Response to Regulation 28 Request

Title	Coronor Regulation 28 – Prevention of Future Deaths Report into the death of Adrian Stuart Green
Author/Role	[redacted], Associate Director of Patient Safety and Quality
Accountable Executive Director	[redacted], Interim Chief Nurse

Concerns raised by the coroner leading to the Regulation 28 – Prevention of Future Deaths Report:

Adrian Green died on 1st November 2021 following admission to Torbay and South Devon NHS trust via ambulance on 26th October 2021. Adrian Green was admitted acutely unwell, in organ failure and in a state of neglect. Prior to his death Adrian Green had been assessed as requiring a 3 x per day care package and support with shopping, no concerns were raised regarding Adrian Green's welfare by his carers (care support-based at Whitley court). Neighbours raised concerns that they had not seen Adrian Green and they raised the alarm to being visited by the carers.

A safeguarding alert was raised by Adrian Green's sister following his death. The safeguarding enquiry made recommendations directed at care support (the agency responsible for the care package). The safeguarding referral referenced a number of findings including:

- Adrian Green had been seen by other residents with bruising to the face, in previous months/weeks indicating an altercation, yet there was no welfare concerns or safeguarding's raised by the care provider.
- Adrian Green was reportedly declining medication which will have been prescribed to assist in his health and well-being and could have been important in any subsequent deterioration in his health and presentation.
- Adrian Green was reportedly receiving intercom calls as opposed to face to face visits. The Trust considers that face to face visits from the care provider, which would have furnished carers with additional risk assessment information as to the living conditions, and his general health and well-being.
- The Record of log sheets is inadequate dating back to 2020 as there are few visits recorded. It is also not clear in the record what is a telephone call or a face to face visit . Several entries worryingly report "no MARS (medication administration record) sheet ". It is a requirement for the administration of medications that they are recorded safely and appropriately.
- There is inadequate record keeping in many areas of Adrian Green's care planning and delivery of care.
- It is reported by head office and [redacted], Care Support, that records have been deleted and are not available to the investigating officer. It is reported that outgoing management deleted records from their own IT equipment. As a Trust we suggest this is not appropriate, safe, confidential or good record keeping practices.
- It was reported by a whistle blower that efforts were made to clean up the flat prior to SWAST(South West Ambulance Service Trust) attendance,
- [redacted] (Adrian Green's sister) states that if Adrian Green had been admitted to hospital or received medical attention earlier, he would have had a greater chance of survival.

Following Adrian's death, the subsequent HM Coroner's Inquest delivered a regulation 28 report detailing actions to prevent future deaths. The **matters of concern** raised by the coroner are detailed below:

(1) *Despite there being a safeguarding meeting following Mr. Green's death on 22nd January 2022 there appeared to be no review of whether the local authority ought to be have had policies in place to ensure that independent providers were adequately carrying out their contractual duties towards vulnerable individuals especially if the CQC duties towards vulnerable individuals especially if the* CQC were correct and there was no role for them in this case

(2) [redacted] *gave evidence to the inquest that she believed that there was a role for the CQC here as she believed that Mr Green had been in receipt of a personal care package*

(3) [redacted] *made a referral to the Disclosure and Barring service in respect of the former manager's actions and received no response as to what action if any the service were taking or an acknowledgement of her concerns*

The Trust sought further clarification from the Coroner and she advised:

An issue arose during the inquest surrounding the attached Safeguarding report and not treatment within the hospital and for that reason I did not consider it necessary to adjourn the inquest (the death was in 2021) and invite representation on the issue as the area I was concerned about was the apparent lack of investigation at that safeguarding meeting into how a similar situation could be improved upon and or prevented .

The meeting minutes appeared to simply ask the provider Care Support to revise their systems and report back to the meeting. My worry as expressed in the Regulation 28 report was that there should there be a way of the Trust overseeing any systems put in place by independent contract providers to avoid something like this happening again.

I was left in a difficult situation at inquest because the CQC had told my officers there was no role for them as the client was not in receipt of personal care and the contract provider manager had simply left her employment and destroyed records along the way.

