Safeguarding Adult Assurance Review

Overview Report: Adult S

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Date: August 2022

Publication Date:
24th April 2023

lancashire safeguarding adults board

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1. Introduction

1.1 Adult S died on 24th November 2019 from bronchopneumonia due to or as a consequence of immobility, epilepsy, and longstanding brain injury whilst a resident in a care home (care home 2). Adult S had a diagnosis of brain damage, epilepsy, curvature of the spine and aspiration pneumonia. Adult S suffered brain damage following him receiving an immunisation injection when he was 10 weeks old. Adult S had been placed in care home 2 since 12th August 2019. Prior to this had resided at another care home (care home 1) between 21st December 2011 and 12th August 2019. Adult S was 51 years old when he died. Care home 2 was outside of the Lancashire area.

1.2 At age 4 ½ , Adult S' home became one of the Children's Wards at Calderstones Hospital in Lancashire. At the time, this was an institution for children with severe disabilities where he was a patient from September 1973 until April 1983 (when Adult S was 14 years old) when he went to reside with one of the staff nurses, Mr A together with another child from the ward (Person of Interest 1). Adult S resided with Mr A and Person of Interest 1 for 28 years until he moved to care home 1 on 21st December 2011.

1.3 In 2007 around the time of his retirement from the NHS, Mr A contacted Shared Lives, a service which matches adults with learning disabilities, physical disabilities, older people and/or mental health needs with carers and their families, to live within their home. This is not to be confused with the Shared Living Scheme which is referred to later in the review. When the review refers to the service that was involved in Adult S from 2007, the name Shared Lives will be used. When the review is referring to the scheme which Mr A cared for Person of Interest 1 and Adult S from 1983 until 2007 as a health employee, the name Shared Living Scheme will be used.

1.4 Shared Lives commenced an assessment of Mr A to become a Shared Lives Carer in 2007. This assessment concluded in 2008 and recommended that Mr A become a Shared Lives Carer for Adult S and Person of Interest 1. In March 2011, respite carers caring for Adult S and Person of Interest 1 when Mr A was on holiday raised safeguarding concerns in respect of home conditions, neglect and financial abuse. During discussions which took place, Mr A decided that he wished to care for Person of Interest 1 only and that he was struggling to manage both adults. Adult S moved to care home 1 in December 2011 and a best interest decision was made that Person of Interest 1 would remain in the care of Mr A. To date, Person of Interest 1 remains in the care of Mr A.

1.5 Lancashire Safeguarding Adult Board agreed to carry out a Safeguarding Adult Review (SAR) following discussions with the HM Senior Coroner in the area where Adult S died. During the coronial investigation, Adult S' family raised concerns as to the care that was provided to Adult S by Mr A including financial abuse and neglect. HM Senior Coroner investigating Adult S' death raised questions as to how Adult S had come to live with Mr A and Person of Interest 1. Concerns were also raised regarding the placement of children following the resettlement of children from the Children's Wards at Calderstones Hospital in 1976. Following these discussions, the Lancashire Safeguarding Adult Board agreed that the identified concerns warranted a Safeguarding Adult Review in relation to Adult S under the Care Act 2014.

1.6 A Learning Disabilities Mortality Review (LeDer Review) was carried out following Adult S' death.

1.7 Under Section 44 of the Care Act 2014, Safeguarding Adult Boards are responsible for Safeguarding Adult Reviews in the following circumstances where somebody has died and where the Safeguarding Adult Board knows or suspects that the death resulted from abuse or neglect. In those circumstances, Safeguarding Adult Boards are responsible for Safeguarding Adult Reviews where there is reasonable cause for concern about how the Safeguarding Adult Board, its members or some other person with relevant functions involved in the case worked together.

1.8 The Safeguarding Adult Board may also arrange for there to be a review of other cases involving an adult in its area with needs for care and support.

1.9 The purpose of Safeguarding Adult Reviews described in the statutory guidance is to enable effective learning and improvement action to prevent future deaths or serious harm occurring again. The aim is that lessons can be learned from the case and for those lessons to be applied to future cases to reduce the likelihood of similar harm re-occurring.

1.10 The Board of the Lancashire Safeguarding Adult Board established a case review panel (the Panel) to oversee the Safeguarding Adult Review. Membership of the Panel is shown at Annex A. Stephen Ashley, the Chair of the LSAP Board (the Chair) chaired the Panel established to oversee the Safeguarding Adult Review. Louise Rae was appointed as the Independent Reviewer for the Safeguarding Adult Review (the Reviewer). She has no connection to any agency in Lancashire.

1.11 The Panel will critically appraise and quality assure the review prior to its submission to the safeguarding board for ratification and publication. After the review is shared with the family, the Reviewer and Chair will offer to meet with the family to discuss the report and the learning recommendations made.

1.12 Lancashire Safeguarding Adult Board wishes to express sincere condolences to the family of Adult S.

2. Terms of Reference

2.1 The timeframe of the review is from 1983 when Adult S left Calderstones Hospital until the date of Adult S' death. It is acknowledged that this is an unusually wide timeframe for a Safeguarding Adult Review but this timeframe was considered appropriate given the concerns raised and the need to understand Adult S' journey and lived experiences since leaving Calderstones Hospital in 1983. Any significant incident which occurred prior to, or following this timeline will also be included.

2.2 Key time-periods were identified during the review process. These are periods which are deemed to be central to understanding of Adult S' journey and the care provided to him. These time-periods do not form a complete history but they were recognised as being important periods for the review to focus upon. Professionals at the panel meetings explored the following key time-periods with the Chair and the Reviewer:

Key Time-Period	Description
1983	Adult S' discharge from Calderstones Hospital and placement with Mr A
1983 – 2011	Adult S' placement with Mr A
2011	The response of agencies to safeguarding concerns raised

2.2 Person of Interest 1 and Mr A were identified as relevant persons for the purpose of the Safeguarding Adult Review of Adult S.

2.3 The terms of reference for the review were agreed as:

1. Examination of the circumstances and process around Adult S moving to care within the community following the closure of the Children's Ward at Calderstones Hospital.

2. Consideration of whether there are other vulnerable adults who, following the closure of the Children's Ward at Calderstones Hospital moved to receive care within the community.

3. Comparison of practices and procedures that were in place at the time of Adult S moving into the community with current best safeguarding practice.

4. Consideration of how appropriate the care given to Adult S was following his discharge from Calderstones Hospital.

5. Consideration of the effectiveness of safeguarding practices during the period Adult S was cared for in the community.

3. Methodology

3.1 The review used a combined method of the traditional review model together with elements of the Welsh concise model[1]. Whilst the Welsh concise model focuses on recent practice, in order to adhere to the terms of reference, it was necessary for the review to encompass a wide timeframe. Therefore, the review was extended past recent events to encompass the time from when Adult S left Calderstones Hospital to the date of his death.

3.2 It was difficult to adopt an entirely Welsh concise model in this review given that the timeframe covered 28 years. Elements of the Welsh concise model such as the use of timelines and chronologies completed by agencies were insufficient in this case given the lack of records and information available of Adult S' early years. Whilst ordinarily a Welsh concise model would place strong emphasis on the engagement of Safeguarding Adult Review practitioners and managers by way of a Learning Event, it was determined that a Learning Event would not be held in this case due to the historical nature of parts of the review.

[1] Bright C (2015) Review of the implementation of the Child Practice Review Framework. Welsh Government Social Research

3.3 Panel Members completed timelines and chronologies, which described and analysed relevant contacts with Adult S, Person of Interest 1 and Mr A. The Reviewer analysed the chronologies and identified issues to explore with the Safeguarding Adult Review Panel. The Reviewer also considered available health, adult social care and partner agency records alongside the timelines/chronologies provided.

