SAFEGUARDING ADULT REVIEW

PERSON 1

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MARIA DUNMORE GRAY
Independent Overview Report Author

Edited and Reviewed by Deborah Stuart-Angus
Independent Safeguarding Adult Review Chair

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1 Introduction

1.1 Overview of the circumstances leading to this review.

On 11th June 2016, a 92-year-old woman with 'end stage' dementia was reported to police as being subject to a violent physical assault in her room at a residential care home, whilst she was in bed and unable to mobilise. For the purposes of protecting her anonymity and in consultation with her family, this Safeguarding Adult Review, (where here forwards will be referred to as the SAR) will refer to her as P1. Police reports documented that P1 was assaulted by a male resident aged 94, who had dementia and a recorded history of violence and aggression towards residents and staff at the care home. He will be referred to in this SAR as P2.

The residential care home is regulated by the Care Quality Commission (CQC) to provide care and accommodation for a large number of residents, some of whom have dementia. There are two units: The Residential and the Dementia Unit, the latter accommodating residents with dementia who require a higher level of support. At the time of the incident, the published CQC Inspection October 2013 found that overall, CQC standards were met.[1]

Police were notified of the aforesaid incident and both P1 and P2 were taken to hospital 1 where P1 was treated for her injuries and P2 was admitted to a mental health ward but did not return to the care home. Adult Social Care (ASC) were notified of the incident, the safeguarding process was initiated, and a Section 42 Enquiry was carried out under the Care Act 2014. The outcome was shared with P1's family and was subsequently identified as containing inaccuracies and typographical errors, consequently, ASC requested a second Section 42 (S42) enquiry to be completed, this time, by the care home.

It commenced on 1st December 2016 and was completed on 11th June 2017. ASC Safeguarding Leads met with P1's family in May 2017. During the meeting, the family advised that the second report did not, in their opinion, meet the statutory requirements of the Care Act 2014 or fully reflect their view. They did not feel that it answered their questions and concerns about the incident that took place on the 11th June 2016, or surrounding circumstances. It was then agreed that ASC would undertake a third S42 Enquiry, concluding on 6th July 2017.

A referral was made to the Safeguarding Adults Board for a Safeguarding SAR to be considered, as condition 2 was met under Section 44 Care Act 2014, on December 5th 2017, given that there were similarities between this case and a previous Serious Case Review (SCR) undertaken by the SSAB re: Mr J and Mr Y.[2]

This report is based on information gathered from agencies identified as having contact with P1 and P2, but the latter has only been considered where it is has been deemed to the safeguarding of P1.

1.2 Statutory duty to conduct a Safeguarding Adults Review (SAR)

A Safeguarding Adults Board (SAB) has a statutory duty to arrange a SAR when:

a) An adult with care and support needs has died and the SAB knows or suspects that the death resulted from abuse or neglect, or an adult is still alive, and the SAB knows or suspects that they have experienced serious abuse or neglect,
b) And when there is reasonable cause for concern about how the Board, its members or others worked together to safeguarding the adult.

Board members must co-operate with and contribute to the SAR, with a view to identifying lessons learnt and ensuring that learning is shared and applied in the future. The purpose is

[1] *https://www.cqc.org.uk/what-we-do/how-we-do-our-job/fundamental-standards*
[2] https://www.surreysab.org.uk/safeguarding-adults-reviews/

not to allocate blame or responsibility, but to identify ways of improving how agencies work, both singularly and together, to help and protect adults with care and support needs who are at risk of abuse and neglect, and who are unable to protect themselves.

1.3 SSAB Decision to conduct a SAR

On 11th December 2017 the SAR sub-group of the SSAB (which includes representatives from the Guildford & Waverley Clinical Commissioning Group, Surrey and Borders Partnership NHS Foundation Trust, Surrey Adult Social Care, Surrey Police and Surrey Fire and Rescue Service) met and decided that the case of P1 met the criteria for a SAR to be carried out.

1.4 Terms of Reference

The SAR Panel's Terms of Reference were agreed (*at Appendix 1),* along with the scope of the SAR, which was to focus on circumstances surrounding the physical assault to P1; to consider professional engagement and intervention, and her family's views.

An independent SAR Chair, Deborah Stuart Angus, was appointed to oversee progress, derive a methodology and to drive outcomes for the family and the SAB. Within the terms of reference, there were specific issues that the Panel were asked to consider:

Risk Management

- What was the risk management methodology, deployment and quality assurance regime within the care management system (including human resourcing, management supervision, training and qualifications) in relation to:
  a) Management of potential violence and aggression in the care home
  b) Its impact when caring for individuals receiving end of life health care in isolated circumstances
- What impact did the outcomes of the above have on the risk management for P1 and P2 in relation to care home management, partners, family and visitors?
- What knowledge of P1 and P2 assisted organisational and partnership responsibilities to contribute to risk assessment, when providing social and healthcare, and the delivery of statutory safeguarding responsibilities, including Making Safeguarding Personal?

Post Incident

- How did the post incident response contribute to the effectiveness of risk management for P1, P2 and other residents within the environment?
- How were P1's former wishes represented, and her views advocated, particularly given that P1 had been subject to an approved Deprivation of Liberty Safeguards (DoLS) application?
- How were P1's family enabled to contribute to P1's risk and social needs assessment and enabled to understand the ramifications of the Mental Capacity Act and the DoLS Amendment?
- What monitoring and review requirements from the regulator (CQC) and service commissioners, Continuing Health Care (CHC) and from ASC contributed to effective safeguarding?
- How did the S42 Safeguarding Enquiry enable understanding of key issues?

Information Sharing

- How were the family advised of the risks their mother was facing in relation to being cared for in bed and the risk posed from other residents?

Previous Safeguarding Adult Reviews

- Are there connections to any previous SAR's held by SSAB?
- Is there any known research that may contribute to the learning from this SAR?

1.5 Other investigations, parallel process and linked safeguarding adult reviews

In January 2016, six months before the reported assault, SSAB had published (what at the that time) was referred to as a Serious Case Review re: 'Mr J and Mr Y'. This considered the circumstances in which on a previous occasion a person in a care home was assaulted by another resident. It made recommendations based on its findings, which also raise questions for this SAR on how well care homes in the area, and those commissioning or regulating services, have applied lessons learned, and how well the SSAB assured itself that those lessons were acted on. See Recommendations for further comment.

