South Gloucestershire Safer & Stronger Communities Strategic Partnership

DOMESTIC VIOLENCE HOMICIDE REVIEW

EXECUTIVE SUMMARY OF OVERVIEW REPORT

Into the death of Molly (pseudonym) on 18th June 2014

David Warren QPM, LLB, BA, Dip. NEBSS
Independent Domestic Homicide Review Chair and Report Author

Report Completed: 7th April 2015

Section One: Introduction

1. This Domestic Homicide Review examines the circumstances surrounding the death of Molly (pseudonym), who was 87 years of age and lived in a care home in South Gloucestershire.

1.1. The circumstances of Molly's death are:

1.1.1. On 18th June 2014, just before 1pm, the Police received a call from the manager of a South Gloucestershire care home informing them that Molly, one of the residents, had been found on the floor of her bathroom apparently deceased. Edward (pseudonym), her step-grandson had been seen in the room when Molly had been brought her lunch. A short time later Molly's assistance bell was activated and a member of staff went to respond. The ensuite bathroom door was shut and when the care assistant asked, through the closed door, what Molly needed, a male voice responded that everything was OK. The staff member alerted a nurse who sent her back to speak to Molly. Edward was seen running from the room and the care assistant found Molly in the bathroom not breathing. Edward was later arrested.

1.1.2. Edward gave an account to the police admitting killing Molly as a so-called 'mercy' killing because he thought she had Alzheimer's disease and epilepsy and he "did not want her to wander around like a zombie". He tried to kill her by smothering her with a pillow for a period of 5 minutes. She was still alive fighting for her life, whereupon he dragged her into the bathroom and smothering her again using the pillow and his pushing his knee into her throat to ensure she was dead.

1.1.3. Edward was charged with Molly's murder and remanded in custody. While in prison awaiting trial he attempted to kill a fellow inmate who is consequently now in a persistent vegetative state (PVS). Psychiatric reports agreed that at the time of Molly's death and the attempted murder of his fellow inmate he was suffering from a mental disorder, namely paranoid schizophrenia which substantially impaired and reduced his mental responsibility for his actions.

1.1.4. The Judge at Edward's trial made a hospital order under section 37 of the Mental Health Act (MHA) 1983, with a section 41 MHA restriction order. The judge acknowledged that this might mean he will never be released and it will ensure that he is never released when he remains a danger to the public.

Section Two: The Review Process

2.1. This summary outlines the process undertaken by the South Gloucestershire Domestic Homicide Review Panel in reviewing the death of Molly.

2.2. The South Gloucestershire Safer and Stronger Communities Strategic Partnership sought advice from the Home Office and after receiving a response on 1st September 2014, made the decision to undertake a Domestic Homicide Review on 4th September 2014.

2.3. The process began on the 17th October 2014, with an initial Review Panel meeting of all agencies that potentially had contact with the victim Molly or perpetrator Edward prior to the point of Molly's death, and it was concluded on 7th April 2015.

2.4. Molly's nephew (her next of kin) and Edward's mother (Molly's step-daughter) were contacted at the commencement of the Review. Both confirmed they wanted to assist the Review and they respectively provided pseudonyms and gave written consent for the Review to access the medical records of Molly and Edward. Both were informed of the outcome of the Review on 3rd March 2015. Edward's mother declined the invitation to read the Overview Report or to attend the final meeting on 7th April 2015. Molly's nephew and one of her step-daughters read the Report and attended the final DHR Panel meeting.

2.5. The agencies participating in the Review are:-

Avon and Somerset Constabulary

Avon and Wiltshire Mental Health Partnership NHS Trust

Edward's School

Care Quality Commission

Health Care Company (Care home owner)

Home Choice South Gloucestershire Council

Merlin Housing

National Probation Service,

Next Link

North Bristol NHS Trust

Off The Record

South Gloucestershire Clinical Commissioning Group

South Gloucestershire Council Children and Young Peoples Service

South Gloucestershire Council Department for Environment and Community Services Department

South Gloucestershire MARAC

South Western Ambulance Service NHS Foundation Trust

Survive

University Hospitals Bristol NHS Foundation Trust

Victim Support

2.6. The agencies were asked to give chronological accounts of their contacts with the victim and/or perpetrator prior to the homicide. All relevant documentation was secured. Where organisations had no involvement, or insignificant involvement, they informed the Review accordingly. In line with the Terms of Reference, the DHR has considered all contacts during the period from 1st January 2013 and the death of Molly on 18th June 2014, as well as those contacts prior to 1st January 2013, which could be relevant to domestic abuse, violence or mental health issues.