3.4 In addition, the Reviewer held telephone interviews with past members of staff from the Children's Ward at Calderstones Hospital and the retired Manager of Community Services of Burnley, Pendle and Rossendale Health Authority. Both of these staff members retired over 15 years ago. The Reviewer would like to thank them for sharing their memories of Adult S and Person of Interest 1 and their experience of the service provision that was provided to Adult S and Person of Interest 1. Their contributions were invaluable to the review process given the lack of heath records available in Adult S and Person of Interest 1's journey.

3.5 The Reviewer interviewed Mr A and met Person of Interest 1 by way of a video meeting.

3.6 The Coroner's Court investigating Adult S' death assisted the review by providing copies of statements and reports obtained as part of the coronial investigation.

3.7 Family involvement in a Safeguarding Adult Review is an important part of the review process. Family members of Adult S were notified of the review by the Lancashire Safeguarding Adult Board and invited to participate. Adult S' mother, father and sister met with the Reviewer and participated in the review process. They provided their views of the care provided to Adult S and shared their memories of Adult S' journey during their meeting with the Reviewer.

4. Contribution of Adult S' Family

4.1 Adult S' family contributed to the review. His mother, father and sister met with the Reviewer at their home. The family said that Adult S was a happy baby and that when he was 10 weeks old he received a vaccination, which caused him to fit and have a very high temperature. Adult S was diagnosed with brain damage and he did not develop the way that other children did. Adult S' mother said that the doctors told the family that Adult S should go to live at Calderstones Hospital. Adult S remaining at home was not an option in those days and there was no support available for children with severe disabilities, and complex health needs to be cared for at home. Adult S' father recalled how doctors told the family that they should get on with their lives when Adult S went to live at Calderstones Hospital. Adult S moved to Calderstones Hospital when he was 4 years old.

4.2 The family said that Calderstones Hospital was not a local hospital to Adult S' family. There was no local provision that specialised in the care of children with disabilities and complex needs. Adult S moved some distance away from his home in the Oldham area of Manchester and it was his parents recalled a long way for them to travel to see him at Calderstones. That being said, they regularly made the journey to see Adult S at weekends.

4.3 The Children's Ward at Calderstones Hospital closed when Adult S had been there for some time although they could not remember the year. Adult S' parents recalled being told that Adult S would be moving to live with Mr A and that they thought this was best for Adult S as he would be cared for by a specialist nurse who knew him. The family's recollection was that Mr A put himself forward to care for Adult S. They did not recall meeting Mr A at the hospital or being involved in the decision making process as to where Adult S would be moving to. More recently, Adult S' mother has become aware of a passport of money that the Health Authority were given to relocate the children living at Calderstones Hospital. She asked why Adult S was not moved back to be nearer to his family in Manchester as she understands some other children were.

4.4 At the time that Adult S went to live with Mr A with Person of Interest 1, he could walk, feed himself and drink independently. He was non-communicative and could not understand what was being said to him. He exhibited behaviours such as rocking and biting his fingers. Adult S' mother did not recall Burnley College being involved with Adult S and said that Adult S did not go to college or other places such as day centres. The family remembered Rebecca (a pseudonym) who was employed as a Nursing Assistant to assist Mr A in caring for the boys and that she gave Mr A respite, but that she had retired some years ago.

4.5 The boys moved into Mr A's house which the family recalled having steep stairs. It was a terraced house and the family said that it was not suitable for the boys as it had only two bedrooms. They said that they visited once per month and that at the time they did not think that it was too small for the boys. They said that the boys shared a bed and that they should not have done. The family did not raise this with any service or agency at the time.

4.6 Thereafter, the family recalled Mr A moving to a lovely bungalow, which was more suitable for the boys' needs. The bungalow had three bedrooms and Adult S had his own bedroom in this property. The family said that they noticed the curvature in Adult S' back after Mr A and Adult S moved to this property. The family recalled that it became increasingly difficult to visit Adult S, that the phone was often not answered and that Mr A did not ring them back. Mr A was spending more time in Manchester and they would visit Adult S at a hotel in central Manchester.

4.7 The family's concerns begin around this time, although they were unable to recall specific dates or years. They said that they visited Adult S in the hotel room where they believe he was being left for long periods, sat in a chair, by a window. They don't believe that this was in Adult S' interests to visit Manchester and described how Mr A would tell them that they had been to the Christmas Markets in Manchester but they struggled to understand how Mr A could have managed Person of Interest 1 in a wheelchair and Adult S on his own. The family also recalled how there was a large round bed in the hotel room but that the boys did not appear to have a bed of their own in the hotel. The family were also concerned that Adult S was being taken to restaurants for steaks but that neither Adult S nor Person of Interest 1 could have eaten this type of food. The family said that they did not raise their concerns with any agency or service

4.8 Mr A purchased a flat in Manchester where the family visited Adult S on two occasions in 2010. They were told that Adult S was going swimming in the pool on the rooftop but don't believe that the pool had a hoist which Adult S would have needed to get into the pool.

4.9 The family believe that Adult S' curvature of his spine developed due to the care that he was given by Mr A. Specifically the family believe that Adult S was left for long periods sitting in the same position and that Mr A did not have specialist equipment for him. They said that Adult S was provided with a specialist chair in his care home and the family recall that when he left Mr A's care, he arrived at his first care home in a wheelchair that was too small for him. They believe that Adult S' muscles decreased due to the care that he was provided in his placement with Mr A. Adult S was not able to feed himself when the family visited the hotel in Manchester but had been able to when he was younger.

4.10 Adult S' mother said that she believed that Adult S had been sexually abused whilst in the care of Mr A. Adult S' sister was surprised when her mother said this as this was not a view that she held. The family have not raised any sexual abuse allegations to any other agency at any point either prior to or after Adult S' death.

4.11 The family had concerns that Adult S had suffered financial abuse whilst in the care of Mr A. They allege that Adult S' money was used to fund Mr A's lifestyle including visiting hotels and restaurants in Manchester and to take a trip to Gleneagles Hotel in Scotland. Adult S' mother said that she had obtained the receipt from the trip and that the penthouse on the top floor had been booked which wouldn't have accommodated wheelchairs. Despite being told by Mr A that he had taken Adult S and Person of Interest 1 to Gleneagles, Adult S' parents do not believe that he went on this trip and allege that Adult S' money was used to fund this trip. They said that the trip included activities such as 4 x 4 driving and shooting which Adult S could not have taken part in.

4.12 Adult S received compensation for suffering brain damage from the vaccination he was given. The family were not aware at the time that the money had been claimed on Adult S' behalf by Mr A. This money was held in a trust fund and managed by a solicitor . The family allege that the solicitor was a friend of Mr A and that this fund was not managed in Adult S interests with Mr A being allowed to draw down money for his own use. Adult S' money whilst living with Mr A was not audited and Adult S's mother said that when she telephoned the offices of the solicitor who managed the fund, she was told by the firm that they had no records for Adult S' fund. In comparison, Adult S' mother said that Adult S' finances were regularly audited at the care homes he resided in after leaving Mr A's care and that records were kept when the care homes spent money from Adult S' fund.

4.13 The family were happy with the care given to Adult S after he moved into care home 1 in December 2011 and then to care home 2 in August 2019, when care home 1 closed.

5. Analysis and Learning Points

5.1 The terms of reference to be addressed by this Safeguarding Adult Review are set out at 2.4 above. The family raised two specific questions for the review. They wanted to know why Adult S' finances were not the subject of auditing during his placement with Mr A as it had been at his subsequent care homes and why Adult S was not moved closer to Manchester when the Children's Ward at Calderstones Hospital closed.

