



SAR-NOAH Executive Summary

July 2023



Bexley Safeguarding Adult Board Independent Chair

All Safeguarding Adult Reviews are commissioned to help agencies learn lessons and develop practice following circumstances where in some cases a person has died. In this case the review reflected on practice leading up to the sad death of Noah.

Noah was loved by his family and the Bexley SAB offers sincere condolences to Noah's family and friends. In addition, I want to record my thanks to Noah's mother for her support of this review and her contributions in assisting all of us learning lessons to improve future practice and to ensure Noah's death leads to improvements in other people's life experience.

My thanks also extend to the Independent Chair and author of the review for their focus and determination to ensure all aspects of Noah's care were reviewed and the voice of the family clearly heard throughout the review.

This review makes important recommendations for improvements in practice surrounding many different aspects of Safeguarding. Ethical and Cultural needs of people receiving care, transitional safeguarding for people leaving children's services, and the role of the Police in better protecting vulnerable people by using criminal law, were some of the key themes standing out in this review for me.

Noah indeed had complex needs and there are examples throughout this review of good practice and practice where Noah was let down by services, and because of poor practice he at times endured unnecessary pain and discomfort. My hope is that everyone reading this review will reflect upon Noah's life and the recommendations made to ensure this is a catalyst for improved collective practice across all agencies.

Andrew Rabey



Merton Safeguarding Adults Board (SAB), Interim Independent Chair

On behalf of Merton SAB, I offer condolences to Noah's family. Please be assured that both Merton SAB and Safeguarding Children's Partnership commit to take forward the learning from this review.

This review does not focus on the cause of Noah's death, yet the SAB recognises the immense learning from Noah's lived experience.

Merton SAB would like to thank Bexley SAB for their leadership of this SAR and the reviewer for their intensive work on this review to identify areas for improvement across multiple services in several boroughs.

The SAR demonstrates the impact of the lack of appropriate care provision for individuals such as Noah, with complex needs. For Noah, he had a family advocating for him and alerting agencies when the care was not acceptable. Not all individuals would have families to do this for them. This SAR shines a light on the severe lack of appropriate community care provision for those with learning difficulties/disabilities. Nevertheless, the key learning for the SABs is the need for those responsible for commissioning health

and social care placements, and those responsible for the quality monitoring of such placements, to work together to only accept the best care for individuals with complex needs.

Nicola Brownjohn

Interim Independent Chair Merton Safeguarding Adults Board and Safeguarding Children Partnership

1. Background & Context

Noah was 22 years old at the time of his death. Noah had diagnosed Severe Learning Disability and Attention Deficit Hyperactivity Disorder (ADHD). In September 2021, he was presented to Queen Elizabeth Hospital, Greenwich (QEH) Emergency Department (ED) with shortness of breath. He was treated for aspiration pneumonia and put on a non-invasive ventilation (high flow oxygen), clinically improved, maintained oxygen saturation with a nasal cannula.

His last hospital admission to hospital was following a burn on his arm. Although burn reportedly healed in hospital, he was kept for longer for other medical complications raised whilst on admission.

Noah's health and social care needs were very high and complex. A number of agencies have been involved in his care and support. There were two open safeguarding enquiries open at the time of death; but there had been numerous safeguarding enquiries since coming to live in Bexley.

2. Terms of Reference for the Safeguarding Adult Review

2.1 Reason for the Review

Noah came to the attention of the Bexley SAB in May 2022 and went to Bexley SAB SAR Subgroup in May 2022 to make recommendations to then Independent Chair, Eleanor Brazil, on whether or not SAR Criteria had been met. Although his mother apparently reported that she had expected her son's death (although not as quick as it happened), it was deemed to be good practice to review each agency's involvement, with the view of extracting lessons, individually and as a team working around a service user.

The Bexley SAB Chair had agreed the criteria had been met, but also needed to escalate to Merton SAB / partners some concerns that have been raised regarding safeguarding enquiries, placement and reviews and existing provider concerns with remaining service users at the site.

Bexley SAB commissioned an Independent Reviewer to Chair and lead the SAR. Subsequently, Merton SAB coordinated the engagement of Merton services and to provide representation at the review panel.

2.2 Methodology

The SAR was commissioned by Bexley SAB as a combination review using IMR and Chronology Methodologies

2.3 Key Lines of enquiry identified by the Bexley SAR panel

- The assessment of Noah's health and social care needs and those of his family to develop effective care and support plans
- The effectiveness of the Transition Procedures between Children and Adult Services in Merton

- The implementation of the Continuing Health Care (CHC) Criteria in commissioning, identification and monitoring of Noah's placements
- The effectiveness of commissioning Noah's out-of-borough placements
- The effectiveness of hospital discharge planning procedure and processes
- The implementation of the Bexley Safeguarding Adult Procedures
- The implementation of the Mental Capacity Act 2005 in respect of Noah
- The appropriateness of Noah's placement with Parkhill Support Services (PSS)

2.4 Time Period for the Safeguarding Adults Review

The time period for analysis through the Review was from January 2017 to March 2022. This period was chosen as starting from the point at which Children's Social Care stopped their involvement with Noah, until the time of his death.