2.7. Of the nineteen agencies contacted about this Review, eleven responded that they had had no contact with the victim or perpetrator.

2.8. Eight agencies completed either an Independent Management Review (IMR) or a report with information indicating some level of involvement with either Molly or Edward.

2.9. A summary of the facts obtained from the IMRs, reports and from the family are as follows:

2.9.1. In the 1970s Molly, married a widower, who had nine children. They had no children together. Edward was one of Molly's step grandchildren. He lived with his mother, younger brother and sister. His father was murdered when he was 10 years of age.

2.9.2. In 1999, when Edward was 18 years of age, his mother took him to their GP, as she was concerned that he was suffering with depression. The GP subsequently referred him to a psychiatrist.

2.9.3. Edward was assessed as not being a risk to himself or others. He was placed on antidepressants but later, after his mother described his behaviour as angry and destructive, he was referred to a therapy unit. He was given one to one counselling, referred to a social worker and allocated a community care worker. Later, due to none attendance, he was discharged from the Unit, but retained the support of the community care worker.

2.9.4. In 2002 Edward was referred to the Community Mental Health Team, because of his ongoing problems with social phobia and anxiety. He commenced treatment for depression but nine months later he was again discharged because of his poor attendance.

2.9.5. In September 2004 Edward's GP noted that Edward had lost his job and not been out of the house for 18 months, isolating himself from his family. The GP referred him for counselling. Although a community psychiatric nurse visited him at home he would not leave his bedroom and only agreed to have email contact with the CPN. This was followed by further visits to the house by a psychiatrist and the CPN. Most of the work with him was cognitive behavioural therapy (CBT) for his extreme anxiety, provided at the house. In May 2006 Edward was discharged after Edward and his mother agreed that while significant changes had been made,

further psychological work would be of little benefit.

2.9.6. On 17th January 2013 Edward's grandfather (Molly's husband) died after a long illness. Edward was upset he had not seen him before he died and he started to spend a lot of time with Molly.

2.9.7. On two occasions during 2013 Edward was reported to the police as a missing person. Both times he returned home of his own accord within 24 hours. He told officers he had been feeling guilty living at home without contributing financially.

2.9.8. After the second time he went missing his GP made an urgent referral to the Avon and Wiltshire Mental Health Partnership NHS Trust Primary Care Liaison Service (PCLS) due to concerns raised by Edward's sister that he was obsessed by the Bible. The sister asked that he was not told the nature of her concerns. An appointment was made with a CPN, who found no obvious signs of mental illness and Edward was advised on primary care counselling and vocational support before being discharged from the PCLS.

2.9.9. In May 2013 Molly fell and broke a bone in her foot. She was treated and allowed home as she was able to walk with the help of a zimmer frame. A month later she was admitted to hospital suffering from back pains after another fall. The Hospital notes recorded that she had decreased mobility, epilepsy and had urinary problems. Her mental state was described as disorientated. As she was living alone, arrangements were made for her to move temporarily into a care home.

2.9.10. Molly was unhappy in the care home as she felt lonely. She wanted to go home but as her step-daughters were not able to help she was discharged home with the help of a home support service, calling four times a day to assist her.

2.9.11. After only five days Molly was re-admitted to the care home, as she had been falling at home and not managing. A safeguarding adult alert had been raised by the ambulance service after they had been called out to assist her 3 times within 24 hours. Molly's GP, suspecting she was suffering from dementia, referred her to the memory clinic. She was diagnosed with probable vascular dementia. Her nephew was informed and a new care home was found as it was recognised that she could not cope with living on her own.

