Safeguarding Adults Review

A Report commissioned by Norfolk Safeguarding Adults Board into the cases of Ms F and Mr G, two unrelated residents at the same care home in Norfolk.

Both residents died in separate circumstances.

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Executive Summaries

1. Executive Summary: SAR Overview

1.1. The present report presents the findings of a Safeguarding Adults Review (SAR) concerning the cases of two elderly residents of XYZ Care Home in Norfolk, identified in the present report as Ms F and Mr G. Neither resident knew each other and both residents died in separate circumstances. There was evidence of both residents experiencing, or being placed at risk of experiencing, abuse and/or neglect.[1]
The SAR report presents a chronology of events for each of these people from **June 2017** until the time of their death, and considers learning and recommendations in relation to both SARs.

2. Executive Summary: SAR F

2.1. Ms F was an elderly lady with dementia, who at the time of her death was a resident at XYZ Care Home in Norfolk. She had been in this care home for a number of years.

2.2. The focus of the SAR begins in **June 2017** after another male resident, Mr Z, was admitted to the same care home. Mr Z was admitted as a private resident, meaning that statutory services were not involved in the process of his admission.

2.3. Soon after Mr Z's admission, Mr Z began to demonstrate challenging behaviour. This took a variety of forms, including resistance to personal care, shouting and verbal aggression. Relatively soon after admission, this developed to include violence towards staff members, and after this, other residents. Violent behaviour included hitting or punching residents in the face/head.

2.4. The care home described Mr Z's violent behaviour as unpredictable. However, analysis of the process by which violent incidents were recorded and analysed leads to a question of whether these incidents could have been better understood and more effectively responded to. The home explained that they did not commonly look after residents demonstrating violent behaviour and the staff team agreed that Mr Z's needs exceeded their capacity throughout much of the admission.

2.5. There was some evidence for an escalation in behaviours in **August 2017**, with the Dementia Intensive Support Team (DIST)(the local acute/intensive support service from the mental health trust) being involved from the beginning of July. The role taken by DIST appears to largely monitor Mr Z and provide medication, which appears to be in Mr Z's case of limited effectiveness, and concerns about the care home's ability to safely manage Mr Z do not appear to be escalated by DIST. DIST close the case at the **end of August 2017** without referring on for ongoing support by the community team.

2.6. By the **middle of December 2017**, there had been a series of violent incidents (detailed in **Appendix 1**), including at least nine occasions where residents were hit or punched in the head/face area by Mr Z. Many of these incidents had the potential to cause more serious physical injury than that which occurred, and it is noted that the 'index' incident towards Ms F, on the **19th December 2017**, did not appear fundamentally dissimilar to these previous incidents, apart from circumstantial

[1] I note that although the report does not attribute the cause of this to a specific agency, the care home involved in the care of both residents objects to this view.

changes which led to a more serious outcome. This is in addition to a greater series of more minor but still challenging behavioural presentations, as well as violence directed towards staff.

2.7. The 'index' incident on the **19th December** appears to be the fourth time that Ms F was assaulted by Mr Z. It appears that Mr Z pushed Ms F towards the ground, leading her to hit her head as she fell, and leading to her sustaining a fractured neck of femur. This required her to be admitted to a local acute hospital for surgery, where she remained over the Christmas period. Consequent to this incident, Mr Z was detained under the Mental Health Act 1983, with the process here bringing severe challenges, ultimately requiring four separate ambulances to attend before Mr Z was conveyed.

2.8. Ms F was then admitted back to XYZ home in **January 2018**. By this stage, the incident and subsequent surgery seems to set in motion a chain of deterioration in Ms F's physical and emotional health. Whilst it is not for the report to consider causation of Ms F's death, it appears important to note Ms F's death then occurred some weeks after at XYZ Care Home on the **31st January 2018**.

2.9. The most severe incidents of violence towards residents were generally reported by the home to the local authority safeguarding team. However, the wider context of this violence in terms of its frequency and breadth did not seem to be understood, and steps that may have been taken to more effectively manage the risk (e.g. considering an alternative placement; detention under the Mental Health Act) did not appear to be considered by statutory services until too late. This may be for several factors, including an over-reliance on assurances given by the home about the ability of risk management plans (broadly enhanced observations) to manage the risk, some apparent inconsistency in the message given by the home about their ability to care for Mr Z, poor communication between professional agencies, Mr Z's status as a private resident, some potential concerns with the electronic recording system in the safeguarding team, and a lack of professional curiosity (e.g. in reporting or requesting details about the wider history and in particular the wider range of attacks towards staff).

2.10. The SAR was commissioned given concerns expressed, particularly, about the extent to which Ms F and other residents had been protected from harm including through the management of Mr Z by the care home. Questions around the process of interagency working and communication are also considered within the wider analysis of the SAR. More broadly, the process of the SAR also revealed questions in practice around the assessment of Mental Capacity, the process by which detentions under the MHA are made (and particularly conveyance under the MHA by a secure ambulance), and the way in which challenging behaviour is assessed and managed in a residential home context in what appeared to be a largely 'medication first' way. The SAR concludes with a number of recommendations relating to these factors, and these recommendations are presented in the context that their implementation may work to prevent other residents in care settings experiencing abuse or neglect as a consequence of another resident's violent behaviour.

2.11. It is right that the Executive Summary acknowledges the concerns expressed by the family about the care of their mother in this case, and it is certainly hard not to empathise with their broad analysis of events, which is as follows:

> *'Our mother was physically fit and healthy on the 18th December, weighing in at approx. 78+kg, singing, humming, laughing, chatting and dancing, and coming to the café with us for tea and cakes.*

On the 19th December she was viciously attacked, knocked to the ground and never recovered from surgery. Not only did mother suffer a broken hip but had a large bump on her head and several contusions on her right harm[2] giving evidence of the ferocity of the attack.

She subsequently passed away on 31 January after several seriously painful weeks, a skeletal lady weighing approx. 50 kilos suffering from painful bed sores'

3. Executive Summary: SAR G

3.1. Mr G was an elderly man with dementia and a range of other health conditions. At the time of his death on the **22nd November 2017**, he was an inpatient at GHI Hospital, a local acute hospital in Norfolk. He had been admitted to GHI hospital from XYZ Care Home, where he had been a resident from the **10th – 19th November 2017**.

3.2. The scope of the SAR in relation to Mr G begins in **June 2017**. He had been admitted to GHI Hospital following an incident in a previous care home which led to him falling and sustaining an injury (not a fracture). Whilst in hospital, as well as staff managing the physical aspects of Mr G's behaviour, there are reported a number of concerns about the behavioural elements of Mr G's presentation.

3.3. Ultimately, concerns about Mr G's behaviour are serious enough to warrant Mr G being detained under the Mental Health Act 1983, and subsequent to this he is admitted to a psychiatric hospital (DEF Hospital) that is outside Mr G's commissioned area. This is discussed in the SAR report as reflecting a potential resourcing issue, as the local mental health trust did not have sufficient beds to admit Mr G to one of their own units more local to Mr G's family. The SAR report also considers concerns around the process of assessment, with family members and the Nearest Relative indicating that they believed they were not involved as they should have been.

3.4. Mr G was admitted to DEF hospital on the **15th July 2017**, and shortly after this he was admitted to this hospital's local acute hospital with a suspected infection and dehydration. It appears that fluid treatment and treatment of Mr G's infection led to a rapid improvement in the behavioural elements of Mr G's presentation, leading one to ask the question of whether this infection was also the cause of the challenging behaviour previously observed at GHI Hospital. After this point, the behavioural elements at Mr G's presentation appear of significantly reduced acuity. Overall, despite being an out of area placement, Mr G appears to have a relatively positive experience of care at DEF hospital and the SAR report comments on the positive aspects of practice observed.

3.5. From DEF Hospital, arrangements are made to transfer Mr G to a more local psychiatric hospital operated by the local mental health trust. This transfer occurred on the **14th August 2017**. By this time Mr G's section under the MHA had ended and so this transfer is conducted informally, and it does not appear that there is any formal process of consideration of Mr G's best interests in this process. Despite the potential for disruption caused by this move, it is noted that Mr G's experience of JKL hospital, in Norfolk, also appeared broadly positive, with staff from this team seeming to understand well Mr G's care needs and demonstrate an ability to develop and implement an appropriate plan for managing Mr G's physical health and behaviour.

3.6. Mr G was discharged from JKL hospital and admitted to XYZ Care Home on the **10th November 2017**. There are a number of concerns about the process by which

[2] This has not been verified

Mr G was transferred. Most prominently, these relate the fact that the local commissioning group allocated this placement under the 'Discharge to Assess' pathway (DTA) which provides 28 days of funding to assess clients in a less restrictive environment. However, JKL psychiatric hospital indicated that this process did not apply to patients detained or admitted to their hospital or indeed any mental health hospital. Consequently, they held Mr G's bed open which would have allowed him to return at any point if necessary (the bed was held open originally for 7 days but this was then increased to 14). The care home, believing that Mr G was discharged under the DTA process, reported that they were not aware of the option to return Mr G to the psychiatric hospital (although several occasions where such information was conveyed to XYZ are noted). The SAR considers how this might have occurred, and further considers the basic suitability of the DTA process when applied to patients in psychiatric hospital such as Mr G.

3.7. Unfortunately, XYZ had significant difficulties in effectively managing Mr G and providing him with adequate care. Personal care was often refused, or delivered under challenging conditions. The specifics of the behavioural elements of his presentation are less clear as care records from XYZ over this time are relatively limited. The DIST service, who remained in contact with Mr G during his admission to XYZ, noted concerns about the ability of XYZ to safely manage Mr G, although this is not flagged as a safeguarding referral. Concerns raised by the care home about the family's behaviours interfering with effective care delivery also do not appear to be translated into a safeguarding referral.

3.8. Despite their concerns, three days later, the DIST service propose to discharge Mr G to the care of his GP based on apparent improvement in his presentation. This does not ultimately occur. However, it is possible that DIST's assessment of Mr G's needs and risks at this point was compromised by the lack of records noted above and, perhaps, an over focus on his presentation on the day in question. Certainly, the decision-making around this issue seems to lack detailed inquiry or professional curiosity, which is reflected on more widely in the wider SAR. Later the same day, during a family visit, the family are concerned enough about Mr G's physical state and lack of attention to his care needs that they request the home escalate medical assessment and intervention for Mr G. This brings its own concerns, as the family, unhappy with the care home's response, communicate directly with the GP and arrange for Mr G to be prescribed antibiotics without clinical assessment. The care home shared a number of difficulties in working with the family members which are expanded on in the body of the SAR report.

3.9. Mr G's condition is reported as deteriorating the following day, and there is evidence suggesting significant difficulties in the delivery of his care. Ultimately, there is significant concern for Mr G's physical health and a paramedic is called who arranges for Mr G to be admitted back to GHI hospital, with a query of sepsis. The ambulance crew who admit Mr G to hospital, however, were so concerned about Mr G's physical state that they made a safeguarding referral, querying the possibility that Mr G had experienced neglect at XYZ care home. The care home has disputed the concerns documented by the ambulance service, stating that these concerns were simply those relayed by the family. Therefore, to provide greatest clarity of this incident, the records taken by the ambulance crew members in the Patient Care Record state the following:

> *'Pt has been in care home for approximately 10/7 [10 days].*
> - *Family are concerned that pt has not been out of bed and now has bed sores, staff uninformed of pt hx [patient history]*
> - *Also concerned pt is not being hydrated properly (current UTI), had meds residue behind mouth ? effectively medicating, was faeces on his table, has*

not been given appropriate care (top not changed, no evidence of cleaning, new bruising on upper limbs ??origin'

3.10. These concerns were then relayed by the ambulance service in a safeguarding referral, which is then summarised verbatim below:

> *'An ambulance crew were called on 19/11/2017 at 17:15 and arrived to find [Mr G] in bed conscious but not fully alert. His family were present and they told the ambulance crew they were concerned as [Mr G] (who has dementia) had been in the home for 10 days and is currently being treated for a UTI since last Tuesday and he looked worse than he did yesterday (he had become pale, clammy and agitated/unsettled). Ambulance crew were told by family he had not been out of bed since being admitted.*[3]
>
> *Care home staff were said to have little information and records shown were minimal.*
>
> *There was evidence of not being hydrated properly (dry lips) and he had developed bed sores. There was residue of medication around his neck and he smelt (body odour) and he did not appear to have had his upper clothing changed for some time.*
>
> *Bruises were on upper limbs and family had stated they were unable to find out how these had occurred. Faecal matter was located on his bed side table and family stated they had cleaned some off his face.'*

3.11. Unfortunately, Mr G died in GHI Hospital on the **22nd November 2017**.

3.12. As well as consideration of the points already noted, the SAR developed learning in relation to the process of assessment and response to mental capacity, inter-agency working and communication between professionals and organisations, as well as the process by which care needs are assessed in a hospital environment. Recommendations are then drawn from this learning, which would seek to prevent other residents from experiencing abuse or neglect in care settings in future.

[3] The latter sentence does not appear to be correct.

Introduction and Scope of Review

4. Introduction

4.1. Safeguarding Adults Reviews (SARs) were introduced in the Care Act (2014) as a form of learning following the death of an adult at risk of abuse or neglect, and where there is concern that partner agencies could have worked more effectively to protect the adult.

4.2. The two Safeguarding Adults Reviews (SARs) considered in the present report were commissioned by Norfolk Safeguarding Adults Board (NSAB). This report is the final output from two SARs which relate to service users who had both received care from the same care home in Norfolk (referred to as XYZ Care Home). The two residents were not related to each other in any way, and their cases are quite different. However, there are overlaps in a number of the learning themes, and the Safeguarding Adults Board (SAB) agreed it would be beneficial for both cases to be reported in a joint report.

5. About Norfolk Safeguarding Adults Board (NSAB)

5.1. Norfolk Safeguarding Adults Board brings together representatives of the main agencies in the statutory, voluntary and independent sector, responsible for working with and providing services for adults, some of who may be at risk of abuse.

5.2. The purpose of NSAB is to help and safeguard adults with care and support needs. It does this by:

a) assuring itself that local safeguarding arrangements are in place as defined by the Care Act 2014 and statutory guidance
b) assuring itself that safeguarding practice is person-centred and outcome-focused
c) working collaboratively to prevent abuse and neglect where possible
d) ensuring agencies and individuals give timely and proportionate responses when abuse or neglect have occurred
e) assuring itself that safeguarding practice is continuously improving and enhancing the quality of life of adults in its area.

6. About the Report Author

6.1. I am a Consultant Clinical Psychologist currently employed by the University of East Anglia (UEA) as the Deputy Programme Director on the Clinical Psychology doctoral training programme. My role involves taking overall responsibility for all practice elements of the doctorate training programme and related governance, as well as staff management, teaching, and supervision of research projects.

6.2. Prior to my current role at UEA, I was employed by South Essex Partnership NHS Trust (SEPT) as the Head of Secure Services Inpatient Psychology. I worked for SEPT from 2009 until July 2016, originally as a Clinical Psychologist, and as a Consultant Clinical Psychologist from June 2014.

6.3. My primary clinical experience is in working with adult offenders with mental health problems, particularly those who are detained under the Mental Health Act (1983; MHA). I have extensive experience in assessing people with complex mental health problems and personality disorder, who have also committed various offences and/or pose a risk of violence. I have also experience in completing assessments for and giving evidence in Magistrates, Crown and Coroner's court settings. I have specific post-qualification training in the administration of a range of tools related to the assessment of risk and complex psychopathology.

6.4. In terms of my academic qualifications, I hold a degree in Experimental Psychology from the University of Oxford (First Class, 2005), a Doctorate in Clinical Psychology from the Institute of Psychiatry, King's College London (2009), and an LLM (Master of Laws) in Mental Health Law (with Distinction) from Northumbria University (2018).

6.5. In terms of my professional qualifications, I am a chartered member and Associate Fellow of the British Psychological Society (BPS). I am a registered Practitioner Psychologist with the Health and Care Professions Council (HCPC), the legal body that regulates Practitioner Psychologists in the UK. I am in good standing with both organisations.

6.6. Of relevance to the present report, I note that I do not have specialist clinical experience of working in care homes or indeed in clinical services working with elderly populations. Nor do I have, as a psychologist, any medical expertise.
I am grateful for the support of other members of the SAR Panel (SARP) in supporting my role as Independent Author, whose collective expertise has been invaluable in understanding the wider system in which Ms F and Mr G's care took place.

7. Method of Review

7.1. The primary purpose of a SAR is to learn lessons so that professionals can work more effectively to improve care and prevent abuse in future cases. The criteria used to decide whether a SAR is conducted is outlined in s.44 of the Care Act 2014, which is not further expanded on here. However, broadly, the aim of this SAR is to try to improve the response of services to other people with similar needs, and to make practical recommendations for future service development. The aim is not to hold practitioners or organisations to account, or to attribute blame. Other processes exist to do this, and it is recognised that the analysis in this report may contribute to such decisions. However, to generate meaningful learning, the report does need to address and consider concerns and failings in practice, including at the level of individual organisations.

7.2. Ordinarily, SARs are conducted in regards to one specific case; however in the present case, there were clear overlaps in learning themes between both cases considered. Furthermore, both service users had been resident at the same care home. Together, this warranted a more integrated approach being used.
The SAB thus agreed that learning from both SARs would be presented in a single report. Notwithstanding this integrated approach to developing learning themes, this approach has not prevented a very specific and separate analysis of the facts and learning arising from both cases. The relevant histories of each service user are analysed separately in the present report. It is noted that despite residing at the same care home, it seems unlikely that either service user would have known of the other.

7.3. It is further noted that the circumstances of Ms F significantly overlap with another service user, who will be referred to as Mr Z in this report. This service user was also a resident at the same care home. He had been aggressive and violent towards Ms F, as well as other service users and members of staff at the home. Thus, whilst it is clear that the SAR is focused on Ms F's experience of care, the SAB have been able to access relevant clinical information in regards to Mr Z's care and treatment, to the extent that this influenced learning in Ms F's case and the ability to safeguard other residents more generally.

7.4. The SAR Panel (SARP) determined that the most appropriate way of generating learning which was likely to have a direct impact on improving services was to conduct the SAR in a collaborative and inclusive way in which relevant professionals were involved directly in the learning process. Therefore, two whole-day Learning Events in which practitioners, managers and commissioners – who had either directly worked with Ms F or Mr G, or who were professionally involved in service management or commissioning of services – were invited to develop a wider understanding of the events that had led up to the deaths of Ms F and Mr G, and to consider lessons for future practice. These learning events were held on the **21st January 2019** (Ms F) and the **13th February 2019** (Mr G). These events were an opportunity for agencies to share and challenge each other's perspectives and experiences in a way directed towards future improvements of services.

7.5. The Learning Events themselves were planned by the SARP who met prior to the Learning Event to review the chronologies of both cases, and determine the specific content and process of the learning event. The learning themes were agreed at these meetings. Following the learning events, the SARP met again to review a draft version of the present report, which had been circulated to all members of the SARP. This allowed a process of fact checking, but also verification that the learning had meaningfully reflected that which was identified through the SAR process. Representatives from each agency represented on the SARP thus had opportunity to comment on this draft, and subsequently a revised draft. During the re-drafting process, further information provided by involved agencies regarding the chronology of events has been integrated into the report.

7.6. This final SAR report therefore brings together much of the learning that was identified at the learning workshop, as well as collating the historical input from the various agencies who were involved in the provision of care. In addition, it presents the Independent Author's analysis of the events leading up to the deaths of these two individuals, as well as the Independent Author's own recommendations for future practice.

7.7. I am grateful to the all the agencies who have assisted and contributed to the preparation of this report. [If you wish to know more about the agencies involved in this review please contact NSAB. Contact can be made via: nsabchair@norfolk.gov.uk

7.8. Staff from the agencies supporting this review attended Learning Workshops for Ms F and Mr G.

8. Sources of Information

8.1. The independent author has relied primarily on the following sources of information in compiling the narrative of events described in the present report. Whilst events have been triangulated to the greatest extent possible, the narrative provided can only be

as accurate as the records on which it is based. I have endeavoured to highlight discrepancies or differing perspectives where possible.

8.2. The independent author notes that the process of information sharing for SARs is governed by s.45 of the Care Act 2014.

Discussions with Family Members

8.3. As the independent author, I was able to meet with family members from the families of both Ms F and Mr G. This occurred prior to the Learning Events, and thus I was able to share family perspectives with professionals in this forum.

8.4. I am indebted to the information provided by both families, who, in both cases, despite the distress and upset caused by the loss of their family member, and the circumstances surrounding their death, were keen to provide as much information as possible to help the process of the SAR and thus assist future learning. In both cases, after meeting directly with family members, both families were willing to remain in contact with me to clarify specific points or questions, and I am again grateful for them providing me with this opportunity. Whilst I am sure that I have not, and never could have, obtained a full picture of the life and experience of either Ms F or Mr G, the information provided by families has allowed me to develop a much better understanding of the likely perspectives of the service users at the heart of this SAR.

8.5. Both families raised questions with me about the context in which their family member died, and had questions as to '*why*' this had happened. This is of course understandable. Both families viewed the deaths as having been preventable, based on the information that was known to them at the time. Primarily, I hope that the recommendations presented are understood by the family as important and relevant to prevent other residents in similar settings experiencing abuse or neglect in the future.

Chronology Collation Exercise

8.6. All agencies who provided care for either Ms F or Mr G were approached as part of a wider chronology collation process. This process was coordinated by the SAB. The combined chronology was significantly relied upon by the SARP in the planning of the Learning Events, and by the Independent Author in the drafts of the initial report. The chronology had been made available to all members of the SARP prior to the Learning Events. This has been a 'live' document which has developed as further information from agencies has become available. It is noted that significant additional clinical information from the care home was made available to the Independent Author after the first draft of the combined SAR report had been completed, and which had not been included in the chronology provided to the SARP.

Learning Events

8.7. As stated above, a day long learning event was carried out in relation to each of the two cases considered as part of the SAR process. At these events, practitioners brought further information – sometimes not fully recorded or contextualised in the written record, and sometimes based on their recollection. I have attempted to integrate this information where possible.

Meetings with relevant staff groups

8.8. After the learning events, it was noted that additional meetings would be helpful with frontline practitioners from both XYZ Care Home and the Dementia Intensive Support Team (DIST). This was partly for the review to be able to gain further information and so contribute to the learning in the SAR, but also to provide a supportive opportunity for staff members who had been directly involved in the care of Ms F, Mr Z and Mr G to reflect on their experiences.

Other sources of information

8.9. Additional information was sought as deemed necessary by the Independent Author to enrich the analysis and learning. This has included through the independent author or members of the SARP requesting information in direct correspondence with various professionals, as well as various clinical records. The family also provided me with a number of important documents. These documents have included (this is not an exhaustive list):

In relation to Ms F:

- All safeguarding reports where Mr Z was the recorded perpetrator
- All safeguarding reports where Ms F was the victim
- Clinical records from DEF hospital (provided as an entire printout)
- Records from the relevant ambulance service in regards to events on 19.12.17

In relation to Mr G:

- A discharge summary from JKL Hospital
- Copies of responses to complaints raised by Mr G's family about practice at XYZ Care Home
- A statement and summary from the CCG regarding their involvement and the process of funding the care home placement
- Records from the relevant ambulance service in regards to events on 19.11.17

8.10. As stated above, whilst the care home contributed to the chronology of events used by the SARP and Independent Author, some further information was provided following requests made to the home during the process of the SAR (e.g. copies of incident records). After the first draft was completed, the home then provided the Independent Author with more detailed care records including all assessments completed, all progress notes recorded on the electronic system, care plans, incident reports, and various other documents. These have been subsequently incorporated into the narrative to the greatest extent possible.

9. Key Areas of Learning for Consideration: Ms F

9.1. The SARP agreed that the key areas of learning that should be considered by the SAR were as follows:

- Ms F's overall experience of care
- The process of assessment of an individual both into and out of XYZ Care Home, particularly in relation to Mr Z.
- Mental Capacity Act, including DOLS and Best Interests Decisions
- Information management, to include sharing of important safeguarding information and escalation by various agencies
- Management of the escalation of violent behaviour by Mr Z
- Involvement of the family

9.2. I have also been asked to make specific comment on relevant human factors potentially cutting across the above learning themes.

10. Key Areas of Learning for Consideration: Mr G

10.1. The SARP agreed that the key areas of learning that should be considered by the SAR were as follows:

- Mr G's overall experience of care
- Assessment of Mr G into XYZ Care Home from JKL hospital, to include both process of the assessment and funding and care pathways
- Legislative frameworks including MHA and MCA
- Care coordination

10.2. I have also been asked to make specific comment on relevant human factors potentially cutting across the above learning themes.

11. Scope of SAR: Timescale of Review

11.1. Both Ms F and Mr G had lengthy and complex histories of contact and engagement with services, and it is not the purpose of the SAR to address or consider the entire experience of care received by either service user. The SARP therefore recommended that the SAR focused on incidents related particularly to the most salient events in the run-up to their death. Doing so does not mean that events before this time are unimportant, but rather that relevant learning is most effectively generated when the review has its primary focus on the most contemporary events.

11.2. For Ms F, the scope of the SAR was agreed to run from **June 2017**, which was approximately when Mr Z was admitted to the care home, and her death in **January 2018**. Over this time, Ms F was largely at XYZ Care Home except for periods of treatment received at the local acute hospital, which is referred to as GHI hospital in this report.

11.3. For Mr G, the scope of the SAR was also agreed to run from **June 2017**, when Mr G was an inpatient at the local acute hospital. From here, he had been detained under s.2 of the Mental Health Act (1983), and transferred to a privately run psychiatric hospital located approximately 75 miles away from his family address and outside of Norfolk (DEF Hospital). From there he was transferred to an NHS psychiatric hospital within Norfolk, and from there he was transferred to XYZ Care Home. He was transferred back to the local acute hospital (GHI Hospital) in the last days of his life.

11.4. The decision to set the scope of the SAR review from the same starting point (**June 2017**) is coincidental, and separate decisions were made for each SAR about the timeline and scope. It is, of course, observed that the time limitation does mean that the totality of Ms F's and Mr G's experience of care cannot be considered. In this regard, it is noted that both families raised some concerns about aspects of the care their family members received in the time prior to **June 2017**. For Ms F, these were additional concerns about care received whilst at XYZ care home. For Mr G, these were additional concerns about care received in at least one other care home which is not the focus of the learning in the report.

11.5. As the Independent Author, I am satisfied that the focus of the report, encompassing a period of eight months prior to the death of Ms F and six months prior to the death of Mr G, does allow an in-depth analysis of the circumstances of the concerns of abuse and neglect that ultimately preceded their death.

Introduction to key agencies

12. XYZ Care Home

12.1. XYZ Care Home is a purpose-built care home in Norfolk. It provides care for clients with dementia and associated conditions. The care home is able to provide residential care as well as nursing care. It also has dementia provision.

12.2. Ms F was at XYZ Care Home for a number of years until her death on the **31st January 2018**. She had returned to XYZ from the local acute hospital (referred to as GHI hospital) approximately three weeks prior to her death.

12.3. Mr G was at XYZ Care Home for a much shorter period, being admitted there on the **10th November 2017**, and subsequently being transferred on the **19th November 2017** to the local acute hospital (GHI hospital), where Mr G died on **the 22nd November 2017**.

13. DEF Hospital

13.1. DEF Hospital is a large private psychiatric hospital outside the Norfolk region. The organisation provides inpatient psychiatric care for a range of conditions. As a private (non-NHS owned) hospital, DEF Hospital is a hospital which is used by the local NHS mental health trust to admit patients detained under the Mental Health Act, if a bed is not available locally.

13.2. Mr G was admitted to DEF Hospital on the **15th July 2017** and discharged on the **14th August 2017**.

13.3. Ms F did not receive any treatment from DEF hospital.

14. GHI Hospital

14.1. GHI Hospital is the local acute hospital to XYZ Care Home. It provides acute medical treatment for a population spread over a large rural area.

14.2. The hospital provided medical care and treatment to both Ms F and Mr G at various points. In regards to Ms F, this included acute medical care after she was assaulted by Mr Z. In regards to Mr G, this included acute medical care prior to his admission to DEF Hospital, as well as after his brief residence at XYZ Care Home. Mr G died whilst at GHI Hospital.

15. JKL Hospital

15.1. JKL Hospital is an inpatient psychiatric ward for older adults within Norfolk. It is owned and operated by the local NHS mental health trust. Ms F did not receive care from JKL Hospital. Mr G was an inpatient here from the **14th August 2017.** He was transferred to XYZ Care Home on the **10th November 2017**, but was not formally discharged until two weeks after this date.

15.2. Ms F did not receive any treatment from JKL Hospital. Mr Z, however, was transferred here briefly after the 'index' incident on the **19th December 2017**, and their role is briefly considered at this point.

16. DIST Service

16.1. The DIST Service (Dementia Intensive Support Team) is a community-based service providing intensive, short-term, care and support to people with a range of mental health problems and dementia. A significant part of their role involves working to prevent the admission of patients to psychiatric hospital. DIST provided support to Mr Z (who assaulted Ms F) as well as Mr G at various time points detailed in the narrative below. During the time period of the SAR, Ms F was not a client of DIST, though I understand that she had been on their case-load previously.

16.2. The DIST service is owned and operated by the local mental health trust, i.e. the same provider organisation as JKL Hospital.

Ms F: History and Experience since June 2017

17. Ms F: Background History

17.1. Whilst it is clearly indicated above that the scope of the SAR is to focus on the events from **June 2017** until Ms F's death in **January 2018**, it is important to contextualise the case by summarising pertinent background information. This is especially important to consider in the context of Ms F having progressive deterioration in her cognitive function as a result of her dementia, and the fact that the SAR only focuses on a time when such impairment was well established. Whilst the SAR cannot hope to provide a detailed understanding of Ms F as a person, it must be recognised that Ms F had a long life and loving family prior to the period of review of the SAR, and the SAR will be weakened if no contextualisation of this is provided.

17.2. In this regard, I note that Ms F's family told me that she had previously worked in many vocations including as a dressmaker, childminder, in sweet factories, and in a launderette. They told me that they tried to make sure that somebody from the family visited her every day. Whilst the family reported some misgivings about the quality of care provided by XYZ prior to June 2017, they broadly felt she had a good quality of life, noting that she went to the hairdresser once a week, could make trips to the cafe, and was relatively mobile.

17.3. Prior to her admission to XYZ some years earlier, Ms F had been in her own accommodation. However, this was some distance from the family. The family had been initially impressed with XYZ's ability to support her physical needs (noting particularly that each room had an en-suite).

17.4. It is understood that Ms F's dementia was vascular in origin. She had developed increasing care needs over her time at XYZ care home, and certainly by 2017 her dementia was quite advanced. Vascular dementia can be characterised by 'step-wise' impairment following specific cardiac events; it may not have the same pattern of insidious progression as observed in Alzheimer's Dementia, for instance.