Key Events - The Review Period was considered in 9 sections as follows:

- 1st January 2017 – 6th August 2018 - Woodstock House, Kisimul Group
- 6th August 2018 – 7th January 2019 - Fountain Care – The Willows
- 7th January – 14th January 2019 - Gormanach House, Kisimul Group
- 14th January 2019 – 25th May 2019 - Brampton Hospital via Kingston Hospital
- 25th May 2019 – 9th July 2019 – Epsom Hospital
- 9th July 2019 – 16th September 2021 – Park Hill Sidcup (PSS)
- 16th September 2021 - 9th December 2021 - Queen Elizabeth Hospital
- 9th December 2021 – 8th February 2022 - Park Hill Sidcup (PSS)
- 8th February 2022 – 22nd March 2022 - University Hospital Lewisham
- 22nd March 2022 - 25th March 2022 - Park Lodge, Magic Life, Enfield

N.B It was agreed that the SAR would not consider the quality of medical care and treatment provided to Noah but would consider the social care and support provided and the discharge planning that took place during the periods he was hospitalised during the Review Period. Equally, it was agreed that the SAR would not consider the circumstances of Noah's death.

2.5 Issues relating to ethnicity, disability, sexual orientation, or faith

Noah's ethnicity was Black Caribbean/British,

2.6 Family participation

Noah's parents, sister and grandparents were offered the opportunity to participate in the SAR through meetings with the Independent Reviewer and the BSAB Manager.

3. Noah's Childhood

Noah had been accommodated when he was 8 years old when his behaviour at home was considered to put his young sister at risk, and he was placed at a residential school. In 2016, Noah moved school after an unexplained change in his attitude to attending school. His mother described the family being very satisfied with the schools Noah attended and with the support provided by Merton's Children and Families Service. From the family's perspective, the quality of support declined once Noah entered the Transition Procedures between Children and Adult Services.

Noah had complex health and social care needs which changed as he grew up and developed into a young man from a particular ethnic and cultural background.

Noah was referred to the Merton Transitions Procedures when he was 17 years old; by this time, the nature and degree of his complex health and social care needs had been known to Children and Families Services for almost 10 years.

4. Summary Timeline

During the period under review, Noah had four placements, as well as admissions to acute hospitals.

4.1 1st January 2017 – 6th August 2018 – Placement 1: Woodstock House, Kisimul Group

Noah was placed at Woodstock House, part of the Kisimul Group. Woodstock House was a residential children's home with an on-site school and educational provision where Noah had a 52 week a year placement. His previous placement broke down when, for reasons that aren't known, he began to refuse to go to school. After an initially "bumpy start", Noah settled, and his family was happy with the placement.

On the 23rd February 2018, Kisimul Group completed an assessment to determine whether their Adult Service could meet Noah's care and support needs when he transitioned to adult services. The assessment was that it could, and an offer of a placement was made, supported by Noah's mother. However, funding for the placement was not agreed, for reasons that are not known to the SAR, and Noah remained until almost his 19th birthday when the placement's registration terminated. On the 6th March 2018, an adult education placement at Orchard Hill College for Noah was offered to commence in September 2018.

4.2 6th August 2018 – 7th January 2019 – Placement 2: Fountain Care – The Willows

Noah moved to The Willows on 6th August 2018. On the 3rd September 2018, Noah's mother contacted the Kisimul Group stating that Noah was incompatible with The Willows, that the placement was breaking down and asking if he could return to their care. Within the Kisimul Group, it was agreed that the offer of a placement at their adult service still stood.

On the 5th September 2018, an unplanned Care and Support Review was held; the Review recorded that, on the 16th August 2018, "*The director of the home ... said they were unable to manage Noah's care needs any longer*" due to "*some challenging behaviours*". Noah had been visited and seemed "*quite happy*" and not to be "*at any risk*". Fountain Loving Care had suggested an alternative placement as the sole occupant of a flat at a meeting with Noah's family, but this was considered inappropriate due to its impact on his social wellbeing as well as being isolating.

The Review confirmed that "*Noah need a new placement where his present care need could be met.*" Consequently, Fountain Loving Care gave notice on the placement for Noah in August 2018. He did not move until January 2019, by which time he was found to be eligible for CHC funding.

4.3 7th January – 14th January 2019 – Placement 3: Gormanach House, Kisimul Group

On the 7th January 2019, Noah moved to Gormanach House, a residential home for young adults with "high need Learning Disability". He appeared to settle in, and his family visited on 2 occasions during the placement.

Between 8th January and 12th January 2019, the Registered Manager of Gormanach House commenced assessments under the Mental Capacity Act (MCA) relating to Noah's capacity to consent to care as well as the use of restraint at times of "severe aggression", and his ability to manage his finances. The manager completed a Positive Behaviour Support Plan for Noah to set out the use of physical interventions. During this time a Deprivation of Liberty Safeguards (DoLS) had been submitted to Merton Adult Social Care (MASC).

Noah's placement at Orchard Hill College continued after his move to Gormanach House. Staff at the college became concerned at his increased weight and bloating, leading to them calling an ambulance and Noah was taken to Kingston Hospital and subsequently transferred to the Royal Brompton Hospital (RBH) on the 14th January 2019 for a cardiology review.

4.4 14th January 2019 – 25th May 2019 – Hospital Admission 1: Brompton Hospital via Kingston Hospital

On admission to hospital a Best Interests Meeting was held to enable cardiac investigations to take place for Noah. It was noted by the Royal Brompton Hospital (RBH) that Noah had been admitted without

a hospital passport, but that one was completed and uploaded into his notes. An Urgent DoLS was put in place and Merton Clinical Commissioning Group (MCCG) was contacted to request care staff who know him to support Noah in hospital. MCCG agreed to fund outreach 1-1 support in the RBH from Kisimul.

During Noah's admission he was reviewed by a Psychiatric Nurse in relation to his behaviour which was considered to place the safety of both him and staff at risk.