5.2 In this section of the report, the learning themes emerging from the review will be explored. Each learning theme will address one or more of the terms of reference as well as the answering the questions asked by the family.

5.2.1 *The circumstances and process around Adult S moving to care within the community following the closure of the Children's Ward at Calderstones Hospital.*

5.2.1.1 A retired Director of Nursing from the Children's Ward of Calderstones Hospital assisted the review with this term of reference. Calderstones Hospital was described as a typical learning disability institution which cared for men, women and children. In the late 1960s the government's view and approach was that children shouldn't be in long stay hospitals and that they should be looked after by their own families or in the community. The catchment area of Calderstones Hospital was large with 19 districts sending children to Calderstones Hospital for specialised care. Calderstones Hospital had 5 or 6 children's wards that were transitioning into smaller wards to improve the quality of life for the children. In the early 1970s there were around 100 children who were patients at Calderstones Hospital. Adult S and Person of Interest 1 were living with 16-18 other children in a single large ward.

5.2.1.2 The decision was made that the Children's Wards would close and a resettlement programme was designed and implemented. Funding was provided from the government for core funding with the expectation that Local Authorities and local health services would add to it. This was a type of dowry system and Adult S' mother had referred to it as a passport but this was one and the same.

5.2.1.3 The retired Director of Nursing who assisted the review wrote a document titled 'A Model District Service'[2] in response to the Department of Health requesting assistance in developing the strategy for working in the community with persons with learning disabilities.

5.2.1.4 During this time of planning to resettle the children, people put forward ideas for how the children could be cared for in the community. One of Mr A's ideas was that he would take his ward out into the community with the money provided by the government and use a converted house in Burnley to care for the children. This idea was not developed and discussions about care in the community stalled. The Director of Nursing at Calderstones suggested that rather than one building be used to house a ward, it would work if there were several houses. The resettlement programme became Burnley Community Service initiated by Calderstones Hospital and run and led by the Burnley, Rossendale and Pendle Health Authority (who then became an NHS Trust) in partnership with Adult Social Services.

5.2.1.5 Adult S and Person of Interest 1 were part of this resettlement programme. Mr A was described by the senior strategic lead as being *'inspirational in care and lovely with children but not much of a manager of large resources*.' Mr A wanted to set up a shared living arrangement which was described to

[2] A Model District Service (1983) 'A Model District Service' | Policy | Lancashire Learning Disability Institutions (lancslearningdisabilityinstitutions.org.uk)

the review as a unique approach to community care that was not a group home. The idea behind shared living was that staff move in with other people and live and care for them with a rota for relief. The Shared Living Scheme that was set up for Person of Interest 1 and Adult S was modelled on LARSH (a national movement to encourage people to live with someone with a learning disability) and Person of Interest 1 and Adult S went to live with Mr A in a Shared Living Scheme.

5.2.1.6 Adult S and Person of Interest 1 went to live with Mr A in his house in Burnley in April 1983. Mr A remained paid by the Health Authority to look after Adult S and Person of Interest 1 as a nurse. The Shared Living Scheme was supported by a nursing assistant, Rebecca who was employed full time and worked two long shifts each week to help Mr A care for Adult S and Person of Interest 1. Rebecca also provided respite care when Mr A had time off.

5.2.1.7 During the initial years, the scheme attracted a lot of attention both nationally and internationally. In 1994, a researcher wrote a paper on the scheme which details interviews with staff, friends and family. The paper which was written some 10 years after Adult S and Person of Interest 1 had moved to live with Mr A described the day to day living arrangements of Person of Interest 1 and Adult S. It also described that the members of the household were a family and this is also how Mr A described the living arrangements to the review.

5.2.1.8 The retired senior strategic lead told the review that parents were involved in the decision making when the resettlement programme was planning for the children's move and that their views were taken into account but could not recall the details of planning meetings. In the absence of any records from Calderstones Hospital it is not possible to say how Adult S' parents were involved in the decision making for Adult S to move into Mr A's home under a Shared Living Scheme.

5.2.1.9 Mr A did not recall meeting Adult S' parents at Calderstones Hospital but suggested that they had perhaps visited the hospital on his weekend off. He described first meeting Adult S' parents at his home after Adult S and Person of Interest 1 had moved to live with him. The researcher in 1994 wrote that the families of Adult S and Person of Interest 1 visited regularly and were very happy with the arrangement.

5.2.2 ***Whether there are other vulnerable adults who, following the closure of the Children's Ward at Calderstones Hospital moved to receive care within the community.***

5.2.2.1 The resettlement programme involved all the children who were well enough to move into the community until the children's wards closed at Calderstones Hospital. The review learnt that many children went into group homes within the Burnley and Rochdale area with the retired senior strategic lead telling the review that each district took its own children back

to their area where possible. The dowry or passport money provided was for the children to be resettled back to the district where they had come from but that there were exceptions. The view of the retired Director of Nursing was that Adult S did not go back to his district because his family had confidence that his needs were being met by the staff at Calderstones Hospital

5.2.2.2 Only Adult S and Person of Interest 1 moved to a home which was modelled on the Shared Living Scheme. The majority of the other children moved into group homes either within the Burnley area or returned to their home districts. Each group home had a team of staff of around six people. Exact numbers are not available but the senior strategic lead who spoke to the review estimated that there were 20 group houses set up in Burnley with some also set up in the Rochdale area. A retired operational manager told the review that what started as a small scheme with two to three houses, a day care centre and respite care homes blossomed to a service employing 400 staff across 45 locations.

5.2.2.3 Mr A told the review that on his ward, there were 29 children with three staff caring for them. He described that nine children from his ward had to live in the hospital with 20 moving to what he described as a commune to be cared for by staff. His recollection was that the commune would have failed if Adult S and Person of Interest 1 had not left because of their behaviours and he had to take them into his home. The description provided by Mr A is at odds with the recollections of the other staff interviewed although the word 'commune' is used in the paper written on the Shared Lives Experience in 1994 when the other group houses were being discussed.

5.2.3 Comparison of practices and procedures that were in place at the time of Adult S moving into the community with current best safeguarding practice

5.2.3.1 The review gathered recollections that regular supervision and training was provided to Mr A and with a system of supervision in place. This included at least monthly supervision by a manager from Community Services and the overall manager who spoke to the review said that he would also attend to see Mr A and Adult S and Person of Interest 1 on at least a monthly basis in addition to formal supervision. Mr A had to attend training and was subject to appraisals. This is in line with Mr A's recollection of the supervision that he received and there is consistency in recollections that Mr A's care of Adult S was formally supervised. The retired manager of Community Services told the review that this was recorded and documented and that there was a lot of paperwork and records that were kept.

5.2.3.2 The managers of Mr A described the Shared Living Scheme to the review as being one which needed 'a light touch.' Whilst the review was told of robust systems of supervision in place including forms to be completed when Adult S fell, which he often did and statutory training of which there was described to be lots of, the review also gathered a sense of more casual approach from the researcher's paper. This described the scheme having a support group rather than management and supervision taking

place but however, it was termed, it was clear that Mr A, Adult S and Person of Interest 1 were regularly seen by managers from Community Services and Calderstones Hospital.

5.2.3.3 Discussions with the retired operational manager revealed that there was a difference of approach between his service and what he described as tension between his service and those who were involved in setting up the scheme. The scheme was set up by Calderstones Hospital with external influence. There were those who thought that any oversight from health was inappropriate and that the scheme should be left to be as natural and normal a home as possible without monitoring and supervision. Indeed the review was told that the level of monitoring in place for the scheme was frowned upon by some involved in it.