17.5. The care home staff told us that there had been times when Ms F demonstrated challenging behaviour herself. They noted that there were times when it was difficult to provide for her personal care. They also noted that sometimes she would be distressed and would swear a lot. The staff team noted that there were some differences in views between the staff team's approach to care and the family's expectations. However, the staff team broadly felt that they were able to meet Ms F's care needs.

17.6. The care records provided over the period of the SAR are largely unremarkable. They generally describe Ms F as '*settled*' and describe activities she had engaged in on each day. There are no more than a handful of occasions in which swearing is documented over the period of the SAR and this is not presented as a significant concern in the records. Other behavioural concerns are also not prominent.

17.7. Being frequent visitors to the care home over a relatively lengthy period of time, it is understandable that Ms F's family built up relatively close relationships with some of the staff working within the home. They believed the quality of care was inconsistent, with some staff providing good care, and others less so. The family noted, also, that they felt that at times staff would share openly with them their fear about working with Mr Z or specific incidents which had occurred, and that they '*knew too much*', particularly in relation to the care home's care for Mr Z.

These topics were discussed at the relevant learning event but are by their nature hard to triangulate with information from other sources.

17.8. XYZ care home has questioned the family's statement to me about the inconsistency in the quality of care provided, indicating that the family's lack of action to move their mother to a different care home must have indicated they were broadly satisfied with the care received. It is important to acknowledge therefore that moving a relative from a care home is a difficult and personal decision balancing many factors including the resident's familiarity with the environment, their relationships, activities and routines within that environment, the relative distance from family members, and the availability of realistic alternatives. Therefore, whilst it is correct that the family chose not to move their mother out of the care home over many years, I do not believe this necessarily conflicts with or undermines the validity of the concerns they expressed.

17.9. Of note, Ms F's family advised us that they obtained a Lasting Power of Attorney (LPA), covering Health and Welfare decisions only, in 2013. The LPA had been signed in **April 2013** and was registered with the Office of the Public Guardian in **July 2013**. Family members reported there had been a deterioration in their mother's memory around this time. The LPA document itself has not been seen by members of the SARP but the report author has no reason to doubt its existence, validity or scope of application.[4]

18. Ms F: Case Chronology

18.1. The following account describes Ms F's experience at XYZ Care Home since **June 2017** until an incident when she was admitted to hospital in **December 2017**, referred to as the 'index' incident. Although the account contains a chronological review of Ms F's experience, it also provides 'on-line' analysis, reflecting observations made within the Learning Events, the SARP, and also opinion expressed by the Independent Author.

18.2. **June 2017** was agreed as the starting point for the SAR of Ms F as this coincided with the time another resident was admitted to XYZ, Mr Z. Ms F, along with other residents and staff at the care home, was the victim of violence perpetrated by Mr Z. Therefore, whilst the focus of the SAR is on Ms F's care and her care and safeguarding needs, much of the potential areas for learning in safeguarding practice relate directly to the way in which Mr Z's violence risk was assessed and managed. Therefore, the narrative which follows also integrates a chronology of Mr Z, considering particularly violence perpetrated by Mr Z (whether or not Ms F was the victim), the circumstances around Mr Z's admission and the way in which XYZ provided care and managed his challenging behaviour.

18.3. Mr Z's admission to XYZ on the **15th June 2017** was his first admission to a care home. Prior to this, it is understood that Mr Z had been cared for exclusively by his wife.

18.4. Mr Z had shown a picture of increasing care needs both in terms of physical and cognitive impairment. The care home believed Mr Z had not however been given a formal dementia diagnosis.

[4] I note this here because there was a question, some time before the review period of the SAR, as to the family's decision to decline certain psychoactive medication in regards to management of Ms F's behaviours. During this process a query was recorded as to whether Ms F's capacity to make an LPA had been assessed at the material time.

His admission assessment was completed by a senior staff member of XYZ and he was admitted to the care home based solely upon the outcome of this assessment, in line with the established process of the care home.

18.5. In describing the process of assessment at the Learning Event, XYZ staff explained that they had noted that Mr Z had been very well cared for by his wife, and that there had been no episodes of aggression or violence at this time. The care home staff reported being impressed by the level of care offered to Mr Z prior to his admission.

18.6. Within the Learning Events, XYZ Care Home reported that the assessment had led them to believe that Mr Z had had capacity to make decisions about his accommodation and residence at this point, and thus there were no discussions about deciding about residence on his behalf. However, there appears to be some tension between this view and with records provided subsequently by XYZ; an 'Assessment Form' dated the **15th June 2017** (i.e. the same day as admission) and completed by the Residential Manager indicates '*the resident does not have capacity to consent to care and accommodation*'. In any event, it would appear that if Mr Z did have capacity to make decisions about residence at any point during the assessment process, he quickly lost such capacity. It is notable therefore that there was not any process to respond to this; no formal consideration of Mr Z's 'best interests' in regards to residence/accommodation was carried out and no DOLS (Deprivation of Liberty Safeguards) authorisation was obtained.

18.7. It is understood that it had originally been intended for Mr Z to be admitted to XYZ Care Home purely for a period of respite care. Staff from XYZ reported that he had been struggling to cope with his care needs which presented with difficulty in his wife leaving the house for any period, and had not received a holiday or break from care for some time. Unfortunately, staff from XYZ noted that after being admitted, he suffered further deterioration meaning that it quickly became apparent that he would not be able to return home.

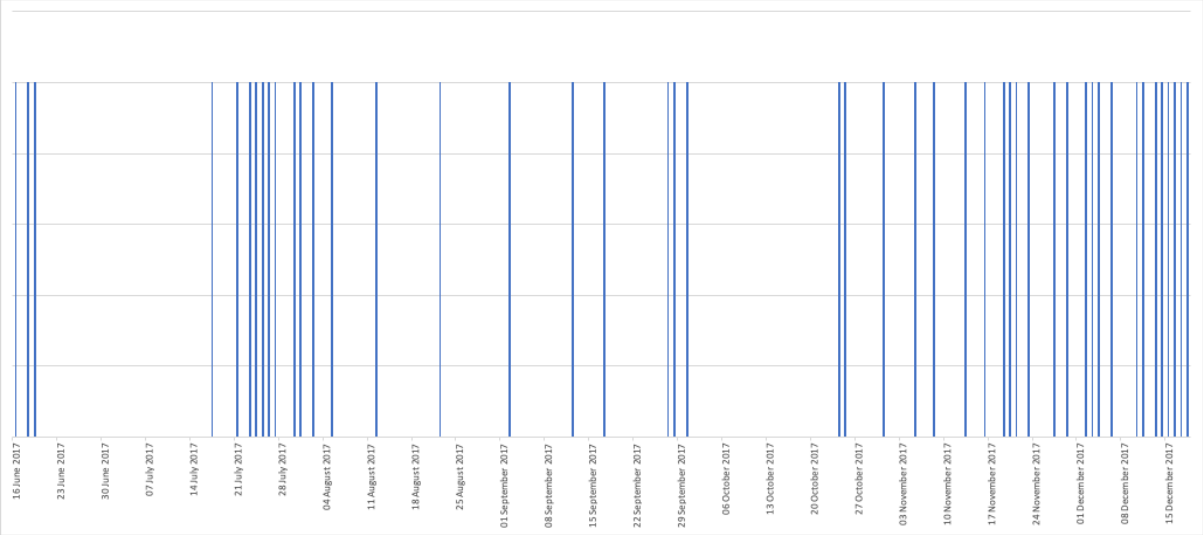
18.8. We know little about Mr Z's own life and history. However, of relevance to the SAR, Mr Z was described as a taller man, who had been a football referee earlier in his life. This was noted in the context of describing somebody's whose stature could be intimidating and who could shout loudly.

18.9. Mr Z was admitted to XYZ as a private resident. This means that fees for his residence and care at XYZ were met directly through his own family finances. This also meant that statutory services (e.g. Adult Social Care) were not involved in the assessment of Mr Z, as they would have been had his placement have been determined by them.

18.10. As part of the Learning Event, the frequency and broad nature of violent incidents was summarised based on information that had been made available to that point. This included a summary list of incidents, which had been provided to the independent author by XYZ. It was established, after the first draft of the combined SAR report had been completed, that this summary report had not in fact been completed by XYZ, but most likely by a safeguarding professional involved in reviewing Ms F's care after the 'index' incident in December 2017. At this point, XYZ queried the use of this summary and indicated it did not represent their own record keeping. Subsequent to this, XYZ then provided fuller care records including all copies of incident report forms involving Mr Z to the independent author, copies of behaviour charts, and copies of the narrative entries in the electronic care record. I note however that the summary provided and originally relied upon broadly reflects the care records accurately. In a further response, XYZ have again queried the use of the summary.

18.11. All available information has been used to compile a list of known incidents of violence perpetrated by Mr Z, including incidents where staff and residents were victims. The full list of incidents is included as **Appendix 1.** This summary has adopted an operational definition of violence '*actual, attempted or threatened infliction of bodily harm on another person*'.[5] Incidents are included up until the index incident on the **19th December 2017**. Not all incidents are described in the records in sufficient detail to be completely clear in all cases whether this definition is met, and the table includes such incidents where there is doubt. There are numerous other incidents, not recorded in Appendix 1, but scattered throughout the care records, of verbal aggression (e.g. shouting), wandering into bedrooms, and what might be best described as generally hostile or intimidating behaviour. There were additionally some episodes where Mr Z would expose himself (sexually) to other residents and carers and many episodes in which personal care was either refused or delivered under very challenging conditions. The table in **Appendix 1** details the source from which information about the incident was obtained, and notes whether the incident was also reported to/recorded by the local authority safeguarding team.

18.12. In order to provide a summary of the frequency of such events during Mr Z's admission, a graph below shows the breakdown of violent incidents (those recorded in **Appendix 1**) over the course of Mr Z's admission to XYZ. Each incident is represented by a single line.



18.13. Together, one can make the following general observations about the way in which the incidents were recorded:

- It is hard to determine a clear pattern of which incidents would or should have been recorded on incident report forms, behaviour charts, or when they would be simply recorded in the care record. Many incidents were recorded in one of these ways, but not any other.

[5] This definition is utilised in the HCR-20, one of the most commonly used approaches to the assessment of risk of violence. The HCR-20 is a Structured Professional Judgement tool which aims to help practitioners make better decisions about violence risk, particularly that occurring in the context of mental illness (see, for example, Douglas, Hart, Webster, Belfrage, Guy & Wilson (2014)). To clarify, I would not expect to see this tool routinely used in a care home and only provide this reference as a widely accepted definition of violence.

- Indeed, on some occasions incidents are reported in one form (e.g. a behaviour chart), but the clinical record provides a narrative that Mr Z had 'been settled' on the day in question and implies no incident had occurred. This could have occurred for a number of reasons, perhaps most obviously poor communication between staff working on the same shift. However this observation relates to later questions around XYZ's 'on line' awareness of Mr Z's risks.

- The details recorded about incidents are generally very brief and lacking in detail. Specifically, it would be reasonably observed that the behaviour charts rarely include information about antecedent or consequent behaviours. These are typically key questions in behaviour charts as without such information one can only guess at the function of the behaviour (i.e. what the behaviour is achieving; *why* it occurs). It is notable that XYZ described Mr Z's violent behaviour as almost totally unpredictable. It is hard to see how understanding of the function and triggers of Mr Z's behaviour could have occurred without such information being consistently recorded and then systematically analysed.

- The records indicate that the most serious incidents of harm towards residents were generally reported to safeguarding.

18.14. One can make further observations about the actual pattern of incidents themselves:

- It is clear from the records that violent behaviour started very shortly after Mr Z was admitted to XYZ. Indeed, after Mr Z was admitted to XYZ on **15th June 2017**, the first unambiguous incident of violence was reported to occur to carers on the following day on the **16th June 2017** when it was reported 'he started hitting and shouting verbal and physical abuse at carers'. I note only briefly that this information appears to contradict information given by XYZ verbally in the early SARP meetings that the first violent incidents did not occur until **August 2017**. However, the records do suggest that the most serious incidents towards other *residents* did not start until that time (August 2017).

- Whilst there were a small number of violent incidents shortly after admission, these appeared to reduce relatively quickly, with a period of approximately a month being the longest time without incidents occurring. The available information means that it is hard to know why this is and it does not appear that this was questioned at the time. Explanations that can neither be ruled in or out included changes in pain, medication changes, or the effects of infection or UTI. It does not appear to be about increased immobility preventing violence (during these periods Mr Z is recorded as being mobile).

- The apparent frequency and intensity of incidents which occurred in **July 2017** appears similar to the frequency of incidents which then occurred in **December 2017** and ultimately led to Mr Z being transferred from the home.

18.15. With this summary of Mr Z's violent behaviour noted, it is important to proceed to a more detailed discussion of specific aspects of Mr Z's admission and particularly the response and management of Mr Z's behaviour.

18.16. Dementia Intensive Support Team (DIST) were first involved following an urgent GP referral from the GP covering the home on the **19th July 2017**. The concerns were noted as 'physically and verbally aggressive, confused, spitting out meds, refusing personal care'. On this occasion, a urine sample was taken to check for infection. It is understood that this is carried out to rule out a potential UTI (Urinary Tract

Infection), which is a known and not uncommon cause of behavioural changes in people with dementia.
This is ruled out two days later. DIST contacted the home the following day **(20th July 2017)** to advise them that they were going to accept the referral.

18.17. Pharmacological options for the management of Mr Z's behaviour are quickly considered. By the **21st July 2017**, the DIST team consider prescribing memantine.[6] It is also recorded that XYZ had been giving Mr Z diazepam[7] regularly and frequently. Memantine medication is started on the **25th July 2017**. Notably, there does not appear to be any discussion or note of the decision making around Mr Z's capacity to consent to this medication. Care home staff observed that Mr Z probably lacked capacity to make decisions about his medication at this time and this is supported by the care record. Rather than assessing Mr Z's best-interests and prescribing on this basis, it appears the DIST team sought consent from Mr Z's wife (notes indicate '*wife agrees to medication*'). Of course, Mr Z's wife would not in fact have been able to give such consent, as it is understood that she did not have an LPA (Lasting Power of Attorney) to make health and welfare decisions about her husband's care.

18.18. There is a further potential issue around capacity which must be noted. By this point, the care records demonstrate that the care staff were struggling to give Mr Z his medication, and that he would often refuse.[8] The care records also note that medication, including Memantine, were given in liquid form to Mr Z. Liquid form psychiatric medications may be prescribed for a range of reasons. These could include very practical reasons such as to overcome issues with swallowing, or, at the other end of the scale, may be prescribed to allow medication to be given covertly (i.e. without the patient's awareness of the medication being given, potentially mixed in food or a drink). Covert medication practice is, understandably, a highly controlled process and would, by itself, warrant a need for an MHA detention to be considered, due to the additional safeguards afforded by this process. In the current case, the available detail does not allow one to have clarity on clinical reasoning behind prescribing the medication in this way, and, indeed, leaves a number of questions for the oversight of the process of administration (e.g. in relation to the assessment of capacity). There is no evidence for a Speech and Language Therapy Assessment (SALT), which would have been indicated had the issues been related to swallowing. This adds wider concern to the lack of formal Best Interests assessment in the prescription or administration of this medication. This concern is further amplified by the fact that there does not appear to have been a DOLS application for Mr Z, or an LPA in place allowing for decisions to be made by another on Mr Z's behalf in relation to his healthcare and treatment.

18.19. Unfortunately, the relatively rapid response in terms of medication prescription does not appear to be matched in terms of implementation of a behavioural,

[6] BNF (British National Formulary) information describes Memantine as a 'Glutamate Receptor Antagonist', which is indicated to treat 'Moderate to severe dementia in Alzheimer's Disease'. Its use, under the right conditions, is broadly supported within NICE guidance (National Institute of Clinical Excellence). However, it is noted that formally, my understanding is that Mr Z had not received a diagnosis of dementia by this time.

[7] Diazepam is a benzodiazepine used in a range of scenarios, commonly for anxiety and agitation. However it is also noted to have significant addictive potential. Notably, NICE reviews of evidence for benzodiazepines suggest that long term use may actually increase risk of dementia (https://www.nice.org.uk/advice/ktt6/chapter/evidence-context).

[8] It is observed that in the 'Care Assessment – Medication, Healthcare Assessment and Treatment Form' provided by XYZ (completed on 15.06.2017, 21.09.2017 and 22.12.2017) it is documented that 'the resident is assumed to have the capacity to make decisions relating to medication, healthcare and treatments'. This however appears at odds with the broader view expressed by clinicians over this time. It is noted that this may be stated because the question is phrased 'Has the resident been assessed or assumed to have capacity…'. The response may therefore reflect a lack of assessment of capacity.

psychological or functional assessment/analysis of Mr Z's challenging behaviour. Despite the frequent challenging behaviours exhibited by Mr Z, the incident records completed by the home lack significant detail, and had not been used in any way, either by XYZ or by any other involved service, to conduct a detailed or meaningful functional analysis of Mr Z's behaviours. In any case, the lack of detail in these records would have made this difficult. In simple terms, the reason or reasons for Mr Z's behaviour were not understood, and the attempts to do so were limited.
This is perhaps particularly noteworthy, given that XYZ believed that Mr Z's behaviours were very unpredictable and could not identify any consistent triggers. They noted one of their management strategies was to try to divert other residents away from Mr Z, as he was not easy to divert himself. Behavioural and functional approaches should be a routine part of care for people demonstrating challenging behaviour in the context of dementia; for instance, NICE guidance in regards to the management of 'non-cognitive symptoms' of dementia provides clear guidance that 'psychosocial and environmental interventions' should be provided routinely.

18.20. By early **August 2017,** the situation appears critical, with a series of several concerning incidents towards staff and other residents. These incidents are hard to fully disentangle, and the chronology below represents the best overview of the separate incidents recorded.

18.21. The first such incident occurred on the **5th August 2017.** This is recorded against a resident (not Ms F) and is described in the XYZ care records as follows:

> '*[Mr Z] and the other resident shouting the resident was begging for him to leave but refused when carers started to walk him out he swung round and smack* [sic] *her across the face where the resident covered her face but [Mr Z] caught her still*'

18.22. After the incident, staff from the care home contact DIST who indicated they would review Mr Z the following day. The care home asked if DIST can come the same day, reflecting the level of concern experienced by staff members at the time.
The incident is also reported to adult safeguarding the same day, and is recorded by adult safeguarding, but unfortunately under the name of the victim only. It has been established that this is a departure from expected practice where the incident should have been recorded under both victim and perpetrator. Of course, recording it under the victim means that incidents against multiple victims may not be tracked as relating to the same perpetrator.

18.23. The following day, the **6th August 2017,** The Local Authority records indicate a conversation occurred between the care home manager and the safeguarding practitioner. Reassurance is given by the home that '*Mr Z is being observed every 15 minutes and if he gets up staff will follow to ensure no other resident is harmed*'.
There is a discussion between colleagues in the safeguarding team and it is decided that the care home have taken adequate steps and therefore the issue is logged as a safeguarding alert (rather than a referral) with no further action required. Later the same day, DIST visit the home. Notably, the care records indicate that DIST believed that Mr Z '*should not be in this home as a massive risk*[9] *to towards residents and staff fallowing the incident with [victim previous day]. DIST nurse has advice [Mr Z] is not in the suitable home [sic]'*. This is confirmed in the DIST records: '*Mr Z was a risk to residents and staff and should be placed elsewhere*'. However, there is no action taken to resolve the apparent divergence in views between the safeguarding team and DIST, and it is not clear that DIST appreciated that the safeguarding team believed that adequate risk management was in place.

[9] This term is not quantified in any way

18.24. Separately, it is of concern that in the DIST notes from the visit on this day, it is commented that '*care home staff told DIST that their manager had told them not to tell the resident's family about the incident*'. XYZ dispute this was the case, and state that this may be a misinterpretation of guidance to staff in responding to family members who were seeking information about Mr Z. However, this is perhaps hard to reconcile with the understanding reported by the DIST worker, as there would be no reason why the resident's family could not be told about the incident in a way that did not breach Mr Z's confidentiality. In any event, having made this judgement, it does not appear that the DIST worker or service took any action about this, or escalated this concern more formally.

18.25. On the **7th August 2017,** the police review the incident from the **5th August** and the following is documented:

> '*[Mr Z] is being observed every 15 minutes and if he gets up staff will follow to ensure no other resident is harmed… This is resident on resident, both lacking capacity, and therefore, there will be no police investigation. This has been recorded for NCRS [National Crime Recording Standard] compliance, and this will be managed by Adult services. There are no injuries and neither resident can recall the incident. DIST are involved with the suspect and will be following up and assessing him to assist with his behaviours. He is currently on 15 min obs to safeguard other residents*'.

18.26. The following observations are made about this incident and subsequent response:

- It is notable that the police and safeguarding team were making their judgements about the ability of XYZ to effectively manage Mr Z in the absence of the view expressed by the DIST team (that Mr Z was unsuitable for the care home and remained a risk).

- Concerns expressed by DIST that XYZ were unable to cope with Mr Z do not appear to translate into any concrete action to locate Mr Z another placement, nor any concrete action to reduce Mr Z's risks to allow him to be safely managed at XYZ. There is no referral to Adult Social Care at this stage by XYZ nor DIST. This was a missed opportunity.

- The reasoning in the police and safeguarding response presumes that staff would be able and willing to physically act to prevent such violence presumably through some form of physical restraint ('*staff will follow to ensure no other resident is harmed*'). However, they were not able to do so and were not trained to physically restrain. This is reflected in the care records ('*staff remain scared of [Mr Z] and won't attempt to give him meds if he is agitated*') and implied in the assessment by DIST ('*staff are scared of him and worry about the other residents*').

18.27. On the **12th August 2017,** there is a further incident. This time Ms F is the victim. This incident appears referred to briefly in the care home's records for Mr Z but it is not included in the incident report forms or behaviour charts for Ms F that the home has provided nor in her daily care records. There is, however, evidence that this incident was reported by the care home to the safeguarding team, as records from the safeguarding team record the following:

> '*T/C from [XYZ] to EDT reporting that [Mr Z] has slapped [Ms F] on the face. Both live in same unit and this is first reported incident between them. [Mr Z] was being*

administered meds by senior worker when [Mr Z] began to cough. Senior worker went to find a tissue for [Mr Z], [Ms F] began to speak with [Mr Z]. Conversation content unknown but [Ms F] heard to say the word 'shit'. [Mr Z] became agitated and slapped [Ms F] around the face. Witnessed by staff who stepped in quickly to de-escalate. Small red mark following incident which faded quickly; staff to monitor cheek and would contact GP if necessary. [Ms F] did not appear emotionally impacted regarding the incident'.

18.28. The care home records for Mr Z appear to confirm the nature of the injury to Ms F:

> *'Norfolk Adult service called about the incident between [Mr Z] and [Ms F]. They said this incident to be reported to managers and to be monitored overnight. If the red mark on [Ms F]'s face still remains, the [sic] she is to be seen by a GP on Monday.'*

18.29. In regards to the actions taken as a result of this incident, the safeguarding records note the following:

> *'Staff have advised family (no reported concerns) and manager plans to contact QA/CQC/[Placing Authority] Social Services to inform. Staff to monitor the situation. Discussed with SAPC MASH. Reassurances have been made by care home that plans are in place to reduce the risk of further incidents. In agreement with decisions made by EDT; no full safeguarding referral necessary'.*

18.30. The incident is also described by the safeguarding team as '*a one off incident which the staff will now monitor*'.

18.31. Importantly, it is observed that within the accident/incident reports within Ms F's records, this incident is described as being perpetrated by another resident (though sharing the same first name as Mr Z). It is therefore unclear whether Mr Z was indeed the perpetrator of this incident, but the timings and descriptions of the incidents given would indicate this is not a different incident. It has not been possible to resolve which record is incorrect.

18.32. Notwithstanding the above query about whether Mr Z was indeed the perpetrator of this specific incident, it does appear that the safeguarding team were advised the incident occurred in relation to Mr Z and this is clearly recorded in their files in relation to him. Therefore, regardless of the actual perpetrator, the following observations are made and remain relevant about this incident and subsequent response:

- Given the foregoing narrative, it is important and problematic that the safeguarding team have inaccurately conceptualised this as a '*one off*'. One might suppose this was a misunderstanding that this was the first incident involving Ms F herself (as opposed to any other resident). But this understanding, if intended or communicated, would be to miss the bigger point: that a pattern of risk was emerging. The language of '*one off*' implies that no further action is required to prevent a repeat scenario.

- The reality is that this was the second resident to be injured by Mr Z in a matter of a few days, and when combined with the information that other staff had also been injured in the preceding weeks (six assaults against staff can be counted to this point from **Appendix 1**), all the information was available to allow a more accurate appraisal of Mr Z's risks to be developed at this stage.

- There are various reasons why this may have occurred. One factor may well have been the fact that the safeguarding team previously did not log the

incident on the **5th August** against Mr Z, instead only recording it against the victim (see 18.22). Thus, this would have appeared to them as the first incident against a resident. Similarly, although specific incidents against staff are not routinely reported to the safeguarding team, they also do not appear to have been made aware of them in their wider discussions with the care home about the ongoing risk management.

- For reasons already discussed, the safeguarding team had already reached the view that the care home was able to manage the risks presented by Mr Z (18.23) and it appears that further reassurances had been given by the care home to the same effect. Again, there seems to be an over-estimation of the extent to which the care home's risk management strategies could realistically have managed the risk (18.26), which were in turn not robustly challenged or queried by the safeguarding team.

- Police commented that the safeguarding hub (MASH) could have additionally recorded the event as a crime, which would have led them to conduct further follow-up (although the response may well have been similar to the **5th August**, this would at least have allowed the police to see the pattern emerge earlier than it had done).

18.33. In sum, the incidents on the **5th August** and **12th August** were the beginnings of the creation of an 'information gap' which existed between the various professionals involved and led to involved professionals not appreciating the full picture of Mr Z's risk. This led to a situation where statutory agencies including police and local authority safeguarding team underestimated the severity and frequency of the likely risk (by believing these were 'one off' incidents and not part of an emerging pattern) and overestimating the ability of the care home to implement strategies which would likely be effective in mitigating against any future risk.

18.34. In light of the narrative so far, and particularly the concerns and view noted by DIST (18.23), it is reasonable to ask why Mr Z was not moved to other accommodation at this time. For clarity, during the Learning Events, XYZ indicated that by this time they would have wished to seek alternative accommodation for Mr Z due to their difficulties in managing Mr Z (this perhaps appears somewhat at odds with the reports to the safeguarding teams that they were effectively managing the risk). There would broadly have been two pathways out of the home for Mr Z at this time; firstly, detention under the Mental Health Act (1983) and secondly, referral to Adult Social Care for assessment of placement needs. However, neither option appears to have been explored. Some factors that may have contributed to this and considered by the SARP are considered presently:

- Firstly, as Mr Z was a self-funded client, he was not 'on the system' and therefore had not been assessed by Adult Social Care who might otherwise have had responsibility for identifying a different and more suitable placement. It appears the first contact with statutory services is in regards to the aforementioned safeguarding referrals.

- Secondly, Mr Z's wife was very keen for her husband to remain at XYZ. Staff from XYZ noted that even after Mr Z was finally detained under the Mental Health Act 1983 (MHA), Mr Z's wife still paid the home for several weeks to '*keep the bed open*' in the hope that he could have improved and returned there, though the care home reported that they had told her that her husband would not be returning. They described Mr Z's wife's experience of the process of Mr Z's discharge from the home as '*heart breaking*' (itself a difficult process, see s.19).

- Third, the DIST service, who would have been most obviously positioned to make the practical arrangements for a Mental Health Act Assessment (MHAA), did not appear to consider whether Mr Z would have been detainable under the MHA at this time. Related to this, XYZ Care Home had limited experience with the workings of the MHA (noting they have very few residents in their homes who require this to be considered), and so did not '*ask the question*' about MHA until much later. Any of the agencies involved, including XYZ, could have contacted Adult Social Care (ASC) or the mental health team (in this case most obviously via DIST) requesting a MHAA at this stage.

- Fourth, despite acknowledging that the care home was not able to manage Mr Z's risks safely, DIST did not then explore, recommend or seek out other options, short of detention under the MHA, which could have provided for Mr Z's needs. This is unfortunate, as a referral from DIST to the local authority may well have carried significant weight.

- Similarly, despite receiving a clear opinion from DIST that they could not manage Mr Z's risks appropriately at this time (and despite agreeing with this view), it is not clear what active steps XYZ took *at this stage* to seek alternative accommodation. Of course, it would not be for XYZ to identify alternative accommodation, but as the organisation primarily addressing Mr Z's care needs, they had the option to initiate a referral to ASC requesting an assessment of Mr Z's placement needs. Alternatively, a safeguarding referral could have been made by DIST at this point.

18.35. The overall result of these factors was that Mr Z remained at XYZ at this point despite clear indications that he remained a risk to other residents and staff.

18.36. Another specific concern might also be highlighted at this stage: that of Mr Z's ongoing capacity to consent to decisions about his residence. As noted above, XYZ noted that upon admission, Mr Z appeared to have capacity to make decisions about his residence according to the requirements of the MCA (though this is challenged somewhat by the written records – see 18.6). In any case, by this stage, it was agreed that Mr Z had lost such capacity. He was also objecting to remaining a resident in the home, asking to leave, with staff reporting he would become particularly distressed after his wife left him after visits. The home has agreed that there is no record of a DOLS application being made. The SARP reflected that had Mr Z's residence been properly authorised using DOLS this itself may well have led to further consideration of the appropriateness of accommodation in regards to Mr Z's best interests (from this perspective, it was surely not in *Mr* Z's best interests to continue assaulting other residents and staff, if other options were available to manage this behaviour). This issue of a lack of authorisation of Mr Z's deprivation of liberty potentially raises a wider question about the general practice of care homes, including XYZ, and how other residents who may be in in this position might be identified by the wider system.

18.37. Over the next few weeks in the latter half of August, the records indicate there appears to be some improvement in Mr Z's presentation and a reduction in violent behaviour. There are some concerns about his swollen legs. There are, however, very few entries in the XYZ care records provided; for instance no records between **21st** and **27th August**, and no records between **28th August** and **12th September**. There also seem to be some apparent gaps in records in this period; for instance between the **14th August** and **1st September** the fluid intake charts only have one

record (all other days seem to have multiple records made). Food intake charts appear missing from **14th August** until **9th September**. It is not clear why this is the case.

18.38. By the **23rd August 2017** (11 days after the home's second safeguarding referral), DIST record that Mr Z is '*more settled*' and '*if he continues to improve DIST to consider for discharge next week*'. This visit is not recorded in the care home records. The following week he is reviewed again by DIST and it is recorded '*continues to be more settled did shout at a female resident but in response to her shouting at him. Care home advised that [Mr Z] will be discussed at the MDT [Multi-Disciplinary Team] and possibly be discharged*'. It does not seem that this incident was recorded by the care home (**Appendix 1**). Whilst there is perhaps some basis for a view that Mr Z's presentation had improved, DIST do not appear to be aware of several less serious incidents around this time, which stop short of violence, but are recorded in the behaviour charts: '*shouted with underwear at knees and covered in faeces*'; '*shouted shut up at residents, went to residents room*'; '*shouted at resident C and staff in her room*'; '*threw bowl at carer*'; '*shouted shut up to D in corridor*'. This omission is important, as of course the drivers of these incidents may well be very similar to the more serious acts of violence, potentially suggesting continued reasons to be concerned about on-going risk. DIST also did not appear to query or challenge the limited notes in the care record. In any case, the decision to discharge appears quick after the safeguarding referral; the records indicate that DIST closed Mr Z's case on the **30th August 2017**. Whilst this may be appropriate given the short-term focus of the DIST service, it is also concerning that the case was not referred to the Community Mental Health Team, who would have been best placed to provide continuity of care.