By the end of March 2019, plans were in place for Noah's discharge. However, Gormanach House was considered not to be the right place for him due to his complex health issues. This led to the Kisimul Group formally serving notice to MCCG, in April 2019, on Noah's placement as they were unable to meet Noah's "health and mobility needs". MCCG commenced Care brokerage search via CHS as RBH had confirmed that Noah was medically fit for discharge.

During April 2019, the search for a placement continued. It was reported that a number of providers had concluded that they were unable to offer Noah a placement due to a combination of his age and complex physical needs. Meanwhile, it was agreed to consider a transfer to Epsom Hospital to make it easier for Noah's mother to visit.

4.5 25th May 2019 – 9th July 2019 – Hospital Admission 2: Epsom Hospital

At the end of May 2019, Noah was transferred to Epsom Hospital. Whilst he was there, the CHS Brokerage Team continued to seek a new provision for Noah. By June 2019, they confirmed that 19 provider organisations had assessed that they were either unable to meet Noah's needs or did not have a vacancy.

Subsequently, Parkhill Support Services (PSS), an Out-of-Area provider, assessed Noah and offered a placement. There continued to be consideration of other options. On the 4th July 2019, a Best Interests Meeting was held which decided it was in Noah's Best Interests to be discharged to 263, Main Road, Sidcup, rather than extend further his stay in hospital as he was medically fit for discharge, while long-term alternatives were considered. At this stage, some 57 possible placements had been contacted without success.

4.6 9th July 2019 – 16th September 2021 – Placement 4: 263, Main Road, Sidcup (PSS)

On the 9th July 2019, Noah was discharged from EH to 263 Main Road, Sidcup (263). His father visited to see the service and helped him settle in. The placement was fully funded under NHS Continuing Health Care criteria by MCCG but managed by CHS on their behalf.

In January 2019, Bexley ASC's Quality Assurance Team (BQAT) had undertaken a Property Assessment of PSS's property at 263 Main Road Sidcup; at that time, no one was living there and

there were concerns about the condition of the property and the need for security and direct access onto the main road. A report identifying these concerns was provided to PSS. When Noah was placed there, Bexley ASC were not informed of the admission.

On 19th August 2019, Noah's mother emailed CHS and PSS to express her concern that, having visited Noah that day with his father and sister, they had found him inappropriately dressed, without a continence pad and with his genitals exposed. She also reported that there was also a lack of food available for Noah, he appeared to have lost weight, various health and safety issues such as broken door handles, carpet that needed replacing and broken wardrobe doors. There was no response to mother's email by either service.

On the 20th August 2019, Noah was taken to the Queen Elizabeth Hospital, Greenwich (QEH) by ambulance accompanied by a support worker from 263 as he appeared to be in pain, pointing at his stomach and hadn't opened his bowels. He was given an enema and sent home after opening his bowels. On the same day, ONHSFT Community Learning Disability Team (CLDT) received a referral from the manager at 263 for an Occupational Therapy (OT) assessment for adaptations and a Community Learning Disability Nurse (CLDN) assessment for Noah's diet. Subsequently, CHS allocated a nurse assessor with experience in learning disability for Noah.

On the 11th October 2019, BQAT undertook an unannounced visit to 263. A number of concerns were identified, including stained carpet, holes in walls, lounge used for storage, no homely effects, no garden furniture and no sensory equipment or things to do. Support workers confirmed they had not been trained in the use of Noah's EpiPen and were seen giving him a chocolate biscuit despite his being allergic to chocolate. There was evidence of a visit from the PBS service commissioned via the CLDT but no outcomes or guidance for staff. The only care plan for Noah was an old one from January 2019. Various suggestions were made to improve the service provided to Noah and staff were advised a DoLS needed to be applied for. A full report was provided to PSS who responded on the 14th October 2019 answering the concerns, including explaining that they had only just received Noah's old care plan as the residential school he had been at had been closed over the summer.

On the 14th October 2019, PSS and BQAT record a Section 42 Enquiry was completed on the concerns identified during the BQAT visit. The Enquiry found the following concerns to be substantiated:

- Neither MASC or CHS had visited or reviewed Noah's placement
- PSS did not obtain all necessary information and documents on Noah before accommodating him
- Neither MASC or CHS provided PSS with sufficient information on Noah's health, social and behavioural needs

The Enquiry also found that PSS had taken steps to address the identified issues: 263 had been refurbished, Noah's care plan, risk assessment and medical information had been obtained and updated and a review was to be held to ensure these were updated and in place.

On the 15th October 2019, ONHSFT record that Noah failed to attend a CLDT Nursing Clinic with no reason given. As a result, the manager at 263 was contacted on the 21st October 2019 and a home visit arranged to complete the initial nursing assessments.

On the 14th November 2019, BQAT undertook an unannounced night visit to follow up on previous issues. Evidence was found of some of suggestions having been implemented and a report sent to PSS identifying ongoing concerns and that a front room window had been shattered, which support workers had been unaware of. On the 22nd November 2019, BQAT record receiving a response from PSS detailing remedial actions that have been taken, some of which had already been completed.

On the 19th and 25th November ONHSFT record identifying gaps in the medication processes in place, including the crushing of medication to administer it without legal authority under the MCA – there was no recorded Best Interests Meeting or Decision; whether the medication was crushed due to Noah having difficulty swallowing it whole or because of his non-compliance, he lacked the capacity to agree to the decision to crush the medication. Also agreed provision of “pull-up” continence pads to encourage self-toileting. On the 29th November 2019, ONHSFT record a SaLT assessment that concluded that no further input was required and the referral was closed on the 2nd January 2020.