ASC conducted and or instructed, several Safeguarding Enquiries, and due to concerns regarding the outcomes, it was necessary to repeat twice, taking a long time to conclude. The SAR will reflect on contributory factors to why this was the case and the lessons that need to be learned to improve future responses. **(However, it should be noted, a number of service improvements have already been made by various agencies involved in this SAR, documented at Appendix 3).**

Police held an initial criminal investigation into the events on 11th June 2016 and during the course of this SAR, their investigation and contributing factors, were reviewed.

During the course of this SAR, CQC undertook an investigation which resulted in the commencement of criminal proceedings against the care home under Regulation 12 of the Health and Social Care Act 2008. The care home subsequently pleaded guilty to two charges; firstly, failing to provide safe care and treatment, resulting in avoidable harm to P1 while she was resident at the care home. The care home also pleaded guilty to failing to provide safe care and treatment exposing other people living in the service, to a significant risk of avoidable harm.

The proposed period for completion of a SAR would normally be in the realm of six months, however, in order to manage the number of parallel process featured in this case, the timetable had to be extended.

1.6 The review model

The approach chosen by SSAB involved:

- An independent reviewer and report writer was appointed to work with the Panel to provide an Overview Report and an Executive Summary, using thematic analysis; to include lessons learnt, conclusions and recommendations for action.
- The process was overseen by the SAR Panel Chair, Deborah Stuart Angus, who was appointed independently of SSAB.
- Individual Management Reviews (IMRs) were commissioned by the SAR Panel, where agencies had been identified as having relevant contact with P1 or P2.
- Individual follow up interviews were conducted by Panel members with particular organisations, where it was felt necessary to discuss outstanding matters or stimulate debate regarding learning points
- Formal reporting to the SSAB and Overview Report will be used to assist the SAR Subgroup to devise an action plan, regarding implementation of the recommendations, to include required action; who will be accountable; timescale for completion and what will be as a result. The plan will be monitored by SSAB.

1.7 Combining and evaluating evidence sources

The SAR Author and SAR Panel Chair worked with the family to further develop the Terms of Reference and to collate all available evidence sources. The SAR considered and cross-referenced previous S42 reviews, chronologies and IMRs. All available information and evidence gathered from subsequent interviews was analysed in relation to the Terms of

Reference. Towards the end of the evidence gathering process, the SAR Panel held a meeting on 20th September 2019 to identify emerging themes.

The SAR considers individual and organisational learning for those involved, since its onset. A summary of agency's own recommendations and improvement planning already undertaken, can be found at Appendix 2. Additional recommendations have been made where deemed necessary.

1.8 Individual Management Reviews

The SAR Panel received reports from the following agencies:

Agency	Nature of involvement with P1
Adult Social Care	Provided safeguarding responses to incidents involving P1 and P2 and oversaw the S42 enquiry processes
The Care Home	Residential Care Home where both P1 (and P2) lived
CCG 1 and CCG 2	Commissioners of care for P1. CCG 1 was the host for both Safeguarding and CHC
Continuing Health Care	P1 was given CHC funding in the last months of life owing to the level of care needed, her illness and disability
Hospital 1	Provided the accident and emergency response to P1 (and P2) following incident on 11th June 2016
Community Health Services (CHS)	The District Nursing team provided community nursing and therapy services for P1
Mental Health Trust	Provided health services for P1 and P2's mental health needs.
Ambulance Service	Provided medical response for incidents involving P1 and P2
Hospice 1	Provided palliative care support to P1, when required
Police	Provided criminal justice response to incidents involving P1 and P2
GP Practice	Delivered patient health care and consultations to P1 and P2 at the care home

In addition, CQC provided a range of responses to questions from the SAR Panel Chair and Author. A full IMR was not submitted but the CQC did engage with the SAR via a face to face meeting, telephone calls and written submissions. P1's family also made a submission, reflecting information they gathered, with a later addendum and SSAB gave information about the aforesaid Serious Case Review.

The SAR Panel extends its gratitude to all participants for their co-operation in sharing information, enabling completion of the Overview Report, attending meetings and interviews. Sharing individual and partnership experience has contributed significantly to the learning that has emerged within the analysis and understanding of what happened.

1.9 Participation of P1's family

Four family members were contacted to establish if they wished to engage with the SAR. It was confirmed that they wished to be represented by two family members. The SAR Author met with the chosen family representatives on 19th July 2018 who were keen to be involved throughout the process. They have also expressed their wish that the learning from this SAR should be used to prevent the reoccurrence of such an incident.

The Independent Chair of the SAR Panel remained in close contact with family representatives throughout, and also met with them to engage their understanding of the process and to listen

to their views. The Chair has provided regular updates on progress, parallel processes and queries. Family views are reflected throughout this report and on its completion, a copy was sent to them, for their perusal. During March 2020, the Independent Author; The Independent SAR Panel Chair and the SSAB Independent Chair met with family representatives, to discuss final findings; to listen to their views and comments regarding the Overview Report.

Pro-active family participation has enabled P1's voice to be heard in this SAR. The Independent Chair and SAR Panel would like to thank the family for their commitment; their involvement and for sharing their experiences, given the traumatic impact that this incident has had on them all.

2 Person 1 and Person 2

2.1 Person 1

The family shared an insightful memory of their mother, of her life and her determination to become a teacher. They described how, as a young woman, by the generosity of an unknown benefactor, she trained as a primary school teacher and was grateful for this opportunity for the course of her life, as she valued education for its "**life changing potential***".* They described their Mother as "**a kind, dutiful, community minded, family centred person***"*. She was white, married, widowed and had had three girls and a boy, all of whom were involved in her support. As P1 grew older and her health deteriorated and was unsafe for her to stay at her home. The family were set on ensuring that their mother lived her final years in maximum comfort, and very much wanted to her to have the best possible care.

P1 moved to care home in March 2007. She had memory loss and initially lived in the Residential Unit. The GP practice recorded a diagnosis of advanced dementia. P1 was unable to consent care, treatment and accommodation needs. She became increasingly frail with significant sensory deterioration. By 2013, due to further deterioration P1 was moved to the higher needs unit, unable to weight bear or mobilise and needing care and health support for all aspects of daily living. She was unable to verbally communicate, unable to orientate or make decisions, and a S42 Enquiry notes that those who were familiar with her could help understand facial and non-verbal communication.

Such was her condition; all care was delivered on a daily basis in her bed. Of note, she was unable to summons help, or use the call bell to request assistance. Her frailty and medical condition influenced the decision to provide end of life care (for several years), so on occasion P1 received palliative care from community nurses. In April 2016, CHC were approached, and agreed to fund P1's nursing care needs, prior to this, she had funded her own care and it is believed that a DoLS assessment took place on 19th April, however a dedicated at ASC workflow was not in place at the time, so it is not possible to confirm the outcomes of this.