18.39. Thirteen days later, on the **12th September 2017**, there is another significant incident in which Mr Z is reported to have slapped a male resident across the face (referred to as Mr Q below). The safeguarding records relating to this incident provide the most comprehensive account of the incident itself:

> *'Mr Q is reported to have walked out of his room, turned left to walk down the corridor and met Mr Z who was walking the opposite way. Mr Z reportedly slapped Mr Q across the face without prior warning before continuing to walk down the corridor; this was witnessed by staff members at a nearby desk. Staff intervened and encouraged Mr Z to continue walking and to offer support to Mr Q. Mr Q is said to have 'looked surprised' immediately after the incident and sustained no marks, bruising or other injuries. Mr Z is reported to have become tearful following the incident; referrer said she believes Mr Z 'was aware that something had happened but could not understand what it was'. Both parties have a diagnosis of dementia and neither is thought to have capacity regarding the incident.*
>
> *Referrer advised me that Mr Z is on 15-minute observations following previous incidents of similar nature. DIST team are also involved[10] and medication is currently being reviewed. Mr Z is on an open-ended period of respite at [XYZ Care Home]. Families have been informed and are reported to have no issues with current situation.'*

18.40. This is clearly a remarkably similar incident to the two previous incidents in which Mr Z reportedly assaulted two female residents only some weeks previously. **This is now at least the third such incident in which a resident is slapped or hit in the face/head by Mr Z**. The incident again seems to lead to police involvement but understandably no further police action against Mr Z given this would not be in the public interest. There is little to add in terms of the wider analysis of the response to this incident: little further

[10] It is noted that this is incorrect – see later comments.

action is taken, and the incident does not appear to lead to any further action to increase the likely effective management of the violence risk (the suggestion of increased 15 minute observations at this time is clearly one effort to do this, but the likely effectiveness of this is again questioned given that this incident is being recorded as occurring whilst in sight of staff members).

18.41. One notable omission at this stage is that this incident does not trigger any re-referral back to the DIST team. Indeed, a re-referral to the DIST team does not occur for another two months despite multiple further incidents. Presumably this was at least partly because the safeguarding team believed that DIST were already involved. This is clearly unfortunate, although it is unclear whether this reflects a misunderstanding or miscommunication on behalf of XYZ or the safeguarding team. Given that DIST were seen as the 'gatekeepers' for the Mental Health Act Assessment (and even though XYZ could have made a referral for a Mental Health Act Assessment without the involvement of the DIST team), this apparently small omission could have had significant consequences for the ability of services to respond in the face of a continued pattern of violence. It also, again, increased the safeguarding team's over-estimation of the ongoing management of Mr Z's risk.

18.42. On the **27th September 2017** there is a further recorded incident when Mr Z '*slapped resident across the face causing fall*' (**this is now the fourth incident in which a resident is punched or slapped by Mr Z on the face/head**), and then a similar incident on the **30th September** where Mr Z '*hit carer round the back of the head*' and '*threw punch at carer who ducked out of the way*'. Whilst this latter incident would not have been reported per se to the safeguarding team as the victim was a staff member, the incident on the **27th September** should have been reported. There is no evidence it was reported. No further action is taken. Again, this is particularly unfortunate because the pattern of behaviours is now becoming reasonably well established.

18.43. There then appears to be a period of approximately one month, over most of **October 2017**, during which no incidents or concerns in regards to Mr Z are recorded. There is very limited information available to allow any speculation as to why an apparent improvement in behaviour might have occurred over this time (see 18.14).

18.44. Towards the end of October, there are a number of further incidents. The first three of these (dated **25th October**, **5th November** and **8th November**) are recorded in the list of incidents in **Appendix 1**. All of these incidents are towards staff. They appear to be related to care delivery. There is also an incident on the **31st October** where Mr Z is reported to have '*tried to throw belongings at the other resident*', but this record only appears in the behaviour charts, and is not reported to safeguarding. Again, the level of detail recorded prevents any full analysis of the function of these incidents (see 18.13).

18.45. On the **13th November 2017**, there is an incident towards another female resident, Ms R. This is described in the care records from XYZ that the victim '*tried to push her way past [Mr Z] resulting him into grabbing both her arms and pushing her the other way to fall over on her right side*'. This incident is recorded in the adult social care safeguarding records, after a telephone call was made by XYZ on the **14th November** indicating:

> *'T/C from XXX at [XYZ Care Home]. Reporting an incident that happened between 2 residents at 17:00 hours. [Ms R] has been in a bad mood all afternoon and has been trying to go into other residents bedrooms. [Ms R] went into the bedroom of [Mr Z] - he shouted at her to get out and grabbed her by both arms and pushed her and she fell to the floor. [Ms R] fell on her right side but XXX said*

there do not appear to be any injuries to her. Both parties separated. Incident witnessed by XXX. Raised as a Safeguarding Adults Referral.'

18.46. Notably, XYZ have stated that the above incidents are two separate incidents but this is not clear from the incident reports and care records provided. They have therefore been treated as a single incident in the present analysis. It is also possible another incident had occurred which is unrecorded.

18.47. Given that the safeguarding referral referred to regards to another client, this referral has not been seen/requested.

18.48. The police records do however also record this incident:

'[Ms R] had been in an agitated state, and tried to get into [Mr Z's] room. Mr Z shouted at Ms R to get out of his room, she didn't leave so he grabbed her by both arms and pushed her backwards, causing her to fall to the floor. This caused skin tears to Ms R's left leg and right arm'.

18.49. **This is now the second time that Mr Z's actions caused a client to fall to the floor.**[11] In many ways it must be remarked that this incident does not appear dissimilar to other previous incidents for instance those in which residents are slapped/hit across the head. This emphasises the point that the risks of Mr Z's behaviour would have been better understood by an analysis of the potential outcomes, rather than of the actual ones. **The fact that Mr Z's victims were often frail, unwell and vulnerable people**[12] **is also very important as this increases the probability of violence leading to more serious physical harm**. Again, it seems very little action beyond reporting to safeguarding occurred.

18.50. Unfortunately, a further incident then occurred on the **16th November 2017.** This time the victim was Ms F herself. **This was therefore the second time in which Ms F was recorded as a victim of violence by Mr Z.** This incident is described in the adult social care safeguarding records as follows:

On 16.11.17 at approximately 19:55, Mr Z and Ms F were walking around the unit together, as they usually do all day.[13] *The two residents stopped at the lounge door. Ms F said something angrily to Mr Z. Mr Z then shouted at Ms F and slapped her on the forehead. The staff then intervened to separate Mr Z and Ms F. They then noticed that Mr Z had a deep scratch on his arm which was bleeding. The staff feel that Ms F may have scratched Mr Z which provoked him to slap her, although this was not witnessed. Mr Z and Ms F are reported to lack mental capacity around the incident. They both have dementia. Ms F did not have any visible markings or bruises on her forehead and was not distressed. Mr Z's arm was bleeding and cleaned and dressed by the staff. They applied dressings to the wound 7 times, but Mr Z removed them each time. The home felt that there was no point in calling the district nurse. After the incident Mr Z was taken to his room for a cup of tea and Ms F was taken into the lounge. Neither Mr Z nor Ms F have expressed any wishes or feelings about the incident or appear to have memory of the incident. Mr Z and Ms F have resumed walking around the home together all day, as is their usual routine. Both families have been informed of the incident. The home have not taken any measures in regards to the incident. Mr Z already*

[11] The previous incident was on the 27th September.
[12] In reviewing a draft copy of this report, XYZ sought to clarify that many of their residents were not necessarily particularly frail and potentially not all were vulnerable. Whilst this may be the case, it is conversely noted that as a population as a whole, it seems reasonable to conclude that residents in the care home would be more likely to be frail, unwell and vulnerable than the general population.
[13] Staff from XYZ confirmed that Mr Z would walk around with other residents as well

takes diazepam to manage aggression, as and when needed. Neither resident has 1:1 support or formal observations.

However, as they are constantly walking around the communal areas of the unit, they are usually in view of the staff. Risk: Blue. Outcome: To be recorded as a Safeguarding Alert

18.51. This is the first clear indication of Mr Z also receiving an injury in an altercation, although understanding the sequence of events is difficult as it would appear the initial part of the incident is not witnessed.[14] Regardless, **it is notable that this is now the fifth recorded time that a resident has been slapped/hit on the head/face by Mr Z**, with several other staff reported to have been similarly assaulted. As documented, no further action was taken directly to enhance the immediate risk management approach. The incident does not appear to be reported to the police. Ordinarily this should be done automatically by the MASH team as part of the processing of the safeguarding referral.

18.52. XYZ advised during the SARP meetings that on the day after this incident, the **17th November 2017,** they made an urgent referral by telephone to the safeguarding team requesting, in turn, that they make an urgent referral to ASC for a review of Mr Z. They explained that they did not go direct to ASC because they believed that a referral from the adult social care safeguarding team could trigger a more urgent response. This conversation does not however appear to be recorded in the notes provided by XYZ, but there is a brief record in the notes provided by safeguarding that '*contact form received to request a reassessment due to recent safeguarding incidents involving [Mr Z] as the alleged perpetrator*'. It seems, however, that the need for this had already been recognised by safeguarding as a result of the incident the previous day, with the records after this incident noting: '*Safeguarding referral with [Mr Z] the alleged perpetrator – this is the third incident where [Mr Z] has been involved in safeguarding concerns since September and the outcome of current Safeguarding Concern was for a new assessment to ensure XYZ are able to continue to meet [Mr Z's] needs safely and look at how to minimize risk to other residents*'.

18.53. Unfortunately, it appears that this referral was then allocated on the wrong holding list (for an Occupational Therapist, not a Social Worker). A view expressed was that this may have partly been related to the transfer to a new electronic records system (see 18.72) which occurred around this time. It was then moved to the correct holding list from the **5th** to the **18th December**. It appears that this correction may have been triggered by involvement of a social worker allocated to one of Mr Z's victims (i.e. not Mr Z's or Ms F's social worker) raising concerns about Mr Z's behaviour. Nonetheless, this is clearly unfortunate, since this likely contributed to a delay in an assessment of Mr Z by ASC.

18.54. XYZ's account was that having made this phone call they were then in a state of presuming that action to address the risks would be rapidly forthcoming. However, other action to support risk management (e.g. a referral back to the GP to request reassessment by DIST) does not occur at this point. However, it is also noted that records from the adult social care safeguarding team, regarding the incident on the **16th** (and noted as relating to a discussion on the **20th November** – i.e. four days after the incident) that the care home had advised them that '*the existing care plans were sufficient at that time and did not make any changes*'. There is a tension here with the view that the request to the safeguarding team for a further assessment of

[14] There is a potential apparent inconsistency on this point with the clinical record provided by XYZ, which in an entry dated 16.11.17 at 20:04 lists three staff member names and says 'he was witnesse' [sic]. The entry does not appear complete; an incident record form further appears to indicate that the injury against Ms F was witnessed but that Mr Z's injury was not.

Mr Z was a definitive statement by the home that they were unable to manage Mr Z, and further seems in tension with other views such as those expressed by DIST, that as early as August they had *not* been able to manage Mr Z's risks adequately at this time (see 18.23 and 18.34). It is notable, also, that staff at the care-home reported that they had struggled to manage Mr Z relatively consistently *throughout* his admission. It does not appear that there had been any obvious changes to Mr Z's broad risks nor to the effectiveness of associated risk management. This statement to safeguarding therefore provided false assurance of the ability of XYZ to manage the presenting risks and may have worked against further follow-up occurring. The fact that this occurred shortly after a serious violent incident is particularly important in contextualising the later actions.

18.55. On the **19th November 2017**, Ms F's family (who visited the care home daily) reported observing Mr Z behaving very aggressively and assaulting a male carer. During my meeting with the family, they showed a short excerpt of a video they had taken of Mr Z at this point to demonstrate his aggressiveness. On the **20th November,** a further incident is recorded against a carer who recorded two punches to the arm and one punch to the head.

18.56. A further incident, in which a staff member is hit by Mr Z, is recorded on the **27th November 2017**. A similar 'near miss' had also occurred a few days earlier. Little detail is recorded about either incident. However, the incident on the 27th was serious enough for XYZ to contact the GP to request an urgent re-referral to DIST. This results in DIST reviewing the case on the **30th November** and recommending that Mr Z be commenced on Quetiapine (an antipsychotic). DIST also recommended to stop/reduce benzodiazepine medication (Diazepam/Lorazepam) as staff had reported these to be ineffective.

18.57. It is important to note that the use of antipsychotic medication in people with dementia[15] is not without controversy. The general overuse of such medication was formally highlighted in a 2009 independent government report.[16] This report highlighted that, '*while some people with dementia receive excellent care, for the large majority it appears that current systems deliver a largely antipsychotic-based response*', estimating that '*we are treating 180,000 people with dementia with antipsychotic medication across the country per year. Of these, up to 36,000 will derive some benefit from the treatment*'. And whilst there is no moratorium on the use of antipsychotic medication in dementia in NICE guidance, the guidance indicates this needs to be used carefully and cautiously, and in a system that appropriately supports other non-pharmacological approaches to the management of challenging behaviour.[17] Thus, whilst there is no suggestion that the use of Quetiapine medication was necessarily inappropriate in the present case, it does seem reasonable to conclude that the response by DIST did reflect a 'medication first' approach (please also see comments in 18.17).

18.58. Two days later, on the **2nd December 2017**, it is recorded that Mr Z has another incident where he slapped a patient in the face (Ms R, who had previously also been

[15] The fact that there is not evidence that Mr Z ever had an assessment for dementia is noted, and also a separate concern.

[16] Banjree, S. (2009) The use of antipsychotic medication for people with dementia: Time for Action. A Report for the Minister of State for Care Services

[17] https://www.nice.org.uk/advice/ktt7/chapter/Evidence-context and https://www.nice.org.uk/guidance/ng97/chapter/Recommendations#pharmacological-interventions-for-dementia

the victim of violence perpetrated by Mr Z). **This by now is at least the sixth such incident**.

18.59. The home noted that DIST had provided them with an emergency contact number to call if the behaviour changed. XYZ advised at the Learning Events, and have subsequently reiterated, that they were provided with the wrong number. However the clinical record adds further context to this and therefore the following notes from Mr Z's care records are detailed below:

- On the **30th November**, it is recorded that DIST provide XYZ with the phone number for the Emergency Duty Team (EDT). The number recorded in the clinical record is the correct number for all local authority enquiries and is the correct approach for contacting the EDT. It is recorded in the notes that '*this is a 24 hour service… for an urgent mental health assessment when [Mr Z] exhibits behaviours which are a danger to self or others. It must be stressed to EDT that we must have the assessment urgently*'
- On the **2nd December,** after the aforementioned assault of Ms R, a Care Assistant records that '*Tried to phone to the number what has been given for emergency but could not get through*'. However, the reasons for this are not recorded.
- On the **3rd December**, DIST visit again, and this time also record '*if aggression becomes worse contact DIST [telephone number] 8am-8pm*'. A telephone number is provided which is indeed the correct number for DIST. It then states '*Otherwise ring 111 or 999 if very urgent or out of control*'.
- On the **5th December,** DIST visit again, and the advice about contacting DIST (along with the telephone number) is reiterated, recorded in an entry made by the care home manager. The telephone number is the correct telephone number for DIST. The entry states '*In case there will be incident we have to contact DIST team which is open 8-8pm at [telephone number] and there is a possibility they will use a Mental Health Act in action. If incident will happen after 8 please call 999*'.

18.60. It is of course possible that an incorrect number was provided on a different occasion, and of course possible that calls were not answered (and if so this would be an important observation), but it does seem clear that telephone numbers that should have allowed for a 'stepped up' response were recorded correctly in the care records over this period based on the records observed (the EDT, DIST or 999 could have been 'routes in' to a potential assessment for detention under the MHA). It should be noted, however, that this is not itself a highly significant issue.

18.61. In any event, the incident concerning Ms R is recorded by a social worker, allocated to Ms R, on the **4th December** as follows:

> *'Occurred 17:05. He slapped her on face for no reason. Witnessed? - yes by a carer. He was just walking down corridor. Just as they passed, he slapped her. What measures to manage? DIST visited [Mr Z] yesterday (3rd December) and their advice continue with medication which was started last week. [Worker at care home] said it is medication to calm him. DIST say if he gets aggressive then ring DIST. [Worker at care home] said Ms R's son was informed about this incident'*

18.62. It appears that the incident leads the social worker to review the files and notes that previous similar incidents have occurred. This triggers the social worker to request that Mr Z's file is reviewed. The chronology seems to indicate that it is then at this point that the file is allocated to the incorrect list (in contrast to the earlier indication that this

was after the 17th November review by safeguarding). This has not yet been fully clarified.

18.63. On the **4th December 2017**, there is a further incident where Mr Z hits another resident over the head, apparently in a similar manner. **This is now the seventh such incident**. The care home report that this is reported to adult safeguarding. This incident is reviewed by the Emergency Duty Team (EDT) and recorded as an unprovoked assault. It is also reported to the police, again with no further action taken or planned. No other significant details are recorded. There is no clear documentation of expected actions taking place or planned.

18.64. The next day (**5th December**), Mr Z is reviewed again by DIST. DIST have reported that there are then daily entries made in their records between the **5th** and **15th December** (though individual entries here have not been seen). Upon review on the **5th December,** DIST note that there does not seem to be any evidence of an infection, review Mr Z's medication, note the seriousness of the situation, and '*consider detaining if does not improve due to aggression*' (this reference appears to be the first active consideration of the possible use of the MHA). This is important as it appears the clearest recognition of the fact that XYZ was unable to meet Mr Z's care needs and manage his risks safely (XYZ's report that they contacted ASC on the **17th November** is noted, as are the social worker's concerns from the **4th December**).

18.65. DIST's advice at the time is for XYZ to keep Mr Z on 1:1 observations. Again, there is no consideration of how or whether 1:1 observations could have effectively and satisfactorily mitigated Mr Z's risk in this environment. Indeed, XYZ agreed that in retrospect the advice to keep Mr Z on 1:1 observations was not necessarily helpful. Given that there are no other planned changes to Mr Z's care that might be expected to work to mitigate Mr Z's risks, one may question why the suggestion of an MHA Assessment was not followed up more robustly at this stage and why a 'wait and see' approach was adopted. The SARP speculated on the possibility of human factors contributing to this decision-making process, for instance the possibility that an awareness of a lack of available beds might cause workers in DIST and similar services responsible for arranging Mental Health Act Assessments to set an artificially high threshold for MHAAs to occur. Thus, bed availability may impact on a decision (or not) to assess somebody for detention. This is of course speculative, but from a psychological perspective it would not be surprising if such pragmatic factors influenced decision making more than they should (it is noted that a decision to detain should of course be driven by presenting need, risk and whether the criteria under the MHA are met). Alternatively, as DIST involvement had only re-started recently they may have approached the case, understandably, with a view to implementing interventions to avoid an admission. In hindsight, however, there appeared sufficient information available at this time to indicate that XYZ was not able to implement interventions to effectively reduce or manage Mr Z's risk.

18.66. On the **9th December**, DIST recorded that a senior care home worker had advised them that Lorazepam was being given to Mr Z routinely at 8.30am (despite this being a PRN – or 'when needed' medication). There was concern also that administration of Lorazepam within two hours of Quetiapine may have reduced the effectiveness of the latter. DIST reported that they updated the medication chart for the home to resolve this. Certainly, it doesn't seem that by this stage the antipsychotic medication is supporting a reduction in challenging behaviour.

18.67. The earlier noted comments about the prescription and administration of Mr Z's medication should also be considered here (18.18); the need to give Mr Z medication that he was not able to consent to, where there was no process by which somebody could consent on his behalf, and which was clearly medication with significant risks

and side effects suggested the accounting process of determining Mr Z's 'best interests' in this regard would be difficult. Had Mr Z been detained under the MHA, medication would have had a clearer legal basis, but also afforded Mr Z more safeguards (for instance in terms of access to an advocate, and opportunity for his case to be heard by hospital managers/a Mental Health Review Tribunal).

18.68. On the **12th December**, the care home record that they are given guidance from DIST to use plastic knives and forks and alter the dose of Quetiapine. This was some point of discussion at the Learning Events, as XYZ had felt that such advice (providing plastic cutlery) had not been helpful nor, at all, within their typical scope of care provision. On this point, however, it is worth noting that DIST's records indicate that their advice was for plastic *crockery*, not primarily because of concerns about cutlery being used as weapons (which is what XYZ reported they had understood), but because of the fact that Mr Z would bang/throw his cup/plate on the table/floor. In any event, from the perspective of an external observer, it perhaps does not seem unreasonable that staff would have been concerned about Mr Z's use of cutlery and crockery. By this stage there are a number of incidents of Mr Z throwing items which, deliberately or not, were sometimes directed towards people. Changes to reduce the risk of these causing injury therefore do not seem unreasonable. However, of course, such changes are outside the usual parameters which would ordinarily be provided for by a care home; again suggesting the need for an MHA assessment to occur.

18.69. On the **13th December**, an incident is recorded as Mr Z having punched a staff member on their left shoulder (another incident in the record towards Ms R recorded on this date is stated by XYZ to be an error in the records, which in fact relates to the incident on the 13th November).

18.70. On the **14th December 2017**, Ms F becomes a victim of violence from Mr Z for the third time. The nature of the incident against Ms F is most clearly recorded in the adult social care safeguarding records, and in this regard represents an example of good practice, demonstrating clear recording of known facts about the incident and a clear plan of intended next steps:

> *'Spoke with [Senior Care Assistant] who confirmed Ms F and Mr Z were wandering around the unit, they hadn't realised they'd both gone into Mr Z's bedroom. Staff heard Mr Z shouting and entered the room to find that Mr Z had slapped Ms F across the face. Mr Z was shouting 'get out of my room', however it took staff a couple of minutes to remove Ms F from the situation because she was hiding behind a duvet.*
>
> - *Ms F has redness in her face and was crying.*
> - *[Senior Care Assistant] reports that Ms F did not understand what was happening, however she has reason to believe that Mr Z did understand.*
> - *Ms F's daughter was telephoned and advised of the situation. A message was left for Mr Z's wife.*
> - *Ms F remains shaken up and was described as 'shaky, pale and jumpy'. Ms F was with her daughter when I called. Ms F's daughter is upset with the situation as this has happened previously.*
> - *Ms F has a diagnosis of Dementia which can be described as advanced. Ms F is unable to hold a conversation.*
> - *Ms F's daughter has advised this is the third incident in a month and both she and the home feel they are unlikely to continue to manage Mr Z's needs.*

Complexity: Medium – Visit needed to address concerns and consider if provider are able to continue to meet the needs of Mr Z.
Priority: Amber.[18]
Conclusion – Case to be reassigned to (redacted) Locality for follow up.'

18.71. It is noted that after reporting the incident initially on the **14th December**, the adult social care safeguarding team made further telephone calls back to the care home to establish further information and develop a plan. They recorded two telephone calls were unanswered and indicated that when they do speak to a staff member there are no management staff available until the following day. The conversation is then held with a Senior Care Assistant who relays her concerns that she '*reported this is an ongoing problem as [Mr Z's] behaviour has become unpredictable. She believes that the placement is no longer appropriate for [Mr Z]'*. However, she also remarks that '*she was confident that staff would be able to call for assistance from the other units if another incident was to occur*'. The telephone call is followed up the following day by a Safeguarding Practice Consultant, leading to the plan documented as above (18.70). Further calls are made with family members who continue to express concern about the immediate risks.

18.72. Although agreeing the above plan represented clear recording of information and appropriate planning based on the information obtained about this specific incident (and ASC's first direct decision to review the ability of XYZ to safely manage Mr Z), one might comment that the recording does not seem to recognise or reflect the multiplicity of incidents which had occurred to other victims by this stage (the only reference being the information from Ms F's daughter that this was the third incident in a month). It was considered that this might have been reflected in the decision to grade as 'amber' and that recognition of the multiplicity of historical risk incidents may have increased this rating further. In this regard, it is notable that from reviewing the information in **Appendix 1**, this was now the eighth similar incident which had been reported to the safeguarding team. It feels reasonable to presume that the safeguarding practitioner would have documented this history if they had been aware of it. Thus, one must question why they might not have been aware of the full picture of Mr Z's risk. There appear two explanations. First, because some of these incidents were recorded only under victims, the safeguarding worker here may have somewhat underestimated this frequency. Second, it has been confirmed that the safeguarding team transitioned from one record system (CareFirst) to LiquidLogic Adults System (LAS) in **November 2017**. The timescales mean that the practitioner would have been logging the current call in LAS, but without much previous historical information that would have been logged under CareFirst.

18.73. In regards to the first issue (only recording incidents under victims not perpetrators), the report author has been able to confirm with the Head of Service for Safeguarding that practice guidance to safeguarding professionals is clear on this point, and that the relevant local manager has been informed of this observed deviation in practice. In regards to the second, it appears that the passage of time and implementation of LAS has naturally reduced the extent to which this is an active concern in future cases.

18.74. Another issue that may have complicated the judgement is, however, the message given by XYZ that they could '*call for assistance from other units*'. It is quite possible to appreciate that the safeguarding team may well have understood that this reasonably reduced the immediacy with which the risk issue required response.

[18] This rating relates to a 'RAG' rating system (Red-Amber-Green) used to prioritise the level of risk or concern about a reported safeguarding issue

Certainly, in the family's record of events, it appears that the safeguarding team did communicate that the home were implementing a risk management plan.

18.75. In any event, it is unclear that substantively different action would have been taken by the safeguarding team had they been aware of this information, beyond, perhaps, escalating the rapidity of the visit.

18.76. XYZ noted that after this incident they started to liaise directly with one of the Safeguarding Adult Practice Consultants from the adult social care safeguarding team. They indicate that there had been an assessment planned to occur on the 15th December, which did not occur. It is not clear why. An urgent multi-professional meeting was then called for 1.30pm on the **19th December**, which was unfortunately almost coincidental with the time of the index incident in which Mr Z's assault of Ms F led to her admission to hospital.

18.77. There are several further observations to make about this incident on the **14th December** that must be noted.

- First, this is now the **eighth recorded incident of a resident being hit in the face or head by Mr Z.**
- Second, the apparent severity and likely emotional impact of this incident on Ms F simply does not appear within the XYZ records. These record only that '*Mr Z slapped Ms F in face. Ms F was found in Mr Z bedroom and could not be persuaded by carer to leave*'. To add context as to the level of distress, the family reported that she was still '*upset and shaken*' an hour and a half after the incident, and progress notes describe her as '*jumpy*' after being approached by a staff member.
- Third, there is a potential conflict between the records as to whether this incident was witnessed. The language recorded by safeguarding, where staff 'found' Mr Z in the room is subtly different to that recorded in the XYZ clinical record which more clearly states that '*As [staff member] opened the door she witness him slap [Ms F] in the face*'.

18.78. The incident does lead to some concrete recommendations and a strategy discussion between DIST, Safeguarding, and XYZ. It was noted that XYZ had agreed to instigate 1:1 care '*for the time identified as being most challenging*'. Whilst this may have reasonably appeared a pragmatic solution given the situation, as a learning point the ability of 1:1 observations to effectively mitigate risk is not considered by any of the involved services (18.26, 18.65). DIST agreed to review and reassess the case, but no police action was determined as necessary due to Mr Z lacking capacity.

18.79. On the **15th December 2017**, the care records received from XYZ indicate there is another incident involving Mr Z where a male resident is assaulted by Mr Z. The incident occurs at 06:10 and is at least partly witnessed by a carer. The incident involves Mr Z going into another resident's bedroom and slapping him around the face, sufficiently hard to break the resident's glasses. **This would now be at least the ninth such incident of a resident being hit in the face or head by Mr Z.**

18.80. On the same day, and presumably without awareness of this specific incident, Ms F's son calls the Emergency Duty Team with concerns about Mr Z's behaviour, and the potential of risk towards other residents and his mother. It is noteworthy that in discussions with the family, Ms F's son was clear that he believed the response received at this time was unsatisfactory, in that he felt that all professionals involved broadly failed to appreciate the potential seriousness of the situation. The safeguarding team also note a phone call received from Ms F's daughter, who expressed similar concerns. Both son and daughter report that their concerns are

not just for their mother but also for other residents and staff. Ms F's daughter is recorded as noting that staff members had disclosed that they reported having been assaulted by Mr Z.

18.81. On the same day (**15th December**) at 17:16, there is a note in Mr Z's care record that the '*manager has informed me that she has spoken with the safeguarding team they have advised for him to have 1:1 for 12 hours if there is any incidents even small ones they said we are to call 999 straight away*'.

18.82. Over the following days, there are a number of further incidents which are only briefly recorded and an escalation in frequency of incidents – if not of severity. These include raising his fist towards a staff member (**17.12.2017 at 00:30**), exposing himself in front of other residents (**17.12.2017 at 02:25**), raising his hand to hit a member of staff (**18.12.17 at 18:35**) and an incident where he is '*heading straight towards me [staff member] with his arms up shouting bastard*' (**18.12.2017 at 19:35**). There are further discussions about the case with various involved professionals and agencies, but mostly these discussions do not reach any new conclusions.

18.83. The social work review recommended from the safeguarding strategy discussion occurs on the **18th December 2017** and the social worker concludes, after discussion with a manager at XYZ, that the care home cannot manage XYZ's needs. At this point there appears a clear indication from a manager at XYZ that they wanted Mr Z to move out of the care home. This appears the first time that the potential implications of this appear documented by Adult Social Care. The social worker recognises that moving Mr Z out of the home will pose a risk to other residents, later observing that other care homes would not have been able to support Mr Z at this stage, and recommends instead a potential MHA assessment with a view to Mr Z being detained in hospital. Although the social worker then speaks with the DIST team to update them, the specific question of a Mental Health Act Assessment is not recorded in the notes. The home report that they were advised that Mr Z was referred to a placement at another local psychiatric hospital following this, but do not receive a telephone call back to confirm this.