5.2.3.4 The retired manager who spoke to the review had managed Community Services having first started working at Calderstones Hospital as a Junior Ward Orderly many years ago and then obtaining the position of Resettlement Officer before becoming an operational service manager. He inherited the Shared Living Scheme which was already operational with a framework in place. He did not agree that the Shared Living Scheme should be given a light touch, as Mr A was a health employee and had responsibilities to comply with.

5.2.3.5 What became clear from discussions was that Community Services had no responsibility for the finances of Adult S or Person of Interest 1. That was left in the control of Mr A by those who had set up the Shared Living Scheme. There was no oversight of finances by Community Services with the retired manager of Community Services being told that this was not within his services' remit. The review was told by the retired manager of the service that he was not comfortable with this as his service had accountability for and managed the overall finances of all of the other vulnerable adults in the group houses but not Adult S and Person of Interest 1 because the Shared Living Scheme was not set up in that way. The finances of the other adults managed by Community Services were audited by the Finance Department at Burnley Hospital but Adult S and Person of Interest 1's finances were not audited. In the period of 1983 to 2007, Adult S and Person of Interest 1's money that they received from their benefits was paid into Mr A's account which Mr A later described as a 'household account'.

5.2.3.6 Community Services were aware that Adult S had received compensation for the brain damage he suffered when he was 10 weeks old but they had no involvement in it because of the way that the scheme was set up. Mr A told the review that he was contacted by the court and told that there was uncollected money for Adult S. He could not tell the review when this was but he organised the trust with a solicitor for Adult S. Adult A denies that any of Adult S' monies were mismanaged and told the review that he would use his own monies for a lot of activities and trips for Adult S and Person of Interest 1 including the trip to Gleneagles in Scotland. Shared Lives have confirmed to the review that Mr A has provided them with documentation to

show that he paid for holidays and trips to Gleneagles in Scotland from his own funds.

5.2.3.7 Managers of Community Services were aware that Mr A was taking Adult S and Person of Interest 1 to a hotel in Manchester for weekends away. It is included in the 1994 researcher's paper. These trips did not form part of the remit for monitoring and supervision and were not something that were enquired about either as to the funding of the trips nor how the practicalities worked and whether the trips met the needs of Adult S and Person of Interest 1. There is reference in the Shared Lives records to Person of Interest 1 and Adult S visiting Manchester in 2008 and that Mr A had reported that they had enjoyed car racing that weekend. The review can find no evidence that there were any concerns about these trips raised however; no curious questioning took place in areas which were marked as not being within the remit of Community Services.

5.2.3.8 It does not appear to the review that in the meetings and monitoring of the scheme that any discussions were held around finances nor did any curious questioning take place as to how finances were managed. Nobody appeared to challenge whether the way that the Shared Living Scheme was set up was appropriate or whether this met best safeguarding practices. As such, there may have been increased opportunity for both financial abuse and/or sub optimal care to be provided due to the lack of oversight of the Shared Living Scheme where Adult S and Person of Interest 1 resided. Mr A, was left in the situation where he was to manage all finances by himself and whilst he was happy to do so, this was not appropriate and left the Scheme open to finance abuse and mismanagement.

5.2.3.9 It is clear that there were many people involved in Adult S and Person of Interest 1's life especially in the early part of the Shared Living Scheme. Mr A described how Adult S would regularly see the GP and have epilepsy reviews (at least every 6 months) and that it was important that Adult S received his medication to control his epileptic seizures. The GP notes are not complete but do show that Adult S was registered and prescribed medication over the years that he was cared for by Mr A. Despite the records being incomplete and with periods missing, the review accepts that Adult S would have required GP input to provide his medication and there is no evidence to suggest that Adult S' seizures were not managed or that they increased in frequency due to noncompliance with medication or not being reviewed by a GP. It is documented within the Shared Lives paperwork that Adult S and Person of Interest 1 had been registered to the same GP for 25 years although the GP did not appear to fully understand the set up for the men to live with Mr A and did not regularly see either Adult S or Person of Interest 1.

5.2.3.10 The review was informed that supervision by Community Services noted Mr A had to be reminded that Adult S had his own needs as well as Person of Interest 1 and that at times Adult S' needs weren't being met particularly with regard to activities around the home. The review was not able to collect any examples of when this had occurred or what the concerns were from any of the people that were spoken to. The retired manager of Community

Services told the review that Adult S was not neglected whilst in his service but that he "could see how things may have started to slip" following the retirement of Rebecca in around 2004 as Mr A was reluctant to have the support staff who were employed to replace her visit.

5.2.3.11 The review notes that Adult S attended a day centre from 1987 until the early 1990s which was arranged through Lancashire County Council although there are no records to indicate that Lancashire County Council were involved in Adult S' during the 1980s and 1990s. Those who spoke to the review confirmed that Adult S did attend a day centre for some time. The 1994 paper details that whether Adult S and Person of Interest 1 attended a day centre was an issue that people had different views on with Mr A not seeing the benefit of this as much as Rebecca did. There were six meetings held regarding whether Adult S should attend a day centre. Who these were attended by and when they took place are not known due to the absence of records but this does indicate that there were review meetings taking place that considered the needs of Adult S and Person of Interest 1 within the early years of their time in the Shared Living Scheme.

5.2.3.12 The review was informed that Adult S and Person of Interest 1 shared a bedroom at Mr A's home before they moved to the adapted larger bungalow, and did not share a bed as suggested by the family. There was also a lift put in place in order that Adult S and Person of Interest 1 could access the upstairs of Mr A's house.

5.2.3.13 The review acknowledges that the systems and processes in place today for adults with the types of disabilities that Adult S had is very different to what was in place for Adult S when he resided with Mr A. The review has received assurances from Panel members that a scheme such as the Shared Living Scheme described above with the level of oversight and monitoring that this scheme had, would not be set up today due to the governance, safeguarding and supervision requirements. It is difficult to imagine now that there was no overarching legislation in place prior to 2007 which protected those who lacked capacity. The Mental Capacity Act 2005 came in force on 1st October 2007 and was not in existence at for the majority of the time that Mr A was caring for Adult S.

5.2.3.14 People receiving care funded by Continuing Health Care (CHC) are subject to a high level of monitoring. Adult S was eligible for CHC in 2018 and his care package was fully funded by the Clinical Commissioning Group (CCG) and his case was managed by his local healthcare team. A specific annual health review is held by the person's GP surgery and a care plan is developed. This can be seen in Adult S' GP records as taking place regularly from 2018. Both Adult S and Person of Interest 1 should have been receiving annual health reviews before 2018 however; their GP did not begin conducting these until 2011 when safeguarding concerns were raised.

5.2.3.15 The high level of governance for these care packages include regular supervision and monitoring and a requirement to engage in training including safeguarding training. A person who lacked the capacity to make

decisions around their finances would have a Power of Attorney and the Court of Protection would be used where necessary to put protective orders in place. Finances would be audited with robust procedures and monitoring in place for the drawing down of a person's money and with direct payments made directly into accounts held in the person's name whose money it was. The review has been assured that it is not possible for somebody in receipt of this level of care package to be unaccounted for due to the way that care packages are now funded and the current governance requirements.

5.2.4 ***Consideration of how appropriate the care given to Adult S was following his discharge from Calderstones Hospital.***

5.2.4.1 Without the records for Community Services, it is difficult to fully answer this term of reference. The review has different accounts of how Adult S was cared for during his time with Mr A. The family believes that Adult S was not cared for properly, that he did not have the correct equipment and that he was left for long periods of time sat in a chair. They also acknowledge that they did not raise any concerns in respect of care during at the time that Mr A was caring for Adult S.