The physical assault on P1 by P2 was reported just ahead of her 93rd birthday and P1 sadly passed away in November 2016. The cause of her death was not recorded as being connected to the incident that took place on 11th June 2016.

2.2 Person 2

P2 aged 94, was a white male, recently widowed, and moved into the care home, paying for his care. His primary diagnosis was Depressive Disorder and Mixed Vascular Dementia. By 2015, he was regularly collapsing, although no one specific medical reason was identified, his sight was reported to be poor by the care home and an emergency response was sometimes required to respond to his health care needs. As his mental health worsened, he began to present increasingly distressed, challenging and aggressive behaviour. From March 2016 there was a marked escalation in the frequency and gravity of violence towards residents and staff.

Rise in violent incidents involving P2

The SAR has established, that from information received P2 had been involved in violent and or aggressive incidents from 27th March 2015. Thereafter, incidents that were reported at the care home and by police, occurred on 11th November 2015; 23rd December 2015; 16th,18th and 23rd March 2016; the 3rd, 18th 19th and 29th of April; the 3rd and 22nd of May and the 4th, 5th 6th and 7th of June, and ultimately on the 11th June, when Person 2 assaulted Person 1. This totals 18 different incidents set within an escalating picture. The incidents of 23rd December; 18th March; 3rd May; 5th June and 7th June all involved P2 using his Zimmer frame to either assault or try to assault staff and or residents.

Between 23rd December 2015 and 7th June 2016, the care home in total had recorded 39 incidents that involved P2 on their ABC charts, 27 of which indicated P2's use of verbal aggression, threats of, or use of, violence. Some days there were multiple entries, and 18 of the 39 incidents could be considered as violence related where there had been use of, or threat of use, of his Zimmer frame, as a weapon.

However, it must be clear, that the circumstances surrounding P2 are subject to separate considerations under section 42 of the Care Act 2014, and for the purposes of this SAR, circumstances appertaining to P2 can only be considered, in relation to their impact on P1 and the high level of risk that was posed to her.

2.3 Incident on Saturday 11th June 2016

On this day, the care home recorded 27 residents in the Dementia Unit. A managerial team was providing oversight and 7 carers were on duty in the morning, 6 in the afternoon and 3 at night. The staffing levels were supported by other staff through *'wellness hours'* who assisted with administrative tasks including care assessments, reviews and doctors' rounds. P1's family understand that there was a party planned that afternoon in the communal area of the unit. At approximately15:20hrs, the care home's IMR advises that a member of staff noticed P2 in the communal area, near P1's room. When asked if he was lost, he replied *"***I killed her. I put her out of her misery. I will get the rest now**". Staff checked on P1 and saw she had sustained injuries and was bleeding, and after alerting a senior member of staff, P2 was escorted to his room and kept under supervision. First Aid was administered to P1 who had many cuts/lacerations, bleeding, bruising and swelling to chest, arms, legs and hands, was very pale, distressed, shaking and visibly in pain.

An ambulance was called at 15:23 and paramedics arrived after. Police were alerted by the care home at 15:30, arriving shortly afterwards. They photographed the injuries and the blood-stained Zimmer frame, suspected of being used as a weapon in the assault. Photographs showed the base of the Zimmer frame had worn out rubbers and uncovered, splintered metal. Police spoke with the care home duty manger and the staff who were present. P1's family were notified, who immediately arrived to be with their Mother to give comfort and support.

ASC Emergency Duty Team were contacted, (as it was Saturday), and they called back to obtain details. Police requested that the Community Mental Health Team, be contacted, and they were, but were unable to attend. P2 was sent to hospital 1 for a medical check and a Mental Health Assessment was requested. P1 was sent to the same hospital as P2, accompanied by police. P1's injuries were documented in the hospital notes and on a body map. They included a skin tear to mid-sternum; three skin tears to right hand; bruising over right arm, left forearm and left hand; and small lacerations to left and right lower legs.

It is important to reflect on these injuries, given that they were sustained by nearly 93-year-old, frail woman, in receipt of palliative care, who was unable to provide an account of the incident or to tell others how she felt. In the family's submission to this SAR, they described that after the assault, their Mother was '**quietly moaning in pain and her face was troubled and anguished**'. There can be little doubt about the trauma that both P1 and her family experienced, given they feared, that their Mother may die as a result of these injuries.

The care home meanwhile obtained written statements from all staff who were involved, which were collated by a deputy manager. A debriefing session was held, and support offered via the Employee Assistance Programme. Staff coming on duty were made aware of the incident. It was agreed that the care home would send a CQC notification and Duty of Candour was to be followed up on Sunday.

P1 was treated for injuries at the hospital, which upon examination were not as serious as first thought by emergency services. She was discharged early hours of the following morning. P2 remained at the hospital and received a mental health crisis response.

3 Themed Analysis

This section outlines the findings that have emerged as a result of the analysis of information submitted to the SAR Panel via IMRs, individual chronologies and S42 enquires that were undertaken, as well as supplementary enquires made by the SAR Panel, that included face to face interviews held with particular agencies. The analysis also reflects the views of P1's family. Particular focus has been given to points in the Terms of Reference and single and joint agency actions have been considered, along with an emphasis on how agencies worked together, in relation to the risks of harm faced to P1 from P2.

3.1 Theme 1: Risk assessment and risk management

3.1.1 Apparent risks for P1 within the environment

Until 1st February 2018, the care home used an assessment and care planning software tool called 'Yardi'. The SAR is advised that residents were assessed every six months, with monthly monitoring from a senior carer. The tool specifically asks about distressed behaviour, physical capability, residents' ability to call for assistance, and end of life care. Also any changes to a resident's behaviour were recorded on an 'ABC chart' and behaviour tracker, (A refers to the antecedent to the behaviour; B refers to the behaviour at the time and C refers to establishing what the behaviour achieved and how was it responded to). It was a missed opportunity that such information was not effectively utilised to enable staff to deploy relevant actions and manage risk. There was also a policy in place on how to deal with violent incidents, which advised staff how to manage the immediate risk, calling emergency services if required, and notifying relevant family members. The policy also advised staff to contact any Senior Management for advice and support and to make relevant notifications to other agencies, such as CQC/ the local safeguarding team and that debriefing and support would be provided

if necessary[3].The following represent a range of risks that the SAR has identified, facing P1 at the care home:

- being in receipt of all care in bed in a room where she was predominantly alone and not necessarily immediately visible to staff, with no physical barrier to prevent entry
- isolation and loneliness
- being unable to mobilise or summons help
- being dependent on carers to protect her twenty-four hours every day
- being reliant on the care home to source effective multi-agency support to help meet care and health needs
- not having a robust care plan and risk assessment in place to assure needs were met within a safe environment
- ineffective use of sensor mats on her bedroom floor
- a lack of effective supervision of both P1 and P2
- any emergency evacuation requirement (not a focus of the SAR)
- reliance on her family to make informed decisions on her behalf on limited information

3.1.2 Risks faced by P1 pre and post incident

P1 had an individualised care plan to identify and manage her care needs, but it would appear this was not supplemented with all considerations to provide a safe environment. The care home reported that the care plan included providing a sensor mat beside her bed, and whilst there was a possibility this may alert staff that someone had entered the room, (dependent on where it was placed), its main purpose was to detect P1 falling out of bed.

There was no physical barrier in place between her door and the hallway. The 3rd S42 Enquiry documents her room as being near where staff could see her, with regular planned room checks, the door being left open and staff checking on P1, if they were passing. The family described their Mother's bedroom as being '**well away**' from the communal area. Members of the SAR Panel who visited the care home had a room identified by staff which was some distance from the staff and communal area. The pre-incident risk management arrangements for P1 did not explicitly include the risks of a person entering her room and harming her. The risk management for P1 was inextricably linked to that of P2, and the management of his violence and aggression that had arisen as a result of his mental ill health. It was also dependant on effective supervision of P2 on a unit where there were a number of very vulnerable people.

Post incident on the 11th June, P1 returned to the care home in the early hours of 12th June 2016. There was a meeting held on the 16th attended by CHC and the family, who expressed their wish for their mother stay at the home, on the grounds that she was safe.

A further meeting took place on the 21st with ASC and the care home but the family were not invited, however the care home did inform them of the outcomes, one of which was a proposal to move their Mother back to the Residential Unit (Res).The corporate memory of why P1 had been placed in the Dementia Unit appears to have been lost, as P1 had been originally moved there because the care home could no longer manage her increasing needs in the Residential Unit - which the family pointed out. The family advised the SAR that the decision to keep their mother at the care home was based on information supplied to them, post the incident on 11th June 2016 on a 'drip fed' basis.

[3] sourced from the S42 enquiry completed 6th July 2017

3.1.3 Risks faced by P2 pre and post incident

P2's care plan and risk assessment were reported by the care home as being up to date. During 23rd December 2015 and 11th June 2016, P2's mental ill health resulted in him demonstrating increasingly, serious verbal and physical aggression, and violence. His risk assessment and care plan did not explicitly address the risk of his potential violence and aggression towards either P1 or other frail residents or those receiving care in bed.

On 23rd December 2015 a violent incident had occurred involving P2 assaulting P3. The care home sought a multi-agency response to manage this incident, informing the police, ASC and the GP. The care home later challenged the ASC response and their decision not to take any further safeguarding action. The care home, however, was inconsistent in sharing information with other agencies and when they had shared it, it was predominantly prompted by incidents where violence was used by P2 against another resident.

A significant amount of information regarding the potential risk that P2 posed, was noted within ABC charts, but there was no evidence that reflected gravity and escalation of risk. Nor was it evident that the entirety of such information was shared with other agencies, who may have been able to help, such as the CMHT, thus there were many missed opportunities by the care home to both request assistance from the GP in order to make relevant requests for help to the CMHT.

The care home's assessment for P2 considered some possible triggers for changes in his behaviour, including interaction with others, noise levels and music. The term 'challenging behaviour' was used in numerous records relating to P2, between December 2015 and June 2016, which did not accurately reflect his violence towards others. The care home required that reviews were carried out for residents, particularly if a change occurred in their needs, or circumstances. The 3rd S42 enquiry, completed by ASC on 6th July 2017, concluded **that 'based on the information and experience of previous transfers to the Dementia Unit that this decision was considered in P2's best interest. A risk assessment was completed but did not consider wider potential risks that he may pose within that unit or the need to increase his supervision level'. It went on to say that P2 'had no history of being disorientated to place or going into other's rooms and this particular risk factor did not form part of the risk assessment'**.

The Enquiry was an inadequate in that it did not make reference to a care home record where the care home had informed ASC on 1st April 2016 that P2 '**misinterprets his environment. His room is next to two other male residents that go into other people's rooms' and goes on to say, that P2's 'whereabouts are monitored as far as possible by staff but this cannot always be guaranteed as he is very agile and moves around the community, entering other people's bedrooms and bathrooms'**, and '**What further action is necessary to reduce the risk? The CMHT have been contacted to re-assess P2. The residual risk rating is scored 12, though the risk matrix on the document shows a maximum score possible of 9 (which is where likelihood is 'Very likely' and impact is 'Extremely harmful major injury or death').**

This represents a key episode requiring an immediate risk management response to safeguard P1 and others. It was a critical missed opportunity for intervention by both the care home and ASC, also no reference exists that this information was shared with the CMHT. Their policy states: '**Where there are significant social or mental health changes or other risks an immediate review of risk must be undertaken, and the case presented in a**

multidisciplinary setting i.e. ward round or agreed clinical review in the community and actions taken accordingly'. [4]

It is not clear, whether incidents prompted the care home to conduct a review of P1's existing risk, and or, care plan, or whether they requested a review from the CMHT. Neither the care home's IMR, or other IMRs, or chronologies submitted to the SAR, indicate that the care home had holistic knowledge of P2's behaviour, aggression and violence or that this factor was fully known by other agencies, prior to the incident on 11th June 2016. Incidents appear to have been responded to inconsistently, on an individual basis, and the overall impact of this increasingly dangerous behaviour, was not apparent.

ASC's chronology stated that the care home advised them that the CMHT were informed about this incident, but the care home chronology does not correlate with this. CMHT records indicate that a review was due for P2 in January 2016 and a follow up Best Interest meeting was scheduled for the 12th, of the same month. However, the latter was cancelled on the day, by the care home and the reason why is unknown. However, CMHT records indicate that this was due to the arrival of auditors at the service. It appears that this meeting was not rescheduled, either by the care home or the CMHT. On 1st April 2016 there is evidence that the care home contacted ASC and referred the violent incident of the 30th March 2016, involving P2. ASC recorded three outcomes from their involvement: firstly, that the care home was to review P2's risk assessment; secondly they were to contact the GP for assistance and thirdly to contact the CMHT. The S42 enquiry did identify that the incidents involving P2, that had taken place took place prior to June 11th, had not been holistically assessed, and so P2's behaviour, its impact and associated risk to others had previously, not been fully considered.