18.84. It is worth briefly noting a report by Ms F's son that he had observed Mr Z walking around the unit unaccompanied over the weekend, when he had understood that Mr Z should have been on 1:1 observations. To this end, XYZ have provided documents which confirm that from 5pm on the **15th December** until the **18th December** (time not documented), 1:1 staffing for Mr Z was factored into the staffing rota. It appears that one specific member of staff was allocated for these 1:1 observations. However the records only confirm the staffing allocation and do not provide details of observations completed over this time or how breaks in the continuity of observations were managed. It appears that the 1:1 observations may not have continued beyond the **18th**, though this is not clear from the records from XYZ, and the police records (after the index incident) that 1:1 observations were '*in place until Monday*' (**18th December 2017**). There is however one note in Mr Z's care records from the **19th December** that a Care Assistant carried out 1:1 observations of Mr Z from 2pm until 4pm (i.e. **after** the index incident below); '*during this time [Mr Z] laid on his bed and was sleeping at 4pm doctors and other professionals came to visit [Mr Z] so the one to one session ended*'.

18.85. The critical or 'index' incident, which triggered Ms F's admission to hospital, occurred the following day on the **19th December 2017.** At the outset, it is worth noting that although the consequences of this incident are certainly more serious than other incidents that have occurred, it does not appear that the actual act of violence is itself significantly different or more serious than the many incidents which have occurred up to this point. **Note that including this incident, there have been at least**

nine other incidents of residents being slapped or punched in the face/head, and two other residents have been pushed over. Presumably a number of these incidents could have resulted in a similar level of physical injury as that which occurred to Ms F if circumstantial and environmental factors had been different.

18.86. In regards to the account of the incident itself, the records from XYZ are quite limited. Of those available, the notes from the daily care records indicate:

> '*[Ms F] had a fall, because another resident pushed her. She hit her head to the wall and fell on her right led [sic]. She cannot get herself from the floor. Staff hoisted [Ms F] to the chair. Her right leg seems to be in pain, but because [Ms F] cannot describe it, I phoned to ambulance. Observation been taken and documented, family aware*'.

18.87. (Notably, the care records, which are dated **19.12.17 at 13:46**, record the 'event' time as 12:35 but then refer to 21:35 in the text of the report of the incident. It appears that 21:35 is likely a mistake as other records seem to refer to a time around 12:35).

18.88. The notes from the behaviour chart recorded by XYZ indicate:

> *'I was holding [Ms F] hand and I was trying to go past [Mr Z] cause he was sitting in the middle of the corridor wandering. I tried to take [Ms F] but she let my hand go and I shouted for help'*.

18.89. The records provided by the adult social care safeguarding record:

> '*[Ms F] has fallen and hit her head on the wall and has also hit her right leg. [Ms F] is currently unable to stand up and there may be a fracture'*.

18.90. A further record from the safeguarding team indicates:

> '*[Mr Z]'s 1:1 carer was trying to stop [Mr Z/Ms F] walking together; [Ms F] became verbally aggressive, both residents became agitated. [Mr Z] pushed [Ms F] and she fell into the wall. [Ms F] sustained a fractured right neck of femur; surgery required'*.

18.91. A record from the police, made after the incident, records:

> *'the carer was with [Mr Z] walking down the corridor, when [Ms F] started swearing at him, and although the carer allegedly tried to separate them, [Mr Z] pushed [Ms F] and she fell, hitting her head and knocking her leg, causing a fracture'*.

18.92. It is noted that family members state that they were advised by XYZ that the incident occurred after Ms F was being accompanied back to her accommodation after a children's carol concert. Within this narrative, the carer was present during the attack, but then retreated due to being fearful. This narrative appears broadly consistent with that recorded in the behaviour chart. XYZ have indicated however that the additional details here were not recorded in their notes.

18.93. Several specific observations about this incident must be made:

- The terminology '*had a fall*' used in relation to this incident by XYZ, whilst strictly or semantically true, belies the causality and seriousness of the incident, given that the fall was precipitated by Mr Z pushing her. Clearly management of falls

is an important part of clinical practice in care homes, but this is a very different situation even though the physical injuries may be similar.

- Given the seriousness of the consequences of this event, the relative lack of details recorded by XYZ about the sequence and detail of events is notable. This makes it difficult to gain a clear account of what actually happened in the incident, which is itself complicated by some apparent inconsistencies in the narratives recorded (e.g. Were Ms F/Mr Z trying to walk together? What was Ms F doing prior to the incident? What was Mr Z doing?)
- Clinicians in the SARP queried the use of a hoist for somebody who had injured themselves, indicating that the safest thing for a resident who had injured themselves would be to leave them in position whilst calling for help.

18.94. After being pushed and falling to the floor, the ambulance are called by the care home. Ambulance records indicate the call was made by the care home at 12:42. This records '*Patient was pushed over by another resident – care home is a care home for dementia pts*'. The ambulance service explained at the SARP however that because of the fact Ms F was in a care home (considered a place of safety by the ambulance service) and the injury was a fall the call would not have initially been classified as requiring a high priority response. At **14:49** there is a recorded welfare check conducted by the clinical coordinator, where the operator speaks with Ms F's son. The records indicate further details about the nature of the injury and her situation, provided by the son, that the injury is on the right side, she has been hoisted, and that they were unable to wake her as normal. The priority of the call was then stepped up ('rrv to make first if available to assess loc' [Loss of Consciousness]). The note suggests the increase in rapidity of response was because of the son's concerns about the loss of consciousness. A Rapid Response Vehicle (RRV) is despatched at that point. This account is broadly consistent with that of the account given by the family, which was that the son's conversation with the ambulance service led to the response being 'stepped up'. However, the family reported that they had additionally believed that the initial report given by XYZ to the ambulance service had not described the seriousness of the situation properly. The records available from XYZ unfortunately do not allow further analysis of the sequence of events beyond that explained here.

18.95. After this incident, of course, the stories of Ms F and Mr Z diverge as Ms F receives treatment in hospital, and Mr Z is detained under the Mental Health Act. These are therefore dealt with separately.

19. Mr Z – Process of detention under Mental Health Act (MHA)

19.1. Whilst the focus of the SAR is not on Mr Z's care directly, it is important to briefly consider the circumstances of Mr Z's transfer from XYZ to an inpatient mental health ward after the incident in which Ms F's hip was broken. This is because these circumstances are directly relevant to the ability of the care home to safeguard other residents.

19.2. After assaulting Ms F, XYZ liaised with both DIST and the safeguarding team. DIST ultimately arranged for an assessment under s.2 of the Mental Health Act (MHA) 1983, with a view to Mr Z being admitted to hospital. DIST requested this assessment on the **19th December** at **16:50**, but at the time there were no Approved Mental Health Professionals (AMHPs) available to conduct the assessment. AMHPs are responsible for a number of the practicalities of the process of admission to hospital under the MHA. Two medical opinions are also required, and once these are received, it is for the AMHP to judge whether an application is appropriate to be made for admission to hospital.

19.3. The records indicate that due to resource issues in identifying an AMHP, this assessment was not completed until **11:30** the following day (**20th December**). This is 24 hours after the incident in which Ms F was injured, and nearly 19 hours after the assessment was requested by DIST.
This delay required the care home to continue to care for Mr Z overnight. On this point, one notes guidance from the MHA Code of Practice, which states that:

> *'14.35 Local authorities are responsible for ensuring that sufficient AMHPs are available to carry out their roles under the Act, including assessing patients to decide whether an application for detention should be made. To fulfil their statutory duty, local authorities should have arrangements in place in their area to provide a 24-hour service that can respond to patients' needs.'*

19.4. The status of the Code of Practice is described as 'statutory guidance' (at least in regards to Local Authorities to whom this statement is directed). This means that departures from the code should only occur in the presence of 'cogent reasons'.[19] Departures made otherwise will potentially allow for legal challenge to occur.

19.5. It appears reasonable to conclude that on this occasion, the delay for the Mental Health Act assessment was not responsive to the needs of Mr Z and this therefore gives rise to a question about the arrangements the local authority does have in place in its provision of the AMHP service. There are no obvious 'cogent reasons' for the delay, beyond a resourcing issue.

19.6. After the Mental Health Act Assessment had been completed, the AMHP would have made an application to admit Mr Z to hospital. This is recorded as occurring directly after the assessment. There is then a requirement for Mr Z to be conveyed to this hospital. In this regard, I note the following guidance from the MHA Code of Practice:

> *'14.91 Once an application has been completed, the patient should be transported to hospital as soon as possible, if they are not already in the hospital.'*

19.7. It should be noted that whilst this guidance does not lay down an expected time-frame for this to occur, the focus is on a rapid and prompt response.[20] In Mr Z's case, an ambulance was booked through the local NHS Ambulance Trust to convey Mr Z to hospital. The arrival time of this ambulance is recorded within the notes provided by XYZ as 18:24, around 7 hours after the Mental Health Act Assessment was completed. It is clear that such a long wait was far from ideal in the circumstances, particularly given the previous lengthy wait for the Mental Health Act Assessment itself.

19.8. Unfortunately, Mr Z was not to be admitted to hospital by this ambulance, and indeed it would take four ambulance attendances to allow conveyance. In regards to this first ambulance, this was a non-secure vehicle (i.e. a standard ambulance provided by the local Ambulance trust), and it was reported that during the process of Mr Z being transferred to the ambulance, he assaulted the two ambulance crew. The police were called and attended the scene, recording the incidents with no further police action.

19.9. Following this, the Emergency Duty Team were contacted who then make arrangements for a Secure Ambulance to convey Mr Z to hospital instead.
The commissioning arrangements here are of note. The NHS Ambulance Trust does not provide a secure ambulance service, and so a private provider has to be used

[19] *Munjaz v Ashworth Hospital Authority* [2005] UKHL 58
[20] Note that the Code of Practice does not form statutory guidance for the ambulance service or the police

instead. It does not appear however that there is any contractual arrangement between the Local Authority and any specific secure ambulance provider, and so arrangements to use a secure ambulance are made by the AMHP on an ad hoc basis.

19.10. It is noted that on this occasion, the request for a secure ambulance was made to a private provider who has subsequently – separate to the events of the SAR – been subject to an adverse review by the Care Quality Commission (CQC). It is understood that the use of this company is consequently no longer permitted by commissioners. Nonetheless, it has been confirmed that there are no secure ambulance providers within Norfolk, with all such ambulances being required to travel from out of county. The potential difficulties in arranging secure ambulances are concerning as they may lead to AMHPs basing their decision-making about conveyance on pragmatic reasons (i.e. to use a non-secure ambulance initially to get a faster response) rather than making decisions based upon clinical risk.

19.11. The precise timings of arrival of the secure ambulance are unclear, but it does not appear that the secure ambulance arrived at XYZ until the following day, the **21st December**. Unfortunately, there is then a problem with the paperwork provided to the secure ambulance provider, meaning that this second ambulance then left without conveying Mr Z. In regards to the Code of Practice, the following guidance is relevant in specifying what should occur:

> *14.92 A properly completed application supported by the necessary medical recommendations **provides the applicant** with the authority to transport the patient to hospital even if the patient does not wish to go. That authority lasts for 14 days from the date when the patient was last examined by one of the doctors with a view to making a recommendation to support the application. See chapter 17 for further guidance on transport. [emphasis added]*
>
> *17.13 If the patient is likely to be unwilling to be moved, the applicant will need to **provide the people who are to transport the patient** (including any ambulance staff or police officers involved) with authority to transport the patient. This will give them the legal power to transport patients against their will, using reasonable force if necessary, and to prevent them absconding en route. [emphasis added]*

19.12. Furthermore, Norfolk County Council policies for the operation of AMHPs state that an AMHP '***must** provide written and signed authorisation to whoever is conveying the patient to hospital. (Usually the ambulance crew). Form A(AMHP)3 is provided for this purpose*'.

19.13. It is unclear precisely what paperwork was available to the secure ambulance service on arrival at this point, but it does seem agreed that the A(AMHP)3 form was *not* available. If this is the case, the wording of the Local Authority's policy in regards to the A(AMHP)3 form does suggest it was reasonable for the secure ambulance provider to refuse to convey the patient. It is, of course, unfortunate that the secure ambulance provider was apparently unwilling to wait whilst this paperwork was provided for them. However, in the absence of a contracted arrangement with the provider requiring the ambulance service to wait, it is hard to see what the AMHP could have done to prevent the ambulance from leaving.

19.14. It is understood then that after this second ambulance left, efforts were then made to rectify the paperwork or provide the ambulance provider with assurance that they do have the AMHP's authority to convey the patient. A third ambulance arrives. At this point, it is documented that JKL Hospital, contacted at the point of

conveyance being initiated, then decline to accept Mr Z as there is a postcode error in the paperwork. Some errors made on MHA paperwork are 'rectifiable' and it is likely that this error should not formally have prevented the conveyance from occurring.[21] Nonetheless, it appears that in the process of gaining an appropriate member of staff to authorise the rectification, the secure ambulance left.
Again, whilst one might have hoped the secure ambulance provider might have been able to remain to await this outcome, as a private company it would be unreasonable to suggest that the company should have done so in the absence of a standard requiring them to do so. The issue seems a more fundamental one relating to the way in which the secure ambulance service is commissioned.

19.15. A fourth secure ambulance was then dispatched to the home which was able to successfully convey Mr Z to JKL Hospital on the **22nd December**. Certainly it does seem that there was a significant failing in this process considered as a whole; leading to Mr Z experiencing unnecessary distress, other clients at XYZ being exposed to unnecessary risk of further harm and abuse, and potentially two ambulance drivers being unnecessarily assaulted.

19.16. The story of Mr Z is not continued beyond the **22nd December** since this is not relevant to the SAR's focus on Ms F and the risk presented to residents at XYZ.

20. Ms F – Chronology following events from 19.12.2017

20.1. Ms F, after being assaulted by Mr Z, was conveyed by ambulance to a regional acute hospital (referred to as GHI hospital in this report) where she is recorded as an emergency admission at **16:09**. This is 3 ½ hours after the original incident and 1 hr 20 minutes after the second telephone discussion with the ambulance service. Medical investigations report that Ms F had a fractured neck of femur (broken hip – see p.98 for a brief summary of the nature of this injury), which required surgery. Notes from GHI record that this surgery was carried out rapidly, the day after the incident.

20.2. There is little of concern within the clinical records at GHI Hospital. After receiving surgery, a decision is made by the hospital to keep Ms F on the ward over the Christmas period until the safeguarding issues are resolved. This is a sensible and pragmatic decision showing the prioritisation of Ms F's needs by the hospital at a point of significant pressure on bed availability.

20.3. Ultimately, Ms F was discharged by the hospital back to XYZ on the **5th January 2018**. It is of note this decision was made with the belief that XYZ had given notice on Mr Z's tenancy. Whilst it is correct that Mr Z was no longer a resident at the home (as he had been transferred to JKL hospital under the MHA), and thus the immediate risk from Mr Z to Ms F and other residents had been removed, XYZ have confirmed that they did not give notice on Mr Z's tenancy. It is fortunate, therefore, that decisions were made after this to ensure that Mr Z did not return to XYZ.

20.4. After her readmission to XYZ, Ms F was moved to the nursing unit within XYZ where her medical needs could be more appropriately addressed. Consistent with this move, the care records completed by XYZ appear to become more detailed with a range of assessments relating to her health and care needs being documented at this point.

20.5. Unfortunately, over this period Ms F's physical and emotional health worsened. Very soon after her transfer back to XYZ, concerns about her dietary intake and nutrition

[21] See, for example, Mental Health Act 1983, s.15; Mental Health Act Reference Guide 8.90 – 8.94; Mental Health Act Code of Practice 35.6 & 35.11

are recorded and it appears these continue. Much of her care appears to be focused on recovery from the surgery, management of pain, treatment of wounds, and supporting personal care.

20.6. On the **14th January 2018** there is a note in the care records that Ms F's wound from the operation had started to '*open up and weep and appears to look* inflamed' and the GP is asked to review.

20.7. On the **16th January 2018** Ms F is reviewed by a Nurse Practitioner from the GP surgery who gives advice to the home (asking this to be passed to the family) that Ms F needed to be mobilising to allow her hip to recover ('*and it is vital that she is not left in bed all day*'). The Nurse Practitioner records that she will refer Ms F to a physiotherapist and implement dietary supplements to support her poor diet. The care records do not indicate whether the recommended mobilisation was possible or took place (please also see comments at 20.16).

20.8. Continued concerns about dietary intake are noted over the subsequent days until the **18th January 2018** when she is described as having '*eaten and drank extremely well*'.

20.9. On the **21st January 2018** the care home make a call to 111, as she '*has a running temperature of 38.7 after speaking to clinicians they have advised to push fluids and if there are new symptoms to call back*'.

20.10. On the **23rd January 2018** it is noted that Ms F's '*hip started weeping*' again , with the care home requesting a district nurse to review this.

20.11. On the **25th January 2018** it is recorded that Ms F's daughter visited to complete end of life wishes (Ms F's daughter is recorded as visiting regularly otherwise).

20.12. On the **26th January 2018** Ms F was transferred to another unit at XYZ Care Home. This was a nursing unit however it is recorded that Ms F still remained a residential patient. The records over the following days indicate that Ms F was nursed in her bed, provided with personal care, and generally observe '*no changes*' or '*no concern*'.

20.13. It also appears that on the **26th January 2018** a drug error is recorded. It was noted that Ms F had been administered 40mg of furosemide instead of 20mg since her hospital discharge. It appears this was only noted as Ms F was transferred to the other unit. The care record in this case is noted as a late entry, recorded on the **29th January**. Consideration of the clinical risks associated with this error do not appear in the care records.

20.14. On the **28th January 2018** there is an observation that Ms F became aggressive, although the care record is unclear whether this occurred in relation to/after a family visit or in relation to medication administration ('*she would only take some of her medications as she became aggressive her family visited earlier*').

20.15. On the **29th January 2018** Ms F was observed to be coughing when taking fluids. The care home recorded that they called the GP practice to ask for a referral to a Speech and Language Therapist (SALT). Later this day, her wounds are redressed by the district nurse.

20.16. On the **30th January 2018** Ms F is visited by the physiotherapist, who notes that there is no evidence of Ms F being mobilised since discharge from hospital, and that Ms F would not be appropriate for physiotherapy today. Whilst the physiotherapist does not specify a causative link between these two things, this is clearly unfortunate given

the recommendations made on the 16th January. The care home have indicated that there was some limited evidence of mobilisation over this period for example being seated in the lounge, and at one point being treated by a member of the community nursing team in the lounge. However, the SARP reflected that being transferred is different to being mobilised, and the lack of mobilisation after surgery did pose a risk to Ms F.

20.17. On the **31st January 2018**, after a '*settled night*', a GP visit is requested following reported deterioration in her physical presentation. The GP visited and it was noted in the care home records that that '*[Ms F] was unresponsive, sounds chesty. GP Stopped all medication. NBM [Nil by Mouth]. Ms F's daughter and son present on doctor visit and they were agreed that it is in [Ms F]'s best interest to stay in [XYZ]. GP prescribed anticipatory medication and will arrange DN to administered [sic]*'. After further deterioration, it is noted that Ms F died at 19:40 at XYZ Care Home. The medical cause of her death was recorded as '1a Bronchopneumonia; 1b Old Age; 2. 2 Alzheimer's dementia'.

Mr G: History and Experience since June 2017

21. Mr G: Background History

21.1. Mr G's background history was summarised to me by the family. They advised me that Mr G had worked as a farmer, and had an interest and skill in woodwork, having trained initially as a carpenter. He had been married for over 60 years to his wife.

21.2. The family told me that concerns about his health first developed in 2014, after a fall at home. He was aged 81 at the time, although the family reported '*he didn't look 81*'. The fall led to him experiencing a blood clot, which led to him receiving hospital treatment from local and then regional specialist hospitals. He required surgery, I understood to the brain, and this led to deterioration in his functioning, although I did not gain a very specific idea of how this changed. The family explained '*for the first couple of days he wasn't making sense and then suddenly he was back to his old self*'. The family noted that after this, he lost his ability to read, as well as other skills for example in drawing.

21.3. The family were unclear on precise timescales, but at some point after this Mr G was diagnosed with dementia and small vessel disease. He was initially cared for at home by his wife, having increasing physical health care needs, for example incontinence. The family noted a fairly rapid deterioration in his clinical situation and care needs around six months after the fall, and ultimately Mr G was admitted to a care home for respite in **early 2017**. This was initially due to be for a month, but shortly after admission his condition further deteriorated. It is noted that the family had raised some concerns about the care received in this care home though these were not explored in detail with the family. However, I understood the reason for transfer after two months was so that Mr G could live in a care home closer to the family.

21.4. Mr G then moved to a second care home. The family reported a number of concerns with this care home. The care records indicate that there were a number of difficulties in manging some behavioural aspects of Mr G's presentation at this home. Indeed, there are two recorded incidents **around April 2017** in which Mr G pushed over a female resident in this care home. The family however felt that Mr G had reacted in this way because a female resident had been entering his room without consent, touched his personal belongings and eaten his food, and this had been distressing to him. In **May 2017**, the family were called to a meeting with the manager who

informed them that they were taking steps to evict Mr G.
The family said this was a complete surprise to them and they were shocked.
Overall, it was noted that the family's understanding of some of the behavioural problems or challenges indicated by previous placements was that these problems had been overblown.

21.5. Unfortunately, a few weeks later on the **6th June 2017**, Mr G experienced what is recorded as an '*unwitnessed fall*'. This necessitated his admission to GHI hospital which is the point in which the following case chronology begins. The account given by the family of this situation is notable. They indicated that Mr G should have been on regular observations every ten minutes. They explained that each night he would ordinarily have a wet shave. The home had been supporting this but had stopped because of soreness. The family believed that Mr G then tried to give himself a shave. He was found in his room with '*cream all over the floor, shaving foam in his teeth*'. The family believed that the amount of mess and damage done to himself and the room could not have been caused within a ten minute window, and so raised a concern as to whether Mr G was, indeed, on effective ten minute observations.
I have not triangulated this account with records from the care home, as this care home has not been involved in the SAR process. However, I am aware that after this Mr G was conveyed to GHI hospital for treatment.

22. Mr G: Case Chronology

22.1. As already noted, the scope of the SAR in relation to Mr G begins on **the 6th June 2017** after Mr G is admitted to GHI hospital. An X-Ray is completed which rules out a fracture. Clinical notes from the acute hospital focus on the difficulties in managing Mr G's behaviour within the hospital environment; he is described as agitated and aggressive towards staff. On at least two occasions over the first few days of his admission, security staff are required to be called to the ward to assist clinicians in safely managing Mr G. There are concerns about his blood glucose levels and also about urinary retention; a trial without a catheter is unsuccessful.

22.2. On the **13th June**, the clinical record indicates that Mr G attempts to discharge himself from hospital. This is responded to immediately by the hospital who assess his capacity, find that he lacks capacity to make decisions about his residence, and therefore complete a DOLS application to authorise his continuing care in hospital. (The DOLS process is intended to provide authorisation against a potential Deprivation of Liberty violation for somebody who is detained, for example in a hospital, and who lacks capacity to make decisions about remaining in hospital, and who may be asking to leave). Whilst the SARP reflected that the DOLS application could technically have been made before this, it was agreed that the clear and prompt response here to the immediate circumstances is an example of positive practice on behalf of the hospital.

22.3. Over the following days, there are several incidents where Mr G is recorded as being aggressive towards staff, including records of him throwing chairs, '*grabbing and twisting the wrists of staff*' and '*punching/shouting*'. Mr G is given Lorazepam to sedate him. By the **15th June**, it is recorded that the placement at his previous care home has broken down due to these same behavioural concerns and so efforts to locate a new placement begin. There is a medical opinion expressed that the concerning behaviours should be managed through psychological/behavioural approaches and medication should not be used.

22.4. On the **22nd June**, it is recorded that Mr G has '*triggered positive for discharge to assess*'. It appears that this assessment had been initiated by the social services team

within GHI hospital.
This decision is important to understand as it contextualises the decision making around his anticipated care needs at the time and becomes relevant much later in Mr G's care pathway (please see page 98 for a summary of the intended purpose of the DTA process). In regards to Mr G, therefore, this decision meant that the next step in Mr G's care would be for him to be discharged to a care home in the local area with 28 days of funding in place.

22.5. The reasons for reaching this decision, nor the reasons for asking the question about this are, however, not fully clear at this time. The SARP reflected that at this point it had not been established whether his primary needs would be best understood through a physical health pathway (where DTA was possible) or a mental health pathway (where DTA was not appropriate). The SARP reflected on the likelihood that, clinically, the primary differentiation here was whether or not Mr G's behavioural concerns were caused by or driven by a UTI (Urinary Tract Infection).
UTIs are common in people with dementia and can be a cause for behavioural changes. If the UTI can be treated this would broadly be considered to fall within the domain of 'physical' health. It does not appear from the available records that a UTI had been diagnosed by this time point, but fuller clinical records to check whether any assessment for UTI had occurred have not yet been obtained from GHI hospital.

22.6. On the **28th June**, it is noted that Mr G is reviewed by a Consultant Psychiatrist. Contrary to the view expressed on the **15th June**, it is noted that the outcome from this meeting was to start Mr G on Sodium Valproate medication. This medication is an antiepileptic medication that is also used as a treatment for mania and hypomania (e.g. in Bipolar Affective Disorder). There is some literature considering the use of this medication in people with dementia who display challenging behaviour. It is noted that although available clinical guidance at the material time did generally advise against medication for management of challenging behaviour as a first line approach, there does not appear to be specific guidance against its use *per se*. However, approximately a year after this incident (in June 2018), NICE (National Institute for Health and Care Excellence) issued guidance advising against the use of Sodium Valproate in people with dementia. In any case, it does not appear clear from the available records that a range of behavioural interventions were tried prior to this medication being prescribed. The SARP reflected on the probable lack of training of acute hospital staff in delivering such interventions.

22.7. Notably, on the **4th July**, Mr G is assessed by XYZ Care Home for a potential admission for the first time. They reported not being willing to accept Mr G, reportedly due to the behavioural elements of his presentation.

22.8. Ultimately, despite input from the Mental Health Liaison team over the next few days, there does not appear to be an improvement in the challenging behaviour experienced in A&E, and Mr G is considered for admission to a psychiatric ward under the MHA. A Mental Health Act Assessment planned for the **12th July** is deferred until the **13th July** so that Mr G is able to be assessed without being sedated. The medical recommendations summarise the reasons for admission to hospital as follows:

> *[Mr G] is an 81 year old man with a diagnosis of Vascular Dementia. He has significant cognitive impairment and generally worsening challenging behaviour. He has been admitted to the [GHI] hospital on 7/6 after an unwitnessed suspected fall. He has been treated for suspected infection and is now medically fit for discharge. He has been aggressive both physically and verbally for at least 4-5 months and this has escalated in the last few weeks. He has assaulted nursing staff and has been abusive. He also threw objects at other vulnerable patients on the ward. He lacks insight into the situation. He also lacks capacity to consent to*

treatment or informal admission. Managing him under MCA is not appropriate given the levels of aggression. He needs a period of assessment and management of risks in a psychiatric unit under section 2 MHA.

22.9. It must be observed that there are a number of concerns about the process of transfer, including a question as to the availability of beds, necessitating Mr G being transferred to an out of area bed some 75 miles away from the family home, and a question about the way in which the AMHP involved the Nearest Relative in the detention process. Both of these concerns are considered in more length later in this report in s.35.

22.10. In regards to the medical input received whilst at GHI hospital, the records obtained indicate that Mr G was treated for cellulitis during his admission with antibiotic medication. There is no record of a clinical indication or treatment specifically for a UTI, but it was documented that he was known to be vulnerable to UTIs. He was initially not catheterised but after three attempts of removal and retention, it was decided to insert a long term catheter. The summary of records provided by GHI indicated that evidence of dehydration was not noted at the point of transfer to DEF.

22.11. Ultimately, Mr G was transferred to DEF hospital on the **15th July 2017**. A clinical description recorded in Mr G's notes indicates that the pattern of challenging behaviours demonstrated in the acute hospital continued in this environment:

[Mr G] was admitted on the ward this afternoon. He has presented as fairly settled in mood and behaviour. [Mr G] has been shouting on and off for help in the lounge which has been upsetting most of the patients. Staff went to [Mr G], offered him reassurance and what he would like to do for him. [Mr G] was not able to elaborate why he has been calling for help.

22.12. A further record notes that Mr G assaulted a member of staff on this day when giving him medication, and further notes difficulty in obtaining bloods from him because of the challenging behaviours.

22.13. Notably, however, on the **17th July**, Mr G is admitted to the acute hospital local to DEF hospital. This is of course not the same local acute hospital in which Mr G had previously been an inpatient. At this point, upon admission, it was noted that Mr G was dehydrated, and was reported that he had a UTI. Following receiving intravenous fluids, antibiotics, and regular monitoring on a fluid and food chart, Mr G showed a rapid improvement. He was discharged on the **20th July**.

22.14. It is clear from the observations following this date that upon return to the ward, Mr G's presentation was much improved, and generally remained so during his stay at DEF. Within 14 days of his admission to DEF, the DIST team record '*much improved and no evidence of mental illness… fit for discharge for mental health*'. The SARP considered that the most obvious explanation for this improvement was that Mr G did indeed, as the family believed, and notwithstanding the lack of evidence for this at GHI, have an untreated UTI which was only properly assessed and treated when transferred to the other acute hospital. This explanation would potentially raise concerns about the process by which this was or was not assessed whilst Mr G was at GHI Hospital, and indeed therefore whether the MHA admission may have been avoidable had such treatment been provided earlier. Whilst this may be a reasonable hypothesis, is difficult to reach a certain conclusion on this point, particularly given the clinical records from GHI summarised in 22.10, since other factors may have also caused the improvement.

22.15. There is much positive to say about Mr G's stay at DEF hospital, a view also shared by the family. The clinical record reports that a comprehensive approach was taken to assess Mr G's functioning, with the first evidence of neuropsychometric testing (an approach used to systematically assess cognitive functioning, and generally recommended as part of the standard approach for the assessment and diagnosis of dementia) being completed. In addition, Mr G is engaged in Cognitive Stimulation Therapy, and provided with physiotherapy input, Speech and Language therapy input, and support to complete a 'life story' book. The problems or concerns about Mr G's experience at DEF seem to come largely as a result of distance and separation from his family, with an incident on the **1st August** being recorded after Mr G threatened to damage the garden if he was not given the phone number for his wife (on this point it is not explicitly stated if Mr G was enabled to contact his wife by telephone or other means). There are some other incidents also noted (throwing his breakfast on the floor; scratching skin of a member of staff when he was being cleaned after being incontinent), but these appear more minor than the behavioural concerns reported at GHI Hospital. It seems fair to conclude that Mr G's experience of care at DEF as overall relatively positive.

22.16. Mr G is discharged from DEF on the **14th August**, about a month after his admission. The discharge occurs because a bed has become available within a local NHS psychiatric hospital. This hospital will be referred to as JKL hospital. Whilst on one hand this is a positive move, it is notable that this further transfer is only necessary because of the lack of available beds at the point of the Mental Health Act assessment. It is clear that this process of change is likely to be highly disorienting and may be significantly distressing to patients with dementia such as Mr G. Familiarity built up with staff members is lost, and the patient likely lacks the cognitive and emotional resources to deal with this loss. In Mr G's case, this is all the more problematic given the improvement that Mr G had demonstrated in DEF up to this point. This transfer emphasises the fact that placing patients out of area has a much wider impact than the geographical inconvenience for families visiting these patients.