5.2.4.2 The recollection of the retired Managers that the review spoke with was that the Scheme was monitored and that Adult S was cared for properly. They do not recall any issues with Adult S being left for long periods of time or not having the correct equipment but the detail of their recollections was affected due to the passage of time. They told the review that no concerns were raised and save for it being discussed in supervision that Adult S had his own needs separate to that of Person of Interest 1 the review has not collected any evidence of incidents where anything of concern was noted.

5.2.4.3 Having reviewed the available GP notes, the review has not been able to ascertain with certainty of how or when Adult S' mobility began to deteriorate. The earliest handwritten note is dated 1983 and in 1986 the notes record that Adult S cannot walk independently without support. On that basis, it is therefore difficult to imagine how Mr A managed Adult S and Person of Interest 1 in Manchester on his own. However, the 1994 paper notes that Adult S is moving in the home and does not mention significant mobility issues. Marked scoliosis of the spine deforming chest is noted in Adult S' GP records on 23rd June 2012 after he has left the care of Mr A.

5.2.4.4 Adult S was peg fed at his last placement but according to Mr A was eating solid food in his care. This is confirmed in the Shared Lives records where Adult S' support plan details on 6th October 2010 that Adult S can eat solid foods which are cut into small pieces. The support plan details that Adult S enjoys eating Roast Beef and Yorkshire pudding and that Adult S can drink from an adapted beaker. There is no record of the Speech and Language Team being involved with Adult S during his time with Mr A but there is reference in 2010 and 2011 to a referral being made for an Occupational Therapy Assessment.

5.2.4.5 An Occupational Therapy assessment took place on 12th May 2011 after safeguarding concerns were raised. These considered Adult S' wheelchair and bed amongst other things. The review can find no evidence that an Occupational Therapy assessment took place prior to this and finds that

assessments should have been taking place during the men's placement with Mr A. There are no recorded observations or comments which suggest that Adult S' curvature is due to him being left for long periods of time or from having the wrong type of equipment. However, in the absence of Occupational Therapy Assessments prior to 2011 it is difficult to assess whether Adult S and indeed Person of Interest 1 were provided with the necessary equipment and support that they required prior to May 2011.

5.2.4.6 As the years went on and Rebecca retired, Mr A was getting older and was looking after two vulnerable and highly disabled individuals. View from professionals working with Mr A was that he was starting to struggle to manage Adult S and Person of Interest 1 as he got older. The Community Service Manager told me that Mr A was reluctant to take additional support after Rebecca retired but the Community Service insisted that he took the support offered.

5.2.4.7 Mr A was regularly visited by the Shared Lives team from 2007 until Adult S moved from Mr A's care. As part of those visits, Mr A was asked whether he required help in caring for Adult S and Person of Interest 1 and which he always declined apart from asking for respite care for holiday periods. Mr A was also asked if he was managing and only disclosed issues with his health after the safeguarding concerns were raised in March 2011.

5.2.4.8 Mr A did not like lots of people in the family home and held strong views about the benefit to Adult S and Person of Interest 1 attending local day centres. He was described in the Shared Lives assessment in 2008 as 'anti-establishment.' These views were in contrast to Rebecca who thought that Adult S and Person of Interest 1 would benefit from such centres for their socialisation and stimulation. There are references in the papers to requests being made for the same named personal assistants following Rebecca's retirement. Mr A said that Person of Interest 1 does not like change and different people coming into the home unsettles him, however the care records from the respite care company used when Mr A went away in 2011 demonstrate that both Adult S and Person of Interest 1 settled well with new respite carers coming into the home.

5.2.4.9 Rebecca's retirement was in many ways very unsettling for the household. Whilst the placement had the benefit of a family feeling rather than a placement with lots of staff, relying solely upon one other person for a long period of time, meant that Mr A found it difficult when new staff were introduced.

5.2.5 ***Consideration of the effectiveness of safeguarding practices during the period Adult S was cared for in the community***

5.2.5.1 It is almost impossible to compare the safeguarding practices in place now to those in place in the 1980s. The landscape and development of safeguarding has entirely changed with legislation such as the Children Act 1989, the Mental Capacity Act 2005 and the Care Act 2014 not being in place for much of the time when Mr A was caring for Adult S. It is also difficult to draw conclusions as to the effectiveness of safeguarding practices during the time that Mr A was caring for Adult S due to the lack of available records.

5.2.5.2 The culture of employing a light touch to oversee the Shared Living Scheme meant that robust safeguarding practices were not in place in the sense of how safeguarding would be understood today including the Mental Capacity Act 2005 not being in force until 2007. Safeguarding practices were a part of the Shared Living Scheme with Adult S being seen and regular supervision taking place. There was however, a lack of curious questioning present from the information gathered in the review and the supervision sessions appeared to be quite informal. It is not possible without the records to draw firm conclusions on the quality of safeguarding practices and the supervision that Mr A received when caring for Adult S and Person of Interest 1 under the Shared Living Scheme. As such and as previously concluded, the review found that there may have been increased opportunity for both financial abuse and/or sub optimal care to be provided due to the lack of oversight of the Shared Living Scheme where Adult S and Person of Interest 1 resided.

5.2.5.3 In 2008, Shared Lives completed their assessment of Mr A's application to become a Shared Lives Carer. The assessment concluded positively. Having reviewed the assessment documentation, the review finds that the assessment would have benefited from more details being recorded regarding the Adult S and Person of Interest's activities and finances. The assessor completing the assessment in 2008 noted that Adult S and Personal of Interest 1 had their own bank accounts and savings however; it was in 2011 after the safeguarding referral that Mr A set up individual bank accounts for the men and arranged for their benefits to be paid into the individual bank accounts. These were two of the recommendations from the Multi Agency Strategy Meeting and the assessment did not identify that these benefits were being paid into a household account in Mr A's name. Given that the assessment form contained a section where the assessor records the evidence that they have seen in respect of finances, this was filled in to indicate the men had separate bank accounts and savings. It is not clear from this assessment what was seen in terms of documentary evidence. The assessment missed the fact that the men's benefits were being paid into the household bank account.

5.2.5.4 It is clear that there was no monitoring or oversight of Adult S' finances until after 2008 when Lancashire County Council completed a social care assessment and reviewed Adult S care package with health. Records from Shared Lives, show that in September 2008, a solicitor was to be instructed to make an application to the Court of Protection and Mr A was to alter the banking arrangements for Person of Interest 1 and Adult S. The application to the Court of Protection was not however made until 2011 following safeguarding concerns being raised on 23rd March 2011. A professional deputy was appointed on 12th September 2011. It is unclear why this did not take place until 2011 and indeed and as found above, the assessment document did not sufficiently discuss the financial arrangements for Adult S and Person of Interest 1. The arrangements for separate bank accounts and Court of Protection applications should have been made in 2008 and it is not clear to the review why these steps were only taken in 2011. The review therefore finds that there was a missed opportunity to protect Adult S from financial abuse in 2008 when Mr A was approved as a Shared Lives carer.

5.2.5.5 Adult S' and Person of Interest 1's finances should have been part of regular audits from the time that Mr A was approved as a Shared Lives Carer in 2008. However, the records indicate that financial auditing was not put in place until 2011 following the safeguarding referral where Mr A was asked to record any spending over £50 for Adult S and Person of Interest 1. The review finds that auditing should have been in place from 2008 when Mr A was approved as a Shared Lives carer.

LP1: Assessments considering whether to approve a person as a carer for a vulnerable adult should consider finances in detail. This should include detailing how the person's finances are being managed and where any monies being received including any benefits are being paid. This should include checking relevant documentation including bank statements and documentation from regarding benefit payments.

LP2: Statutory partners should ensure that financial auditing is in place and across their services where carers are approved for vulnerable people.