The care home chronology shows they had written a letter to the GP on 19th April 2016 and were instructed to contact the CMHT. The CMHT received a request on 25th April 2016. It is also unclear if contact with the GP (and then CMHT) was a delayed response to the three ASC outcomes required following the incident on the 30th March 2016, or whether the action taken by the care home in April, was actually instigated as a result of the further incidents that had taken place on the 10th, 18th and the 19th April 2016, involving P2. The CMHT have told the SAR Panel that they were not contacted by the care home from January 2016 until the receipt of the GP's letter, sent on the 19th April 2016.

The final S42 enquiry made a recommendation for the care home to remind staff to report and record incidents and add more detail. This could have been a valid recommendation in its own right, if the records had contained a summarised history. The volume of ABC entries suggested that care home staff did record a significant number of incidents and that there was sufficient information to indicate the deterioration of P2's health and the impact on his behaviour, as well as the significant risk he posed to others.

Both P1 and P2's care plans and risk assessments were subject to a monthly review by a senior carer. The care home IMR refers to the incident on 24th December 2015, stating that monthly assessments will outline P2's behaviours and '*how to respond*'. Given that P2's behaviour escalated over the course of several months and was subject to care home review, it indicates there is scope for improvement in the care home's system. There was very little information given by the care home to the SAR in respect of any activity or recommendations from monthly reviews, nor is recorded how the Yardi risk assessment software supported staff to input any review of risk information. In addition, P1's risk assessment and care plan did not explicitly address the risk of harm, or of violence and aggression posed by other resident(s) or visitors entering her room.

[4] Trust Clinical Risk Assessment and Management Policy and Procedure Feb. 2016

There was recognition from the care home that they did not access their own resources in relation to '**regional expertise'** and their Dementia Specialist only saw P1 after the incident on the 11th June, following their notification to their regional support team on the 12th. Given the extent of dementia related incidents for P2, the lack of contact with their regional resource was a missed opportunity, particularly given the escalation rate of violent and aggressive incidents, from April onwards, however it is fair to say that it is unknown if more intervention from the Dementia Specialist would have changed outcomes, however it may have helped staff to mitigate risk.

Applying hindsight bias, the care home could and should have chased up referrals to the GP and CMHT and involving multi-agency support in care homes in relation to in situ assessment is good practice and a lawful requirement. [5]

A best interest process /meeting was not put into place by the care home to ascertain what was in P2's best interests even when it became evident that by the 16th March 2016, the ABC behaviour profiling for P2 did not appear to add value to actually managing risk. The care home's chronology refers specifically to a response from ASC on the 7th June 2016 in respect of an incident on 4th June 2016 when by that point 17 incidents had taken place.

The care home told the SAR that they felt that it was difficult for them to access urgent help for their concerns about P2. Whilst the care home and agency's chronologies show that they did not share information about the incidents that involved P2, professional curiosity by all who had contact with him, may have helped identify and mitigate risk.

The CMHT advised the SAR Panel that Care Homes and GP's had guidance regarding behaviour associated with psychological symptoms related to the dementia pathway. The CMHT advised the SAR that there is now a care home protocol in place. This model can include Intensive Support Therapy underpinned by evidence base of the Newcastle Model applied to challenging behaviours.

The care home submitted an IMR to this SAR, which reflected on potential learning and made recommendations. During the course of the SAR, the panel wished to conduct a follow up interview with the care home to explore opportunities for further learning, but they decided against further participation with the SAR.

No further information was made available to this SAR on P2's subsequent placement or details of his forward risk planning. He has sadly now passed away.

3.1.4 The risk identified at the interface, between the CCG and CHC

There is no evidence to suggest that after becoming eligible for CHC funding prior to the incident in June 2016, that a healthcare plan was in place from CHC for P1. After the incident, the CHC team were notified by the duty nurse in the CCG. The CCG Safeguarding Lead then raised a number of questions to CHC, to establish the facts, however the response was not received for several months. This could have identified whether a CHC review had taken place and if any action had been taken (including assessment of risk) by other agencies in order to safeguard P1 and other residents. A lack of supervision, leadership and professional curiosity contributed to both an unnecessary and elongated response period and actions not being checked.

3.1.5 The risk identified at the interface, between Police and Care home

Police were involved in four incidents linked to this SAR involving P2. The Care Act 2014 and other legislation makes it clear, that police have primacy in investigations where it is thought a crime has taken place. In such circumstances police should, as good practice, seek

[5] Health and Social Care Act and Care Standards Act 2000

reassurance that there is effective risk management in place by the provider. Where there is also a need to consider criminal offences that may have been committed by the care provider or staff, there is an enhanced role for police in risk management.

There was no evidence of Police ownership of risk when dealing with the incidents raised herein. It appeared that a 'hands off 'approach was adopted, which may have been due to a perception that all risk responsibility rested with ASC or the care home. Risk assessment and management is however referenced following the incident on 24th December 2015, and the police IMR and chronology acknowledges that there was no Police consideration of risk related to other residents when P2 moved to the higher dependency unit. This was a missed opportunity, as the proposed course of action should have been challenged by the Police, if or when they were aware of ASC's decision. It is imperative that Police crime investigations reflect how potential risks to adults with care and support needs have been mitigated. This should include seeking advice from other relevant professionals and a documented risk management action plan, to include actions taken with, or by others.

3.1.6 The risk posed at the interface between the Care home and CQC

Analysis of records submitted, herein show that an unconnected incident, involving other residents, had been reported to CQC by the care home in August 2015, where one resident was alleged to have hit another, but no physical injury was sustained. The care home at that point was noted to have responded appropriately to '**keep people safe'**. The CQC inspection that was due, requested that the care home consider assessment of risk and staff support for people whose behaviour may challenge.

(CQC were unable to share any specific details of what those responses or measures were, as the residents involved were unconnected to this SAR). CQC seemed however, to be unaware of the accumulative number of incidents related to violence that P2 had exhibited from December 2015 onwards.

3.1.7 Community mental health services and risk management of violent patients

A CMHT review was held at the care home for P2 on 14th December 2015 and stated that he remained unsettled. The reports to the SAR do not reflect any advice that may have been given to the care home by CMHT. A follow up meeting in January 2016 did not happen and no effective interim risk assessment was put into place.