On the 22nd January 2020, ONHSFT record a joint visit by ALD Nurse and OT. It was noted that “Home has no charts for bowel/bladder and food intake nor medication guidelines for PRN or EpiPen. Lack of clarity re restraint used when travelling and home’s management of his ‘challenging behaviour’ and “no record of prescription by present GP”. Previous script ended in Aug 2018.” These concerns were raised in a phone call with the manager at 263 on the 24th January 2020.

On the 28th January 2020 a safeguarding concern was raised by ONHSFT with BASC after a Nursing Review identified that, although the GP had removed paracetamol from the MAR sheet, there were still no PRN guidelines in place, the EpiPen was out of date and without guidelines on its use, and the Nurse had to explain the hospital passport to support workers.

BASC record the safeguarding concern was substantiated. The outcome was for the Nurse and ONHSFT to jointly produce a “robust and personalised care plan and guidance in place. BQAT notified “to complete checks regularly”. There is no reference to CHS or MASC being informed.

On the 2nd March 2020, BQAT emailed PSS asking for an update on progress of plans to deal with previous issues re the placement plus concerns about support workers being positioned outside Noah’s door. A reply was received on the 5th March 2020 to the effect that Noah is “free to roam” as he wishes.

On the 4th March 2020, BQAT undertook another unannounced visit to 263; there were now two tenants living there and some concerns raised applied to the other tenant. Those relevant to Noah included two support workers sitting outside his door to support Noah with eating, Noah’s support plan needs to include additional guidance re his allergies, his risk assessment needing updating, no MCA authorisation re living at 263, continence care and medication, the DoLS application sent to Bexley when it should’ve gone to MCCG (or CHS as their agents) and the environment is still very sparse with no pictures, plants, posters or homely touches. A report was sent to PSS. Subsequently, PSS responded that the concerns had been addressed.

During the first week of November 2020, ONHSFT record 2 unsuccessful visits to take blood; the first due to Noah’s agitation, the second to possible dehydration. At the second appointment, support workers at 263 were advised to hydrate night and morning before the nurses attend.

On the 13th November 2020. Lewisham and Greenwich NHS Trust (LGNHST) record that Noah attended QEH with abdominal pain. Before a surgeon could see him, he opened his bowels and was discharged to 263.

On the 23rd February 2021, LGNHST record that Noah was taken to QEH by ambulance with shortness of breath, abdominal pain and vomiting. He was admitted to hospital and diagnosed with a bowel obstruction but was discharged to 263 on the 25th February 2021 after successfully opening his bowels. He was taken back to the Emergency Department QEH the following day with shortness of breath; he opened his bowels while being examined, all observations in normal age. After his chest and abdomen were x-rayed but found to be clear, Noah was discharged to 263.

On the 8th April 2021, BQAT visited 263. A number of issues were identified and brought to PSS's attention by email. These included issues around medication recording and administration and Noah's support plan which had been recently updated but with old information and had numerous areas not covered, such as mobility, skin integrity, continence, nutrition and hydration, hearing and communication, religion and cultural background, social activities, hobbies, night and sleeping. It was advised that Noah's DoLS was chased. It was noted that no examples of MCA or Best Interest were seen. Support staff advised that Noah's mother had Power of Attorney – which she hadn't and couldn't have had as Noah had never had the capacity to appoint her as his Attorney – but didn't provide any funds for Noah. BQAT advised that 263 should raise a safeguarding concern if Noah was going without or missing out on community activities as a result. BQAT staff also reported a member of support staff making "uncomfortable and unnecessary comments" to Noah but didn't bring their concerns about the service to the attention of the commissioner, CHS. PSS responded to the concerns raised and worked with BQAT to develop a Service Improvement Plan.

In July 2021, BQAT visited 263 and advised that some repairs and redecoration were required. PSS responded that the comments had been forwarded to Trinity Housing for action.

In July 2021, the Metropolitan Police record receipt of an allegation that Noah had been "slapped round the head and verbally abused by a care worker" at 263. There were 2 witnesses, but despite repeated attempts by the Police to contact them, they did not respond to make statements. The Police also contacted management at 263, who also didn't respond. As Noah is non-verbal, without the witnesses there was no realistic prospect of conviction. A new manager at 263 contacted the police to say, "she would chase the staff to make statements, but nothing was provided" and the case was closed.

At the end of July 2021, CHS record that they received a phone call from Noah's mother, who had visited Noah on the 25th July 2021 and found him in severe stomach pain; an ambulance was called, but despite PSS being funded to provide 2:1 support in the community, there were only 2 support workers on duty and she had to accompany Noah in the ambulance on her own. Noah's mother also raised concerns about the state of Noah's toenails, which were uncut and beginning to curl. An email was sent to PSS that day asking for explanations of the above and confirmation that records were being completed of the 2:1 and 1:1 cover provided to Noah and if these can "be shared with the CHC Team". This was followed up by the CHS Nurse Assessor in August 2021, with PSS required to address the staffing issues and implement the appropriate referrals for Noah's health care.

In August 2021, BQAT record forwarding details of a number of quality assurance and safeguarding adult concerns about 263 to the Care Quality Commission (CQC) for their information and to ask if they had received any notifications about the service. This led to a meeting between BQAT, PSS and CQC; discussion covered the quality assurance and safeguarding issues at 263 and the registration of the service at 263. CQC were concerned that they weren't being informed by PSS of incidents as they occurred.

In September 2021, ONHSFT SaLT undertook visits to 263 and raised a safeguarding concern with BASC and MASC in relation to medication errors, Noah's presentation on previous visits, the *"management of documentation/guidelines, staff not carrying out programmes or guidance recommended by clinicians"*.