I believed that action could be taken by the Trust to ensure that this type of death could be prevented from happening again by some Trust oversight of independent providers, whilst understanding that it was an independent contractor who held the contract for these services.

Background:

Adrian Green died on 1st November 2021 following admission to Torbay and South Devon NHS trust via ambulance on 26th October 2021. The care team, at Adrian Green's accommodation, were alerted to check on him by a neighbour who raised concerns about not hearing Adrian Green's music or seeing lights on in his flat for some time. Upon entering the flat the care and housing staff members found him to be 'unwell' and an ambulance was called. Safeguarding records show that Adrian Green was acutely unwell on admission to hospital 'with a 10% chance of survival with complete organ failure and nutritionally deprived.' Adrian Green was observed by hospital staff to present as neglected and 'dirty'.

Adrian Green's brother and sister report that the staff who entered the flat found him

lying in blood and faecal matter. His family shared they had been told that if he had received medical attention sooner he would have had a 50 % chance of survival. [redacted] raised a safeguarding alert to the Police and the Trust and made a referral to the Disclosure and Barring service.

Prior to his death Adrian was residing in Whitley court (which was under the management of Care Support), and his assessed package of care was for 3 x per day support with medication and 3 x per week support with shopping. Adrian Green was not in receipt of any domiciliary care.

It should be noted that Adrian Green's death occurred during the Covid 19 pandemic, from the 14th October 2021 (the weeks leading up to his death) there had been a relaxation in coronavirus restriction to allow greater mixing.

Safeguarding referral and alert 3rd November 2021

Following Adrian Green's death two safeguarding alerts were raised on 3rd November 2021. The first referral was made on behalf of his sister, regarding Adrian Green's condition on admission to hospital, his subsequent death and the fact that the care provider had not raised any alarm. This was referred by Torbay and South Devon NHS Foundation Trust. On 3rd November the care provider, Care Support, also raised a safeguarding referral via [redacted].

The referrals stated his sister and other family had visited the property on the 2nd November and it was in a poor state with evidence that Adrian Green had been lying in pools of blood and faecal matter. The alert advises Adrian Green's package of care 'was for medication three times per day and for 3 shopping trips per week'.

The referrals also advised of an issue that 3 members of the senior team in Whitley Court all left on the 15/10/2021, and on that day those 3 members of staff deleted all the company data that they had on their systems and devices, such as laptops, desktop, and mobile phones. This data included service user information, safeguarding concerns, complaints, investigations etc.

The referral advised that deleting data, which belonged to Care Support, is against company policy, procedure and legislation that governs how we should protect, store and dispose of any data.

The provider's referral states checks have taken place for all service users, and reviews were underway with all services users to identify they are happy with the service they are being provided and ensure it is safe and meeting their needs.

The Torbay Safeguarding Adult Single Point of Contact (SPOC) received further information as part of their review advising that a neighbour had raised welfare concerns to Care Support on the 26th October. There were also concerns that the new manager and agency staff had cleaned Adrian Green's property before paramedics attended allegedly to cover up any evidence of neglect.

A section 42 safeguarding adults meeting was held on **3rd February 2022** which identified the following ongoing risks:

- Adrian Green is deceased and the risks going forward will be related to those of the wider community and those being cared for by the provider (care support)
- [redacted] (Adrian's sister) outlined her concerns at her brother's passing and that it may have been preventable. She was particularly struck by the

comment that he would have had a 50% chance of survival if he had received medical treatment earlier. It was the shared view of the family and social care that there are wider implications and lessons to be learned for the wider public following the death of Adrian Green.

The section 42 enquiry made the following recommendations:

- Care support to detail what protocols are in place for the recording of safeguarding incidents and concerns and how this is relayed to carers.
- Care support to outline their own internal enquiries into the death of Adrian Green and their own internal findings.
- Care support to outline how they report and record daily carer logs and the advice and guidance given to carers as to what should be recorded.
- Care support to ensure that all MARS sheets are available and consistently used in the administration and recoding of medication.
- The communication handbook which provides handover information should be more detailed and use appropriate and compassionate language when referring to the cared for person.
- Information should be secured as to the name of the whistleblower in order that their views should be obtained in relation to the enquiry.