Given the escalation of violence from P2 between March to 11th June 2016, the GP Practice recorded receiving one referral from the care home regarding P2 (25th April 2016). Informal discussions during the GP's weekly visits, regarding P2, may have occurred, but there is nothing in chronologies to supports this. The GP's IMR and chronology had a snapshot of the volume of incidents of violence and aggression about P2. The GP told the SAR Panel they felt it was their role to access a CMHT assessment in relation to medication and potential placement. The GP had referred P2 to the CMHT because of his aggression, who then decided psychosis was not evident, thus they recommended measures but not a medication review. During the SAR Panel interview the number of the incidents was shared with GP2 who was evidently unaware of the extent of P2's violent behaviours. GP2 stated that if the Practice had been aware of the gravity, this would have affected their risk management response. The GP shared with the Panel that the care home had an incident tracking system and that the Practice would receive an alert if someone had a deteriorating medical issue. However, this does not appear to have been used in this case, which represents a missed opportunity to assist with risk management. Advice to the care home from the GP Practice on securing an urgent response from the CMHT, and a discussion on interim risk management options, would have been beneficial.

Likewise, CMHT say they were not aware that so many incidents had occurred between March and 11th June 2016. The chronologies show that there was no approach made by the care home or any action proposed by any of the agencies involved to secure a mental health assessment for P2, until post the incident on 11th June 2016. They reported that after receiving the GP letter in January 2016, there had been no further contact from the care home to access support for P2, resulting in their view that P2 was settling well into the Dementia Unit , also the care home did not a request the GP to try and access an assessment from a psychiatric geriatrician, for a mental health review.

The GP referred P2 to the CMHT again on the 26th April 2016. He had last been seen in December 2015. The GP described P2 as being pleasant, but then aggressive and that he could be extremely aggressive and could hit out at other residents. P2 was referred to as a 'new patient', albeit he had never been discharged from CMHT. Their IMR, and chronology, clearly demonstrate that there was knowledge that P2 posed increasing levels of risk to others from 11th May 2015 to 11th June 2016, but it did not reflect the full extent of incidents that the care home was aware of. The CMHT expressed to the SAR Panel, that responsibility for risk rests with the care home providing the care, and that CMHT oversight would be based on what was reported to them by that home. They advised that any person of concern could be discussed as often as was required, and on a weekly basis, if they were identified to be in 'Red Zone', i.e. high risk to themselves or others. There is no record within the chronologies to suggest P2 was ever identified in this way, and the CMHT representative did not recall weekly discussion sessions being required for P2. The GP described taking conservative medication measures with P2, due to concerns about his health and the 'risk of falls'.

P2 was not seen until 3rd June 2016, following the GP referral. This timeline was reported as being within CMHT timeframes for non-urgent cases. Given the level of violence that was happening, and that medication was not having a positive impact on behavioural change, this time frame does not represent effective and responsive clinical risk management.

There appears to be a misunderstanding as to whether P2 was presenting as an urgent case or not. The CMHT assessment seemed to focus on P2's loneliness and the loss of his wife, as opposed to documented violent behaviours. The CMHT say this information was not shared with them by the care home, but that they did ask to see the ABC charts. The unavailability of this information, prior to a senior practitioner meeting with P2, was described as '*an unfortunate oversight*' indicating that the seriousness of this omission may not have been recognised. The CMHT advised the SAR that the care home did not emphasise they were experiencing difficulty in managing P2's behaviour. The CMHT assessment sought '*additional evidence of behavioural difficulties*' and did not reveal that P2 posed a risk to others living at the home.

The CMHT Clinical Risk Assessment and Management Policy and Procedures state that: '**The care co-coordinator must ensure that the other professionals and or care agencies involved or potentially involved are fully aware of the identified risks and the care plans to address these. The risk management plan for high-risk patients must be discussed with other professionals involved in the care provision at all times (except in exceptional circumstances when this is not possible) the professional must formulate a management plan and discuss the identified risk and management plan with the relevant professionals at the first clinical meeting. High risk patients may be presented to the Trust multi-agency risk management panel. Risk assessment will therefore be completed during admission and or initial assessment, reviewed at every care plan review or at a CPA review, until the people who use our service is discharged from mental health service. A record of all reviews will be maintained in the people who use our service's case files".**

The CMHT representative acknowledged to the SAR, that the risk assessment should have been updated, both after the review and following the serious incident. Also, that the care plan should have been linked to individual risks and that recommendations should have been made to the care home regarding 1:1 observation, until a Multi-Disciplinary meeting could have been agreed. They advise that normal practice is to provide verbal advice on the day and went on to expand on this that medium/high risk assessments should have a corresponding care plan, recorded within seven days, (in P2's case this was completed the day after the reported assault on P1). A CMHT Datix entry was not made in respect of the incident on the 11th June 2016, therefore no consideration for a Serious Incident Enquiry was prompted.

In a letter dated 16th June, following up on the referral from April 26th, the CMHT, (post incident) wrote to the GP, setting out the advice given to the care home on planned activity for P2, but it did not acknowledge risk management required. Nor did it document that they had checked with the care home regarding both the recording in, and contents of, the ABC charts. The CMHT review does not seem to have taken into account P2's serious decline and the fact that vast majority of violent incidents had taken place from March to June that year.

On the 2nd June a CMHT medication review had taken place, but it does not appear that the practitioner recorded the outcome. It remains unclear, how or if, the CMHT gave interim advice to care homes or how updates are communicated for the immediate benefit to the care and risk management of a patient.

3.1.8 Medication

P2 had a mental health condition that resulted in him displaying aggression and violence towards others without understanding the consequences of his action. An option to support his health and wellbeing, manage his behaviour and mitigate risk to others, could have been considered by clear diagnosis and prescribing suitable medication.