4.7 16th September 2021 – 9th December 2021 – Hospital Admission 3: Queen Elizabeth Hospital Greenwich

On the 16th September 2021 Noah was admitted to QEH with aspiration pneumonia and possible bowel obstruction. During his admission concerns were raised due to the quality of PSS carers on the ward. Subsequently, MCFS led a Care and Support Plan Review which recommended that *"Noah*

needs to be found a new placement because the provision of care at Parkhill does not seem to reflect that adequate care is being provided. The staff appear to be poorly trained to carry out their roles as required. The funder, CCG, will be informed about this outcome and required to act accordingly. I also recommend that a specialist care home may be considered where more specially trained staff will be able to provide the needed support service.”

On the 8th November 2021, a virtual discharge meeting was held. It was agreed to delay Noah's discharge until after his assessment by the potential alternative placement. It was accepted that Noah didn't need to be in hospital any longer.

On the 19th November 2021, CHS record receipt of an email from LGNHST advising that Noah currently had nursing needs due to pressure ulcers and mobility issues that mean he required a residential placement with nursing support and supported living would not be suitable. CHS also record that 26 providers had been unsuccessfully contacted to provide a placement for Noah.

On the 2nd December 2021, CHS record receipt of an email from Noah's mother in which she stated she didn't want Noah to be in QEH over Christmas but would only agree to his returning to 263 short term and with conditions; she would accept this as there is little choice.

On the 3rd December 2021, LGNHST record that the discharge planning team met and was advised by CHS's clinical lead *“that they have tried 40 different care homes to take Noah”*.

On the 6th December 2021, it was agreed that Noah would return to 263 with 2:1 support funded by SLWLCCG via CHS and with a revised care plan and risk assessment.

On the 9th December 2021, Noah was discharged from QEH to 263.

4.8 9th December 2021 – 8th February 2022 –Placement 4 continues: 263 Sidcup

Once Noah was back at the placement, he was visited by the SaLT and community nurses. No issues were reported. On discharge Noah had a grade 3 pressure ulcer. Community nurses trained the home staff and were visiting 3 times a week to dress the wound. It was reported that the pressure ulcer was healing well.

On the 20th January 2022, BQAT record a visit to 263 to meet the new manager and look at Noah's Support Plan and the support provided by external professionals. It was noted that Noah's Support Plan needed updating since his discharge from QEH. It was also noted that Noah's bedroom ceiling had collapsed. He was moved to another room, described by his mother as *“a tip”*.

4.9 8th February 2022 – 22nd March 2022 – Hospital Admission 4: University Hospital Lewisham

On the 8th February 2022, Noah was taken to UHL with burns on his arm, accompanied by two support workers. It was unclear how he had sustained the burns. Noah was seen by the medical team, full bloods were taken, as were photos and a safeguarding request not to discharge until the safeguarding concern had been investigated.

During this admission, an alternative provider was identified in Enfield. Meanwhile concerns were raised that PSS were not providing carers to support Noah during his admission. Additionally, LGNHST recorded that Noah's medical condition - not linked to his burns – was seriously deteriorated due to a large bleed in his stomach.

4.10 22nd March 2022-25th March 2022- Final Placement in Enfield

On the 22nd March 2022, Noah, having been assessed as being medically fit, was discharged from UHL to the placement in Enfield. On the 25th March 2022, Noah died; he was having difficulty breathing and paramedics were called but, despite staff attempting CPR, he died before the paramedics arrived.

5. Learning Themes and Recommendations

5.1 Overview

The SAR found three specific factors that impacted on the care and support that Noah and his family received prior and during to the Review Period.

- Noah had both complex health and complex social care needs, which at times were in conflict. For example, he would have benefited from a bespoke residential placement, but that could have caused him to be somewhat socially isolated
- assessing and meeting Noah's care and support needs were, at different times, the responsibility of various combinations of Children and Families Services, Transition Services, Leaving Care Services, Adult\Social Care Services, Community Health Services and Continuing Health Care Services, leading to confusion as to which services were responsible for what and who had overall responsibility for the co-ordination of his care and support package and
- part of the Review Period fell during the Lockdowns imposed because of the Covid-19 pandemic.

5.2 Good Practice

The SAR identified areas of good practice:

- in the reviewing of Noah's Education and Health Care Plan (EHCP) taking place regularly
- in some of the preparatory work undertaken to facilitate Noah's moves between some placements
- of agencies trying to provide continuity of care for Noah to reduce the number of moves he experienced but recognising when they could not provide an appropriate service for him
- on the occasions where the need for a DoLS or a Best Interest Decision was identified
- in the rapid development of a Hospital Passport when the lack of one was identified
- in the support provided by ONHSFT Learning Disability Services to Noah while he was an in-patient
- on the occasions where his family were involved in decision-making about Noah and kept aware of any developments
- in BQAT's persistence in pursuing the Service Development Plan with PSS
- in some agencies checking on Noah's placement during the periods of lockdown
- in ONHSFT staff identifying and responding to specific training needs of PSS staff
- in the raising of several safeguarding concerns by community staff and about the lack of PSS staff on the ward to support Noah
- in the sharing of concerns about the safety of Noah returning to 263
- the response of the Adults Emergency Duty Team to mother's concerns
- in the information sharing that came from the Safeguarding Procedures
- there were elements of good practice demonstrated in the hospital discharge planning procedures, including delaying the discharge due to existing safeguarding concerns, to provide an effective placement for Noah

5.3 Theme 1: Transition from childhood to adulthood

Noah had been accommodated when he was 8 years old when his behaviour at home was considered to put his young sister at risk, and he was placed at a residential school. In 2016, Noah moved school after an unexplained change in his attitude to attending school. His mother described the family being very satisfied with the schools Noah attended and with the support provided by Merton's Children and Families Service. From the family's perspective, the quality of support declined once Noah entered the Transition Procedures between Children and Adult Services.