2.9.12. On 17th June 2014 Edward left home at approximately 5pm, leaving behind a note saying he was going away, would not be coming back and did not want to be found. The family did not report this to the police but at 1.15 am on 18th June 2014 he phoned home saying he was in Chippenham and was returning home, he arrived at 6am. This was the day he killed Molly (see paragraph 1.1).

Section Three: Terms of Reference

3.1 Purpose:

3.1.1 The purpose[1] of the Domestic Homicide Review is to:

[1] Paragraph 7 of the Home Office Revised Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews, 2013

- Establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard victims

- Identify clearly what those lessons are, both within and between agencies, how and within what timescales they will be acted on and what is expected to change as a result.

- Apply these lessons to service responses including changes to policies and procedures as appropriate; and

- Prevent domestic violence homicide and suicide, and improve service responses for all domestic violence and abuse victims and their children through improved intra and inter-agency working.

3.1.2. DHRs are not inquiries into how the victim died or into who is culpable; that is a matter for coroners and criminal courts, respectively, to determine as appropriate.

3.1.3. The DHR Independent Chair will ensure the review is conducted according to best practice, with effective analysis and conclusions of the information related to the case.

3. 2. **Overview and Accountability:**

3. 2.1 The decision for South Gloucestershire to undertake a Domestic Homicide Review (DHR) was taken by the Chair of the South Gloucestershire Safer and Stronger Communities Strategic Partnership on 4th September 2014, after consultation with the Home Office

3. 2.2 The Home Office Statutory Guidance advises where practically possible the DHR should be completed within 6 months of the decision made to proceed with the review. As there are criminal proceedings pending relating to this homicide, a decision has been made to adjourn the Review until the completion of the trial.

3.2.3. This Domestic Homicide Review, which is held within the spirit of the Equalities Act 2010, to an ethos of fairness, equality, openness, and transparency, will be conducted in a thorough, accurate and meticulous manner.

3.3. This Domestic Homicide Review will consider:

3.3.1. Each agency's involvement with the following family members between 1st January 2013 and the death of Molly on the 18th June 2014 at her address in Yate, South Gloucestershire. Agencies will also include specific contacts with either the victim or perpetrator, prior to this period, which might relate to domestic abuse, violence or mental health issues.

Victim: Molly 87 years of age of Yate, South Gloucestershire

Perpetrator: Edward 33 years of age of Yate, South Gloucestershire

3.3.2. Whether there was any previous history of abusive behaviour towards the deceased, and whether this was known to any agencies.

3.3.3. Whether the alleged perpetrator has any previous history of violence and if so was this known to any agency?

3.3.4. Whether the alleged perpetrator has any previous history of mental health concerns known to any agency.

3.3.5. Whether family, friends or colleagues want to participate in the review. If so, ascertain whether they were aware of any abusive behaviour to the victim, prior to the homicide.

3.3.6. Whether, in relation to the family members, were there any barriers experienced in reporting abuse?

3.3.7. Could improvement in any of the following have led to a different outcome for Molly? Considering:

a) Communication and information sharing between services.

b) Information sharing between services with regard to the safeguarding of children and adults.

c) Communication within services

d) Communication to the general public and non-specialist services about available specialist services

3.3.8. Whether the work undertaken by agencies in this case was consistent with each organisation's:

a) Professional standards

b) Domestic Abuse and safeguarding policies, procedures and protocols

3.3.9. The response of the relevant agencies to any referrals relating to Molly concerning domestic abuse or other significant harm. It will seek to understand what decisions were taken and what actions were carried out, or not, and establish the reasons. In particular, the following areas will be explored:

a) Identification of the key opportunities for assessment, decision making and effective intervention in this case.

b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.

c) Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made

d) The quality of any risk assessments undertaken by each agency in respect of Molly.

3.3.10. The response of the relevant agencies to any referrals relating to Edward concerning his mental health. It will seek to understand what decisions were taken and what actions were carried out or not and establish the reasons. In particular, the following areas will be explored:

a) Identification of the key opportunities for assessment, decision making and effective intervention in this case.

b) Whether any actions taken were in accordance with assessments and decisions made and whether those interventions were timely and effective.

c) Whether appropriate services were offered/provided and/or relevant enquiries made in the light of any assessments made.

d) The quality of any risk assessments undertaken by each agency in respect of Edward.