Following a care home request to the GP in December2015, P2 had been prescribed Lorazepam, to assist with behavioural related issues, which was stopped on 29th December 2015, due to medication seeming to cause him to fall. There does not appear to be sufficient consideration as to alternative medication, or measures to help manage the risks P2's behaviour posed. A similar issue arose on 26th April 2016 when it was noted by the GP to the CMHT that Finasteride had been prescribed for potential urine retention which may have reduced testosterone, but this did not impact on P2's behaviour. The prescribing of interim medication also featured in the letter dated 16th June 2016 to the GP from CMHT, stated that '**Discussion** *(*was) **needed with regard to current medication regime and especially mood'.**

Post incident, P2 was immediately assessed as high risk by the Hospital team and P2 was prescribed 0.5mg Risperidone; Lorazepam (as required) and he was placed on 1:1 supervised care. P2 was reviewed daily by the psychiatric liaison nurse who noted on 15th June 2016 that he was high risk to self, from and to others. On the same date, the nurse records:

'**He isn't on 1:1 nursing. Case notes report episodes (of) black outs which the care home has also reported. He can fall into a deep sleep and be aggressive when he wakes up. Case notes also record him becoming more settled and not irritable. He is also calm and pleasant, showing no agitation, aggression or psychosis.'**

This represents a significant change in P2's behaviour. The IMR chronologies do not reflect any revised risk assessment, but the entry indicates that this was a successful intervention which reduced risk to himself and others, demonstrating the importance of medication review and effective prescribing.

Family Perspective

The family have explained how they had been told at post incident care home meetings, that there was nothing about P2's behaviour to cause concern. The family expressed their anger at finding out subsequently, this was not the case. Furthermore, the family were advised that P2 had been carefully reviewed and assessed before being admitted to the unit by the care home and by the CMHT, and that this was also the case after he was moved from the Residential Unit to the Dementia Unit. The family were keen for the SAR to establish what happened and what opportunities the care home (and others) had, to identify, manage and respond to the risks that P2 was known to present.

The family expressed particular concern about the open plan layout at the care home and felt that was a contributing factor to the risks faced by their mother. On the day and time of the incident on 11th June 2016, they understood that a party was happening in the communal area, however this has not been verified with the care home. This could also have been a contributing risk factor to the circumstances surrounding the reported assault, if one of P2's 'triggers' for was music and noise, when he went to P1's room. They raised the issue of whether events and in particular that event, was risk assessed for its impact on individual residents. The family also understood that P2 also regularly used the toilet near their mothers' room.

After the incident, the family requested and obtained information from the sensor mat response charts for 11th June 2016, from P1's bedroom. The chart showed delayed response times to the alarm. On two occasions on 11th June 2016, the alarm was running for 32 and 40 minutes respectively without being attended to. At 2.15pm, the response time was 7 minutes, this was the last activation before P2 was seen by staff coming out P1's room at 3.30pm, which raises questions about staff supervision and the efficacy of the sensor mat.

Following the incident, the family stated they were not included in a Best Interests Meeting that was held, and they were given no opportunity to share their views, regarding risk assessment and management, for their Mother, or what they felt to be in her best interest. They expressed their concern that families like them, have to choose a care home without being aware of potential risks posed to their loved one, by other residents.

3.2 Theme 2: Practice of the Mental Capacity Act 2005 and implementing The Statutory Code of Practice

In relation to both P1 and P2, there was an apparent lack of consideration of the requirements under the Mental Capacity Act 2005, to carry out 'decision specific' mental capacity assessments.

In relation to P2, there is a consistent theme across all agencies and throughout the pre incident chronology, where there were various missed opportunities to assess P2's capacity, such as following the S42 Enquiry in March 2015, (carried out by ASC) in relation to best interests, health, welfare, accommodation needs and advocacy. As P2 appeared not to have easy access to a family representative, the appointment of an Independent Mental Capacity Advocate (IMCA) may well have been warranted.

Following the incident on 27th March 2015, which relates to an allegation of assault against P2, by a staff member, the care home recorded that P2 did not wish to make a formal complaint as he '*deemed* (the incident to be) *an accident'*. On 1st April 2016 the care home advised ASC that P2 had 'varying capacity' but no formal mental capacity assessment regarding this decision, was recorded within any IMRs or chronologies. P2 was not seen in person by ASC, the CMHT, the GP or police at the time and it remains unclear who and how it was determined that P2 lacked capacity in relation to either not pursuing a criminal allegation, or his future

needs. This may have been due to a lack of legal literacy by agencies involved in this decision and is a breach of requirements for this 'decision specific' issue as outlined within the Mental Capacity Act 2005[6]. This should have been identified and challenged by both ASC and Police as part of safeguarding and criminal investigation enquires. MCA assessments should have been in carried out on various other occasions, such as post the incidents between March 2015 and 11th June 2016, in relation to accommodation needs.

Prior to 11th June 2016, the ambulance service had received 11 call outs about P2, mostly relating to unwitnessed falls. On the 11th June, ambulance crews attended to both residents. Before P1 and P2 were taken in separate ambulances to Trust 1, police recorded that P2 had been assessed by paramedics, and that P1 and P2 were to be kept separately at the hospital as they were victim and suspect. The expectation from police was that P1 was to be treated for injuries, and P2 given a mental health assessment.

It is recorded that the first response officers sought advice from their Safeguarding Investigation Unit (SIU) who advised that as the suspect in this case had health conditions and ***'does not have capacity'***, the incident would be recorded as an assault (Grievous Bodily Harm) and finalised. It is not clear why the SIU made this assumption, and no advice was given regarding a mental capacity assessment.

Evidence submitted to the SAR suggests that police officers and staff involved in the 11th June 2016 incident formed a view that as there was no prospect of prosecution, and that '*their role was just to gather very basic information and ensure that the victim and suspect were conveyed to hospital'*. It appears that officers involved, considered that this action would ensure that P1 and P2 had been safeguarded and s44 of the Mental Capacity Act 2005 was seemingly not considered, in relation to any neglect of both residents, thus no further investigation seemed to be required (section 44 of the Act created an offence of ill-treating or wilfully neglecting a person who lacks capacity, or whom the offender reasonably believes to lack capacity).

The initial police focus appeared to have been conducted purely in relation to the culpability (or otherwise) of P2, with no evidence of professional curiosity/and or knowledge displayed, during the primary or secondary investigation phases, as to the actions or lack of them, of the care home; whether these were in any way contributory factors to the incident and whether there was any criminal culpability to be considered.

There were no details provided to the SAR of the policy that was in place at the care home on 11thJune 2016 that informed best interest decisions around risk assessment options such as stairgates or sensor mats. If the Statutory Code of Practice had been followed, which is fully available to the care home and other professionals, this may have expedited improved decision making and enabled immediate risk management measures to be deployed. In relation to Best Interest Decision Making, there were numerous examples where the understanding of the applying the Statutory Code of Practice was poorly understood, and as previously detailed this also applied to the CCG and CHC and the application of the lawful requirement to involve 'relevant others' such as the family and the CMHT.