TSDFT response to HM coroners Matter of Concern 1

Despite there being a safeguarding meeting following Mr. Green's death on 22nd January 2022 there appeared to be no review of whether the local authority ought to be have had policies in place to ensure that independent providers were adequately carrying out their contractual duties towards vulnerable individuals especially if the CQC duties towards vulnerable individuals especially if the CQC were correct and there was no role for them in this case .

Mr. Green died on 1st November 2021 and the safeguarding meeting took place on 3rd February 2022. The Trust can confirm that a Provider of Concern Protocol (PCP) 2020 was in in place at the time of Adrian Green's death to support action to be taken in response to concerns raised relating to residential, nursing home, day and domiciliary care services in the unitary authority of Torbay and for which Torbay and South Devon NHS Foundation Trust commission services.

This PCP (which is now obsolete and has been replaced by a more rigorous process-see below reference to Provider Quality Support Protocol) detailed the process in place to manage concerns with respect to a number of adults at risk in one establishment, or where there are serious concerns about poor quality of care from a provider, but for which the threshold for safeguarding whole home / large scale intervention is not met.

The PCP is clear that any action taken does not replace individual adult safeguarding investigations. The protocol is intended to supplement the guidance provided in the Torbay Safeguarding Adult Whole Home / Large Scale

Safeguarding Adult Policy and Safeguarding Adults, Commissioning and Quality Assurance, Guidance for staff.

The PCP detailed a number of possible triggers for the provider of concern process which include external concerns such as a poor CQC inspection, safeguarding referrals, incidents reports etc.

Adrian Green had his own tenancy for a flat within Whitley Court. Mr Green was in receipt of a 3 x per day medication support package and 3 x per week support with shopping. No concerns had been raised by health or care professionals, or by any other mechanism to trigger the PCP to be enacted. Whitley Court had been rated as good by the CQC in Jan 2020. As Adrian Green had his own tenancy there was no legal right of access for the trust or tiggers of concern.

It is the view of the Torbay and South Devon NHS Foundation Trust that Care support was in a position of Trust in providing care for Adrian Green and that they failed to provide the agreed level of care for Mr Green per the contract arrangement, this lack of care contributed to his state of neglect and ill health. In addition records were deliberately deleted which is a significant concern.

Since this tragic case the Torbay and South Devon NHS Foundation Trust and local authority have taken a number of steps to improve oversight via robust contract management, including contract review meetings and quality assurance oversight of providers commissioned by Torbay adult social care. The frequency of review meetings is adjusted based on the type of service, the value and risk of the service with some being quarterly and others 6 monthly.

Actions taken to improve oversight and assurance (all documents referred to in this section are included at appendix TSDFT1)

1) The Market Management Lead was brought into post in October 2022 to oversee the Independent Sector Market and Contracts and line manage the four Contract Managers.

2) Creation of a Contract Management procedure and toolkit, and set-up of a contracts register were delivered between October 2022 and October 2023 **(Doc 1)**.

3) The team are currently in the process of reviewing and re-issuing all contracts to include updated quality standards and key performance indicators within our service specifications **(Doc 2)**

4) In January 2024, the Market Management Lead took over line management of the Quality Assurance and Improvement Team (QAIT), merging the quality function with the contract management function **(Docs 3 and 4)**.

5) In February 2024 , the Provider Quality Support Protocol (PQSP) **(Doc 5)** was ratified through Care and Clinical Governance, replacing the previous policy, the Provider of Concern protocol. The Provider Quality Support Policy (PQSP) has been developed to establish a formal and coordinated response

to concerns about standards of care within regulated and other care provider services in Torbay.

The Provider Quality Support policy covers all adult social services and encompasses:

- Regulated residential and nursing care homes
- Regulated domiciliary care services
- Outreach services (including unregulated domiciliary care)
- **Regulated and unregulated Supported Living services**
- Day care services
- Extra care services
- Live-in care services

  The PQSP establishes a formal means of responding to concerns about these services where there is reason to believe that there are a number of individuals whose well-being needs as defined within Chapter 1 of Care Act 2014 Statutory Guidance are not being met. This applies to all persons living with the care provider service regardless of whether the host authority or other placing authorities are carrying out a care and support function.