Noah had complex health and social care needs; it was therefore important that they were assessed jointly in order to facilitate the development of an appropriate care and support package to meet them. In addition, he also has specific educational needs, identified in his EHCP, that need to be addressed in his care and support plan.

Noah's health needs were well-known; they were long-standing and chronic rather than acute. Noah's social care and support needs however were changing as he grew up and developed into a young man from a particular ethnic and cultural background. These changing social care and support needs would impact, not on his health care and support needs as such, but on how they might be most appropriately met.

Noah's health and social care and support needs therefore required to be assessed in a way that identified his ethnic and cultural background, which they were not, whether by Merton's Children and Families Services, Transition Services or Adult Social Care. This failure to identify these specific aspects of his care and support needs was compounded by the recording systems used by all services.

When Noah was referred into the Transition Procedures, consideration should have been given to his possible return to live at home; while this may well not have been possible or practical, it should have been considered and his family offered assessments under s10 of the Care Act 2014 of their eligibility for services in order for an informed decision to be made about such a return home.

Noah was only referred to the Merton Transitions Procedures when he was 17 years old; by this time, the nature and degree of his complex health and social care needs had been known to Children and Families Services for almost 10 years. Good practice would have been for Noah to have been referred to the Transition Procedures during the academic year of his 14th birthday to provide sufficient time to assess his needs effectively, to identify potential placements, facilitate his moving to a new placement if necessary and to enable Adult Social Care to make budget for what would be a potentially major drain on the resources.

Recommendation 1: That the SAB seek assurance that Adult Social Care has reviewed and revised as necessary its Assessment and Review Procedures and Processes under the Care Act 2014.

Recommendation 2: That the SAB seek assurance from the Safeguarding Children Board that Children and Families, Leaving Care and Transition Services have reviewed and revised as necessary their Assessment and Review Procedures and Processes

Recommendation 3: That the SAB seek assurance from Adult Social Care that they reviewed and revised their involvement in the Transitions Procedures and Processes.

Recommendation 4: That the SAB seek assurance from the Safeguarding Children Board that Children and Families, Leaving Care and Transition Services have reviewed and revised as necessary their Transition Procedures and Processes.

5.4 Theme 2: Continuing Health Care Funding Decisions during the transition phase

Given the nature, degree, and complexity of Noah's health needs, it is likely that he would have been eligible for Continuing Health care funding as a child. This was not identified in his assessments by Children and Families Services, when he was referred into the Transition procedures or when he was assessed by Adult Social Care. When he was referred, it was to the incorrect Health Commissioner.

Recommendation 5: That the SAB seek assurance from their local Health Commissioner that they publish and promote the Continuing Health Care Criteria and the process for making applications to Adult Social Care

Recommendation 6: That the SAB seek assurance from the Safeguarding Children Board that their local Health Commissioner publish and promote the Continuing Health Care Criteria and the process for making applications to Children and Families, Leaving Care and Transition Services

5.5 Theme 3: Health Pathways for those with complex needs

Given Noah's complex health and social care and support needs, it was predictable that he would require attendance and admission to hospital in emergency situations. Despite, this, there was no Hospital Passport or information pack developed and regularly updated to accompany him to hospital prior to or throughout the Review Period.

Recommendation 7: That the SAB seek assurance from Adult Social Care that all adults with a cognitive disability, including those with a learning disability, will be supported by a Hospital Passport or similar, informed by annual health and medication checks.

Recommendation 8: That the SAB seek assurance from the Safeguarding Children Partnership that all children/young people with a cognitive disability, including those with a learning disability, will be supported by a Hospital Passport or similar, informed by annual health and medication checks.

5.6 Theme 4: Continuing Health Care

While Merton Adult Social Care completed an assessment of Noah's care and support needs under s9 of the Care Act 2014, this was not subsequently routinely reviewed; Adult Social Care were aware that Noah had assessed as eligible for Continuing Health Care Funding but did not offer to review his s9 assessment or to contribute to any review of his placement nor was their involvement sought by the Health Commissioner.

The same is true of Merton's Transitions Service; while Noah's EHCP was reviewed regularly until March 2020, these reviews were not coordinated with or referenced in the reviews held by CHS of his Continuing Health Care funded placement.

Throughout and since the Review Period, responsibility for Continuing Health Care funded services had been delegated from the statutory Health Commissioner to CHS; while this is perfectly legitimate, it does require a further level of quality assurance or contract compliance to be established. The SAR requested details of the quality assurance processes developed and implemented by the Health Commissioner of CHS and of those developed by CHS of the providers they commissioned services from. No details were provided.

Recommendation 9: That the SAB seek assurance that Adult Social Care are offering assessments under s9 of the Care Act 2014 to all referred for Continuing Health Care funded services and subsequent reviews as appropriate.

Recommendation 10: That the SAB seek assurance that the local Health Commissioner has reviewed and revised its Procedures and Processes for applications for Continuing Health Care Funding.

Recommendation 11: That the SAB seek assurance from their local Health Commissioner that they reviewed and revised as appropriate their Procedures and Processes for identifying, commissioning and quality assurance of all Continuing Health Care funded services.