22.17. This issue highlights that the decision making about whether to relocate a patient back to their local area, when such a decision is being made in that person's best interests, is complex and finely balanced. It includes balancing family wishes and familiar relationships with the risks and stress caused by potential transfer. In terms of making the decision to transfer Mr G back to JKL hospital, it is perhaps noteworthy that there does not appear to be a structured approach taken to assessing Mr G's best interests in this process. By this stage, Mr G's detention under the MHA had ended (the section was formally ended on **8th August 2017** and was not renewed although agreed that Mr G would remain in hospital), but it can be reasonably presumed that Mr G would still not have capacity to consent to his ongoing detention, and therefore any transfer should have considered Mr G's best interests; his family did not have an LPA and so could not have made this decision for him. It is not clear if a DOLS application was made at the point of the MHA section lapsing, which would have triggered this process. Regardless, the decision about Mr G's best interests and awareness of issues in regards to his capacity and ongoing residence does not appear prominently in the clinical narrative.

22.18. In any event, it appears that Mr G's experiences at JKL hospital were generally very positive. Indeed, the family's account of Mr G's care at this hospital is quite remarkable – '*I could not fault it*'; '*the best place for him*'; '*everything was top notch*'; '*they were on the ball*' – being some of the phrases used to describe the care Mr G received whilst here. There was evidence of the same kinds of challenging behaviours on admission, although a note made on the **20th September 2017** seems to record that whilst Mr G was still sometimes distressed, this distress was broadly understood by the care team at JKL:

[Mr G] can be loud shouting out this seems to be associated with needing reassurance and will settle if staff sit and talk to him. Confused/scared at times and tearful, some lucid times when asking what will happen to him. Family visiting. [Mr G] could be happy and banter with staff enjoying a joke, he clearly enjoyed the company of staff generally and seems to only shout out when left alone for periods of time.

22.19. Whilst here, Mr G continued to receive treatment for infections, and appeared to be re-admitted for a short time to GHI hospital. Around September, there appears to be an emerging plan for Mr G to be moved back to residential accommodation, though it does not seem that formal plans for this are initiated until some weeks later.

22.20. The CCG recorded that on the **17th October 2017** they sent an email to the Social Worker at NCC who had been involved with the patient and family. There had been some discussions about the best placement for Mr G and initially a care home that had been identified as suitable by the family (just outside of the commissioning border) was considered. The CCG explained that if beds were available they would typically require a placement to be sought within their boundaries stating '*because it is then easier to arrange social workers and clinicians to complete the DST within the DTA process*' (the DST is the Decision Support Tool, which is a framework used to assess care needs under the DTA scheme).

22.21. There was then an email discussion about a potential best interests meeting which other records indicate was planned for the **19th October 2017,** and a '*provisional agreement'* that this care home, outside the CCG boundary, could be used. It is noted that JKL Hospital's notes at this time also include a reference to the DTA pathway, with a record on the **17th October 2017** indicating '*Repetitive behaviour still remains challenging. Deemed fit for discharge now to a suitable placement under DTA pathway*'. Notably, representatives from JKL Hospital gave verbal feedback during the Learning Events that psychiatric inpatients were never discharged under the DTA pathway, but it seems that this was not questioned internally at this point.

22.22. It is understood that this multidisciplinary meeting planned for the **19th October** to discuss Mr G's transfer was cancelled. The reasons for this do not appear clear. However, this is clearly a concern because, firstly, it meant that there was no formal consideration of Mr G's best interests in the decision to move him from JKL to XYZ. Secondly, of course, it meant that there was no formal review of the process and funding mechanism by which Mr G was transferred. This was clearly a significant missed opportunity to ensure that all involved practitioners had a shared understanding of the context in which Mr G's care was being provided, increasing the likelihood of the later issue of XYZ not being aware that they could return Mr G to JKL hospital.

22.23. Thirdly, however, it meant that the discharge pathway for Mr G was not reviewed in line with his care needs. On reflection, it does not appear contentious to suggest that the DTA process was not the correct process for Mr G regardless of whether or not this was the correct process from a service or commissioning perspective. DTA is used to assess care needs where it is believed that the current setting prevents those needs from being assessed properly – i.e. where there is a reasonable prospect that a more familiar or less institutional setting will lead to an improvement in the person's presentation. The historical record shows precisely the inverse pattern in Mr G's case; his very best presentation was in DEF and JKL hospital, and care settings prior to this had also struggled to address his care needs at least to some extent. There seemed to be little basis on which to base a belief that Mr G's presentation would improve in

a care setting, and, on reflection, it appears that the key task of such an admission would be to maintain the stability gained whilst in hospital.

22.24. The CCG records state that after this, given their awareness of Mr G's status as having been assessed under the DTA process whilst at GHI hospital in June (see 22.4), they began identifying placements in line with this procedure. The CCG records indicated that Mr G would be '*discharged under health funding without prejudice up to 6 weeks and then assess him for CHC'* (Continuing Healthcare). The local Community Care Partnership organisation, responsible for managing CHC cases, requested JKL hospital to attempt to identify potential placements in care homes. The CCG noted that '*Commissioning Lead within the CCG spoke with the named Social Worker to support with appropriate placements as the CCG had approached all the contracted Nursing EMI (Elderly Mentally Infirm) homes and none could accommodate at the time. Following intervention by the CCG XYZ Care Home were approached and stated they would assess the patient for potential admission*'.

22.25. The CCG noted that prior to this decision being finalised they had considered options presented by Mr G's daughter which were outside of the county area. However, they noted concerns that if he was placed out of county there could be funding issues with ongoing provision of mental health care. Ultimately, XYZ care home agreed to the placement though requested additional funding above usual DTA rates '*due to the level of additional care and support required along with confirmation that equipment would be in place*'. The CCG recorded that the family were, on balance, agreeable to Mr G being admitted to XYZ and were advised that the bed would be kept open at JKL hospital for a period of one week (though the family reported that they were told that XYZ Care Home was the '*only choice'* they had). The notes indicate that the home were also '*made aware that [JKL hospital] could support*'.

22.26. The assessment by XYZ occurred on the **30th October 2017**. He is accepted by XYZ on the same date. The process of this assessment raises a number of separate concerns which are highly significant to the wider learning, and so I have dealt with these separately in s.34. These issues encompass concerns about both the process of assessment, and also concerns about the understanding of the funding pathway used to fund Mr G's stay at XYZ.

22.27. The CCG's notes indicate that Mr G's subsequent admission to XYZ was then delayed, explaining this as follows: '*Issue of equipment sourcing and delay meant the patient could not go sooner. The CCG were reliant on the area moving and handling assessor to contact [JKL Hospital] to arrange a bariatric bed. This caused delays which were unfortunate. There were also infection control issues at the home and they had to get clearance from Public Health before admission was allowed and this was confirmed by the home*'.

22.28. On the **7th November 2017,** the CCG records a telephone call with Mr G's daughter, who expressed concerns about the forthcoming admission to XYZ. These concerns were, unfortunately, to be proved true:

> *'On the 7/11/17 the CCG Commissioning Lead received a call from daughter [XX] to advise she was not happy for her father to be placed at XYZ Care Home due to moving and handling concerns as she stated that her father needed 4 members of staff to support. XYZ Care Home assessed her father as generally needing 2 staff. Her fears were allayed and she agreed to recommence the admission. The DTA process was reiterated to her ensuring she understood that her father would be assessed for CHC at some point in the following weeks. This was also reiterated by other CCG staff, during various calls.'*

22.29. Again, it is surprising that the narrative here appears to place the emphasis on Mr G's daughter as having the primary responsibility for decision-making in the admission (for instance, noting the daughter '*agreed*' to this). The fact that this decision was not for her daughter to make, but for professionals to make in Mr G's best interests, does not appear to be related to.

22.30. Ultimately, Mr G was admitted to XYZ on the **10th November 2017**. As stated, from the perspective of JKL, and as documented by the CCG, he was admitted on one week's leave, which meant that his bed was kept open for him in case there was a breakdown in the placement. This extra week was then extended to two weeks, meaning that ultimately this option had remained a possibility throughout Mr G's time at XYZ. The CCG records note that '*this had been stated to the home manager prior to admission that [JKL Hospital] would hold the bed open for 7 days and were available if required to support*'.

22.31. It is worth noting, before a more detailed consideration of Mr G's experience of care at XYZ, that during the Learning Events and SAR process XYZ advised that they were unaware of the possibility of Mr G returning to JKL, believing Mr G to be admitted under the DTA process where this would not have been possible. From one perspective, this is understandable, since the CCG had indeed arranged the funding for the bed under the DTA process. The home would have been familiar with the DTA process and reported that they commonly admitted patients via this referral route.

22.32. However, from another perspective, it is hard to fully reconcile the care home's position that they were not made aware of the fact that Mr G could return to JKL with information recorded in the care and clinical records. For instance, as well as the record above that the care home manager had been advised by the CCG of this possibility at the point of admission, there here is also a record that JKL communicated this information to Adult Social Care, who relayed the difficulties that XYZ were experiencing. This note records that '*XYZ care home advised by JKL to ring if they are having difficulties*'. The record also notes the involvement of DIST. Additionally, there is a clear note on the **11th November** from DIST that the belief the care staff had about Mr G's status was corrected, noting '*care assistant thought [Mr G] was there for 28 days but DIST worker informed him that [Mr G] only there for a week's leave initially*'. In addition to this, there is a clear record in the electronic care record – recorded by a DIST worker on the **15th November** which states '*[Mr G] remains on leave from [JKL] hospital*'. In summary, it appears that the broad nature of Mr G's status from JKL's perspective was communicated after this. It appears unclear, therefore, why XYZ management were not aware of this important fact.

22.33. It is undoubtable that this apparent communication issue is a significant concern and, consequently, an important opportunity for future learning. The consequences of this miscommunication are potentially highly significant; senior management from XYZ reported at the Learning Events that had they known that JKL would accept Mr G back, they would have taken the opportunity to return him. The fact that the home do appear to have been made aware of this information is noteworthy; it appears reasonable to speculate that the ongoing deterioration in Mr G's physical condition may have been avoided had Mr G been returned to JKL.

22.34. In any event, the question may be asked whether XYZ could have asked JKL for support and raised the potential of returning Mr G even if they had never been informed that this was a standard potential part of the procedure.

22.35. A more detailed account of Mr G's care whist at XYZ follows.

22.36. After admission on the **10th November 2017,** a care record notes the following about Mr G:

> *'[Mr G] can transfer/stand using a zimmer frame but does need prompting and can re-position in bed with the assistance of 2-3 staff Pre-admission indicates he like to go to bed at 10pm and requires 2 hrly re-positioning overnight. Bariatric bed and mattress in place following delivery this morning [Mr G] requires his BM to be taken 4 times daily Since admission he has become quite agitated in the lounge shouting at staff members despite all efforts to provide reassurance I have contacted his daughter [name redacted] and informed her of his admission and arrival here at [XYZ] and will visit in a couple of days time'*

22.37. A requisition confirms the above comment that a bariatric profile bed and mattress were due for delivery, on loan from the equipment loan service.

22.38. On the **11th November 2017,** there are two care records made. One notes that over the night he had *'slept on and off asking for the place and time'*. This note also records that staff were already experiencing difficulties in repositioning him, noting that Mr G had attempted to hit staff members during this. The second note records that he was seen by DIST that morning.

22.39. There is one care record for the **12th November 2017** which records only that '*[Mr G] has been assisted with personal care and came to the table for his lunch, continuously calling out despite all efforts to reassure and meet demands'*.

22.40. There are no care records provided by the home for the **13th November 2017.** However, DIST record that '*DIST visit to [XYZ] spoke to Nurse in charge, her first day. [Mr G] is requiring a lot of staff to help with personal care and will shout and nip staff. Also shouting out a lot. They do not have an armchair big enough for him so still in his wheelchair*'. The care home have reported that they were in liaison with the CCG to provide the armchair.

22.41. On the **14th November,** there are seven entries in the electronic care record. The events on this day require consideration both from the perspective of the care home and from the perspective of the family. In regards to the care home records, these confirm that Mr G had had been physically aggressive to staff the previous night when he was being put to bed. However, he was reported to have slept well. A note later in the afternoon indicates that '*[Mr G] was unsettled today, was up in the wheelchair, family visited him today and they was upset because [Mr G] was unsettled and rude with them , they believed he has Urine infection or is in a lot of pain*'. The nurse then records that she contacts the GP, who calls back to arrange a home visit for the following day. The nurse was asked to use a dipstick to test the urine for a UTI so the results could be reviewed by the doctor the following day – this was done. The nurse then contacts the daughter to advise her of the chain of events, who is not happy with the fact that there is no GP visit for today. Mr G's daughter indicates that she will contact the GP herself. It is then recorded that she does so, arrives later on in the evening at the home with antibiotics which have been prescribed by the GP, and which are then entered into the medication chart and given to Mr G.

22.42. XYZ stated in SARP meetings that the family had also refused for the nurse who they had dealt with during the day to give Mr G the antibiotics. XYZ indicated that the family had objected to this '*because she was foreign'*, and that the family had gone to another nurse and asked them to do this '*because we don't want that foreign nurse to do this*' (both statements may be paraphrases of the literal words spoken, but this was clearly the meaning XYZ believed had been communicated). The care records from XYZ do not record this; although they do record that the antibiotics were

given by a different nurse to that which they had dealt with earlier in the day, the first record from this nurse indicates that the family had indeed had a more detailed conversation with this nurse: '*[Mr G]'s daughter has come into XYZ this evening to speak to [manager] but I explained that she has gone home and asked if I could help*'. Similarly, an account written by the home after the events (dated 12.02.2018) records that the second nurse felt uncomfortable with the position she had been put in by the family member she spoke to, but does not indicate a concern that the behaviour was racially motivated.

22.43. From the family's perspective, the chain of events follows a similar pattern, though there are also clear parts of divergence. In particular, the family particularly emphasised how distressed they were at seeing Mr G's physical and emotional state at XYZ. They remarked on the rapidity of deterioration in his physical state since his discharge from JKL. The explained that they believed he must have had a UTI again, noting '*he was filthy and not shaved… he burst into tears and so did I… he was wincing when passing water…*'. The family also expressed concerns that Mr G had not left his bed since admission (this is not correct; the notes indicate he had been transferred to a wheelchair on at least a few occasions).

22.44. The family also explained that during the earlier visit on this day, they had requested for Mr G to be brought to the café area (noting that he had not left the bed). This was to prove a challenging task, requiring five staff members to assist in the hoisting process, and leading Mr G to become '*extremely unsettled and became physically aggressive causing physical injury to the Home Manager*'. It is noted that in the process of being transferred, Mr G had fallen to the floor (XYZ clarified this was because he was resisting the process and a deliberate act rather than a 'fall') and so required hoisting to a wheelchair, but was so distressed afterward that staff decided to not remove the hoist sling from the wheelchair. This incident does not appear within the electronic care record provided by the home and XYZ's account is based on a written account from the home completed after Mr G's death (dated 12.02.2018) as well as information provided verbally as part of the SAR.

22.45. There are several observations that must be made about the chain of events on this day:

- **Potential severe decline reported by family but not recorded in XYZ notes.** The family gave a clear account of physical decline which is not reflected in the XYZ notes. Of note, the family's view was that the home had not monitored or assessed his physical state properly. Alternatively, of course, the lack of records may have been because such decline did not occur and the family's account is untrue or distorted; unfortunately, however, the care records on the 14th (or indeed the previous day) do not provide any detailed information as to Mr G's physical state and so it is very hard to differentiate between these competing explanations.

- **Difficulties in delivering personal care not recorded in XYZ notes.** The family's account was that Mr G had not been given personal care by this time. The care home's account, verbally as part of the SARP, was that it was not always possible to provide personal care due to Mr G's behaviour. A statement provided by the home about the chain of events, dated **12.02.2018**, indeed indicates that the recollection of the nursing staff was that Mr G had refused personal care on this day. However, these difficulties in providing personal care on this day (or the preceding day) do not appear in the electronic care records completed at the time. This means it would be harder for staff to ascertain patterns of behaviour or have a clear idea of how/when personal care had been successfully delivered (or not).

- **Prescription of antibiotics without direct assessment of Mr G.**
  The SARP were concerned that the antibiotics were prescribed by the GP without a proper assessment of clinical need. Unfortunately, the GP was not able to be involved within the SAR process to comment on this concern.
  At face value, however, the view of the SARP was that in the circumstances a face to face assessment should have been provided.
  It is noted, however, that the GP did review the patient the following day and maintains the prescribed antibiotic.

- **Concerns about appropriateness of behaviour of the family members towards care staff.** The account provided by XYZ in regards to the family's behaviour is of course concerning, and regardless of the added potential layer of a racial bias, would have been a challenging scenario for the home to respond to. It is noted that, if correct, it would appear that the care home acquiesced with the request for a different staff member to administer the antibiotics. However, it is unfortunate that the care home records do not provide an account of the challenging behaviour itself. Given the contentious nature of the allegations made this makes this particularly difficult to resolve. In any case, such behaviour should have been followed up through the appropriate policies of the care home, whether these were safeguarding processes in respect to their concerns about the effect of such behaviour on Mr G, or health and safety policies, in regards to protecting employees from discrimination.

- **Assessment of Mr G's best interests by XYZ.** Given Mr G's distress during this incident, it is questionable whether the decision to take Mr G from his bed to the café at that time was indeed in Mr G's best interests, or whether this was made simply at the request of the family. Notably, the family did not have an LPA, and so all decisions about Mr G would have needed to be made on his behalf by the relevant care person in his best interests. The care home should not have moved Mr G if they believed this was not in his best interests.

22.46. The following day, the **15th November 2017,** the care record indicates that there were concerns about Mr G's health over the night. The out of hours service from the GP was called, and it appears that a visit occurred. His vital signs are checked. He is described as '*loud on/off although he denied of any pain but making facial expressions when touched*'. His blood glucose is checked and assessed before/after a snack and drink (though it was then noted some drink was spat out). He was prescribed paracetamol. There are in total four records made overnight and before mid-day by the same nurse.

22.47. At **12:20** on the same day, the XYZ notes record that Mr G is seen by a GP. The records indicate that he '*appeared comfortable throughout the examination', and he was prescribed Lorazepam PRN BD (twice daily, as necessary). He legs were examined and noted 'he appears not to have cellulitis*'. He was given no further painkillers, and the antibiotic prescription reviewed (and maintained), but no immediate or imminent concerns for his health were documented.

22.48. He is also reviewed by a Mental Health Nurse from DIST. The record made in the XYZ notes in relation to this visit is as follows:

> *'Seen by DIST with Dr [XXX], concerns raised about [Mr G] sitting in a wheelchair all of the day time, staff nurse [YYY] states [Mr G] doesn't have any pressure sires [sic] but is vulnerable, DIST to discuss with manager of [XYZ], [Mr G] remains on leave firm [sic] the [JKL Hospital], care staff have raised their concerns about their ability to safely manage all aspects of [Mr G's] care'.*

22.49. This is clearly important for several reasons. Firstly, it is a clear indication of another agency observing and expressing concerns about the ability of XYZ to safely provide care for Mr G. There is unfortunately no care record relating to the discussion with the manager. In any event, this factor alone should have led DIST to consider a safeguarding referral, unless their concerns had been properly allayed by the conclusion of the visit. Second, it provides a clear indication that Mr G's status as being 'on leave' from JKL Hospital was communicated to XYZ. Third, the record clarifies concerns about pressure sores at this stage were related to a potential for their development or vulnerability, rather than a concern that they had already occurred.

22.50. Finally, on this day, a late entry on the **15th November** records that there had been problems inputting/saving some food or fluid charts for some residents onto the electronic system (fluid/intake charts for Mr G were not provided by XYZ as part of this SAR).[22]

22.51. On the **16th November 2017,** there are again records overnight (from the same nurse as the previous night) indicating that Mr G had been challenging to care for. He had '*been assisted to bed with hoist and 4 staff was physically aggressive'*. It was recorded that he was provided with a snack and drink and '*assisted with hygiene care needs and was aggressive*'. An entry from the morning indicates that '*drinks offered this morning but very loud of refusing [sic] the drink. care needs attended*'. There are then no further entries through the day until an entry at **20:55** which records:

> '*assisted up with 5 staff and hoist with green toilet sling and large hoist. Sling left in place whilst in chair. Needs. 1 person holding his hands as he attempts to scratch and pinch. Very noisy shouting out. Settled once in wheelchair. ate breakfast and lunch but declined his tea time food. Accepted morning medication but refused tea time meds represented 3 times before destruction.[23] Watched Tv today does not appear to be shouting so much today. Has refused antibiotic this afternoon'*

22.52. Additionally, on the same day, there are notes from a telephone discussion between the CCG and JKL hospital in regards to funding for necessary bariatric equipment (XYZ have clarified that at this stage this related to the arm chair; the bed, mattress and wheelchair were already in situ). The notes record that the CCG and JKL hospital were both aware that the staff at XYZ were struggling and noted surprise that XYZ had not contacted JKL for assistance. It appears however that this may have happened the following day.

22.53. On the **17th November 2017,** there is only one entry (at **16:00**) in the electronic care record, which states:

> *'[Mr G] has been nursed in bed today as sacral area and between buttocks are very sore vulnerable to breaking down/developing to pressure sore. Proshield barrier cream applied. Turned to alternate sides throughout the day to relieve pressure. Continues to be non-compliant with personal care requiring support from 4-5 for intervention'*

22.54. Additionally, on the **17th November,** XYZ have indicated that they telephoned the CCG and indicated that they could not manage Mr G's care needs. They received

[22] These were provided by XYZ for SAR F

[23] The meaning of this is that the staff member returned three times to attempt to give the medication before then destroying it

an email response from the CCG (which XYZ have provided for the SAR) which suggests that the care home should make contact with JKL hospital. The email response to the care home from the CCG however seems to refer to difficulties with the care home's relationship with the family, and doesn't reference concerns expressed by the care home that they were not able to safely maintain the placement (this is not to say that such concerns were not presented; simply that they are not clearly reflected back in the e-mail response). The contact details for the discharge team at JKL hospital are indeed provided by the CCG and it is suggested that XYZ make contact with JKL. XYZ have advised verbally that this contact was made, and although I have not seen any documented records of this phone call I have no reason to question this.

22.55. In any event, it appears that any such telephone call would have been an opportune moment for JKL to note that the option to return to hospital was open. It might be speculated that they did not do so only because they believed that XYZ already knew this. Regardless of the specifics of the communication at this stage, it is clear that a critical 'information gap' was created and maintained.

22.56. On the **18th November 2017**, there are three brief entries in the XYZ electronic care record; one at **07:42** confirms that Mr G '*had a settled night*'; one at **17:13** confirms that Mr G '*had a settled day, assisted with all personal hygiene care needs. Had all medications prescribed*'. A later entry confirms a visit by the family (their account of this is noted below).

22.57. The last entry for the day (**20:30**) confirms that the DIST team visited Mr G at XYZ who make a plan to discharge Mr G back to the care of the GP (although this plan is not subsequently enacted). The reports note that this is planned to occur for the **21st November** (and so in fact, does not occur as Mr G is admitted to GHI Hospital by this time). Records from DIST indicated that they had reviewed the care plan after seeing Mr G at XYZ, and recorded that staff were now managing with challenging behaviours and delivering person centred care. It does not appear that this assessment is contrasted alongside the fact that three days previously DIST had continued to express concerns about XYZ's ability to safely manage Mr G, and the fact that Mr G was still formally '*on leave*' from JKL hospital, and therefore formally one of the trust's patients.

22.58. One factor that may have facilitated this decision may have been the lack of detailed record keeping about the apparent difficulties in providing personal care for Mr G within the electronic daily records (DIST may have overestimated improvement from a review of these records). Another may have been the fact that the care records indicate that Mr G had had a '*good day*' on the day that DIST had visited. This is, unfortunately, not questioned further to consider why such improvement had occurred (had medication begun to take effect on infection or pain, for example?). It is also significantly at odds with the family's narrative (see below).
This is therefore potentially an example where increased professional curiosity might have led DIST to taking a different decision. In any event, had Mr G been discharged from DIST, he should have continued to receive services and input from one of the community teams in the mental health trust whilst his bed remained open at JKL.

22.59. As noted, the family also visited Mr G on this day **(18th November 2017)**. Directly in contrast to the care records, they reported being very concerned with his physical appearance, stating that he appeared both thirsty and hungry: '*he was lent over in bed, clammy, not good at all, no water near him at all… his beaker was out of reach*'. They reported they were also concerned about the nursing staff looking after their father; that the nurse assigned to the care home had returned from a period of leave and was unfamiliar with processes. This appears at least a partial

misunderstanding; the care home has clarified that this staff member was an agency nurse who had been back at work for eight months, and over this period had been working at other care homes in the group of homes, but who was working for the first day since her leave at XYZ specifically. However, management from XYZ advised the SARP that they had chosen this nurse specifically because she knew the home well as she had worked here frequently prior to her leave, and was familiar with processes.

22.60. Nonetheless, because of their concerns the family returned the following day, the **19th November**. Upon their arrival at XYZ they were told that Mr G was quite unwell. Mr G's wife remained downstairs whilst the rest of the family went up to his room to see him. The family noted that he remained in the same outfit as the day before. They observed that he had tablets around his neck and a pill in his mouth that he had not swallowed (in this regard, it is noted that whilst in JKL hospital on the **29th October** Mr G had been reported to have choked on a pill). They added '*when I arrived, he had no water, no jug, no one was around… I couldn't find a staff member anywhere*'. They noted that he was malodorous ('*the smell in the room was awful… he hadn't been cleaned up*'), that he had appeared to have not eaten any lunch, and that he was leaning over on the bars of the bed leading him to have a mark on his arm. The record from the care home's chronology provided for the SAR does not contradict this narrative, stating '*[Mr G] resisted personal care, [Mr G]'s family concerned about his condition and felt he had declined and looked neglected. Family told staff not to provide care for [Mr G] as they wanted other family members to see him in his present condition. Family members shouted at staff. They stated that they had found a tablet under his neck*'.

22.61. The family reported that they gave him water, and explained that '*he couldn't get it in quick enough*'. They have reported him drinking 2.5 cups of water (the size of cup is not recorded), an account that does not appear to be disputed by the care home, and which seems further supported by the narrative from GHI hospital – to which he was subsequently admitted – that he appeared very thirsty, as well as the ambulance service who transferred him, whose report to the safeguarding team included an observation of dry lips. In a response to a complaint raised by the family, XYZ have indicated that the staff on duty explained that they had moved Mr G's beaker away from him because he had thrown it across the room. The family however challenged this on account of Mr G's mobility. Regardless, the drinks bottle should not have been removed for this reason without alternative plans to ensure Mr G would remain hydrated being rapidly enacted. The available evidence suggests that XYZ's decision to remove the drinks bottle may have contributed to Mr G becoming dehydrated (based on the subsequent clinical records), so placing him at risk of physical harm. This does not necessarily rule out the potential for other factors to explain Mr G's thirst, for instance diabetes, which were also considered by the SARP.

22.62. In regards to the medication, this matter was also the focus of a complaint made by the family. The family stated they found one tablet underneath his neck and two other pills in his bed which had not been taken. Ambulance records also note that there was residue of medication around his neck. In response to the family's complaint, XYZ outlined that the nurse:

> '*…stated that she spent around 20 minutes trying to encourage [Mr G] to take his tablets, but he refused. She returned a short while later and spent another 30 minutes with him and he eventually agreed to open his mouth to take the tablets, which he took with water. She stayed with him and asked him to show her that he had swallowed them, but again he refused. She asked him if he had swallowed them several times and each time he replied 'yes'. She asked him several more times to show her but again he refused to open his mouth.*'

22.63. In regards to XYZ's account of the events on this day, there are no care records from the morning, with the only care record being noted at **16:46**. This summarises and appears to confirm much of the account provided by the family:

> *'Today I was asked by both daughters of [Mr G] to see them on [ward name]. I went to them they wanted me to see [Mr G] and explained how highly disappointed they are regarding his condition today. There is a massive difference in [Mr G's] condition from yesterday. As well they concerned his personal care wasn't performed for a long period and is visibly looked neglect. I noticed he wasn't shaved and had rest of tablet on his lip which was dripping on his neck. The family told they found the tablet on his neck which I can confirm that was the tablet. They have been concerns that his dad is very unwell and they want Doctor advice. I asked [Q] nurse, to take observations and then contact 111 for visit. When we tried to put blood pressure caf on [Mr G's] arm he was resistive, anxious but with reassurance and help of daughter able to do it then we found another tablet in his bed. [Q] was politely apologizing she was convinced he took his morning tablets but the family wasn't happy with that answer it was a very intimidating way of conversation. The daughter said she will keep both tablets for evidence. BP was 122/88, pulse around 127, temperature 37C. [Mr G] was offered drink and according to the family, he drank 4 full beakers which are about 800ml and cup of tea. The doctor came around 16:00 checked [Mr G] over and after a chat with Family decided to sent him to the hospital with sepsis.'*

22.64. In addition to the above records made on the day, it is notable that the care home appear to have obtained statements from four members of staff who were involved in the care of Mr G on this day. Two of these statements appear signed the 22.11.2017, the other two appear undated. I will not provide the verbatim account of content of these statements but will note the following (verbatim quotes are taken from any of the four statements):

- The statements indicate that Mr G stayed in his bed in the morning. One carer confirms that '*I gave him breakfast and a drink of tea which he ate and drank*'.
- Mr G was then offered personal care. It was noted that '*he agreed at first, but as we got started he started swearing and lashing out at us, we explained again what we needed to do but he wouldn't let us wash him or shave him or roll him to change his pad. We all agreed to stop at that point and try again later*'. Another statement indicates that they got as far as putting shaving foam on his face before this occurred. The same carer adds specifically that '*he started being verbally abusive, he then grabbed my right hand and dug his nails into my skin and scratched me (I took pictures of the scratch). After this we agreed to come back later to try again*'.
- It is noted that the family then visited '*later in the morning*' or '*about 12:30pm*'. This then appeared to prompt the care team to try to deliver personal care again. One of the statements indicated this was because the family had complained that Mr G had not been washed. However it was noted that '*as we went into his room his family member did not want us to give him any personal care or reposition him at that point as she was waiting for her sister to see him, the nurse explained to the family member that we would have to wait until after dinner to give the family member any personal care which the family member agreed was fine*'. Another statement clarified that the reason for the family member wanting to see him was because '*she wanted her sister to see him in the state he was in*'.
- Two of the carers then went to find what Mr G wanted for lunch. One statement indicates '*the daughters complained and asked to speak to [the manager] so we went and got [the manager]*'. A footnote is added to describe the way

they complained as '*in a manner which was arrogant and very rude'*. Another statement indicates that around the same time, when the manager attended with a nurse, '*the nurse left the room in tears, as she left the second family member showed me her left wrist which had two scratch marks down it, she told me that [Mr G] had done it, she showed him and said 'look what you did Dad, that hurt*''

- Another statement adds that in regards to speaking to Mr G about lunch, '*his daughter spoken to us very rudely saying she is not happy with the state [Mr G] was in. I tried to explain to her that we tried to give him personal care but he refused. Also the daughter said that we should not be asking [Mr G] what he would like but will give him the food that will be acceptable for him to eat. Then again I tried to explain to her that we must give choices to our residents'*.
- Later in the afternoon it appears that further efforts were made to reposition Mr G '*so he could have his lunch'*, which was successful, but '*while we was doing it he was aggressive and wanted to hit us'*. It does not appear confirmed whether or not Mr G ate lunch.