6) The QAIT Officers gather intelligence from a variety of sources to determine which providers require additional support or actions plans to be put in place, for example CQC, Safeguarding **(Doc 6)**, Incidents reported within DATIX, our Incident Reporting System, KPI Data **(Doc 7)**, and soft intelligence from front line operational staff gathered at weekly Quality Assurance Huddle meetings **(Docs 8 and 9)**.

7) Contract Managers complete Contract Review Meetings on a regular basis with all providers **(Doc 10).**

8) QAIT Officers monitor trends and themes and put in place Action Plans (Service Improvement Plans) for any providers which do not meet the required standards **(Doc 11).**

9) Providers who have been rated as Requires Improvement by CQC and those who are falling below the Trust's required standards and are subject to ongoing monitoring are reported through the governance cycles within both Torbay and South Devon NHS Foundation Trust and Torbay Council **(Doc 12).**

10) Please note, not all providers are subject to all parts of the Quality Assurance and Contracts Management process so therefore the assurance evidence below refers to a number of different providers and has been anonymised.

Further actions taken following Mr Green's Death

Immediate Actions taken to ensure safeguarding of residents

- 3rd November 2021 Safeguarding referral/ alert submitted following contact from Adrian Green's sister and a referral the same day from [redacted], Registered Manager for Care and Support relating to the same incident

- 4th November 2021 Safeguarding alert forwarded to CQC. Initial contact made with Devon and Cornall police.

- 4 November 2021; a multi-agency, large-scale safeguarding adults meeting was conveyed. This resulted a full large scale enquiry being convened that included;
  - Full engagement with CQC in response to concerns linked to a regulated care provider.
  - Ongoing engagement with Devon and Cornwall Police.
  - Assessment of risk and engagement with all residents within Whitley Court and Dunboyne Court in which the regulated provider operated within Torbay.
  - Ongoing monitoring and support to the provider in response to the staffing issues, destruction of care plan documentation and need for continuity of care for people impacted by the safeguarding incident.
  - Full participation with commissioners of care to consider their contractual position with the regulated provider. Care and Support subsequently were unsuccessful with the tender for the new contract.

- 5th November 2021 referral was made to Devon and Cornwall Police to consider what if any action they wished to consider in response to alleged gross neglect.

- On the 5th November, the referral passed ownership from Single Point of Contact (SPOC) to the Adult Social Care (ASC) Community Team to pursue the enquiry response.

- 18 November 2021 meeting to review the initial safeguarding plan made for the residents at Whitley Court; this was a multi-agency meeting; which included Commissioners from Torbay Council and CQC. Agreed that the contract notice would be issued, with an expected completion date of 2 December 2021. Geraldine Hodge from CQC advised that CQC would be undertaking a monitoring activity call with the provider

- 2nd December 2021 safeguarding meeting with the provider. The action plan needs to focus on understanding the specific needs of individuals to prioritize who should get priority care. CQC not in attendance however kept updated.

- 6 December 2021 focused meeting to agree the terms of reference for the safeguarding enquiry

- findings of Section 42 safeguarding meeting

Actions to ensure shared learning and wider system improvement to reduce the likelihood of future similar incidents.

- Thematic review commissioned into individuals who had died in Devon of self - neglect. The review was published in February 2023. The recommendations from this review are being monitored via TDSAP and the learning has been widely disseminated.

- 6th July 2022 and as part of the safeguarding adult review (SAR), the Torbay and Devon Safeguarding Adults Partnership (TDSAP) organised a partnership practitioner and manager fishbowl event which enabled practitioners and managers to engage in the review and provider their narrative of the challenges and opportunities in practice to support people who self-neglect.