3.3.11. Whether organisations thresholds for levels of intervention were set appropriately and/or applied correctly in this case.

3.3.12. Whether practices by all agencies were sensitive to the ethnic, cultural, linguistic and religious identity of the respective family members and whether any specialist needs on the part of the subjects were explored, shared appropriately and recorded.

3.3.13. Whether issues were escalated to senior management or other organisations and professionals, if appropriate, and completed in a timely manner.

3.3.14. Whether the impact of organisational change over the period covered by the review had been communicated well enough between partnership agencies and whether that impacted in any way on agencies' ability to respond effectively.

3.3.15. Whether, any training or awareness raising requirements are identified to ensure a greater knowledge and understanding of domestic abuse and safeguarding processes and/or services.

3.3.16. The review will consider any other information that is found to be relevant.

Section Four: Key Issues

4.1. The DHR provided an opportunity to analyse the information obtained from agencies, from Molly's and from Edward's family and from parallel reviews/inspections

4.3. The Review considered whether any of the nine protected characteristics of the Equality Act influenced decisions made by organisations in their contacts with either Molly or Edward. Whilst Molly was elderly and suffering from aged related infirmities, there was no evidence that these adversely affected quality of care provided to her by agencies. Nevertheless it is noted that Edward had told the police that he had killed Molly because he did not want her to become a “zombie” because she had Alzheimer’s disease and epilepsy.

4.4. The Review Panel considers the key issues in this Review to be; the lack of evidence of any previous domestic abuse; Edward’s mental health and treatment prior to the homicide and events at the nursing home on the day of the homicide.

4.5. Lack of evidence of any previous domestic abuse.

4.5.1. The Individual Management Reports of the agencies that had contact with Molly and Edward have carefully checked their records to ascertain if there was any indication of previous domestic abuse or if any opportunity had been missed to check with Molly if she had been the victim of any kind of abuse in the past. Nothing was found, nor were there any records of contacts found by any of the specialist domestic abuse services operating in South Gloucestershire or the neighbouring area of Bristol. Molly’s family were unaware of Molly ever being the victim of abuse in the past.

4.5.2. When Edward was interviewed by the police after the homicide he explained he had done it because he loved Molly and it was a “mercy killing” because he thought she had Alzheimer’s disease and epilepsy and “he did not want her to wander around like a zombie”. He told the police he had never previously harmed her in any way.

4.5.3. The Review Panel is satisfied that it is unlikely that Molly had ever been subjected to domestic abuse by Edward in the past.

4.6 Edward’s mental health and treatment.

4.6.1. Edward’s mother was concerned about his reclusive and introvert behaviour from when he was about 16 years of age as he did not make friends easily and had no confidence. She eventually took him to their GP when he was 18 as he had not left the house for over a month and she felt he was suffering from depression. He spent his time sleeping during the day and watching TV and playing on his computer throughout the night. He was referred to a psychiatrist who noted he had no forensic history, did not use drugs, and only occasional consumed alcohol. Edward was risk assessed as not being a danger to himself or others and he was placed on antidepressants. Later, after his mother described his behaviour as angry and destructive, smashing panes of glass, he was referred to a therapy unit. As he was observed as being shy, not able to make eye contact and had not been out for over a year, he was given one to one cognitive behavioural therapy rather than group therapy.

4.6.2. Between 1999 and 2013 he was referred by his GP to specialist mental health services five times and saw several different clinicians including psychiatrists, psychologists and community psychiatric nurses, as well as social workers and community care workers. These different professionals consistently diagnosed him as suffering from depression, anxieties and social phobia; treatment included medication and therapy. Due to his refusal to leave his bedroom, referrals were characterised by numerous missed appointments, although efforts were made to see him at home and even to engage with him through email.

4.6.3. While Edward was never considered to be a risk to himself or to others he frequently argued with his brother, on one occasion threatened him with a knife. His sister expressed her concerns to their GP in 2013 about Edward's obsession with religion. He was baptised into the Church of England and learnt large tracts of the bible by heart. Although he was referred to the Primary Care Liaison Service (PCLS) his sister asked for him not told about her concerns, they were never therefore discussed during therapy sessions.