22.65. XYZ have additionally indicated that the fluid monitoring chart component of their care records system was malfunctioning, and so on this occasion contemporaneous records of fluid intake taken at the time are not available.
They have stated verbally that his fluid output demonstrated that fluid intake was satisfactory, though records of fluid output do not appear to be within the XYZ care records provided.

22.66. The broader deterioration in Mr G's physical health condition and behavioural presentation, firstly over the short period up to the **19th November**, but more generally in contrast to his situation within JKL hospital, leads one to ask why such a deterioration had occurred. There are four broad possibilities that were considered by the SARP. First, it is possible that the apparent physical infection that was developing (and potentially, given difficulties in medication administration, now not being properly treated) was leading to the behavioural changes. Second, it is possible that Mr G was in pain from physical infections, unknown causes, or potentially hunger and dehydration and had little other means of communicating this distress (in regards to hunger, the above statements from the home suggest that Mr G had been given breakfast, but it is unclear whether lunch was given). Third, the change in environment between JKL and XYZ could itself have been potentially destabilising. Fourth, it is possible that staff at XYZ simply did not work effectively to build up a relationship with Mr G and that Mr G felt threatened by the staff at XYZ compared to JKL. These possibilities are not mutually exclusive and are unlikely to be complete. However, as stated, it is apparent that XYZ did not make efforts to 'rule in' or 'rule out' potential explanations for his behaviour, and in particular, changes to that behaviour.

22.67. Nonetheless, Mr G's physical condition was of such concern to the family that they asked XYZ to contact a paramedic, which the home believed was working for the GP surgery, who in turn was so concerned about Mr G's physical state that s/he advised that Mr G needed to be admitted to hospital. An ambulance was called at **17:14**. Upon arrival, three minutes later, Mr G was described as '*conscious but not fully alert*'. The ambulance crew were clearly concerned about Mr G's physical state, but in the observations made at the time, and subsequent safeguarding referral (see 3.9-3.10), also noted a number of concerns as potential indicators of neglect/acts of omission:

- Mr G had dry lips which was interpreted as evidence of dehydration
- Mr G is '*not on an airflow mattress with bed sores*' (it is now believed to be the case that Mr G was on the correct mattress)
- There was residue of medication around Mr G's neck
- Mr G was malodorous

- Mr G's clothing did not appear to have been changed for some time
- There were bruises on Mr G's upper limbs. The family had reported they had not been able to find out how these had occurred.
- There was faecal matter found on the bedside table.
- The family told the ambulance crew they also had cleaned faecal matter off Mr G's face
- Care home staff were said to have little information and records shown were minimal.

22.68. As stated, XYZ dispute that these observations were correct and state that the ambulance service's concerns are simply the family's concerns relayed by the ambulance service. Whilst I cannot reach a certain conclusion about this (the notes taken by the ambulance service do not definitively state what was observed by them and what were concerns reported by the family), the fact that the ambulance service did formalise these concerns in a safeguarding referral is important, and suggests these concerns were given reasonable professional credence. Furthermore, the safeguarding referral makes reference to a number of issues which would have been likely immediately apparent to the ambulance professionals (e.g. malodorous; clothing not changed; dry lips; bruises) and some which would have been more apparent and obvious from a professional perspective rather than a family perspective (e.g. a lack of records).

22.69. Mr G is conveyed to GHI hospital where it is noted that the GP had raised concerns about potential sepsis. Sepsis is a potential serious reaction to an infection. If untreated it can be fatal (see page 98). Mr G is noted by hospital staff to be thirsty and is given a bottle of water and started on intravenous fluids. Again, the SARP considered the possible factors explaining this as including dehydration from the care home or increased thirst consequent to his diabetes (or both factors working together). He was transferred to the Medical Assessment Unit where he is described as 'disoriented and shouting'. The following day (**21st November**) he is transferred to another ward in the hospital. GHI Hospital have not been able to provide further information about the nature of his admission within the time period of the SAR.

22.70. On the **21st November 2017**, XYZ receive an email from the CCG in a reply to an email they have sent to them (XYZ have shared the reply but the original email has not been seen). This email, directed to the general manager, states:

> *'I have not heard from the discharge team at [GHI hospital] as to what their plan is for the patient. I have had an email from [JKL hospital] in relation to his discharge from their services and a brief on their discussion with you regarding the family restricting care. If you feel it is appropriate you may wish to consider following your safeguarding policy guidelines if you feel that your concerns need further investigation. However it is not my place to instruct you on anything as you as the provider are best placed to make that judgement. The CCG would like to thank you for accepting this patient into your care'.*

22.71. The following observations are made in regards to this email:

- It appears that XYZ's account or understanding of the situation at this time was that the safeguarding concerns were about the actions of the family in preventing care delivery. This is consistent with the view that this was the focus of the concern expressed by XYZ in their earlier conversations on the **17th November.** It is, however, clearly different to the concerns being observed by other agencies by this time (e.g. the ambulance service).

- In any event, it appears that XYZ did not make a safeguarding referral in regards to these concerns, either before Mr G was admitted to hospital, or now after being prompted on this matter by the CCG.

22.72. On the **22nd November**, Mr G is reviewed by the consultant. The records indicate a diagnosis of '*Sepsis secondary to catheter induced UTI/pressure sores/lower respiratory tract infection (LRTI). Acute Kidney injury (AKI) secondary to pre renal dehydration. Delirium secondary to the above problems and background of dementia*'. At **12:00**, there is an emergency medical call reporting a sudden deterioration in the physical state of the patient. The medical note records '*Impression is sudden deterioration due to Myocardial infarction (MI) or massive pulmonary embolism (PE)*'. Mr G's family are called. Mr G died at **13:40**. The cause of death is recorded as '1a. MI 2a. Dementia, HTN (hypertension), CVA, (stroke), IDDM[24] (diabetes)'.

[24] Insulin Dependent Diabetes Mellitus. As a minor technical point, clinical expertise within the SARP reflected that contemporary terminology should simply classify Diabetes as either Type I or Type II.

Analysis: Learning in Relation to Themes for Ms F (& Mr Z)

23. Ms F: Positive Practice Observed

23.1. The decision to keep Ms F in GHI hospital over the Christmas period, partly to ensure that she was not returned to XYZ Care Home before the safeguarding concerns were finalised, was a positive decision that showed prioritisation of Ms F's needs at this time point.

23.2. The safeguarding response of the **14th December** shows effective information gathering in relation to the reported concern and development of a clear plan (notwithstanding limitations acknowledged in the narrative in 18.46-18.72 which appear to relate predominantly to a lack of awareness of important information about other incidents)

24. Ms F's overall experience of care

24.1. It is hard to know exactly Ms F's perspective of her care at XYZ. If the concerns regarding Mr Z's behaviour were removed, it can be said with reasonable certainty that Ms F did enjoy a reasonable quality of life, having regular visits from her family, and being supported in meaningful activity.

24.2. Ms F's experiences in regards to Mr Z are likely to have led her to experience a range of distressing emotions, in addition to the impact of the physical injuries themselves. The experience in this regard might well be reasonably categorised as psychological/emotional abuse. Her cognitive impairment, whilst in some way potentially a protective factor (preventing Ms F from being able to form reliable episodic memories of the events) may also have been a vulnerability (in the sense that it may have been harder for her to make sense of the distressing emotions).

24.3. It is also possible that certain elements of the incidents were remembered; for instance memories of emotions may have been more salient than the memories of the events themselves. This is of course in addition to the physical abuse that Ms F would have experienced as a result of injury from Mr Z.

24.4. There is evidence that good care was provided for Ms F at GHI hospital after the incident on the **19th December 2017**. However, the experience was again likely distressing, requiring Ms F to undergo significant surgery and potentially experience significant pain as well as risk to her physical health. This could have been avoided had the index incident been prevented.

24.5. It is the view of the independent author that Ms F's experience of abuse, and the risk or experience of abuse by other residents at the home (and specifically here I refer to her and other residents being the victim of assaults by Mr Z), was not inevitable, and that there were a number of opportunities – highlighted in the preceding narrative, and borne out through the wider analysis and recommendations – where changes in practice could have resulted in different outcomes.

25. Human Factors including Professional Curiosity

25.1. The consideration of 'human factors' in the present case relates to the way in which decision making and practice may be coloured or influenced by processes such as

bias, incorrectly held beliefs or assumptions, or wider contextual factors which influenced decision making. Since one cannot retrospectively understand the minds of the involved professionals, the factors considered in this section necessarily require some speculation and building of hypotheses. The term 'professional curiosity' is considered within this domain also.

25.2. In general terms, perhaps the most important point to emphasise was that there was broadly a lack of triangulation of information from all agencies involved. Analysis of notes indicates that all agencies had available to them information which would have been helpful (or indeed vital) to other agencies, but which was either not shared, or not requested. This is not an uncommon issue in health or social care situations where there is multi-agency involvement; effective sharing of information requires practitioners to either 'know what they don't know' or to 'know what another agency needs to know', and avoid making assumptions about what factors are or are not known. This task becomes harder in services where there is intense demand for resource and practitioners may show a tendency to focus on their own immediate service needs/requirements. There was evidence of this form of 'silo working' in the present case.

25.3. It is perhaps more tragic to say that there were agencies who had access to important information within their own records but who did not show evidence of being aware of this information. For instance, the safeguarding team had access to information about some earlier incidents that had been reported, but were not aware of this in their decision-making around November because of systems issues already noted. XYZ, too, had information about the breadth and frequency of Mr Z's violence in the form of the incident reports, but showed little evidence of being aware, or able to communicate, the 'whole' of this information to other agencies.

25.4. In regards to these general factors about information sharing/awareness, a number of further specific factors are noted in regards to the relevance of Human Factors:

25.5. Firstly, it was hypothesised that the decision making in regards to the detention of Mr Z under the MHA may have been influenced by beliefs about available bed capacity. It must be stressed there is no direct evidence of this in the current case, but SARP members reflected that the belief about insufficient beds in the local area is 'known' and may have been held by, for example, members of the DIST team.
This is discussed in more detail in 18.65.

25.6. Secondly, it is hypothesised that the home's beliefs (and broadly lack of awareness) about the processes by which a patient could be transferred out of the home in the context of violence/mental illness also influenced their response. The home was not familiar with these processes.

25.7. Thirdly, in terms of the issues with DOLS authorisations, particularly for Mr Z, the SARP reflected on the possibility that wider delays in processing of DOLS by the Local Authority contributed to the lack of action in this area. Care homes may be less likely to follow through on a procedure if they believe that no action will result in any case.

25.8. Fourthly, it is reflected above that beliefs about the availability of secure ambulances may well have influenced the decision to call for a non-secure ambulance first.
This is discussed in more detail in 19.9.

25.9. Fifth, there was evidence that the effectiveness of XYZ's ability to provide acceptable risk management was overestimated. The primary additional risk management offered by XYZ was through 1:1 observations, which were implemented for limited periods of time, and themselves significantly beyond a 'typical' care package offered by the home. However, as noted at several points, such observations could

have at best been partially effective. Care home staff could not have restrained Mr Z. Thus, the effectiveness of risk management provided by the observations was limited to the ability to divert, distract or otherwise engage Mr Z. Given the apparently rapid escalation of violence and lack of understanding of triggers, this seemed unlikely to have been successful.

25.10. There are two issues in terms of the human factors in relation to this point: firstly, an overly optimistic communication, at times, by XYZ that the observations meant that they *were* able to manage the risk. Secondly, a lack of professional curiosity by other agencies, particularly DIST and safeguarding, to 'think through' the actual function of observations in a hypothesised 'blow by blow' account. The question 'how would XYZ respond if Mr Z became violent again? Would they reasonably be expected to be able to prevent this occurring?' did not seem to be openly or directly asked, and there was a presumption that the observations themselves led to effective risk management. This was important, for example, in the incident of the **12th August**, where the safeguarding team could have more assertively questioned XYZ about the likely effectiveness of the management plan proposed.

25.11. Sixth, more general factors applying to the XYZ staff may have been relevant. The frequency and repetitive nature of Mr Z's violence may well have led to desensitisation – that is, getting 'used' to the nature of Mr Z's violence and simply seeing it as an inevitable part of his presentation. The fact that violence started so soon after his admission may have contributed to this as staff had never known him as a person before this, and so did not have access to a 'historical referent' which would have made salient the extent to which his current behavioural presentation was aberrant. Further, in the face of numerous potentially severe incidents which had led to less severe consequences, staff could have become desensitised to the ongoing risk or seriousness associated with Mr Z's behaviours. Finally, the impact of Mr Z's behaviours more widely may have led staff to focus on responding to the immediate consequences and therefore not process or emphasise the longer term response and wider contextual factors. If the staff team felt unsupported or under/minimally staffed, this would have further contributed to this tendency.

25.12. Seventh, and tentatively, one might reflect on the context in **working with violence in older adult populations**. It may be the case that social beliefs about the elderly population, for instance about the need to show deference and care, or an archetypal view of elderly people as non-violent, somehow led professionals or staff to 'miss' the severity of the violence, or to explain the severity away. Certainly, one can imagine that staff may have experienced cognitive dissonance (the process by which two conflicting beliefs or experience are held in mind at the same time[25]), which itself can lead to a tendency to 'muddy' the process of decision making. To make this point, one might question whether the behaviour would have been responded to more definitively if Mr G had been a young or middle aged adult with an acquired brain injury, instead of later-life cognitive deterioration. If this is answered affirmatively, then one must believe there was something about Mr G's age that impacted on practitioner's cognitive processing of his situation and risks.

25.13. Eighth, and perhaps most tentatively of all, after partly pulling together the implications of 25.11 and 25.12, one might note that staff did not more widely reflect on Mr Z's own likely perspective on his violent behaviour in regards to his 'personhood'. Again, a key question that professionals might have asked to assist such perspective taking, would be in asking the 'non-impaired' Mr Z 'what would Mr Z have liked us to do if he knew he would become like this in ten years' time?' Without suggesting that the MCA follows the framework of 'substituted decision

[25] For instance, a social expectation or biased belief that 'old people are caring' being held at the same time of experiencing Mr G's violent behaviours

making' (it does not), such a question may have directly informed consideration of Mr Z's 'best interests' under MCA, and most likely would have illuminated the fact that violence was not an integral part of Mr Z's character, but rather a function of his cognitive decline and related distress. This being the case, one could imagine that Mr Z himself, at another point in time, might have wanted such behaviour to have been robustly managed and responded to.

25.14. The above list is unlikely to be a complete list of the role of human factors, but perhaps highlights some of the most salient factors that are likely to assist in understanding the way in which Mr Z's behaviours were responded to and, consequently, the fact that Ms F and other residents were placed in a vulnerable situation without adequate plans to manage the related risk.

26. The process of assessment of Mr Z both into and out of XYZ Care Home

Assessment into the care home

26.1. There is little to clearly indicate that the process of assessment itself of Mr Z into XYZ Care Home was substandard or fundamentally flawed. The assessment process was discussed within the Learning Event. XYZ's account was that there were no obvious indicators that Mr Z would become distressed and violent upon admission and that his rapid change was a surprise.

26.2. One issue that was felt to be a concern was the fact that because Mr Z was a private referral, there was no connection made with statutory services – for instance Adult Social Care – at the point of assessment and admission. This meant that there was no obvious statutory process to support the need to seek alternative residence when this need became apparent.

Referral and transfer out of the care home

26.3. The process of referring Mr Z out of the care home was significantly problematic. There are broadly two problems. Firstly, the transfer did not happen early enough. Secondly, there were serious concerns about the process of completion of the Mental Health Act Assessment (MHAA) when the transfer did finally occur, with the result that Mr Z was kept at XYZ Care Home for much longer than he should have been after the, already delayed, need for inpatient hospital treatment was identified.
These two issues together meant that Ms F and other residents were placed at risk of further abuse. These concerns are detailed more fully within the narrative in s.19, and summarised as follows:

- The need for a MHAA itself was not responded to in a timely manner and seemed to be a deviation from the Code of Practice. This raises a question about the resource and availability of AMHPs to respond to requests for MHAAs in a timely manner.

- The use of secure ambulances in the detention process was concerning. Fundamentally this seems to reflect the lack of any substantive contract with any organisation to provide these on a basis that allows them to be used when necessary. The ad-hoc approach means there appears to be no way for the Local Authority to assure compliance with the Code of Practice, e.g. in regards to response times; provision of necessary capacity across the region at all times. It also meant the AMHP had no recourse other than persuasion when the secure ambulance declined to wait after the paperwork issue.

- The paperwork issue (not having the A(AMHP)3 form ready at XYZ) raises a potential concern about an individual variation in the AMHP's practice.

- There is a further question about the original decision to use a non-secure ambulance to transport Mr Z. The level of violence demonstrated by Mr Z does suggest that this may have been a poor decision. It is possible that a perceived lack of access to secure ambulances contributed to this decision.

27. Mental Capacity Act, including DOLS and Best Interests Decisions

27.1. Ultimately, it was agreed that these issues predominantly related to Mr Z's care (rather than that of Ms F, where decisions were made in line with the LPA) and are therefore something of an incidental point of learning. The following factors are considered in regards to best interests/mental capacity issues about Mr Z's residence:

- If Mr Z did have capacity about making residence decisions at the point of admission, he quickly lost such capacity (18.6, 18.36). This lack of capacity to make decisions about his residence was never assessed or addressed. The admission was, it is understood, never authorised by a DOLS.

- This means that consideration of Mr Z's best interests in regards to the residence were not considered. A formal Best Interests meeting was warranted. This is particularly the case given the fact that Mr Z's wife was keen for Mr Z to remain within the care home, but that she did not have an LPA and so there was no legal route for her to make this decision on Mr Z's behalf.

- Any such meeting should have considered and discussed the impact of Mr Z's likely views and feelings about his own behaviour. It was unlikely to be in Mr Z's best interests, either, for his violent behaviour to be largely unmanaged. This perspective does not seem to have been considered at all within the clinical reasoning outlined.

- Similarly, there was little evidence that Mr Z's violent behaviour, which affected a number of different residents, led to the best interests of those residents being formally reviewed.

27.2. In regards to the other ways in which mental capacity was relevant, the following factors are noted:

- A decision was made to prescribe Mr Z medication to assist with behavioural control with only his wife's consent (18.17). As it is understood that his wife did not have an LPA, his wife could not have provided consent for this to happen on her husband's behalf. The decision should have been made in Mr Z's best interests. A fuller assessment of Mr Z's best interests would likely have revealed the lack of effective monitoring and psychological responses to Mr Z's violence (see 29.6 onwards).

- The medication in question would have had a high potential side effect profile and with risks and benefits that needed careful balancing. It was prescribed in an unclear fashion to somebody lacking capacity.

This should have triggered a query as to whether detention under MHA was warranted at this time (18.18).

28. Information management including reporting of safeguarding concerns

Reporting of Safeguarding Concerns

28.1. In regards to the reporting of safeguarding concerns, the analysis in **Appendix 1** indicates that almost all of the most serious incidents of violence towards residents were reported to the safeguarding team by XYZ. There was one more serious incident which was not reported and several less serious incidents which were not reported.

28.2. However, in terms of what was reported, it appears that the detail was often not presented against (or at least understood against) the context of violent behaviour that had been a regular and routine part of Mr Z's pattern since admission. XYZ explained, for instance, that they did not report incidents against staff to the safeguarding team because the staff members were not vulnerable. This is indeed formally correct practice. However, the number of staff assaults would have been highly useful information to the safeguarding team in understanding the breadth of the risk to the vulnerable residents. Further, staff incidents should have been subject to appropriate internal review guided by policy, with staff supported to report incidents to the police where that was appropriate. This is an important point of learning.

28.3. In addition, there was some evidence of inconsistent reporting by XYZ on the extent to which they felt able to safely manage Mr Z's presenting risks. Despite on occasions giving a message that they were struggling to cope, this message then appeared to be contradicted by later messages given. One example of this is detailed at 18.54.

28.4. In addition, some of the risk management plans reported to have been implemented, particularly 1:1 observations from staff who were unable to restrain (and therefore acting as false or only partial assurance that risks were being managed) were unlikely to have been fully effective (18.26, 18.65).

28.5. In addition, as noted, incident reporting by XYZ generally lacked detail and although many incidents were recorded, triggers, antecedents and reinforcers commonly were not in any detail. This may have led staff at XYZ to have underestimated, themselves, the frequency and severity of the behaviour. When presented as a clear list of incidents (e.g. **Appendix 1**) the frequency, severity and repetitiveness is stark.

28.6. There were also occasions where safeguarding referrals could or should have been made by other agencies who expressed concerns. For instance, having conceptualised that XYZ were unable to safely manage Mr Z, this should have been formalised within a safeguarding referral (e.g. 18.34).

Responses to Safeguarding Concerns

28.7. In regards to the response to the safeguarding concerns, there are several comments to make:

28.8. Firstly, the initial incidents reported to the safeguarding team seemed to have been conceptualised by them as 'one off' incidents and not therefore representative of Mr Z's wider behaviour or risks 18.30. This conceptualisation explains why no follow up action was taken. However, it very rapidly became an incorrect conceptualisation. The reasons for this are already considered (18.32).

28.9. Secondly, there appeared little consistency in how or which incidents were reported 'upward' e.g. to the police for further investigation. The SARP considered that many more of the incidents would have warranted criteria for reporting from the MASH to the police. Police reporting and recording is important even if the practitioner knows that no further formal action will be taken.

28.10. Thirdly, there were clearly issues around the use of the electronic reporting software by the Local Authority during a transition between two systems in November 2017 (18.72). It appears that this may have caused practitioners to be unaware of (or have less ready access to) incidents reported before the transition period. However, it is likely that the passage of time has already mitigated against this risk significantly.

28.11. Fourthly, also likely because of the transition to the electronic system, it was noted at 18.53 that having determined that Mr Z required assessment by Adult Social Care, he was put onto the wrong holding list. This was then rectified some days later. This is clearly unfortunate since when this assessment did occur, the social worker did appreciate the severity of the risk and recognised that Mr Z would have to be moved to other premises.

28.12. Fifth, it appears there were some practice issues in the recording of safeguarding reports, which were sometimes only recorded against the victim. This meant that if there was one perpetrator with multiple victims, this safeguarding issue would not be immediately obvious to the safeguarding practitioner. I am advised that the guidance provided to practitioners is clear on this point and the individual cases where this did occur will be followed up appropriately.

28.13. Notwithstanding these important concerns, however, the actual process reported by safeguarding practitioners in the reporting, follow-up and reasoning behind decision making conveyed in the safeguarding records appears broadly sound. Some of the responses and decisions by practitioners are much more understandable and reasonable when considering the information about the incident and wider context/history they were aware of at that point in the decision making. Practitioners may have taken a somewhat different approach had they been aware of such information. Certainly, it might reasonably be stated that practitioners might have demonstrated more professional curiosity in triangulating information and requesting contextual information from XYZ, but equally XYZ could have provided more detailed information about the context and wider picture, and a clearer and more consistent narrative about their inability to safely manage Mr Z.

28.14. Some of these issues may be resolved through a more formalised process for communication of incident reports between the care home and safeguarding team. Whilst the incident reports created by XYZ lacked significant detail, the frequency of incidents is apparent from a review of **Appendix 1**, and a formal process by which these were shared may have led safeguarding to see what they were missing.

28.15. Finally, I note also at this stage that the family did raise some concerns with me about their experience in raising safeguarding concerns, following the incident on the **14th December** and in the days before Ms F's admission to hospital. They told me that they felt their concerns were not taken seriously by the safeguarding team. They also reported a concern that the same telephone number was used to call the safeguarding line as any other council enquiry. My judgement is that, broadly, the safeguarding team acted appropriately, triangulating the family's complaint with the safeguarding referral from the home and developing a plan of action accordingly. As above, and in hindsight, the urgency of the response was somewhat disproportionate to the risk, but the factors leading to this were significantly about the 'information gap' that had been created. In regards to the issue about the

telephone number, I can understand that from the council's perspective it is helpful to have a single telephone number and do not see that this is likely to prevent concerns being raised.

I note the number and process is clearly published on the NCC website (https://www.norfolk.gov.uk/care-support-and-health/protecting-someone-from-harm/help-an-adult-at-risk-of-harm/report-a-concern).

29. Management of the escalation of violent behaviour by Mr Z

29.1. The chronology outlined in detail in s.18 and **Appendix 1** of this report details a history of violence and wider aggressive behaviour which can be summarised as having the following characteristics:

- Violent behaviour started very soon after admission to XYZ.
- Violent behaviour continued throughout most of Mr Z's admission to XYZ.
- The longest period without an episode of violent behaviour was no more than a few weeks.
- Residents as well as staff members were victims of Mr Z's violent behaviour.
- Staff members were the first victims but it soon generalised to residents. It is not clear (because no functional analysis was conducted) whether Mr Z assaulted staff members for different reasons than patients.
- Violent behaviour included slaps or punches to the head or face area (which occurred to residents on at least nine occasions), pushing residents over (three occasions) as well as other forms of assault.
- Violent behaviour appeared to remain qualitatively similar in nature throughout the period, with two periods where the frequency of such incidents increased
- Violent behaviour presented alongside other forms of aggression including verbal aggression, threats and sexualised behaviour e.g. exposure
- Records indicate that XYZ reported on several occasions that they felt they were able to deal with the violent behaviour
- Yet staff reported they were fearful of Mr Z
- 1:1 observations implemented to manage Mr Z's violent behaviour were assumed to be an effective solution without consideration of the extent to which such observations could, in reality, reduce the risk
- It was clear that staff would not be able to respond to violent behaviour through restraint if Mr Z was on 1:1 observations
- XYZ believed that Mr Z's violent behaviour was unpredictable

29.2. In response to the above, I believe that the following opportunities for improvement in regards to the management of Mr Z's violent behaviour should be highlighted:

Assessment of Violence and Associated Risk

29.3. There should have been a much more robust assessment of Mr Z's violence and the risk he presented. This should have included, at minimum, regular ABC charts reviewed to develop a better understanding of what was likely driving the violent behaviour. This would have informed the care home in developing more effective behavioural plans for responding to Mr Z. The incidents reports which were completed were generally not completed in any detail (generally lacking any detailed report of antecedents or consequences) and did not appear to have been subject to any formal analysis by the care home.

29.4. There should have been a more formal and structured approach to the assessment of Mr Z's risks. The risk assessment should have considered the potential scenarios in how violence could have eventuated. Any meaningful risk assessment would have considered that the victim group was highly vulnerable, and that Mr Z's behaviour had the potential – demonstrated through numerous incidents – to lead to serious physical consequences for the potential victims. It would have considered the frequency of the behaviour and the apparently rapid onset of the behaviour. I stress that it does not appear that the assault against Ms F on the **19th December** was particularly different to many of the other assaults that had occurred previously, but simply occurred in the context of different environmental, circumstantial and chance factors.

29.5. These issues were partially picked up by DIST, but could have been more robustly communicated to the care home with explicit recommendations about how to achieve these objectives. A safeguarding referral could also have been made about the home's ability to manage Mr Z.

Management of and Responses to Violence Risk

29.6. Potentially partly because of the lack of risk assessment and understanding of the function of Mr Z's violence, the response provided by XYZ to this violence was concerning. As already stated, incident reporting and functional analysis of behaviour did not happen consistently. It is hard to see any clear development of a management plan, other than periods when Mr Z was reported to be on 1:1 observations, and psychotropic medication prescribed by DIST. Efforts to divert or distract Mr Z were at best intermittently successful, and, as noted, not carried out alongside a more coherent understanding of the 'why' of Mr Z's behaviour. It is unclear whether 1:1 observations could have satisfactorily mitigated against Mr Z's risk given that staff would not have restrained Mr Z (it is acknowledged that observation could be partially helpful even without this). It is also unclear whether the medication was effectively monitored in terms of its impact on violence (though given the lack of systematic recording of violent incidents, it is hard to see how that could have been achieved).

29.7. Had XYZ had a clearer understanding of the function of Mr Z's violence, which might have been aided by further involvement from other services, they would have been in a clearer position to develop a management plan that encompassed activities and interventions that more effectively mitigated against violence.

29.8. XYZ did not appear to clearly and consistently report that they were not able to manage the behaviour. Indeed, it appears that at times they gave assurance (e.g. to the safeguarding team) that the behaviour could be or was being managed.

29.9. The management of Mr Z's violent behaviour was supported by input from the DIST service. However, this raises a question as to the role of DIST and how this was differently understood by DIST themselves and XYZ. This difference was picked up on in meetings with staff from both services. Broadly, DIST's role is as a crisis service where a key organisational objective is in preventing admission to a hospital. DIST's view was that the primary responsibility for management of challenging behaviour lay with the care home. Conversely, staff at XYZ saw DIST's role as a service who should be able to support with management of complex behaviour, but who in their view had a very narrow focus on testing for Urinary Tract Infections and provision of medication. These different views appeared to compromise the effective working relationships between these two teams, and therefore likely the effectiveness of the care that was delivered.

29.10. One further observation must be made in regards to DIST's involvement in the current case, which was that they appeared very quick to discharge Mr Z from their caseload (see 18.38). Indeed, at this point Mr Z was discharged back to the care of the GP, without any option to continue to receive input from the CMHT (Community Mental Health Team). In our discussions with frontline practitioners, DIST viewed the sorts of timescales involved (11 days after the safeguarding referral for closure to be discussed) as being within their normal practice. Unfortunately, in this case, it was simply too short a period of stability for Mr Z not to have any further recourse to a mental health/dementia specialist service. If the decision to discharge was consistent with DIST's role as an acute and highly time-limited service, then it is my view that Mr Z's case should have been discharged to the CMHT rather than the GP; there simply was not sufficient evidence of stability by this time.

30. Involvement of the family

30.1. Relationships between the family and the staff at the care home were, at times, quite difficult. However, I believe this predominantly reflects the family's concerns for the wellbeing of their mother. I note that it would have been very difficult for the home to have established a positive working relationship with the family without assuring the core safety of Ms F. I therefore think this is largely an issue that would have been significantly resolved by wider changes in practice.

Analysis: Learning in Relation to Themes for Mr G

31. Mr G: Positive Practice Observed

31.1. Overall, the experience of care at JKL was noted to have been generally very positive. The care team should be commended on this feedback from the family. The potential concerns with the process of transfer to XYZ should be separated from this otherwise positive experience.

31.2. Similarly, the experience of care at DEF hospital was noted to have been generally very positive. The notes indicated that there was a lot to commend DEF on: they responded quickly to concerns about his physical health, they attempted to engage him in meaningful activity, and they provided structured assessment of his functional and cognitive ability. The fact that the hospital was a long distance from the family, and out of the local health trust's commissioned area, is considered separately and is separated from this otherwise positive experience.