- The TDSAP Learning and Improvement Sub-Group has also published and widely distributed a SAR practice briefing in response. This has been widely distributed across the Partnerships boundaries including to front line practitioners

- Torbay and South Devon NHS Foundation Trust has distributed the briefing to all commissioned adult social care services including its commissioned out of area authorities, care home sector, homecare sector, supported living services, daytime activity and enabling services, voluntary and community sector and all other commissioned services.
  a) In response to the thematic self-neglect review, TDSAP has also created and approved Multi-Agency Risk Management Meetings (MARMM): Guidance and Over-Arching Principles. The purpose of this guidance is:

  - To provide a multi-agency forum to coordinate joined up support for individuals displaying high risk behaviours or who are at risk of harm due to the circumstances they find themselves in.
  - To provide an environment enabling a proactive approach, focusing on prevention and early intervention, with professionals responding to chronic or entrenched behaviours as part of their day-to-day work.
  - To identify and escalate cases for multi-agency collaboration and actions.
  - To have senior level representation to support practitioners and offer a fresh approach with creative solutions, access to specialist support and legal advice where appropriate.
  - To enhance local partnership connections and relationships and develop a database of useful contacts. It is hoped this will result in dynamic safeguarding and information sharing taking place outside of the MARMM process.

  Currently TDSAP Operational Delivery Group is undertaking task and finish group activity to implement this guidance into practice.

  In 2023 Torbay's MCN (multiple and complex needs) Alliance was formed. This is an innovative form of commissioning and delivering a range of services under a shared contract, whereby member organisations take collective ownership of and responsibility for all the services being provided. The services within the Alliance are drug and alcohol services, domestic abuse services and the homeless hostel (Leonard Stocks Centre).

Actions taken to improve oversight and assurance

Following Adrian Green's death a full review and restructure of how contracts are managed and continually reviewed has been completed by Torbay and South Devon NHS Foundation Trust.

The Trust now has a more robust system of contract management, quality control and audit in place which, we suggest, would mitigate the chances of another incident like this occurring.

Regular contract review meetings take place with all care providers, all service level agreements are monitored including key performance indicators. A review of the interactions with service users and how many missed appointments a service user has had in this period is also assessed.

By undertaking this review, when a service user misses a number of appointments, or assessment is not carried out by a face to face appointment, a welfare check can be arranged which would seek to ensure that the circumstances such as Adrian's of self neglect would be highlighted at an earlier stage to enable intervention to be undertaken.

Matters of concern No 2 raised by HM coroner

a) [redacted] *gave evidence to the inquest that she believed that there was a role for the CQC here as she believed that Mr Green had been in receipt of a personal care package* - Torbay and South Devon NHS Foundation Trust are not able to answer this point. Adrian was not in receipt of personal or domiciliary care package. Adrian was provided with 3 times daily medication reminders and 3 times weekly assistance with shopping. As no personal or domiciliary care package was provided Torbay and South Devon NHS Foundation Trust aver there was no CQC role

Matters of concern no 3 raised by HM coroner

b) [redacted] *made a referral to the Disclosure and Barring service in respect of the former manager's actions and received no response as to what action if any the service were taking or an acknowledgement of her concerns*. Torbay and South Devon NHS Foundation Trust are unable to answer this concern and this should be raised directly with the Disclosure and Barring Service.

TSDFT Appendix 1

Document 1 – Contract Management Procedure:	Contract Management Procedu
Document 2 – An example of a recently issued Service Specification (part of contract):	Service Secification Final.docx
Document 3 – Current Markets, Contracts and Quality Team Structure:	Team Structure.docx
Document 4 – QAIT Officer Job Description	QAIT Job Description.docx
Document 5 – Provider Quality Support Protocol:	PQSP.docx
Document 6 – Safeguarding Dashboard	Safeguarding Dashboard.png
Document 7 – Example of KPI Dashboard for a provider	Provider%20KPI%20 Dashboard%20Examp
Document 8 – Care Provider Quality Assurance Huddle Terms of Reference	Care Provider Quality Assurance Huddle TO
Document 9 – Care Provider Quality Assurance Agenda and Minutes Template	Care Provider Quality Assurance Huddle Ag
Document 10 – Example of a Contract Review Meeting minutes	Contract Review Meeting Example.doc
Document 11 – Example of a Full Action Plan (ongoing case)	Full Action Plan Example.docx
Document 12 – Sample of Quality Assurance Monthly Reporting	Sample of Monthly Reporting.pptx