4.6.4. After Edward was discharged from the PCLS in February 2013 he had no further contact with any medical services until after the homicide in June 2014.

4.6.5. The Review Panel is satisfied that on the basis of what was known at that time he was being treated with the appropriate level of professional care by his GP and by the mental health services.

4.7. Events at the nursing home.

4.7.1. A number of concerns were raised in May 2014 about the turnover of staff at the nursing home in which Molly was residing and the Care Quality Commission commenced an inspection which is ongoing with the support of the care home's parent company. The Review Panel however, after considering the issues, is satisfied that they had no relevance to Molly's death. Molly's next of kin, who has made complaints about the quality of care at the nursing home in the past, concurs with the Review Panel.

4.7.2. The Review Panel has considered the fact that Edward knew the care home's front door key code and was able to enter without being checked in by a member of staff. This method of entry has become common practice since the review into the Winterbourne View care home. In that case concerns had been highlighted about relatives/visitors not being given easy access to residents and having to wait outside the premises until a member of staff let them in. The Review Panel is satisfied that as Edward was a regular visitor to the home he would have been allowed entry to see Molly, even if he had been required to ring the doorbell.

4.7.3. When Edward was attempting to smother Molly with a pillow in her room she was able to press her assistance bell. Edward then dragged Molly into the ensuite bathroom and continued to smother her. When a care assistant responded to the assistance bell she saw the bathroom door closed and called out asking if Molly needed anything. Edward replied that everything was OK. The care assistant left the

room but informed a nurse of the occurrence. She was sent back to see Molly and confirm that all was well. As she reached the room Edward pushed past her and hurried down the corridor. She entered the room and found Molly in the bathroom not breathing.

4.7.4. The Review Panel is of a view that the care assistant should have insisted on checking personally with Molly but recognises that she had not received any prior training on what to do in such circumstances. The Panel accepts that in this case it is unlikely that she would have been able to save Molly even if she had gained entry to the bathroom. They acknowledge that she informed a nurse immediately and commend the nurse for her response in sending the care assistant back to check on Molly's welfare. The Panel believes that the recommendation made to introduce a policy and to provide training to staff on checking personally with residents may save victims in the future.

4.7.5. The South Gloucestershire Safeguarding Adults Board met in July 2014 and concluded that the threshold for holding a Serious Review had not been met "as no reasonable measures could have been implemented by the care home to prevent Molly's death". The alleged perpetrator appeared to have been focused in his actions and desired outcome. There was "no suggestion of long term abuse or neglect by the step-grandson".

Section Five: Effective Practice/Lessons to be learnt

5.1. The following agencies that had contacts with Molly or Edward have identified effective practice or lessons they have learnt during the Review.

5.2. Avon and Somerset Constabulary

5.2.1. In all contacts with Edward and Molly the police acted properly. Actions taken were both timely and proportionate to the events taking place and were in accordance with Policy and Procedural Guidance.

5.2.2. There are no lessons to be learnt.

5.3. Avon and Wiltshire Mental Health Partnership NHS Trust

5.3.1. Edward level of anxiety and social phobia, which prevented him from attending appointments outside of the family home (and on one occasion, refusing to leave his room to speak with attending clinicians) made engagement particularly difficult. This was addressed by clinicians using emails to communicate with him, offering telephone contact and by the clinical psychologist agreeing to work with Edward at home.

5.3.2. There are no lessons to be learnt in this case.

5.4. Health Care Company (Owner of care home)

5.4.1. The care home has identified that care staff need to be trained to check personally with a resident when responding to an assistance bell, even when a

visitor is present.

5.5. North Bristol NHS Trust

5.5.1. The North Bristol Trust has appointed a lead officer to coordinate and lead on domestic abuse. A domestic abuse policy is in place and training for all staff is being delivered. There is an IDVA service available in the Accident and Emergency service. In conjunction with its health partners the Trust is working toward full implementation of the 2014 issued NICE guidelines for Domestic Abuse and Violence.

