at the meeting and stated that they may need to consider taking more urgent enforcement action. An explanation of what this might be was given at the meeting so that all agencies were aware of the potential actiosn the CQC would consider.

8.35. On 22nd April 2016, it was agreed by the Executive Director of Adult Social Care for Walsall MBC that open communication would take place with all service users and their relatives about the current concerns and that social work assessments would commence to inform and enable the provision of alternative care should this be required. Also on 22nd April 2016, the CQC sought assurance from the provider that there was sufficient number of staff to keep residents safe over the coming weekend and also engaged with Walsall MBC to ascertain whether weekend checks could be undertaken. The provider owner informed the CQC that he intended to close the home due to financial viability and questioned whether emergency closure may be an option as they were not certain that they could keep the residents safe. A face to face planning meeting was agreed for 25th April 2016.

8.36. As the provider could not provide assurance regarding resident's safety it was agreed on 22nd April 2016 with both Walsall MBC and the placing authority that safe and well checks would take place over that weekend. The police also shared with the CQC that day that a review of CCTV footage indicated that staff were sleeping

on sofas during night shifts. An anonymous whistle blower also contacted CQC that day to share that Adult A was known to put things in her mouth; that night staff are known to lie on the sofa with the lights out and that emergency services were not called promptly to Adult A. The CQC passed this information onto both the police and Walsall MBC.

It is evident that the concerns were escalating by this stage and that residents were at risk of harm.

8.37. A meeting was held between the CQC and the provider on 25th April 2016. A Letter of Intent to use urgent powers was given to the provider. The provider was asked to submit an urgent action plan within 24 hours and all of the relevant local authorities were asked what support or resources they could offer as well as whether crisis moves were planned.

8.38. A further anonymous call from a whistle blower was received by the CQC on 26th April 3016 alleging that a staff member was being threatening to a resident and withdrawing food and drink in demand for quiet behaviour. They also alleged that a service user was left unclean after becoming distressed whilst a staff member changed them. The information was shared with the Walsall MBC and the police.

8.39. A meeting was held by Walsall MBC by 27th April 2016. It was agreed that the relevant local authorities were unable to provide ongoing support to the provider and as such all residents should be moved to alternative accommodation. A meeting was also convened by the CQC later that day to discuss the rising level of concerns and its consideration of urgent action to remove the provider's registration. The local authorities felt unable to mitigate the risks within the home.

Urgent cancellation of a providers registration requires the CQC to make an application to the magistrates court and, if granted, the order has immediate effect. This then necessitates that residents are supported to find alternative accommodation. Walsall MBC were seeking to move the residents as a matter of urgency but given the complexity of need, this would require a few days to arrange.

8.40. On 28th April 2016, a family meeting was held at the home, which included the providers themselves and representatives from all the relevant local authorities. The families were told that there were plans to move all of the residents and that the CQC were looking to cancel the provider's registration. The family members were reported to have been very upset as they had not been informed by the provider of any concerns. The CQC formalised its decision to take urgent action as the relevant local authorities were able to support crisis moves and all other mitigating options had been exhausted.

8.41. On 29th April 2016, a further CQC internal meeting was held, it was agreed that an attempt should be made to have the case heard that day. A hearing was confirmed for 2pm that day. The provider's registration was cancelled by an urgent

order made in the Walsall Magistrates Court. By that evening, all residents had been moved by the relevant local authorities to new providers.

9. Analysis

9.1. It is evident from this review that there were no significant safeguarding concerns in respect of Adult A arising from her contacts with agencies. During the scoping period, Adult A had two attendances at the Emergency Department as well as contact with the hospital's Epilepsy Nurse Specialist. These contacts did not raise any safeguarding concerns.

9.2. During the scoping period, Adult A was seen on 4 occasions by a GP and there were 5 telephone conversations to the surgery by the home manager or carers. Carers were present when Adult A was seen by the GP. An annual health action plan was completed in November 2015. No significant events were noted within GP records that would have required multiagency involvement.

9.3. Staff from the placing authority were regularly present in the home throughout the period of the review predominantly due to concerns being raised about the quality of care but not in respect of concerns in relation to Adult A. There is however no evidence to suggest that the concerns about the quality of care were considered in terms of impact upon the quality of care provided to Adult A. That said, Adult A's family were reported to be regular visitors and no concerns were recorded in the agency records from her parents or any other professional regarding the care she was receiving.

9.4. The FACE overview assessment completed in respect of Adult A by her social worker is detailed and thorough in identifying Adult A's needs. It is recorded within the assessment that there were risk assessments in place that were checked and updated yearly within the home to maximize her safety and reduce the risk of Adult A putting inappropriate items or products into her mouth. It is not clear however whether the effectiveness of these risk assessments was scrutinised. Following Adult A's death, risk assessments completed within the home were found to be poor; in that they were generalised and lacked personalisation. In the absence of contribution from the home to this SAR, evidence suggests that risk assessments and plans were completed for procedural compliance as opposed to a robust tool to ensuring that the residents needs were met. Concerns were also noted regarding the inexperience and lack of training of staff employed within the home however the homes' safer recruitment and training policies have not been available as part of this SAR.

9.5. The Acute Learning Disabilities Liaison Nurse did not have contact with Adult A due to her brief admissions to hospital. Had they have done this might have initiated some communication with Adult A and her carers in relation to the development of a Hospital Passport, which might have highlighted further the swallowing risk. The Walsall Healthcare NHS trust Promoting Access to Mainstream Health Services team have been working with care providers for adults with learning disabilities to promote the completion and use of the hospital passport.