5.2.5.6 On 22nd March 2011, respite carers who were providing care to Adult S and Person of Interest 1 whilst Mr A was on holiday raised safeguarding concerns. Those concerns were that the hoist used to move the men had not been serviced in three years, the men's health needs were not being met, the house was dirty and the kitchen could not be used for meal preparation without cleaning. In addition, the bedding was soiled and there was a lack of adequate clothing and food for the men. Adult S was reported to be sleeping on the floor on a blow up bed which Mr A says was a specialised mattress costing £600 which he chose as an alternative to a hospital style bed with sides and which he did not want in the house. Concerns were raised that Mr A lived an exotic lifestyle including expensive hotel stays and restaurants which was in stark contrast to the home conditions found by the respite staff.

5.2.5.7 Following these safeguarding concerns being raised, Shared Lives and Lancashire County Council attended the property. When Shared Lives attended the property the records indicate that the house was not as bad as they expected it to be following the referral which had been received. The kitchen was dirty and Adult S was now sleeping on a mattress which Shared Lives had seen before although the review has been unable to ascertain why Occupational Therapy had not been to visit the property and advise on an appropriate bed for Adult S before the safeguarding referral.

5.2.5.8 The rationale given for the blow-up bed was that Mr A did not want a hospital style bed in his property and that he felt a bed low to the floor would keep Adult S safe if he had an epileptic fit. He would, Mr A, believed be less likely to hurt himself. The Occupational Therapist who attended in May 2011 deemed the mattress on the floor to be safe for Adult S although not suitable longer term. The blow-up bed, Mr A said was bought from Argos at a cost of £600 and was a specialist bed. Enquiries at the time found that Argos did not sell a blowup bed for £600.

5.2.5.9 There were also issues with the account that Mr A provided at the time regarding the hoist which had not been serviced in three years. Mr A thought it had been serviced but the hoist company said that they had been unable to gain access to service it.

5.2.5.10 18 dirty pillowcases were found on one of the pillows and it is thought that this was an indication of Mr A becoming overwhelmed and letting things get on top of him.

5.2.5.11 In respect of the food, Mr A had gone on holiday leaving microwave meals for the men he cared for, believing that this would be easier for the carers coming in. This however, was in contrast to the usual arrangements for food, where records indicate that proper cooking had been apparent in the home and support staff had seen Mr A cooking for the men he cared for including fresh vegetables being prepared and used.

5.2.5.12 Mr A accepted during the home visit that he was struggling with both men although he had not indicated that he had previously been struggling. A series of strategy meetings were convened and held between March and July 2011 and a full medical appointment and Occupational Therapy Assessment were arranged. The outcome of the strategy meeting was to seek alternative accommodation for Adult S with Mr A indicating that he thought it was best if Adult S moved to another placement. This was communicated to Adult S' parents on 22nd June 2011. During that telephone call, Adult S' father said that he had always been happy with the care that Mr A had provided to Adult S although it had been some time since they had last heard from Mr A. The concerns of Adult S family appear to have come after they were made aware of the safeguarding concerns. The family did not make any contact with agencies when they lost contact with Mr A and did not raise any concerns until June of 2011.

5.2.5.13 There is evidence of neglect when reading the records surrounding the home conditions in March 2011. Whilst Shared Lives did not find the home conditions to be as poor as suggested by the respite carers referral, it is clear that the home conditions were poor and that standards had slipped over the preceding couple of months. Shared Lives had visited the property in November 2010 and January 2011 and no concerns were noted. This was not a case of long standing neglect but rather a situation where Mr A started to struggle, didn't ask for help and home conditions fell below an acceptable level in combination with Mr A making some rather poor decisions regarding Adult S' bed and food for the men whilst he went away.

5.2.5.14 It is following these safeguarding concerns that the notes indicate that arrangements were put in place for separate bank accounts to be set up for the men and for Mr A to audit every item that he spends above £50. It is unclear why this was not in place prior to April 2011 as discussed above given the recommendation in 2008 that an application be made to the Court of Protection and that separate banking arrangements would be made.

5.2.5.15 In April 2011 a Day Centre was recommended for Adult S three times a week in discussion with Mr A to increase Adult S' social interaction. Consideration as to the men's social interaction and support plans were discussed in July 2011 with stimulation and small tactile activities being recommended. Support plans were developed for the men and notes begin to discuss activities for them. Support plans were in place in 2010 and 2011 although not prior to this. They record the men's activities as told to them by Mr A which included visiting Manchester and swimming. It is only in April 2011 that increasing Adult S' social interaction is recommended alongside stimulation and small tactile activities. The review could not ascertain why this was being recommended in 2011 but had not been recommended from 2008 and considers that Adult S would have equally benefitted from similar activities in 2008 that were being recommended in 2011.

LP3: All approved placements for vulnerable adults should have support plans which actively consider and review the activities and stimulation which each person being cared for requires.

5.2.5.16 Health Action Plans were also recommended for Adult S and Person of Interest 1 in April 2011. Health Action Plans were brought in by the government in 2002 and should have been an annual plan for both Adult S and Person of Interest 1. The review cannot find evidence that Health Action Plans were in place for Adult S until 2011 and indeed the strategy meeting minutes from 13th April 2011 indicated that Adult S GP was now putting things into place which should have been in place before including Health Action Plans. The minutes record that health checks were not taking place for Adult S or Person of Interest 1 because the men could not be brought to the GP surgery. Professionals working with the placement indicated to the GP that other surgeries would attend to complete these health checks by way of home visit. It is concerning to note that no Health Checks were taking place for either of the men living with Mr A until 2011 despite Adult S being registered to the same GP for 25 years. Adult S had not been seen for 2 years prior to March 2011 and his GP did not appear to be aware of the arrangements as to how Adult S was being cared for by Mr A in a specific placement. From 2008, the review would have expected the lack of health check to have been picked up by Shared Lives in their supervision and reviews of the placement.

LP4: GP Surgeries should ensure that all vulnerable persons who qualify for an annual health check receive the same. This should include making arrangements to visit persons at home to complete the health check for those who cannot attend the surgery.

LP5: Services providing live in carers to vulnerable adults should review whether annual health checks are being accessed and support their carers to access annual health checks for the persons they are caring for.

5.2.5.17 In June of 2011, the family became aware that Adult S had received compensation in 2001 of £68,000 and that money had been put in trust for Adult S. They were unaware of this until June 2011. The compensation was provided by the Public Trust Fund and the money was transferred to a solicitors firm in Burnley. Mr A says that he was contacted by the court to say that there

was money for Adult S. He completed the necessary forms and arranged for the monies to be transferred to a firm of solicitors. Mr A denies any wrongdoing in respect of the monies and told the review that the holiday to Gleneagles was paid for from his own monies.

5.2.5.18 The records indicate that Shared Lives and Lancashire County Council were aware of the trust in January 2011 although no concerns were raised in respect of the trust monies at this stage. As previously noted the Core Assessment in 2008 recommended that a Court of Protection application would be made in respect of Adult S.

5.2.5.19 In July 2011, the family raised concerns by way of a letter to Adult Social Care enquiring as to where £23,000 from Adult S's trust fund was and what that had been spent on. There is no record on the electronic system that a formal written response was sent from Adult Social Care to Adult S' mother. The enquiry may have been dealt with by way of telephone or a meeting but it is important that agencies keep accurate records and respond to enquiries in a timely manner.

5.2.5.20 Adult Social Care go onto make enquiries into the trust fund in July 2011 by way of contacting the Solicitor Trustee TS, requesting for the monies to be held and applying to the Court of Protection for a Deputyship for Finances and Property in 2011. TS indicated that he was not obliged to provide a breakdown of the trust accounts to Adult S' mother as she was not a co-trustee but agreed to do so. Despite writing to TS, the breakdown was not provided to the Local Authority.