31.3. A specific point of positive practice was the quick response to a need for a DOLS application made whilst Mr G was at GHI hospital (22.2).

32. Mr G's overall experience of care

32.1. Mr G's overall experience of care over the period of the review is characterised by a mixture of generally very positive experiences with other experiences that I believe would be fairly characterised as demonstrating the potential for abuse and/or neglect.

32.2. It is the view of the independent author that Mr G's experience of or risk of abuse and/or neglect was not inevitable, and that there were opportunities – highlighted in the preceding narrative, and borne out through the wider analysis and recommendations – where changes in practice had the potential to result in different outcomes.

32.3. Notwithstanding these comments, Mr G's likely experience in each setting is considered in turn:

Overall Experience of care: GHI Hospital

32.4. After the unwitnessed fall in June 2017 and subsequent admission to GHI hospital, Mr G's experience of care is characterised by a number of challenging behaviours within the acute hospital care setting. It is likely that a number of these behaviours were related to distress in the context of Mr G's cognitive impairment and difficulty in making sense of his experiences, with the further possibility that an untreated UTI was further exacerbating these behavioural problems. These behavioural observations were clearly difficult for the staff to work with, but also were likely to have been distressing for Mr G himself.

32.5. It is noted that GHI appeared to reach relatively quickly for psychotropic medication to control Mr G's behaviour. Whilst the medication used was not prescribed contrary to guidelines, at least in place at the time, it is not clear that the hospital appropriately explored possibilities to try psychological techniques to assess and manage Mr G's behaviour prior to this.

This potentially meant that Mr G's behavioural problems continued for longer than necessary, and potentially meant that Mr G was exposed to side effects from medications that may not have otherwise needed to have been prescribed. This experience, however, may be attributable as much to the local mental health trust who provide mental health in-reach services to GHI hospital, rather than GHI as an individual organisation.

32.6. Finally, after Mr G was again admitted to GHI Hospital towards the very end of his life, there is no reason to doubt that Mr G experienced good quality care which attended to his apparent clinical presentation appropriately.

Overall Experience of Care: DEF Hospital

32.7. Mr G's experience of being detained under the MHA and the issues related to Mr G being placed out of area are considered in s.35. These factors are relevant to his broader experience of care, however, as they limited contact with the family, and necessitated an additional move between care environments which was likely itself to be distressing. Access to additional local beds would have prevented this.

32.8. Overall, it appears that, notwithstanding these issues, Mr G's experience of care at DEF was broadly positive, and this is specifically noted above (31.2). Other than perhaps more persistent attempts to involve Mr G's family in his care during his stay at DEF, there seems little that DEF themselves could have done to improve Mr G's experience here.

Overall Experience of Care: JKL Hospital

32.9. Similarly, Mr G's experience of care provided by JKL hospital was also likely to be relatively positive, as noted above (31.1). Notes from the care records (22.18) also indicate that the hospital worked hard to understand Mr G's care needs and worked compassionately with the challenging behaviour that presented. This in turn seemed to mean that the frequency and severity of such challenging behaviour decreased, presumably reflecting reductions in Mr G's distress.

Overall Experience of Care: XYZ Care Home

32.10. Despite being at XYZ only a short time, Mr G's experience of care at XYZ was, unfortunately, of significant concern. The experience of likely distress and pain seemed to be characteristic of his short stay here. Although there were short periods where he may have appeared to improve, the clinical record keeping is significantly limited and means that drawing conclusions about this is difficult. It appeared that XYZ were broadly unable to manage Mr G's presenting clinical needs. The distress was unfortunately compounded by the fact that it appeared XYZ were unable to consistently provide personal care for Mr G, leading him to experience a significant loss of dignity. As with Mr Z, XYZ did not seem able to functionally assess Mr G's challenging behaviour, and thus appeared to lack a strategy in responding to this. Certainly, his presentation by the end of his stay at XYZ is highly concerning, and in this light the concerns about neglect and abuse expressed in the safeguarding referral by the ambulance service appear understandable (3.7; 22.67).

32.11. It was speculated as part of the wider SARP discussions that one of the reasons for Mr G's apparent poor quality care at XYZ was in fact because of the staff being diverted to care and support the risks presented by Mr Z.

There is no clear evidence for this, however, other than to reflect that the staff team working in the home did report being called away frequently to respond to incidents concerning Mr Z. XYZ themselves reported that this did not occur – staff members were not diverted from Mr G's care to cope with Mr Z, and that extra staff were brought in in addition.

32.12. Whilst at XYZ Care Home, Mr G was also a patient of the DIST service. In this regard, one further observation must be made of DIST's involvement in the care of Mr G, which was that, as with Mr Z (29.9-29.10), they appeared very quick to consider discharging Mr G from their caseload (see 22.56), though ultimately decided not to do so because of concerns about the ability of the home to safely manage Mr G. The comments in regards to Mr Z (29.9-29.10) can largely be repeated here.

33. Human Factors including Professional Curiosity

33.1. This section should be considered alongside the comments made in s.25, many of which are also directly relevant in the present SAR. For instance, the comments about poor triangulation of data (25.2) are equally applicable here, and the comments about agencies not having awareness of information which they had access to (25.3) is relevant in the way that XYZ reported they did not have awareness of the possibility of returning Mr Z to JKL hospital, even after records clearly document this information was shared with XYZ on several occasions. The comments about DOLS (25.7) are equally relevant here.

33.2. One of the most important unique factors to consider in the present SAR, however, are the concerns about the process of the decision to discharge Mr G to XYZ Care Home from JKL Hospital (34.8 onwards) and the confusion and lack of shared agreement about the discharge pathway being used. Practitioners from different agencies had very different beliefs about the pathway by which Mr G was being discharged, and there was little evidence that any practitioners in any of these pathways were able to reflect on this difference in views. This difference in views became particularly obvious during discussions at the Learning Events. From the care home's and CCG's perspective, Mr G was being discharged under the DTA pathway; from JKL's perspective he does not appear to have been.[26] Regrettably, these differences of opinion almost certainly would have been resolved had the best-interests discharge planning meeting intended had not been cancelled. The discharge should not have occurred without this meeting going ahead.

33.3. In addition, one might consider the decision-making by DIST in considering discharging Mr G from their case load (22.58). Although ultimately DIST did not discharge Mr G at this point, their decision making about this on the day was potentially influenced by the records seen. DIST's observations that '*they were now providing person centred care*', may well have accurately characterised the care at the point it was observed. However, their judgement about the general pattern of XYZ's ability to safely manage Mr G may well have been affected by the limited care records which were available. Thus, DIST's decision cannot have accounted for any recent change in his presentation meaningfully (improvements or otherwise). It is noted that part of the safeguarding concerns relayed by the ambulance service in their safeguarding referral for Mr G relates to the limited degree of records available. Whilst clearly the responsibility for appropriate record keeping does fall to the home, DIST could have also reflected more fully on the difference between an 'absence of evidence' or 'evidence of absence'.

[26] Verbal reports given by senior staff during the learning events from JKL indicated that patients were never discharged on the DTA pathway from the psychiatric hospital, though there is evidence that this was known to JKL from the clinical record on the 17th October (22.20).

Having recognised the former, DIST could have then taken appropriate follow-up action, for instance requesting more detailed verbal records from staff on duty, escalating concerns with staff management, or even reporting the absence of records as a safeguarding concern.

34. Assessment of Mr G into XYZ Care Home from JKL Hospital

Decision Making around the assessment

34.1. As noted previously, Mr G was assessed by XYZ on the **30th October 2017** for admission. The process of assessment raises a number of concerns which I will try to deal with in turn. However, the narrative around this process requires further explanation.

34.2. It is worth noting at this point the concerns expressed to me by Mr G's family about the process of assessment and admission. Quite simply, Mr G's family believed that XYZ had assessed the wrong patient. They explained to me that when they had spoken to XYZ after the assessment had been completed, they asked the staff member from XYZ whether they had been able to speak to their father. The response was '*I had a good conversation with the staff*'. They then repeated the question to ask if they had spoken with their father. The response was '*we had a couple of words and then he walked off to the toilet*'. The family members advised me they immediately presumed the wrong patient had been assessed as they advised '*my dad doesn't walk*'.

34.3. Having reviewed the pre-admission assessment pro-forma completed by the General Manager at XYZ (dated 30.10.2017), however, it is my view that it is unlikely that XYZ did assess the wrong patient. This is because the assessment pro-forma does contain personal information which is clearly specific to Mr G, for example about his historical occupation, as well as containing the correct contact details for family members. I cannot rule out the possibility that, having met with staff, the staff member then spoke to the wrong patient on the ward, although XYZ report that they were informed by JKL which patient it was. My inability to do this definitively, however reflects more generally the fact that the pro-forma is only sparsely completed, and contains relatively limited information. It also reflects the fact that the contact with the patient, whether they were Mr G or not, appeared very brief and at most a small contribution to the assessment. There is little evidence of any information being obtained directly from observation or assessment of the patient themselves.

34.4. More generally, however, the process of completion of the assessment does raise a number of wider concerns, which are summarised presently:

- There is no indication of the sources of information used to complete the assessment. There is no way of identifying which information has been obtained through direct assessment and which information has been obtained from a review of previous records, and indeed which records were inspected. For example, in Mr G's case it does not appear from the assessment pro-forma that the assessor consulted the medical records kept by the JKL hospital during the assessment process, which would have been readily available at the time of completing the assessment (XYZ have subsequently stated that the assessor looked at Mr G's notes and consulted with a nurse).

- The form is generally very sparsely completed. Certain sections which seem critical to the decision-making process only contain limited information. For instance, under 'Past Medical History' the only information recorded is

'Physical and verbal aggression – historical' and 'Cellulitis'. There is a list of diagnoses given under 'Current Medical Condition'.

- The pro-forma itself does not encourage the clinician to provide fuller answers. For instance, the pro-forma makes use of a number of check boxes to gather information. This may be appropriate where the form is seeking to narrow down options or respond to categorical question choices. However, some of these risk the assessor losing or omitting very important information in the process of assessment. For instance, under '*memory*' there are choices of '*no impairment*', '*short term loss*' and '*long term loss*'. These categories belie the wide complexity of cognitive impairment generally, and memory loss specifically, in dementia and are unlikely to be reliable ratings. Other aspects of cognitive function, including attention, inhibition and language functioning are not captured at all by this question. The option to provide further information about the person's cognitive function is provided for within a follow-up question '*How does living with dementia affect daily life?*', although in Mr G's case a rather non-specific answer given is '*Needs full assistance*'.

- Notably, the proforma does also include specific questions about capacity and consent. These document that the assessor believed that Mr G lacked capacity to make decisions about his residence. However, it also asks '*Has a best interest decision been made with all parties involved in the resident's care i.e. including relatives?*'. This box is checked as 'yes', however there is no indication that this had in fact occurred as part of any formal meeting.

- There is no reference at all, or indeed scope within the form, for the person completing the form to assess or consider the broad reasons for Mr G's admission to hospital at that time, nor indeed past admissions to hospital, previous admissions to a care or residential home, or the level or nature of care received in any previous environment. Positively, the care home have indicated that during the timescale of the SAR process, some of these changes have already been implemented in a revised assessment pro-forma.

34.5. In sum, the form itself appears to lack a structure which would facilitate a broad and detailed review of the clinical factors that might be relevant to the decision at hand. To this end, it is positive that XYZ have indicated they have already sought to improve some of the most important elements of the form. However, the specific form in question also appears to be completed poorly, without any triangulation of information between observations and direct assessment of the patient, reviews of medical notes and previous clinical records, and discussions with the staff members at JKL. It is my view therefore that it is reasonable to conclude that Mr G was accepted by XYZ on the basis of an incomplete and superficial assessment which lacked appropriate depth and inquiry.

34.6. This issue received significant discussion during the learning event for Mr G. Initially, XYZ stated that had they known about Mr G's history of being detained under the MHA and previous 'failed placements' in care homes, they would not have accepted him. This of course raised the question of why this information was not sought out by XYZ at the time during the assessment process. For avoidance of doubt, it is my view that the obligation fell on XYZ to seek out this information throughout the assessment process; it was not for JKL to proactively decide which information XYZ did or did not need to complete the admission assessment. Even had the care home not been able to get this information from JKL's records, a reasonable history taken from a family member would have revealed multiple previous placements and prompted the assessor to follow up this further.

34.7. Nevertheless, upon further discussion at the Learning Event it became clear that given Mr G's apparent stability at JKL, this information would not have necessarily prevented XYZ making a decision to admit Mr G. However, the home acknowledged that had they done so whilst being aware of this information, they would have ensured that Mr G had been provided with further support and potentially developed contingency plans for a potential failure of the placement.

Funding Process and Pathways for Transfer

34.8. This process is a significant theme within the SAR and so requires relatively detailed discussion. However, this is complicated by the fact that different agencies appeared to hold different views about what the process (in terms of funding and assessment channels) should be (and indeed, should have been) applied, and it is clear that what happened did not appear to fit within a process or pathway that was accepted and understood by all agencies, and which potentially falls outside national guidance.

34.9. First, it is important to summarise the broad principles of the Continuing Healthcare (CHC) process. The CHC process provides a formalised route by which care provided for primary health needs, and so funded by the NHS, are differentiated from social care, provided and funded by the local authority. A formalised process of assessment exists which relies on a structured 'decision support tool' in order to reach a final outcome. The process is a two-stage assessment with an initial screening tool being followed by a more comprehensive assessment and multidisciplinary meeting.

34.10. Second, I note the earlier comments about the Discharge to Assess (DTA) pathway (22.4; see also page 98 for a definition). This pathway was started whilst Mr G was in GHI Acute hospital, before he was transferred to DEF Psychiatric hospital under the MHA. However, it was not activated at this time as the MHA detention overtook this. Furthermore, the statutory guidance for Continuing Health Care suggests that the DTA process is only applicable in acute hospitals, a view that was shared by the clinical team at JKL hospital (though not by the CCG).

34.11. Third, consistent with this view, I note that in feedback received from JKL hospital during the learning event, it was noted that the process is that patients who are admitted to this hospital are *never* discharged under DTA, but that they would typically have an assessment for a care home (residential or nursing) within the hospital and then be moved to this home directly. Importantly, JKL hospital also indicated that when patients are discharged from the hospital their bed is typically 'left open' so they are able to return to the ward if the transfer to the new placement fails.

34.12. It should be noted that at the point of assessment, Mr G's care needs were broadly known. For instance, social services record that '*CCG confirmed 3 people transfer and long-term the care setting may struggle to meet needs so may require moving and handling review*'. His susceptibility to infection and apparently consequent behaviour changes were similarly known. Thus, Mr G's significant care and health needs were *known* at this stage. Thus, the rationale of using a DTA placement appears hard to understand.

34.13. Similarly, a review of Mr G's progress over the preceding 12 months would have revealed that Mr G's time at JKL hospital was the *most* stable he had been for some time. Therefore, the broad logic of the DTA process – i.e. to assess people in a less restrictive environment to 'get the best out of them' – seems hard to understand. A review of his current situation suggests that it would be reasonable to believe that Mr G is already in his 'best' state.

This is likely to be the most significant issue with applying the DTA pathway as specified to psychiatric hospitals, where the clinical task is often about maintaining stability that has been achieved in hospital.

34.14. In sum, it is hard to see why further assessment of Mr G's care needs in a residential setting would be needed at this point. This does not mean to say that Mr G should have stayed at JKL hospital on an open-ended basis, nor that consideration of moving Mr G to a different care setting was itself inappropriate, but there should not have been a need to move him to any short-term funded placement with the inbuilt potential for a further move, particularly given the previous history of extensive movements between services. Any move to a care home should move with a view to long-term relocation. Because of this, more comprehensive care planning should have taken place prior to the point of transfer, including more detailed multidisciplinary and multi-agency collaboration, and involvement of the family.

34.15. Thus, it appears that the CCG's decision to move Mr G under the DTA scheme was not consistent with the purpose of the DTA process, should not necessarily have been considered within a psychiatric hospital, and in any event, was unlikely to provide further information to help onward decision making. This raises the question of whether the decision to fund under DTA was made with Mr G's best interests in mind, a question that is even more pointed when one notes that there was no formalised assessment of Mr G's best interests, apparently at any point, in the transfer of care between JKL and XYZ (see also s.35), and when one considerers the fact that the family expressed objections to the admission to XYZ, including raising concerns about the capacity of XYZ to manage Mr G's behaviour that were unfortunately proved highly accurate in reality.

35. Legislative frameworks including MHA and MCA

Mental Health Act

35.1. There are several observations that must be made of the process of use of the MHA in Mr G's admission to DEF hospital. Firstly, there is little evidence that they had tried or been supported to try behavioural management techniques for responding to Mr G's challenging behaviour. There is not a referenced use of, for example, ABC Charts or other tools of Functional Assessment/Analysis which may well have proved effective options for managing Mr G's behaviour. This runs contrary to a number of forms of clinical guidance, which generally recommend that psychological or behavioural approaches should be considered first. It is acknowledged however that staff in the hospital were likely unequipped or untrained/resourced to be able to respond to such behaviour in this way.

35.2. Second, there is a potential concern about the engagement of Mr G's Nearest Relative (his wife) in the detention process. Section 11(3) and (4) of the Mental Health Act 1983 require the AMHP to consult with the Nearest Relative about the possibility of admission to hospital. The Nearest Relative then has the power to object and indeed block the admission to hospital. Whilst the records from the AMHP note that this occurred ('*MHAA completed on XX Ward, following consultation with Nearest Relative*'), the family, and in particular Mr G's wife, have no recollection of being involved in this process in a meaningful sense. Mr G's wife reported to me that although she remembered being telephoned, she only understood that there was to be an assessment and they were going to '*do some tests*' in regards to Mr G. She was unequivocal that there had been absolutely no mention in this conversation of the possibility of Mr G being admitted to hospital, and was clear that she had no understanding that this related to an assessment under the Mental Health Act.

It is of course impossible for me to reach a definitive resolution to this difference in views and recollections, but this does perhaps, at the very least, suggest that the AMHP did not exhaust possibilities to check understanding of the processes explained to Mr G's wife.

35.3. Third, the conclusion of the assessment necessitated the AMHP to locate an appropriate hospital bed for Mr G. Unfortunately, however, there were no available beds within the Norfolk area and therefore Mr G was transferred to an out of area bed provided by a private hospital provider. The location of this hospital (which will be referred to as DEF hospital) was around 75 miles from where Mr G's family lived. This was noted as particularly difficult by Mr G's daughter, who advised me that her mother and father '*had not been apart for more than a few weeks in 62 years of marriage*'. This has been noted as a broader regional and national issue, with the local mental health trust provider having well publicised problems with access to inpatient beds, and ADASS (Association of Directors of Adult Social Services) has published guidance to directors in the form of an 'Advice note for Directors of Adult Social Services relating to the commissioning of out of area care and support services'.[27]

Mental Capacity Act

35.4. There is a broad concern that a number of decisions in regards to Mr G's care do not appear to be made with any formalised assessment of Mr G's best interests. This includes very serious decisions, including concerning Mr G's residence. Most prominently, it is noted that there did not appear to be any formal consideration of Mr G's best interests in *either* the transfer of care from DEF hospital to JKL hospital or in the transfer of care from JKL hospital to XYZ Care Home. There is little question that Mr G would have lacked capacity to make decisions about his residence at both of these times. Therefore, these decisions could only have been made for and on his behalf in his best interests. As explained in the following two paragraphs, they do not appear to have been:

35.5. In the transfer between DEF and JKL, it appears that this was significantly done to bring Mr G closer to his family members, at this request of his family. However, his family did not hold an LPA so there was no automatic right for them to make any decisions about Mr G's residence. Of course, in considering Mr G's best interests, it would be expected that his family's wishes would have been accounted for. However, this might also have been needed to be considered alongside his relative stability at DEF. This would therefore have been a potentially finely balanced decision.

35.6. In the transfer between JKL and XYZ, the fact there was no best interests meeting or formalised assessment of Mr G's best interests at this time is equally concerning. Again, Mr G's relative stability at JKL should have been balanced against a need for long term stability in his accommodation, which JKL could not ultimately provide. I do believe that it would have been hard to conceptualise a 28-day discharge to XYZ Care Home as being in Mr G's best interests, and it is quite possible that had these been formally reviewed, a different decision would have been reached.

35.7. In addition to these omissions regarding a lack of formalised assessment of Best Interests in decision making about complex issues such as residence, there was also a lack of evidence that best interests were actively considered on a day-to-day basis. For instance, I refer to the example at 22.44.

[27] https://www.adass.org.uk/advice-note-for-directors-of-adult-social-services-relating-to-the-commissioning-of-out-of-area-care-and-support-services

36. Care Co-ordination

36.1. Overall, it appears that there was a lack of any coordination of Mr G's care. In practice, this should have been a role held by a case worker who was known to Mr G and Mr G's family and who had a specific responsibility to liaise with the various involved agencies. The case worker ideally should have remained as part of Mr G's care across different service delivery settings.

37. Involvement of the family

37.1. XYZ reported clearly that as an organisation, they had a difficult relationship with the family, with reports of aggressive and hostile behaviour towards staff members. Concerns about this are recorded within the care records. An allegation of racist behaviour made by XYZ (22.42) is clearly concerning, but this is not noted in the care records clearly at the time, and the family's narrative of events at this point was clearly different. Resolving this specific issue at this point in time is outside the scope of the SAR.

37.2. XYZ felt that the context of the admission of Mr G into XYZ had not helped the family's relationship, in that they had not had the care home they wished agreed in funding. The CCG's records seem to suggest some compromise was reached with the family, but even so one can understand that the funding arrangements may have caused the family to have lowered their expectations of XYZ. Nonetheless, there does appear to have been some basis in reality for the family's concerns, and to this extent there must also be some recognition that seeing the deterioration of Mr G, after being moved out of an environment they were happy with, with a process they had only had limited involvement in, and which didn't seem to objectively consider Mr G's best interests, must have been highly distressing for the family. This does not excuse any inappropriate behaviour on their part, though it may at least partially explain it. Had the care home been effectively able to care for Mr Z, provide for his needs, and manage his challenging behaviour, this may have gone a long way to improving the working relationship with the family.

Practice Recommendations

38. Presentation of Recommendations

38.1. Norfolk Safeguarding Adults Board have adopted a framework for thematic learning during Safeguarding Adult Reviews, with recommendations being presented in one of five categories:

- Professional Curiosity (no specific recommendations are drawn from here, though this is integrated in many of the other recommendations based on the analysis in s.25 and s.33)
- Fora for Discussion and Information Sharing
- Ownership and Accountability: Management Grip
- Collaborative Working and Decision Making
- Manging Risk, Uncertainty and Mental Capacity [this is a theme which underpins all the above themes but specific learning against this theme is derived below]

38.2. These categories are all to be influenced by the Lived Experience of the adult, an overview of which has been specifically included in s.24 for Ms F, and s.32 for Mr G.

38.3. The two SARs have generated a wide range of learning so in order to ensure that implementation of recommendations can be appropriately prioritised, each recommendation has been reviewed by the Independent Author in line with the following table:

Impact: How likely is it that the recommendation, if implemented, would prevent future abuse or neglect, compared to status quo?	Low Likelihood	Moderate Likelihood	High Likelihood
Scope: What is the breadth of scope of potential abuse or neglect that might be prevented if the recommendation was implemented?	Narrow scope	Moderate scope	Broad scope
Resource: What degree of effort or resource is required to implement this recommendation?	High effort	Moderate effort	Low effort
Speed: How quickly could this recommendation be implemented realistically?	Slowly (years)	Moderately (months)	Quickly (Days or weeks)

38.4. Please note, these ratings are not intended to be definitive or rigid, but are provided only to assist the Safeguarding Board with prioritisation of implementation plans. Recommendations with more ratings on the right-hand side would tend to be considered the highest priority for implementation.

39. Recommendations Already Enacted

39.1. Throughout the process of the SAR, there was some feedback that practice changes were implemented directly. Although these recommendations have not been reviewed by the Independent Author, they are noted here:

Recommendation 1 | Reviewing XYZ Admission Processes and Paperwork

39.2. XYZ Care Home reported that they had updated and revised their admission template to improve this and ensure that appropriate historical information was always collected. This is positive. This process should be reviewed by the SAB to ensure that:

- The assessment form is improved to allow greater breadth of clinical information, including more details about past and present risk, previous admissions, other historical factors, daily functioning, and cognitive functioning.
- Processes are in place to clarify how the assessment should be completed and provide a 'bare minimum' in terms of sources of information. This should include an interview with the patient, and interview with any involved staff and family members, GP records, and any relevant hospital and social care records.
- Audit processes are then completed to check compliance against the standards, which could then be reviewed by the QA Team in Social Care, or potentially by the regulator the CQC.

Recommendation 1: Reviewing XYZ Admission Processes and Paperwork

Impact: How likely is it that the recommendation, if implemented, would prevent future abuse or neglect, compared to status quo?	Low Likelihood	Moderate Likelihood	**High Likelihood**
Scope: What is the breadth of scope of potential abuse or neglect that might be prevented if the recommendation was implemented?	Narrow scope	Moderate scope	**Broad scope**
Resource: What degree of effort or resource is required to implement this recommendation?	High effort	**Moderate effort**	Low effort
Speed: How quickly could this recommendation be implemented realistically?	Slowly (years)	**Moderately (months)**	Quickly (Days or weeks)

39.3. In addition, the Head of Service for safeguarding has advised that evidence where individuals deviated from practice recommendations about recording safeguarding incidents against both a victim and a perpetrator will be followed up with an appropriate line manager.

39.4. Whilst not a deliberately enacted recommendation, it is noted that concerns about the safeguarding records system (LAS/CareFirst) have been reduced through the passage of time.

40. Recommendations: Fora for Discussion and Information Sharing

Recommendation 2 | 'Minimum Assessment Standards' for admissions to care homes

40.1. Norfolk County Council's Adult Social Care should set out 'minimum standards for assessment' for admissions to care homes, applying the principles in Recommendation 1 more generally across the county.

40.2. This should include a question to check whether a carer's assessment is offered to involved family members, particularly for privately funded clients, who otherwise may not have a formal means of connection to statutory services

Recommendation 2: 'Minimum Assessment Standards' for admissions to care homes

Impact: How likely is it that the recommendation, if implemented, would prevent future abuse or neglect, compared to status quo?	Low Likelihood	Moderate Likelihood	**High Likelihood**
Scope: What is the breadth of scope of potential abuse or neglect that might be prevented if the recommendation was implemented?	Narrow scope	Moderate scope	**Broad scope**
Resource: What degree of effort or resource is required to implement this recommendation?	**High effort**	Moderate effort	Low effort
Speed: How quickly could this recommendation be implemented realistically?	Slowly (years)	**Moderately (months)**	Quickly (Days or weeks)

Recommendation 3 | Care Coordination

40.3. The care experience of both Ms F and Mr G would have been improved had there been a central person coordinating their care. The SAB should meet with commissioners to review whether this is possible within existing frameworks or whether this needs further resources, funding, or new processes.

40.4. It is acknowledged that meeting this recommendation will be difficult or even impossible if a person is not receiving care from statutory services.

Recommendation 3: Care Coordination

Impact: How likely is it that the recommendation, if implemented, would prevent future abuse or neglect, compared to status quo?	Low Likelihood	Moderate Likelihood	**High Likelihood**
Scope: What is the breadth of scope of potential abuse or neglect that might be prevented if the recommendation was implemented?	Narrow scope	Moderate scope	**Broad scope**
Resource: What degree of effort or resource is required to implement this recommendation?	**High effort**	Moderate effort	Low effort
Speed: How quickly could this recommendation be implemented realistically?	**Slowly (years)**	Moderately (months)	Quickly (Days or weeks)

41. Recommendations: Ownership and Accountability: Management Grip

Recommendation 4 | AMHP Involvement of Nearest Relative (Mr G)

41.1. The SAB should request evidence that the practice in regards to the involvement of the Nearest Relative by the AMHP in Mr G's detention is reviewed by the appropriate line manager.

Recommendation 4: AMHP Involvement of Nearest Relative (Mr G)

Impact: How likely is it that the recommendation, if implemented, would prevent future abuse or neglect, compared to status quo?	Low Likelihood	**Moderate Likelihood**	High Likelihood
Scope: What is the breadth of scope of potential abuse or neglect that might be prevented if the recommendation was implemented?	**Narrow scope**	Moderate scope	Broad scope
Resource: What degree of effort or resource is required to implement this recommendation?	High effort	Moderate effort	**Low effort**
Speed: How quickly could this recommendation be implemented realistically?	Slowly (years)	Moderately (months)	**Quickly (Days or weeks)**

Recommendation 5 | AMHP Paperwork Process (Mr Z)

41.2 The SAB should request that the appropriate line manager reviews practice in regards to the AMHP's apparent failure to leave an AMHP(3) form at the XYZ care home for the secure ambulance service, thus resulting in the secure ambulance provider not having the necessary authority to transfer Mr Z to JKL hospital. NSAB should have requested confirmation of this practice review within **3 months** of acceptance of the report. This recommendation could further be generalised to learning for AMHPs across the county on the process and local paperwork.

Recommendation 5: AMHP Paperwork Process (Mr Z)

Impact: How likely is it that the recommendation, if implemented, would prevent future abuse or neglect, compared to status quo?	Low Likelihood	**Moderate Likelihood**	High Likelihood
Scope: What is the breadth of scope of potential abuse or neglect that might be prevented if the recommendation was implemented?	**Narrow scope**	Moderate scope	Broad scope
Resource: What degree of effort or resource is required to implement this recommendation?	High effort	Moderate effort	**Low effort**
Speed: How quickly could this recommendation be implemented realistically?	Slowly (years)	Moderately (months)	**Quickly (Days or weeks)**

42. Recommendations: Collaborative Working and Decision Making

Recommendation 6 | 'Shadowing/observation' of care prior to admission

42.1. XYZ themselves suggested that one potential improvement would be for the care home to take up a shadowing or observation opportunity alongside staff within the discharging hospital prior to admission. Whilst this cannot replace the need for the detailed assessment above, this is an excellent suggestion, and in turn allows the patient an opportunity to familiarise themselves with care staff in their new home.

42.2. For care home placements funded by the local authority or CHC where complex care needs are identified, this could be implemented through amending the funding contract to set a requirement for staff from the receiving care home to spend time shadowing or observing staff in the discharging hospital prior to admission. Evidence of this action is recorded in the admission paperwork. For care home placements funded privately, this could be implemented through a wider quality standard for care homes set by the QA Team in the Local Authority, or made as a strong recommendation to care homes.