9.6. Walsall MBC Adult Social Care had funding responsibility for 2 residents (neither of which was Adult A). The other residents were funded by another local authority. One area of concern arising from this SAR is that of recording in that information is stored on an individual's record as there is not a central place to store information and/or minutes of meetings held regarding a provider. In this specific case, meetings held were also not clearly recorded within case notes, and although there is evidence of email correspondence to indicate management oversight and interagency communication, this is not recorded in case files. Work is currently being completed so that concerns regarding a provider can be recorded and that safeguarding enquires regarding an individual resident there can be linked to the provider record. In addition, work is being undertaken regarding the recording of quality concerns that do not reach a safeguarding threshold or contractual breach.

9.7. A significant finding of this SAR is that the Walsall multiagency safeguarding policy and procedures do not clearly address concerns in relation to homes and how these are managed. There is a need for a clear threshold and process, including timescales, for when to progress to a 'whole home' investigation. A whole home procedure is now being developed within Walsall MBC.

9.8. Service provision and structures within Walsall MBC now have a locality based approach where each locality has a responsibility for the services in their area. It is anticipated that this will provide a consistent approach and enable provider concerns to be addressed promptly. Where a whole home concern does arise the Locality will respond and coordinate. In addition, all concerns reported to Walsall MBC regarding a home are now screened by the Adult Social Care Access Team within 48 hours of receipt.

9.9. As the home is outside of the area, Adult A's placing local authority do not employ quality monitoring as this is the responsibility of Walsall MBC. This poses the question as to how a placing authority secures intelligence in relation to services that are commissioned outside of their area. It would appear that there is a need for an explicit agreement between placing and hosting authorities regarding arrangements for quality monitoring.

9.10. Procurement and commissioning activity should support the safeguarding process for example by implementing timely contract compliance and default measures and sanctions subject to the timely receipt of intelligence information. The Walsall MBC Quality Assurance Team has been disbanded, meaning that Walsall MBC provides a very limited preventative quality monitoring function of placements.

9.11. Within Walsall MBC Adult Social Care, individual annual review of residents now have a focus upon the quality of care provided. The quality, appropriateness and implementation of plans within a home should form part of this annual review process. The SAR panel are encouraged by this development.

9.12. It is of note that there are quality monitoring processes in place for nursing homes (CCG led), older people's homes (Local Authority led) but not for complex care homes such as that where Adult A was placed. This is a significant gap.

9.13. A Provider Quality Assurance process is clearly required rather than a reactive approach as had been evidenced within this case. In addition the commissioning process needs to be more robust in terms of provider submissions in relation to staff competency and skill sets. However the current position is that as all regulated provider services are required to be CQC registered to be able to operate, Walsall MBC have made the decision to rely upon the checks undertaken by the CQC with regard to staff competency prior to the provider becoming registered. There is however an inherent risk in relying upon this given the information obtained by the CQC is not dynamic enough to appreciate changes in circumstances. In addition, the information gathered by the CQC at registration would not offer assurance as to staff competency as it is unlikely at that stage that the provider would have employed staff or started to deliver the regulated activity.

9.14. With regard to the Care Quality Commission, the inspections were carried out in line with CQC methodology, policies and procedures. As the national regulator, the CQC do not lead on safeguarding investigations and as such information pertaining to individuals was shared with the local authority and the police, as the responsible investigating authorities. .

9.15. An area of exploration within this SAR is with regard to the timeliness and urgency of CQC enforcement action. New multiagency guidance has been issued in 2016 'Managing care homes closures' which includes guidance for urgent closures.

9.16. Some areas of good practice have been identified including proactive information sharing between the police, CQC and funding authorities, as well as escalation to senior managers. Information sharing meetings are being held bi monthly between Walsall MBC and the CQC and terms of reference have been agreed since Adult A's death (although not as a result of her death).

9.17. It is also important to note examples of individual practitioner good practice for individual residents. Social workers were working within their roles and responsibilities however what was clearly lacking was a strategic overview of the concerns regarding the home.

10. Conclusions and Recommendations

10.1. Due to the ongoing criminal enquiries it has not been possible to include the provider, its management and it's staff within this SAR. This has been a gap within this SAR as staff and management perceptions about the home generally and specifically in relation to Adult A have not been ascertained plus the home's policies and procedures have not been examined. This has meant that the robustness of the risk assessments in place to safeguard Adult A also cannot be examined. It is known that there were no significant concerns in respect of Adult A and her placement with the provider.

10.2. There were however a number of significant and escalating concerns in respect of the home, known to the CQC, both local authorities and the police. These were responded to reactively, and ultimately the home was closed and the residents moved.

10.3. The procedure for and coordination of this 'whole home' investigation process, including timescales for action, recording practices, and agreed roles and responsibilities across the relevant agencies is an area of work that requires development and forms the major recommendation from this SAR and it is encouraging that work is already underway. The WSAB will require assurance of the progression of this work and the procedure will need to be presented to WASB upon completion.

Recommendations

a) WSAB to be given assurance by Walsall MBC adult social care regarding the completion of the whole home investigation process

b) Consideration be given to a regional protocol regarding responsibility for quality monitoring of homes where residents are placed from outside of the host authority.

c) Walsall MBC to consider when commissioning a placement out of area that arrangements for quality monitoring is agreed with the host authority.

d) WSAB to seek assurance on performance regarding duties for the provision of statutory reviews within Adult Social Care.

e) e) WSAB to seek assurance from Health and Social Care commissioners, regarding the quality monitoring of Learning Disabilities facilities.

.