5.2.5.21 Actions within the records from Lancashire County Council include a suggestion that the Professional Deputy would make enquiries following appointment as to how the fund had been previously managed. The review has not been able to satisfy itself that those enquiries have been made. The review finds that they should have been and that the Local Authority should have requested that the Professional Deputy, once appointed, make those enquiries in order to fully investigate the allegations of financial abuse.

LP6: Keeping accurate records and in particular responding fully to enquiries/concerns from families in a timely manner. This should be recorded on the case management system.

5.2.5.22 It becomes apparent from the records in 2011 that the men are visiting a flat in Manchester very regularly with Mr A which has been purchased by him. It was an action from the strategy meeting held on 21st April 2011 that the flat should be visited and photographed which it was on 10th May 2011. On 13th July 2011 Shared Lives speak to Mr A about the sleeping arrangements in the flat and advise that it wasn't appropriate for the men to be sharing a room when they were spending 4 nights per week in the Manchester flat. It appears from the records that it was deemed acceptable for Mr A to share a room with Adult S in Manchester when they were spending a weekend at the property which they did every weekend. It is unknown when Shared Lives became aware that Mr A was regularly spending the weekend at the flat in Manchester but they were

aware that Mr A visited a Hotel with Adult S and Person of Interest 1 for weekends.

5.2.5.23 The review has found that in March 2011, home conditions for Adult S and Person of Interest 1 were unacceptable and there was evidence of neglect. Adult S' family became aware of Adult S compensation monies in June 2011 and after they had been asked about their view of his general care. The records indicate that Shared Lives and the Lancashire County Council were aware of the trust in January 2011. At the point of the safeguarding concerns being raised in March 2011, agencies responded appropriately to those concerns and put plans and monitoring (including unannounced visits) in place. The home conditions and neglect issues were not of concern in either November 2010 or January 2011 when Shared Lives visited the property. Conditions either slipped quickly or by virtue of arranged appointments, provided Mr A with the opportunity to clean and tidy to an appropriate standard before their visit. Although the review is satisfied that agencies worked appropriately with Mr A when safeguarding concerns were raised, it took from April 2011 to December 2011 for provision to be put in place for an alternative placement for Adult S due to funding issues. Whilst this was a period of some nine months, the review is satisfied that the appropriate monitoring and safeguarding was in place from April 2011 whilst an alternative placement was being sought.

5.2.5.24 The review found no evidence to suggest that Adult S or Person of Interest 1 had been sexually abused by Mr A and no concerns of sexual abuse had been made to any panel member agency either before or after Adult S' death.

5.2.5.25 The review learnt that a safeguarding referral had been made in respect of Person of Interest 1 since Adult S had moved to into care home 1. Mr A told the review that an incident had occurred five years ago where he lost his temper following Person of Interest 1 screaming after Person of Interest 1's chair had been changed. Mr A left the property leaving Person of Interest 1 alone. Mr A felt that it was important that the review was aware that he had received an official warning for neglect and that following this incident, more support was put in place for him to care for Person of Interest 1. This was not the first time that Mr A had left the men alone. In 2011, one of safeguarding concerns raised was that Adult S and Person of Interest 1 had been left on their own. It appears that when Mr A feels overwhelmed and is struggling to manage, his response is to leave the property. Since the recent incident, the review is satisfied that work has been completed with Mr A around strategies to be used should Mr A feel in those circumstances again but agencies should be aware of and monitor this issue alongside the support provided to the remaining placement. It has remained the case that it has been deemed to be in Person of Interest 1's best interests to reside in Mr A's care and this is supported by Person of Interest 1's family.

5.2.5.26 During the video interview with Mr A, the Independent Reviewer briefly met Person of Interest 1. Person of Interest 1 was observed to moan loudly when Mr A began to talk about Adult S and when Mr A showed the Independent Reviewer a photograph of Adult S, Person of Interest 1 made sounds which Mr

A indicated was Person of Interest 1 saying Adult S' name. This led Mr A telling the Independent Reviewer about how Person of Interest 1 has missed Adult S.

5.2.5.27 The members of the household, Mr A, Adult S and Person of Interest 1 had a significant and long-standing relationship. In Adult S' case he had lived with Person of Interest 1 and Mr A for 28 years but had known them both for over 35 years. The relationship between Adult S and Mr A and Person of Interest 1 ended when Adult S moved to care home 1 in December 2011. Mr A described having to walk away from Adult S and being told by professionals that he had no say in matters concerning Adult S as he was not family. Adult S' family told the review that it was a positive experience for Adult S to move into care home 1 and that he was content.

5.2.5.28 The Mental Capacity Act 2005 sets out that making a best interests decision is a process with a checklist of factors to be considered. This includes considering 'all relevant circumstances' of which a longstanding relationship would be such a circumstance to be considered. A best interest decision can be made even where family members disagree.

5.2.5.29 It is acknowledged that whilst this is an unusual case and set of living circumstances, assessments should have considered the likely impact on either of the vulnerable adults of severing their relationship with each other or Mr A. They had been living together as a household of three for 28 years and were in many senses family. There was no practical reason why the men could not have seen each other or why Mr A couldn't have visited Adult S. The evidence does not suggest that there was an impact on Adult S but Mr A told the review that Person of Interest 1 has been affected by Adult S moving placement and that he does not understand where Adult S went.

5.2.5.30 There was no consideration of the relationship between Person of Interest 1 and Adult S or their relationship with Mr A. This was an unusual arrangement with Mr A being a sole carer rather than employed as a team of carers. There were only two vulnerable adults within the house and as such, they lived very much as a family.

5.2.5.31 At the time the best interest decision was made with regard to Adult S, the Mental Capacity Act 2005 was in the first few years of its existence. It is apparent from speaking to practitioners that they have finessed their approach since then in applying the checklist under the Mental Capacity Act 2005 and the review is satisfied that consideration would now be given to those long-standing relationships.

LP7: Agencies should recognise the importance of all significant relationships when making best interest decisions under the Mental Capacity Act 2005 and that practitioners check their own practice in respect of this.

6. Finding and Conclusions

6.1 The review faced significant challenges due to the lack of health records, which were available to the Reviewer. Records from Adult S' time at Calderstones Hospital were destroyed in line with Trust retention policies and there were no available care records from the time that Adult S and Person of Interest 1 moved to their Shared Lives placement with Mr A in the community until their assessments with Shared Lives in 2007. The information contained within the review pre 2007 with the exception of GP records comes from interviews that the Reviewer conducted with the family, Mr A and retired members of staff from Calderstones Hospital and Community Services of Burnley, Pendle and Rossendale Health Authority.

6.2 The review has considered the weight that can be placed on those recollections when considering both findings and learning points, given the passage of time. The Retired Nursing Director of Calderstones Hospital and the Retired Manager of Community Services of Burnley, Pendle and Rossendale Health Authority had good recollections of Adult S, Person of Interest 1, Mr A and the Shared Living Scheme where Adult S and Person of Interest 1 lived. There were however, some gaps in knowledge and in detail, they were able to provide given the passage of time. Equally, the passage of time had affected Adult S' parents and Mr A in their ability to recall events and details of their recollections. The review acknowledges the difficulties with the length of time since some of the events have taken place and that in the absence of written contemporaneous records, the interviews are the main source of information for the period from when Adult S resided at Calderstones Hospital until 2007.