Recommendation 6: 'Shadowing/observation' of care prior to admission

Impact: How likely is it that the recommendation, if implemented, would prevent future abuse or neglect, compared to status quo?	Low Likelihood	**Moderate Likelihood**	High Likelihood
Scope: What is the breadth of scope of potential abuse or neglect that might be prevented if the recommendation was implemented?	Narrow scope	Moderate scope	**Broad scope**
Resource: What degree of effort or resource is required to implement this recommendation?	**High effort**	Moderate effort	Low effort
Speed: How quickly could this recommendation be implemented realistically?	Slowly (years)	**Moderately (months)**	Quickly (Days or weeks)

Recommendation 7 | Review Process for Continuing Healthcare and application of DTA process

42.3. Norfolk's Clinical Commissioning Groups, the Norfolk Continuing Care Partnership, and Local Authority including leads within NCC Adult Social Services should consider ways to develop understanding and knowledge of the Continuing Healthcare process, particularly within psychiatric hospitals. This communication process should also highlight the requirement of multi-agency best-interests meetings occurring prior to discharge under Continuing Healthcare, for clients who lack capacity to make decisions about their residence, as well as the non-applicability of the DTA process in the psychiatric setting.

42.4. It is noted that feedback from the CCG as part of the SARP was that practice changes had already taken place which would reduce the likelihood of clients inappropriately being assigned to the DTA pathway.

Recommendation 7: Review Process for Continuing Healthcare and application of DTA process

Impact: How likely is it that the recommendation, if implemented, would prevent future abuse or neglect, compared to status quo?	Low Likelihood	**Moderate Likelihood**	High Likelihood
Scope: What is the breadth of scope of potential abuse or neglect that might be prevented if the recommendation was implemented?	Narrow scope	Moderate scope	**Broad scope**
Resource: What degree of effort or resource is required to implement this recommendation?	High effort	**Moderate effort**	Low effort
Speed: How quickly could this recommendation be implemented realistically?	Slowly (years)	**Moderately (months)**	Quickly (Days or weeks)

Recommendation 8 | Meeting or Forum between Care Homes and DIST

42.5. DIST should consider setting up meetings or forums with Care Homes where it has regular working relationships, and particularly in cases where those relationships could be improved. DIST may consider other possibilities for developing more effective relationships with care homes, for instance through 'link workers' that are identified with a particular 'set' or group of homes. The purpose of these meetings should be to build relationships, clarify expectations about DIST service provision, review and discuss the use and purpose of the MHA, as well as clarify methods of communication. A specific recommendation is made for a meeting or forum between XYZ and DIST, which could also incorporate wider involvement from Continuing Healthcare.

Recommendation 8: Meeting or Forum between Care Homes and DIST

Impact: How likely is it that the recommendation, if implemented, would prevent future abuse or neglect, compared to status quo?	Low Likelihood	**Moderate Likelihood**	High Likelihood
Scope: What is the breadth of scope of potential abuse or neglect that might be prevented if the recommendation was implemented?	Narrow scope	**Moderate scope**	Broad scope
Resource: What degree of effort or resource is required to implement this recommendation?	High effort	**Moderate effort**	Low effort
Speed: How quickly could this recommendation be implemented realistically?	Slowly (years)	**Moderately (months)**	Quickly (Days or weeks)

Recommendation 9| Discharge from DIST to the CMHT

42.6 The local mental health trust should review why DIST did not discharge or plan to discharge Mr Z to the CMHT, and instead planned to discharge him to the GP. This issue may need to be discussed at a more strategic level, either with senior trust management, CCGs, or the STP. The review should include a focus on why DIST did not make other agencies aware of their decision and rationale for discharge.

42.7 The SARP reflected that an important component of this relates to the broader process for discharging clients, ensuring a clear rationale is always provided, and risk is considered and documented in a transparent way.

Recommendation 9: Discharge from DIST to the CMHT

Impact: How likely is it that the recommendation, if implemented, would prevent future abuse or neglect, compared to status quo?	Low Likelihood	**Moderate Likelihood**	High Likelihood
Scope: What is the breadth of scope of potential abuse or neglect that might be prevented if the recommendation was implemented?	**Narrow scope**	Moderate scope	Broad scope
Resource: What degree of effort or resource is required to implement this recommendation?	High effort	Moderate effort	**Low effort***
Speed: How quickly could this recommendation be implemented realistically?	Slowly (years)	Moderately (months)	**Quickly (Days or weeks)***

* The review could be carried out quickly but actions from this review may require more time or more effort.

43. Recommendations: Managing Risk, Uncertainty and Mental Capacity (Training Needs and Knowledge Gaps)

Recommendation 10 | MCA Training in Care Homes

43.1 The present review acknowledges that there were widespread gaps in practice in applying principles of the Mental Capacity Act. Yet, it is acknowledged that training in the MCA is a core legal requirement for all care homes. Thus, there is a need to review the effectiveness of training provided to ensure that learning and knowledge development is appropriately translated into practice. This should ensure that all Norfolk Care Homes are delivering training in the MCA which considers, as a minimum:

- Awareness of professional responsibilities to make decisions for and on behalf of patients who lack capacity to make those decisions
- How capacity is to be assessed in relation to those decisions
- How to assess Best Interests
- How an LPA allows the deputy to make decisions for and on behalf of the person, and why it is important to know which residents have an LPA.
- That family members without an LPA cannot make decisions for and on behalf of a patient or resident who lacks capacity.

Recommendation 10: MCA Training in Care Homes

Impact: How likely is it that the recommendation, if implemented, would prevent future abuse or neglect, compared to status quo?	Low Likelihood	Moderate Likelihood	**High Likelihood**
Scope: What is the breadth of scope of potential abuse or neglect that might be prevented if the recommendation was implemented?	Narrow scope	Moderate scope	**Broad scope**
Resource: What degree of effort or resource is required to implement this recommendation?	High effort	**Moderate effort***	Low effort
Speed: How quickly could this recommendation be implemented realistically?	Slowly (years)	**Moderately (months)***	Quickly (Days or weeks)

* The complexity of implementing this recommendation depends upon the extent to which such training is already provided.

Recommendation 11| Moving away from a 'medication-first' approach to challenging behaviour

43.2 The CCG in partnership with Norfolk Adult Social Care and other involved agencies should review the ability of the wider clinical and care system to respond to guidance that challenging behaviour should be understood primarily through a behavioural/functional/psychological approach. This should include consideration of recommendations which have de-emphasised the role of using psychotropic medication as a first-line approach to the management of challenging behaviour. This will mean that services will need to be supported in the development and use of data, which is meaningfully recorded, but also the development of tailored, comprehensive management plans which are rigorously followed within the care team. It also requires appropriate training of staff in wider skills such as de-escalation, as well as relevant additional specialist workplace resource to support this process.

43.3 It may be possible for this recommendation to be included in wider work in the county which is developing in this area, for instance wider developments in NCC to implement principles of Positive Behaviour Support (PBS) in Learning Disability services.

Recommendation 11: Moving away from a 'medication-first' approach to challenging behaviour

Impact: How likely is it that the recommendation, if implemented, would prevent future abuse or neglect, compared to status quo?	Low Likelihood	Moderate Likelihood	**High Likelihood**
Scope: What is the breadth of scope of potential abuse or neglect that might be prevented if the recommendation was implemented?	Narrow scope	Moderate scope	**Broad scope**
Resource: What degree of effort or resource is required to implement this recommendation?	**High effort**	Moderate effort	Low effort
Speed: How quickly could this recommendation be implemented realistically?	Slowly (years)	**Moderately (months)**	Quickly (Days or weeks)

Recommendation 12 | AMHP Resourcing and Response Time Review

43.4 NSAB should seek assurance from the local authority on average response times from the AMHP service to determine if these typically fall within the requirements of the Code of Practice. This may require the local AMHP policies to develop specific standards about expected response times. A wider lack of AMHPs may have resourcing implications which would then need to be separately explored.

43.5 It must be acknowledged that this issue relates to wider issues including an acknowledged national shortage of AMHPs and also s.12 doctors. This national shortage is reflected regionally. If staffing is not sufficient, then it may be that the focus of this recommendation should be to set and manage expectations of professionals and public in regards to the timeliness of the AMHP response.

Recommendation 12: AMHP Resourcing and Response Time Review

Impact: How likely is it that the recommendation, if implemented, would prevent future abuse or neglect, compared to status quo?	Low Likelihood	Moderate Likelihood	**High Likelihood***
Scope: What is the breadth of scope of potential abuse or neglect that might be prevented if the recommendation was implemented?	Narrow scope	**Moderate scope**	Broad scope
Resource: What degree of effort or resource is required to implement this recommendation?	**High effort**	**Moderate effort**	**Low effort***
Speed: How quickly could this recommendation be implemented realistically?	**Slowly (years)**	**Moderately (months)**	**Quickly (Days or weeks)***

* The complexity of implementing this recommendation depends upon whether a resource issue with provision of AMHPs is identified. If it is, this will necessarily increase cost and complexity.

Recommendation 13 | AMHP Resourcing and Response Time Review

43.6 There is a need for care homes such as XYZ to improve their knowledge and skills in working clinically with dementia. The QA Team at Norfolk Adult Social Care should review provision of training and use of clinical models in Norfolk Care Homes for dementia. It should be a basic expectation that dementia care homes are appropriately skilled in the management and care of clients with dementia. Specific models such as Dementia Care Mapping may be considered for adoption.

43.7 It is acknowledged that appropriate training and skills in this area already forms part of core commissioning requirements for care homes. It may be, therefore, that the first task is to review the existing knowledge base in care homes and identify gaps in learning.

Recommendation 13: Dementia Training and Specialist Dementia Care Models

Impact: How likely is it that the recommendation, if implemented, would prevent future abuse or neglect, compared to status quo?	Low Likelihood	Moderate Likelihood	**High Likelihood**
Scope: What is the breadth of scope of potential abuse or neglect that might be prevented if the recommendation was implemented?	Narrow scope	Moderate scope	**Broad scope**
Resource: What degree of effort or resource is required to implement this recommendation?	**High effort**	Moderate effort	Low effort
Speed: How quickly could this recommendation be implemented realistically?	Slowly (years)	**Moderately (months)**	Quickly (Days or weeks)

44. Recommendations: Managing Risk, Uncertainty and Mental Capacity (Practice Recommendations)

Recommendation 14 | Review of Secure Ambulance Provision

44.1. The SAB should request evidence, **within a timescale of no more than six months from the acceptance of this report**, from the relevant partners that a review is conducted of provision for secure ambulances across Norfolk. Having a non-contractual arrangement where ambulance provision is requested on an ad-hoc basis means that the AMHP service is inherently at risk of departures from expected MHA Code of Practice standards without 'cogent reasons'. This is because the secure ambulance service can refuse conveyance without leaving the AMHP any recourse to an alternative arrangement. If AMHPs expect secure ambulances to be unavailable, it may also mean that AMHPs are more likely to request a non-secure ambulance for a situation that requires secure conveyance.

44.2. Block contracts with specific providers may resolve this problem. If ad-hoc commissioning continues to be used, the CCG or Local Authority should ensure that potential providers agree to a set of 'minimum standards' regarding response times and agreed practice requirements. Audit mechanisms should mean that providers who fail to meet these standards are no longer used.

44.3. The SARP wished to acknowledge the practical difficulties in implementing this recommendation, including the significant costs and resources that would be associated with its implementation. However, for the reasons above, it is stressed that analysis of demand to understand this need must be more complex than simply reviewing current usage.

Recommendation 14: Review of Secure Ambulance Provision

Impact: How likely is it that the recommendation, if implemented, would prevent future abuse or neglect, compared to status quo?	Low Likelihood	Moderate Likelihood	**High Likelihood**
Scope: What is the breadth of scope of potential abuse or neglect that might be prevented if the recommendation was implemented?	Narrow scope	Moderate scope	**Broad scope**
Resource: What degree of effort or resource is required to implement this recommendation?	High effort	**Moderate effort**	Low effort
Speed: How quickly could this recommendation be implemented realistically?	Slowly (years)	**Moderately (months)**	Quickly (Days or weeks)

Recommendation 15 | Reducing Out of Area Placements under MHA

44.4. **Within a timescale of no more than six months from the acceptance of this report**, the relevant NHS Provider, CCG and STP (Sustainability and Transformation Partnership) should urgently review strategies to reduce out-of-area admissions. This report is then to be shared with the Norfolk Safeguarding Adults Board. It is common public knowledge that the involved NHS provider organisation has experienced long-term significant adverse media attention already about this matter. Mr G's case is a tragic reminder of the human impact of the inability to identify long-term solutions to this problem.

44.5. The SARP wished to acknowledge recent news that additional bed capacity was being developed in Norfolk following additional central government funding. This is positive. The SARP wished to recommend however that the capacity specifically for older adult psychiatric care and, in conjunction with Recommendation 16, older adult low-secure psychiatric care, was reviewed.

Recommendation 15: Reducing Out of Area Placements under MHA

Impact: How likely is it that the recommendation, if implemented, would prevent future abuse or neglect, compared to status quo?	Low Likelihood	Moderate Likelihood	**High Likelihood**
Scope: What is the breadth of scope of potential abuse or neglect that might be prevented if the recommendation was implemented?	Narrow scope	Moderate scope	**Broad scope**
Resource: What degree of effort or resource is required to implement this recommendation?	**High effort***	Moderate effort	Low effort
Speed: How quickly could this recommendation be implemented realistically?	**Slowly (years)***	**Moderately (months)**	Quickly (Days or weeks)

* Whilst resourcing may well take a long time to develop, a strategy to solve it should be developed much sooner.

Recommendation 16 | Secure Beds for people with neurodegenerative conditions

44.6. NSAB should engage with NHS England / Improvement (NHSE/I) about the intentions to develop provision for low-secure beds for patients with neurodegenerative conditions. NSAB should seek the support of the STP and/or CCGs in developing a system-wide perspective to be raised with NHSE/I.

Recommendation 16: Secure Beds for people with neurodegenerative conditions

Impact: How likely is it that the recommendation, if implemented, would prevent future abuse or neglect, compared to status quo?	Low Likelihood	Moderate Likelihood	**High Likelihood**
Scope: What is the breadth of scope of potential abuse or neglect that might be prevented if the recommendation was implemented?	Narrow scope	Moderate scope	**Broad scope**
Resource: What degree of effort or resource is required to implement this recommendation?	**High effort***	Moderate effort	Low effort
Speed: How quickly could this recommendation be implemented realistically?	**Slowly (years)***	**Moderately (months)**	Quickly (Days or weeks)

* Whilst the resourcing may well take a long time to develop, a review of the demand/need should and could be completed much sooner.

Recommendation 17 | Best Interest Decision meetings at the point of discharge

44.7. All Norfolk Inpatient hospitals, **and any private hospitals outside the region used by local commissioners (specifically including JKL and GHI hospitals in the present case),** should review their policies for carrying out Best Interest Assessment meetings at the point of discharge. For patients placed out of area, the decision to move a patient back to the local region can be seen as the 'default' plan, and whilst this may usually be a decision in a patient's best interests, it is not necessarily so. In all such cases, if a patient lacks capacity to make decisions about their residence, a Best Interests meeting should be carried out to consider how best to make this decision for and on behalf of the patient. All such hospitals included in the scope of this recommendation should provide evidence of their review and any actions taken back to the CCG Safeguarding Adults team. The CCG Safeguarding Adults team should then provide assurance back to NSAB.

Recommendation 17: Best Interest Decision meetings at the point of discharge

Impact: How likely is it that the recommendation, if implemented, would prevent future abuse or neglect, compared to status quo?	Low Likelihood	Moderate Likelihood	**High Likelihood**
Scope: What is the breadth of scope of potential abuse or neglect that might be prevented if the recommendation was implemented?	Narrow scope	Moderate scope	**Broad scope**
Resource: What degree of effort or resource is required to implement this recommendation?	High effort*	**Moderate effort**	Low effort
Speed: How quickly could this recommendation be implemented realistically?	Slowly (years)*	**Moderately (months)**	Quickly (Days or weeks)

Recommendation 18 | Review of safeguarding processes to ensure availability of contextual information

44.8. NCC Adult Social Care Safeguarding team in conjunction with other teams should review the processes and practice for making and responding to safeguarding referrals in Norfolk care homes. This should include consideration of the following questions:

- Can improvements be made to ensure that relevant historical information is always captured when a violent incident is reported? (to avoid incidents being incorrectly captured as 'one off')
- Can improvements be made to the process to ensure that it is clear which agencies are involved, and automated processes for updating involved agencies considered?
- Can safeguarding processes automatically trigger a referral to ASC if a previously unknown patient (e.g. a privately funded client) is referred as the subject of a safeguarding referral?
- Can processes be improved such that the police are able to appropriately record all incidents which are crimes? This process may need to be reviewed alongside the volume of incidents occurring in a given context, as well as the potential reluctance of clinicians to report behaviour as a formal crime.
- Are safeguarding practitioners adequately considering the extent to which a risk management plan will mitigate risk? (e.g. 1:1 observations, as considered in the present report)
- Is there value in a standardised written form be used for making safeguarding referrals?

44.9. The emphasis on the above should be about ensuring that appropriate contextual information about safeguarding incidents is readily available to the safeguarding team when incidents are reported.

Recommendation 18: Review of safeguarding processes to ensure availability of contextual information

Impact: How likely is it that the recommendation, if implemented, would prevent future abuse or neglect, compared to status quo?	Low Likelihood	Moderate Likelihood	**High Likelihood**
Scope: What is the breadth of scope of potential abuse or neglect that might be prevented if the recommendation was implemented?	Narrow scope	Moderate scope	**Broad scope**
Resource: What degree of effort or resource is required to implement this recommendation?	High effort*	**Moderate effort**	Low effort
Speed: How quickly could this recommendation be implemented realistically?	Slowly (years)*	**Moderately (months)**	Quickly (Days or weeks)

Recommendation 19 | DIST Review of Safeguarding Reporting Processes

44.10. The DIST team within the local mental health trust should review their safeguarding practice in relation to expression of concerns that a care home cannot safely manage a patient. If DIST do form such a view, this should be followed up with a safeguarding referral.

Recommendation 19: DIST Review of Safeguarding Reporting Processes

Impact: How likely is it that the recommendation, if implemented, would prevent future abuse or neglect, compared to status quo?	Low Likelihood	Moderate Likelihood	**High Likelihood**
Scope: What is the breadth of scope of potential abuse or neglect that might be prevented if the recommendation was implemented?	**Narrow scope**	Moderate scope	Broad scope
Resource: What degree of effort or resource is required to implement this recommendation?	High effort*	Moderate effort	**Low effort**
Speed: How quickly could this recommendation be implemented realistically?	Slowly (years)*	Moderately (months)	**Quickly (Days or weeks)**

Recommendation 20 | Improving XYZ Processes for Incident Reporting and Use of Recorded Information

44.11. Norfolk County Council QA Team must ensure that XYZ Care Home review their processes for recording incidents of violence. This must consider not only whether such incidents are routinely recorded, but also the quality of information (in regards to antecedents and consequences) that is included. The review must also consider the extent to which such data is meaningfully used in incidents where challenging behaviour is present. XYZ must provide the QA Team with assurance explaining how it has achieved this and implemented this into practice. The SAB may wish to review whether the this can be applied more widely to other care homes in the county, region or country.

44.12. XYZ wished to note that they had already made improvements in this regard, and so this recommendation may already be judged as being met following review by the QA Team.

Recommendation 20: Improving XYZ Processes for Incident Reporting and Use of Recorded Information

Impact: How likely is it that the recommendation, if implemented, would prevent future abuse or neglect, compared to status quo?	Low Likelihood	Moderate Likelihood	**High Likelihood**
Scope: What is the breadth of scope of potential abuse or neglect that might be prevented if the recommendation was implemented?	Narrow scope	**Moderate scope**	Broad scope
Resource: What degree of effort or resource is required to implement this recommendation?	High effort*	**Moderate effort**	Low effort
Speed: How quickly could this recommendation be implemented realistically?	Slowly (years)*	**Moderately (months)**	Quickly (Days or weeks)

Recommendation 21 | Improving XYZ Processes for Clinical Risk Assessment

44.13. The QA Team should ensure that XYZ leads a review into its processes in regards to clinical risk assessment. This review should consider whether the currently established processes are able to satisfactorily and comprehensively assess risks, including the risk of violence. The policy should ensure that risk assessments are appropriately updated, both in regards to important trigger incidents and at regular intervals subsequently. The complexity of the risk assessment should reflect the nature of the potential risks being assessed. Assurance should be provided to the SAB (which may be delegated via the QA team) as to how this has been achieved. Subsequently, XYZ Care Home should then review compliance with the completion of these risk assessments through retrospective audit and provide assurance to the QA team on a regular basis.

44.14. XYZ Care home reported that this recommendation was already enacted and so may simply require further review by the QA Team for assurance.

Recommendation 21:

Impact: How likely is it that the recommendation, if implemented, would prevent future abuse or neglect, compared to status quo?	Low Likelihood	Moderate Likelihood	**High Likelihood**
Scope: What is the breadth of scope of potential abuse or neglect that might be prevented if the recommendation was implemented?	Narrow scope	**Moderate scope**	Broad scope
Resource: What degree of effort or resource is required to implement this recommendation?	High effort*	**Moderate effort**	Low effort
Speed: How quickly could this recommendation be implemented realistically?	Slowly (years)*	**Moderately (months)**	Quickly (Days or weeks)

Report written by:

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Appendix 1: Table of Incidents (Mr Z – SAR F)

This table includes all incidents of violence, or potential violence, recorded where Mr Z was the perpetrator. Incidents are included where the incident was clearly violent, had the potential to be violent, or where the recording is ambiguous but suggests violence was possible.

This table does not include:

- incidents of shouting or verbal abuse unless a threat of violence is recorded or implied (e.g. aggression)
- incidents of property damage unless violence is also present or implied (e.g. throwing object at somebody)

Colours denote victim type:
Red – residents
Blue – staff
Purple – relatives/carers

Please note that a 'No' in the 'Recorded by Safeguarding' column is not meant to reflect a view or opinion that the incident should necessarily have been reported to safeguarding, but to allow easier triangulation of incidents – please see commentary in main text.

Date of incident	Brief nature of incident and victim	Recorded by XYZ in Mr Z's…?			Recorded by Safeguarding?
		Behaviour chart	Incident Form	Care Record	
16th June 2017	Walking down corridor exposing himself to a female resident (x2)	Yes	No	No	No
16th June 2017	When approached started hitting and shouting physical abuse at carers	Yes	No	No	No – staff only
18th June 2017	Punched carer in side during personal care	Yes	No	No	No – staff only
19th June 2017	Exposing self to other residents When challenged raised his hand towards staff	Yes	No	No	No
17th July 2017	Became very aggressive during personal care (hit carer on arm, threatened again)	Yes	No	No	No – staff only
21st July 2017	Raised both fists and threatened to punch staff	Yes	No	No	No – staff only
23rd July 2017	'Entered another's room and shouted abuse at resident' (recorded here as 'made resident unsettled')	Yes	No	No	No
24th July 2017	Pushed staff member and raised fists	Yes	No	No	No – staff only
25th July 2017	Threw plate of biscuits across room narrowly missing another resident	Yes	No	No	No
26th July 2017	Pushed the team leader	Yes	No		No – staff only
27th July 2017	Shouted abuse towards relative and 'headed towards the relative with aggression'	Yes	No	No	No – visitor only
30th July 2017	Shouted at staff member putting away laundry and pointed finger in her face	Yes	No	No	No – staff only
31st July 2017	During toileting started hitting out at two staff	Yes	No	No	No – staff only
2nd August 2017	Threw chocolate back at staff member's face, threatened to hit staff member	Yes	No	No	No – staff only
5th August 2017	Slapped female resident towards face, but resident managed to put hand in way (not Ms F)	Yes	No	Yes	Yes, but recorded by safeguarding team only under the victim not perpetrator
12th August 2017	Hit Ms F in the face Accident/Incident record suggests a resident with the same first name as Mr Z may have perpetrated this incident (this is unclear)	No	No (Victim-yes)	Referred to	Yes
22nd August 2017	Threw a bowl of pudding across lounge towards a care assistant	Yes	No	No	No – staff only
2nd September	Shouting at residents (recorded here as residents reported to be terrified)	Yes	No	No	No
12th September 2017	Slapped male resident across the face	Yes	Yes	Yes	Yes, comprehensively.
17th September	Reported to be 'charging' at three staff members	Yes	No	No	No – staff only

Date of incident	Brief nature of incident and victim	Recorded by XYZ in Mr Z's…?			Recorded by Safeguarding?
		Behaviour chart	Incident Form	Care Record	
27th September 2017	Slapped female resident in the face causing them to fall	Yes	No	Yes	No – does not appear to be reported by care home
28th September 2017	Standing in corridor shouting and punching doors (recorded here as residents reported to be scared)	Yes	Yes	No	No
30th September	Reported to be 'charging' at carer clenching fist Hit carer over back of the head Threw a punch at a carer	Yes	No		No – staff only
24th October 2017	Physically threatened another resident during meal	Yes	No	No	No
25th October 2017	Tried to slap ?nurse around face whilst receiving flu jab	Yes	No	No	No – staff only
31st October 2017	Entered another resident's room, tried to throw belongings at the other resident	Yes	No	No	No
5th November 2017	Grabbed team leader's arm, 'swing it with force away from him'	Yes	No	No	No – staff only
8th November 2017	Hit carer during personal care causing her to fall backwards and bang head	Yes	No	Yes	No – staff only
13th November 2017	Female resident (not Ms F), grabbed both arms and pushed her over	No	Yes	Yes	Yes, leading to formal safeguarding referral (but in respect of the victim)
16th November 2017	Ms F was slapped on forehead (Mr Z also had scratches on his arm)	No	Yes (3 days after)	Yes	Yes (apparently 3 days after incident (20.11.17))
19th November 2017	Followed care worker into lounge threatening to catch and hit her	Yes	No	Yes	No – staff only
20th November 2017	Walked towards team leader, hit twice on the arm, aimed for the head (but blocked by staff member)	Yes	Yes	Yes	No – staff only
21st November 2017	'attempted to go after staff' (included as ambiguous)	No	No	Yes	No – staff only
23rd November 2017	Entered resident's room who then started to call for help Aggressive to staff member and hit staff member in left arm (Same incident)	Yes	Yes	Yes	No
27th November 2017	Hit care worker on right arm during personal care	Yes	Yes	Yes	No – staff only
29th November 2017	Attempted to hit care worker several times during personal care	Yes	No	No	No – staff only
2nd December 2017	Female resident (not Ms F) slapped on face	Yes	Yes	Yes	Yes
3rd December 2017	Threw wooden butterfly figure at staff	Yes	No	No	No – staff only
4th December 2017	Reports of resident reporting being scared by Mr Z shouting at her	Yes	No	No	No
4th December 2017	Female resident (not Ms F) slapped on face	Yes	Yes	Yes	Clinical records indicate this was recorded by safeguarding in the victim's name. Reported safeguarding make contact with home following day 5th December.

Date of incident	Brief nature of incident and victim	Recorded by XYZ in Mr Z's…?			Recorded by Safeguarding?
		Behaviour chart	Incident Form	Care Record	
4th December 2017	Grabbed hand and attempted to pull down another female resident	Yes	No	No	Not clear
6th December 2017	Walked into resident's bedroom shouting whilst sleeping 'this scared her'	Yes	No	No	No
10th December 2017	Unknown. Documented in incident report form 'I witnessed situation I need to report to SOVA team. For more information please see statements in Manager office'	No	Yes	No	Reported that safeguarding team was contacted same day
11th December 2017	'Tried to hit one of the staff members', had been in bedroom with wife, wife in tears	No	No	Yes	No – staff only
13th December 2017	Punched carer on left shoulder	No	Yes	No	No – staff only
14th December 2017	Ms F was slapped on face after Mr Z entered her room	Yes	Yes	Yes	Yes, comprehensively. Case assigned to Western Locality Team for follow up.
15th December 2017	Male resident was slapped on face, glasses broken. Resident reported slapped 5 times.	No	Yes	Yes	Reported in care record that this was reported to safeguarding and in incident form EDT
16th December 2017	Raised fist at carer during personal care	Yes	No	No	No – staff only
17th December 2017	Raised fist at carer during another resident's personal care	Yes	No	Yes	No – staff only
18th December 2017	Raised hand to hit carer (x2)	Yes	No	No	No – staff only

Abbreviations Used in this report:

ABC Charts – Antecedent, Behaviour, Consequence Charts

AMHP – Approved Mental Health Professional

CCG – Clinical Commissioning Group

CHC – Continuing Healthcare

CMHT – Community Mental Health Team

CQC – Care Quality Commission

DIST – Dementia Intensive Support Team

DOLS – Deprivation of Liberty Safeguards

DST – Decision Support Tool

DTA – Discharge to Assess

EMI – Elderly Mentally Infirm

LPA – Lasting Power of Attorney

MASH – Multi Agency Safeguarding Hub

MCA – Mental Capacity Act 2005

MHA – Mental Health Act 1983

MHAA – Mental Health Act Assessment

NCC – Norfolk County Council

NICE – National Institute for Health and Care Excellence

NSAB – Norfolk Safeguarding Adults Board

QA Team – Quality Assurance Team

SAR – Safeguarding Adult Review

SARP – Safeguarding Adult Review Panel

UTI – Urinary Tract Infection

Fractured Neck of Femur (Broken Hip)

[Information taken from Plymouth Hospitals NHS trust information leaflet: https://www.plymouthhospitals.nhs.uk/what-is-a-fracture-neck-of-femur]

Fractured neck of femur (broken hip) is a serious injury, especially in older people. It is likely to be life changing and for some people life threatening. It occurs when the top part of the femur (leg bone) is broken, just below the ball and socket joint.

There are two main types of hip fracture, intracapsular and extracapsular.

Intracapsular Fracture

In this injury the ball on the top of the femur has broken off at its junction with the neck of the upper thigh bone, within the hip joint.

Occasionally, it is possible to re-attach the ball, but it is usually removed and replaced with half a hip replacement (called a hip hemiarthroplasty) or a total hip replacement, if appropriate.

Extracapsular Fracture

This break is further down the femur, outside the hip joint and is fixed using metal work. The surgeon will explain which type of fracture you have.

Sepsis

[Information taken from NICE Guidance 'What is Sepsis' https://www.nice.org.uk/guidance/ng51/ifp/chapter/What-is-sepsis]

Sepsis is a rare but serious reaction to an infection. If you get an infection, your body's immune system responds by trying to fight it. Sepsis is when this immune system response becomes overactive and starts to cause damage to the body itself.

It can be hard to tell if you have sepsis. You might not even have a fever or high temperature, you may just feel very unwell.

Sepsis needs to be treated urgently because it can quickly get worse and lead to septic shock. Septic shock is very serious, as it can cause organ failure and death.

Anyone with an infection can get sepsis. But some people have a higher chance of getting it than others.

Discharge to Assess (DTA Process/Pathway)

The Discharge to Assess (DTA) process has been developed to address the problem of assessing long-term care needs within an acute setting. It is recognised that assessing people outside a familiar or safe community environment (e.g. the person's home, or another residential or community setting), and specifically in an acute hospital, is likely to contribute to poor decision making around long-term care needs. The DTA pathway therefore provides 28 days of funding for a person with potential long-term care needs to be discharged to a community setting and consequently have their care needs fully assessed in a more familiar and less restrictive environment.