5.5.2. There were no lessons to be learnt.

5.6. South Gloucestershire Council Adult Children and Health Institutional safeguarding Team.

5.6.1. There were no lessons to be learnt.

5.7. South Gloucestershire Clinical Commissioning Group

5.7.1. There are no lessons learnt from this case which would have affected the outcome. Until there is an effective early diagnosis for schizophrenia when it presents in an atypical way and effective long term treatments, rare tragedies from this cruel disease will occasionally happen. In most cases there are issues around management of known schizophrenia, but this does not appear to be the case here. There is a recognition that if more information had been available to the GP or mental health services, it is possible they may have been able to identify early signs of schizophrenia before psychosis overcame Edward.

5.8. South Western Ambulance Service NHS Foundation Trust

5.8.1. There were no lessons to be learnt, but the communication by ambulance staff with the GP practice in identifying safeguarding concerns about Molly not being able to cope on her own is an example of good practice.

5.9. University Hospitals Bristol NHS Foundation Trust.

5.9.1. There were no lessons to be learnt.

Section Six Conclusions

6.1 In reaching their conclusions the Review Panel has focused on the questions:

- Have the agencies involved in the DHR used the opportunity to review their contacts with Molly or Edward in line with the Terms of Reference (ToR) of the Review and to openly identify and address lessons learnt?

- Will the actions they take improve the safety of domestic abuse victims in South Gloucestershire in the future?

- Was Molly's death predictable?

- Could Molly's death have been prevented?

6.2. The Review Panel is satisfied that the IMR authors have been open, thorough and questioning from the view point of the victim in conducting their reviews. They have worked in line with the Review's Terms of Reference and in fact gone beyond the required periods to consider earlier relevant contacts. The Review Panel is satisfied that in this case the agencies have followed their correct policies and procedures during their contacts with Molly and Edward.

6.3. In this review no evidence has been found of any prior domestic abuse towards Molly. The Review Panel has had the opportunity to read all of the domestic abuse policies of the agencies who had contact with either Molly or Edward and are satisfied that they are fit for purpose. The implementation of these policies will ensure that any future victims will be safer in South Gloucestershire.

6.4. The Panel is satisfied that the recommendations made within the Review will make life safer for the residents of care and nursing homes.

6.5. The Review Panel does not believe that Molly's death was predictable. Molly had never given any indication that she had ever been abused and the agencies she was in contact with did not find any evidence of abuse. Edward had visited her on numerous occasions without any problems being apparent. In interviews with the police, after the homicide, Edward told the officers that he loved his step-grandmother and had smothered her to prevent her ending up like a "zombie" because of her declining dementia.

6.6. The Panel believes that Molly's death could not have been prevented. In reaching their conclusion the Panel particularly considered:

- Edward had been seen by a number of different clinicians between 1999 and 2013 and they had independently diagnosed that he was suffering from anxieties and social phobia. They had no clear information to suggest he might also be suffering from paranoid schizophrenia.

- From the time he was discharged by the Avon and Wiltshire Mental Health Partnership Primary Care Liaison Service in 2013 he had no further contact with any medical service prior to the homicide in June 2014. During this time none of his family had contacted either his GP or the mental health trust with concerns about his mental health.

- On the two occasions Edward was reported to the police as a missing person he returned home on his own and gave rational explanations for leaving home when he spoke to police officers. They had no evidence to suspect that he was a risk to himself or to any other person and therefore would have no reason to consider that he should be sectioned under the Mental Health Act.

- The fact that Edward was able to enter the care home without checking in with

staff was not considered relevant as he would have been allowed in to see Molly even if he had needed to ring the doorbell. It is common practice nationally for nursing and care homes to give relatives and regular visitors door codes so that they have easy access to residents.

- The care worker who answered Molly's assistance bell did not see Molly; she was aware that Molly's step-grandson was visiting and when she heard a male voice answering her that Molly was ok she did not enter the bathroom. She did however inform a duty nurse of what had happened. The nurse told her to go back and check with Molly herself. She immediately returned to Molly's room where Edward pushed passed her and hurried from the building. When she went into Molly's bathroom she found Molly on the floor, not breathing. Edward later admitted to the police that he had held a pillow over Molly's face for several minutes and was surprised that she was still breathing, he then dragged her into the bathroom where he kept his knee on her throat whilst smothering her again with the pillow.