6.3 The review accepts that the records from Calderstones Hospital were destroyed in line with Trust retention policies given that Adult S resided at Calderstones Hospital until 1972 it is more difficult to understand that no records available from what was the Community Service of Burnley, Pendle and Rossendale Health Authority. The Community Service was at its closure responsible for over 400 staff and 45 locations and caring for around 200 people at which time services should have transferred to other providers and services. Ultimately, health services in Burnley were responsible for the care provided to Adult S, beginning with his time at Calderstones Hospital until Mr A's retirement from the Health Trust in 2011[3].

6.4 There is no record of Adult S' journey through health services (save for his GP records) even in the later years of health services being responsible for his care. In comparison, Shared Lives hold records from 2007 when they first assessed Mr A to be a Shared Lives carer. It is important that consideration be given by agencies working with vulnerable adults to ensure that appropriate documentation is retained around the person's journey and decision making processes.

LP8: Consideration is given by agencies working with vulnerable adults to ensure that appropriate documentation is retained around the person's journey and decision making processes.

6.5 Neither Adult S nor Person of Interest 1 were transferred to the Shared Lives service[4] or any other services following the closure of Community Services and there was a period

[3] Burnley, Rossendale and Pendle Health Authority became Burnley Health Care NHS Trust.

[4] This is entirely separate to the Shared Living Scheme that Adult S and Person of Interest 1 went to live under in 1983, although confusingly has a similar name.

where there was no oversight of Adult S and Person of Interest 1's placement. During this time, Mr A was working solely with Adult S and Person of Interest 1 and not as part of a team. He received no support, supervision or respite care for Adult S and Person of Interest 1 to enable him to take time off. This was at a time when Mr A was approaching retirement and it had previously been identified that Mr A needed additional support following the retirement of Rebecca, the Nursing Assistant who had was employed on a full time basis and provided support and respite to the placement.

6.6 The review cannot be certain on what length of time there was no oversight of Adult S and Person of Interest 1's care arrangements due to the absence of records. People who spoke to the review varied in their accounts and the dates they provided. The review was told that Mr A was receiving supervision at the time of the Community Services Manager's retirement of 2006 and that the service closed some two to three years later. This does not tally with Mr A approaching Shared Lives in 2007 for an assessment having in his recollection received no visits for two to three years. Mr A told the review that when he enquired he was told that the supervision of his care of Person of Interest 1 and Adult S were no longer part of Health Services. It is unknown for how long Mr A did not receive supervision or support but during the period where there was no supervision, support and oversight, there were no safeguarding processes in place for Adult S and Person of Interest 1.

6.7 The review was told that supervision provided to Mr A following the closure of Calderstones Hospital to 2006 was regular and documented. The Community Services Team saw Adult S and Person of Interest 1 regularly and until Rebecca, a nursing assistant retired (circa 2004). There was a Nursing Assistant employed to assist Mr A in caring for Adult S and Person of Interest 1. When Rebecca retired, alternative staffing was put in place to replace her and provide support to Mr A until the closure of Community Services. The review learnt that supervision of Mr A highlighted that Mr A needed to be aware of Adult S' needs as well as Person of Interest 1's needs and could at times focus on Person of Interest 1 and not Adult S.

6.8 In addition, the way that the Shared Living Scheme had been set up meant that Community Services did not have oversight of the finances of the persons being cared for under the scheme nor was there any supervision of the trips that the persons being cared for went on. The team had been specifically told that finances were not within their remit at this location. This was a unique situation as Community Services were accountable for the finances of the other residents (some 200 in over 45 locations) and which were audited by the Finance Department at Burnley Hospital.

6.9 The review found that there was no questioning by management as to the appropriateness of the Shared Living Scheme as time went on and no service reviews were held to ascertain whether the current arrangements met the resident's needs. This meant that the financial arrangements for the men nor the appropriateness of the trips made to Manchester by Mr A were ever questioned by the managers of the service. For example, one of the Managers of the Scheme met Mr A and the boys for lunch in Manchester during one of their trips but didn't make enquiries as to how this was funded nor the sleeping arrangements at the hotel as Community Services was not responsible for this.

6.10 As a result, the review found that there may have been increased opportunity for both financial abuse and/or sub optimal care to be provided due to the lack of oversight of the

Shared Living Scheme where Adult S and Person of Interest 1 resided. However, there was no evidence to suggest that Adult S' death was caused or contributed to by any sub optimal care or lack of access to services.

6.11 The review is satisfied from speaking to retired members of staff from the Health Authority that Person of Interest 1 and Adult S' living circumstances were unique. Of the 40 or so houses that were set up following the closure of the Children's Wards at Calderstones Hospital, and the 200 persons cared for, only Adult S and Person of Interest 1's home was set up using the Shared Living Scheme.

6.12 The review has been assured by East Lancashire CCG that there are no other vulnerable adults who were cared for by Calderstones Hospital as children and who are in the community without appropriate packages of care and support.

6.13 The review is satisfied by the information received from Panel Members that, vulnerable adults who are in receipt of commissioned care packages in the community have systems in place for both the monitoring and auditing of their finances and supervision of care provided.

6.14 The review has found that in 2008 when Mr A was approved to be a Shared Lives carer that the assessment process should have identified how the men's finances were being managed. Despite references to steps to be taken in 2008 including a Court of Protection application these steps were not taken until 2011 and the payment of monies into a household account was not identified until 2011. The report concludes that more could have been done by agencies involved in Adult S' care to prevent the opportunity for financial abuse.

6.15 Adult S should also have had more health involvement in his time with Mr A including regular Health Checks from his GP and Occupational Health involvement. Had this been identified earlier than 2011 particularly from 2002 when annual health checks were in place, more specific and tailored support plans and equipment is likely to have been in place for Adult S.

7. References

Bright C (2015) Review of the implementation of the Child Practice Review Framework. Welsh Government Social Research

8. Summary of Learning Points (LP)

LP1: Assessments considering whether to approve a person as a carer for a vulnerable adult should consider finances in detail. This should include detailing how the person's finances are being managed and where any monies being received including any benefits are being paid. This should include checking relevant documentation including bank statements and documentation from regarding benefit payments.

LP2: Statutory partners should ensure that financial auditing is in place and across their services where carers are approved for vulnerable people

LP3: All approved placements for vulnerable adults should have support plans which actively consider and review the activities and stimulation which each person being cared for requires.

LP4: GP Surgeries should ensure that all vulnerable persons who qualify for an annual health check receive the same. This should include making arrangements to visit persons at home to complete the health check for those who cannot attend the surgery.

LP5: Services providing live in carers to vulnerable adults should review whether annual health checks are being accessed and support their carers to access annual health checks for the persons they are caring for.

LP6: Keeping accurate records and in particular responding fully to enquiries/concerns from families in a timely manner. This should be recorded on the case management system.

LP7: Agencies should recognise the importance of all significant relationships when making best interest decisions under the Mental Capacity Act 2005 and that practitioners check their own practice in respect of this.

LP8: Consideration is given by agencies working with vulnerable adults to ensure that appropriate documentation is retained around the person's journey and decision making processes.

9. Appendix A – Panel Membership

The membership of the case review panel was comprised of the following representatives:

Independent Chair	Stephen Ashley
Independent Reviewer	Louise Rae
Business Manager	LSAB
Designated Nurse Safeguarding Adults	Oldham NHS Clinical Commissioning Group
Head of Safeguarding	East Lancashire & Pennine CCG
Specialist Nurse Learning Disability & Autism	East Lancashire NHS Trust
Specialist Adult Safeguarding Practitioner	Lancashire Teaching Hospitals Trust
Service Manager	Shared Lives
Head of Safeguarding	East Lancashire NHS Trust
Service Manager, Learning Disability and Autism	Lancashire County Council
Safeguarding Adult Nurse	East Lancashire NHS Trust