Recommendation 12: That the SAB seek assurance from the Health Commissioner that they have developed, implemented and monitor the effectiveness of robust quality assurance processes for their contracts either direct with health service providers or with those agencies who commission services on their behalf.

5.7 Theme 5: Effective Management of out of Borough Placements

Noah's residential placements were all outside of the London Borough of Merton; such placements made by Adult Social Care come under Guidance issued by the Association of Directors of Adult Social Services which stated that the placing authority should first of all check the potential host authority the quality of any possible placement and inform the actual host authority when any placement is made. As Noah's placement with PSS was commissioned by the Health Commissioner, this Guidance did not apply and was not followed. This resulted in the placement going ahead without the commissioner being aware of the concerns BQAT had about the provider and without Bexley Adult Social Care being aware the placement had happened.

While the Health Commissioner actually commissioned Noah's placement with PSS, Merton Adult Social Care were party to the process and should have ensured that the ADASS Guidance was followed.

Noah's health needs could not be effectively addressed in isolation from his social care and educational needs and vice versa. While aspects of Noah's care and support plan were reviewed, albeit not always regularly, no agency took responsibility for the coordination of the whole. Had the reviews of Noah's care and support plan be multi-agency, involving the commissioner, Adult Social Care, community health services and Leaving Care Services, this coordination could have been achieved with a resulting improvement in the overall quality of Noah's life.

Recommendation 13: That the SAB seek assurance from Adult Social Care that all out-of-borough placements it is party to, whether they commission them or not, will be commissioned in accordance with the ADASS Guidance

Recommendation 14: That the SAB seek assurance from the Health Commissioner that all out-of-borough placements it commissions will be commissioned in accordance with the ADASS Guidance

Recommendation 15: That the SAB seek assurance from the Health Commissioner that they have reviewed and revised as appropriate their Procedures and Processes for reviewing Continuing Health Care funded care and support packages.

5.8 Theme 6: Primary Care compliance with safeguarding policies and procedures

There were several examples of inaccurate or incomplete recording in the GP Practice records available to the SAR, in particular, reference to child protection procedures and information sharing.

Recommendation 16: That the SAR seek assurance from the Health Commissioner that they have reviewed and revised as appropriate their Contract Compliance Procedures and Processes for recording and sharing personal information with contracted services.

5.9 Theme 7: PSS Policies and Procedures

The SAR identified issues with PSS' Policies, Procedures and Processes for establishing a new service as well as with their Admissions Procedures and Processes. The result was that 263 opened before the property and staff – both managers and care and support staff – were fully prepared to provide a safe and stimulating service. Noah was also placed without PSS being provided with all the necessary information to develop an effective care and support package for him. His placement was not then reviewed to confirm its appropriateness.

The SAR also identified some areas of service provision that were not covered by the service specification of the service commissioned for Noah. While primary responsibility for this must lie with the commissioner, the provider also has a responsibility to its tenants/service users to ensure any service it provides is a safe and high quality one.

Recommendation 17: That the SAB seek assurance that PSS has reviewed and revised as necessary its internal Policies, Procedures and Processes.

5.10 Theme 8: SAB Policy and Procedures

The planning around Noah's discharge from hospital reflected a number of the issues raised around the assessing of his care and support needs and the commissioning, identification and reviewing of how these would be met in the community. These include the lack of input from Adult Social Care or the Leaving Care Service, an agreed care and support package being in place before he was discharged or any review within 8 weeks of the appropriateness of the placement and/or his care and support package.

The Bexley Safeguarding Procedures were not triaged in the case of the safeguarding concerns re Noah in a way to ensure their effective receipt and management. It is likely that, as a result, new safeguarding concerns were added to existing S42 Enquiries, it was not recognised that the safeguarding concerns raised about Noah could have been offences under s44 of the Mental Capacity Act 2005 and PSS were inappropriately tasked with an internal investigation into at least of the safeguarding concerns.

There were several examples where operational staff and their managers failed to raise safeguarding concerns despite identifying issues with the care and support Noah was receiving.

Recommendation 18: That the SAB seek assurance from Adult Social Care and the local Health Commissioner that they have reviewed and revised as appropriate the Hospital Discharge Planning Policies, Procedures and Processes.

Recommendation 19: That the SAB review and revise as appropriate the multi-agency Safeguarding Adults Procedures and Processes.

Recommendation 20: That the SAB seek assurance from its member agencies that their staff, and those in services they commission, are appropriately trained in the recognition of abuse and neglect and how to report it

5.11 Theme 9: Local Authority Quality Assurance of Care Providers

The Bexley Quality Assurance Team (BQAT) visited and reported back to PSS concerns they had about the premises and the service provided at 263 but didn't feedback their concerns to the

commissioners of those services. Not only did this prevent the commissioners from effectively reviewing their placements, but also prevented them from contributing to the development and monitoring of the Service Development Plan that BQAT agreed with PSS.

BQAT were first aware of 263 before any placements were made there; they did not advise PSS of the need for the local authority to be advised of any placements made by a different commissioner.

PSS consistently failed to satisfactorily respond to the Service Development Plan; the lack of any escalation process meant this didn't result in any sanctions being imposed on them. BQAT's internal management and supervisory structure did not pick this up.

Recommendation 21: That the SAB seek assurance that BQAT has reviewed and revised as appropriate its Procedures and Processes for the inspection and monitoring of services and its management and supervisory structures.