6.7. The Panel strongly supports the view of the South Gloucestershire Clinical Commissioning Group IMR author who stated "this case does demonstrate the need for further research to find the causes and effective treatments for schizophrenia; had a test been available to make the diagnosis at an earlier presentation, some intervention might have been possible. A raised awareness of the early signs of schizophrenia, might have allowed the family or contacts to alert the medical authorities, and work around de-stigmatising mental health, which might have made Edward more willing to seek help before psychosis overcame him". This view is also supported by Molly's next of kin who is a retired senior social worker.

Section Seven Recommendations

7.1. National

7.1.1. Care and nursing home providers should introduce a procedural policy that when a resident presses their assistance bell the responding member of staff should check their needs with them personally, rather than accepting the word of a visitor. Management teams should ensure that all staff are aware of this policy and that it is included in all staff induction and refresher training.

7.1.2. That the Department of Health be notified about the circumstances of this case so that:

- Consideration can be given to the need for further research to find the causes and effective treatments for schizophrenia; had a test been available to make the diagnosis at an earlier presentation, some intervention might have been possible.

- That there be a public awareness campaign to de-stigmatise mental health and to provide the general public with information which may enable them to identify the early signs of schizophrenia.

7.2. Multi Agency/ South Gloucestershire wide

7.2.1. Care and nursing home providers should introduce a procedural policy that

when a resident presses their assistance bell, the responding member of staff should check their needs with them personally, rather than accepting the word of a visitor. Management teams should ensure that all staff are aware of this policy and that it is included in all staff induction and refresher training.

7.3. Health Care Company (Owner of care home)

7.3.1. The group will introduce a policy that when a resident presses their assistance bell the responding member of staff will check with them personally other than accepting the word of a visitor. This will be included in all staff training.

7.3.2. The home has changed their protocols so that all visitors have to ring the bell and sign the visitor's book, which now includes their relationship with the resident they are visiting. This will be kept under review.

Appendix 1 Action Plan

Recommendation	Scope of recommendation ie local/ regional/national	Action to take	Lead agency	Key milestones achieved in enacting recommendation	Target date	Date of completion and outcome
17.1.1 Care and nursing home providers should introduce a procedural policy that when a resident presses their assistance bell the responding member of staff should check their needs with them personally, rather than accepting the word of a visitor. Management teams should ensure that all staff are aware of this policy and that it is included in all staff induction and refresher training.	National and South Gloucestershire wide	Through dissemination of findings to local Contracting and Commissioning teams and through CQC provider bulletin	South Gloucestershire Safeguarding Adults Board and CQC	One off action to inform providers of Care Homes and Nursing Homes through National CQC provider Bulletin	1st September 2015	7th April 2015

17.1.2. That the Department of Health be notified about the circumstances of this case so that: • Consideration can be given to the need for further research to find the causes and effective treatments for schizophrenia; had a test been available to make the diagnosis at an earlier presentation, some intervention might have been possible. • That there be a public awareness campaign to de-stigmatise mental health and to provide	National	To provide an update to the Department of Health to update them on the circumstances of the review and national recommendations developed.	South Gloucestershire Clinical Commissioning Group		30th June 2015	

the general public with information which may enable them to identify the early signs of schizophrenia.						

17.3.1. The group will introduce a policy that when a resident presses their assistance bell the responding member of staff will check with them personally other than accepting the word of a visitor. This will be included in all staff training.	In all of the company's care and nursing homes	New Company policy. Communication to all staff. Training organised.	Health Care Company	1. Policy written and agreed by Managers. 2. All current employees notified. 3. Induction and refresher training organised and delivered.	1st June 2015	7th April 2015
17.3.2. The home has changed their protocols so that all visitors have to ring the bell and sign the visitor's book, which now includes their relationship with the resident they are visiting. This will be kept under review.			Health Care Company			