5.12 Theme 10: Criminal Offences against individuals who do not have capacity to safeguard themselves

Noah clearly lacked the capacity to safeguard himself or take basic decisions about his health and welfare or his finances. Despite this, no consideration was given by the Police as to the potential for the assaults, verbal and physical, to be treated as offences under s44 of the Mental Capacity Act 2005. Equally no consideration was given by the Criminal Prosecution Service (CPS) to the use of witness summons to support the prosecution of the alleged perpetrators of the assaults. The above prevented Noah having the access to the Criminal Justice System he was entitled to.

Recommendation 22: That the SAB seek assurance from the Police that they have reviewed their Procedures and Processes for managing criminal incidents against adults who lack capacity or are unable to give evidence.

5.13 Theme 11: NHS Safeguarding Systems relating to individuals in independent care provision

5.13.1 Community Services

Noah failed to attend at least 1 appointment with the Oxleas NHSFT Community Learning Disability Nursing Service; this was not chased up, though an alternative appointment was made, nor was the reason for the failure to attend recorded. While community staff monitored Noah in his placement, they did not consistently provide guidance to non-health professionals on how best to support Noah.

While Trust staff did visit Noah while he was an in-patient in Queen Elizabeth Hospital and University Hospital Lewisham, they were not involved, nor sought to be involved in the Discharge Planning Procedures from Epsom Hospital despite being the agency who would support him in the community on his discharge.

Recommendation 23: That the SAB seek assurance from ONHSFT that it has reviewed and revised as appropriate its internal Procedures and Processes.

5.13.2 Hospital Services

While Noah was an in-patient in Queen Elizabeth Hospital and University Hospital, Lewisham, PSS staff often failed to attend to support Noah on the ward. This was not routinely fed back to PSS; as there was a lack of clarity as to who was responsible for commissioning this support, it was not fed back to the commissioner either.

A safeguarding concern was raised promptly on Noah's admission to University Hospital in February 2022, but information about the safeguarding concerns relating to his care and support in the community before his admission was not communicated to the Hospital's internal Safeguarding Team.

There was also some confusion as to the implementation of the Hospital Discharge Procedures by which Noah was deemed medically fit for discharge without his pressure ulcer being reviewed by the Tissue Viability Nurse.

Recommendation 24: That the SAB seek assurance from the Lewisham and Greenwich NHS Trust that it has reviewed and revised as appropriate its internal Procedures and Processes

5.14 Theme 12: Legal Literacy

The importance of "legal literacy" for operational staff and managers across health and social care services for both children and adults cannot be overstated; an awareness of the legal powers and duties that apply is essential for the effective and safe exercise of professional practice. This is not to suggest that staff and managers need to be legal experts, but they do need to be cognisant of the statutory underpinning of their practice so that they know when to seek specialist legal advice.

Noah clearly lacked the capacity to make informed decisions about his health and welfare and his financial affairs. This had been known since he was a child, but no advice was given to his family by any of the professionals or agencies who supported them as to the implications of the Mental Capacity Act 2005 for decision-making in the above areas.

This was not identified in professional supervision or in the Procedures and Processes that were implemented by Merton's Children and Families, Transitions, Leaving Care or Adult Social Care Services, the Health Commissioner or CHS or Bexley Adult Social Care. As a result, Noah's family were unaware of the measures contained within the Mental Capacity Act 2005 to safeguard his best interests and to provide consistent decision-making with a legal underpinning. The fact that this was not identified even when services were being commissioned that required formal agreement – ie the signing of a tenancy agreement – would suggest that specialist legal advice was either not sought by or wasn't available to operational staff and managers.

At different times, a degree of knowledge of the Mental Capacity Act 2005 and its implications for the assessment and meeting of Noah's care and support needs was demonstrated, such as when a DoLS was applied for, or a Best Interest Decision meeting convened. However, these were the exceptions rather than the rule and Noah was assessed, treated and his personal information shared without any legal basis for doing so. What was poor practice was compounded and reinforced by procedures and processes that were recorded using templates that didn't require staff to question this lack of a legal basis.

While there is no suggestion that his mother did not advocate for Noah to the best of her knowledge and abilities or fail to act in his best interests, it remains the case that there was no overview of the decision-making process or its outcomes outside of the statutory agencies for what were long-term decisions. While the Steven Neary Judgement 2011 related to a case where there was a disagreement between the statutory agencies and the family, good practice would require that measures be put in place in case such a disagreement arose.

Recommendation 25: That the SAB seek assurance from partner agencies that they have reviewed and revised as appropriate their Mental Capacity Act 2005 Policies and Procedures in response to the issues to be addressed identified in the Analysis.

Recommendation 26: That the SAB seek assurance from Adult Social Care and their local Health Commissioner that they have ensured that the Mental Capacity Act 2005 Policies and Procedures of the services they commission have been reviewed and revised as appropriate in response to the issues to be addressed identified in the Analysis.

Recommendation 27: That the SAB seek assurance from partner agencies that their operational staff and managers and those in services they commission are “legally literate” with regard to the Mental Capacity Act 2005 and managers have easy access to specialist legal advice.

Recommendation 28: That the SAB seek assurance from partner members that they have reviewed and revised their Policies, Procedures and Processes relating to the assessment and treatment of adults to ensure they are compatible with the Mental Capacity Act 2005 and its supporting Code of Practice.

Recommendation 29: That the SAB seek assurance from Adult Social Care and their local Health Commissioner that they have reviewed all those adults who lack capacity to assess whether an application should be made to the Court of Protection to seek the appointment of a Deputy.

Recommendation 30: That the SAB seek assurance from Adult Social Care and the Safeguarding Children Board that the Transitions Procedures have been reviewed and revised as appropriate to ensure appropriate applications are made to the Court of Protection for Deputies to be appointed for young people who lack capacity.