There was discussion post incident regarding the family's wish to have a stair gate in place to prevent anyone else entering their Mother's room, following the incident on 11th June 2016. This request became subject to a professional's only debate over whether this represented a deprivation of P1's liberty and therefore subject to the requirements of the Deprivation of Liberty standards. As P1's care and support needs meant that she was nursed in bed, the issue of the stairgate creating a deprivation of liberty was in fact, irrelevant.

[6] http://www.legislation.gov.uk/ukpga/2005/9/pdfs/ukpga_20050009_en.pdf /

Communications from ASC on 15th June 2016 indicate that the discussions on the 16th were to cover reviewing risk management of P1 as well as the decision regarding the stairgate. This appertains to a best interest decision meeting, where there is a lawful obligation to involve the family, yet the case note says that the family will be given 'feedback,' from what is thus described by the social worker as a 'professionals meeting". A Best Interest meeting should also have taken place in addition to any internal staff risk management meeting as a lawful requirement under the Mental Capacity Act 2005.

In a visit to the care home on 16th June 2016, there is an entry from the Occupational Therapist (OT) saying; '**alongside the family'**, it's not clear however what this meant. The OT's gave their view that 1:1 care should be in place for P1, but seemingly without having checked if funding was available, and then later established that it was not available. If CHC had been involved this could have been established.

On the 21st June 2016, professionals should have ensured that a Best Interest Meeting took place, and that the family were involved in decision making, as well as CHC and the CCG, given that P1 lacked capacity. It is likely, CHC as a part funder at that point, and the family, would have been appointed as Decision Makers, and if a dispute was apparent, ASC or the family could have approached the Court of Protection (under s4 of the Act) for a judgement and resolution.

The Mental Capacity Act Code of Practice was not deployed in this situation, as given that the decision in question was to move accommodation, P1 also had entitlement to be represented by her family as her advocates, and if the family had not wanted to participate for whatever reason, an Independent Mental Capacity Advocate could have been appointed. Ultimately without the right professionals and family involvement, the Best Interest Decisions taken, were not only ineffective but also unlawful.

Family Perspective

The family expressed a number of concerns about how actions taken relating to 'Best Interest decisions' effectively excluded them and prevented their mothers' voice from being heard within the process. They described a 'professionals only' approach, where they were informed of outcomes instead of contributing to decisions, being listened to and being fully involved. The family frequently had to challenge professionals on intended courses of action and affirm that initially, they were unaware of their rights and responsibilities and were not advised of the same. When they presented information from a previous Serious Case Review, they faced a lengthy 'battle' with agencies for acknowledgement that the actions that the family proposed were able to be put in place in their mother's best interests.

3.3 Theme 3: Systems Monitoring and Management

There were examples within the SAR that indicated that systems were not being monitored to check the outcome of crucial enquires, which may have impacted on opportunities for earlier intervention.

The care home recorded a considerable volume of information relating to P2's behaviour on ABC charts, outcomes of which were not monitored in a way that they could be used effectively. In addition, there was evidence of ineffective management of the information gathered from this system, which negatively impacted on securing the necessary support from the GP, ASC and CMHT. Vital Information about P2's high risk behaviour was not shared in an urgent manner and there was a lack of due diligence to pursue a time critical response when initial information was shared. Partnership interactions did not influence effective information gathering or holistic assessment, and there was a lack of professional curiosity to establish what had been previously shared, and with whom.

CMHT instructed the care home to use the ABC charts and this information was also shared with the GP. Key information on risk from P2 was shared with ASC in June 2016 but this information was not utilised or acted upon effectively. The systems that were in place did not monitor information when agencies gave or received risk related information or actions to monitor violence.

The need to record patient's information accurately on systems was highlighted on 3rd June 2016 when P2's review was held by CMHT, at the care home. He was incorrectly referred to as a new patient, when he was not. It is not clear why this was recorded about P2, or whether in doing so, outcomes for P2 were adversely affected.

CHC (supported by the National Framework for CHC)[7], determines whether an individual is eligible to receive funding for their healthcare needs, and records are kept on a database called BroadCare. For P1, the first recorded contact with CHC was on 21st April 2016 when a fast track referral was made by district nurses. The IMR does not expand on why the referral was made at that particular point and it is surprising that an earlier referral was not made, given that GP records suggested P1 was considered as receiving end of life care from 2014 onwards.

At the time of the incident on 11th June 2016, the CHC team were noted as having staff shortages and sickness and had a backlog of cases requiring an initial assessment or review. A system was in place for urgent reviews and P1 was assessed on 25th April 2016 and found eligible for funding. The National Framework states that a review for P1 should have taken place three months later. It did not.

The CCG IMR author had an issue accessing some information because multi-agency emails and phone calls were not always retained and uploaded to the BroadCare records, as they were held in individual CHC staff NHS mailbox systems. Safeguarding information should be held in CHC individual patient records and if a CCG do not hold patient identifiable information, then it remains unclear where safeguarding information is recorded or stored.

There were incidences where there was a lack of system monitoring when crucial emails had not been followed up, for example when the CCG Adult Safeguarding Lead e-mailed the CHC Duty Nurse, noted as "high importance' on the 14th June 2016 and as previously stated, no response was received until many months later. The CCG acknowledged that confusion between CHC and the CCG safeguarding lead may have been a contributory factor to this happening.

A further CHC entry appears to be made retrospectively, acknowledging the notification from ASC, indicating issues with recording and systems monitoring.

There was evidence of information sharing by a member of the CHC team, who shared emails concerning P1 with the Lead Nurse for Safeguarding Adults, however it was not clear why the information was being shared and what action they wanted the Lead Nurse to take.

The CHC recording system does not currently identify or flag outstanding actions. Review records are normally held by CHC, but it is unclear who monitors CHC outcomes or how their systems prioritise necessary safeguarding actions and the incident on the 11th June 2016 at the care home, was very serious and should have been fully recorded and investigated. In relation to CHC, as CHC were not providing the care and as such the CHC Serious Incident process would not have been applied, however the then Executive Lead for Safeguarding should have been made aware of the incident, in line with policy. ASC did not appear to consider a request to CMHT (if P2 was on their caseload at that time) to consider a Serious

[7] National_Framework_for_CHC_and_FNC

Incident enquiry, relating to the management of P2 and his demonstrated violent behaviours and the CCG consider that this was a missed opportunity to instigate a Root Cause Analysis.

Similar issues to the learning identified with the CCG IMR for this SAR featured within other cases that were part of a separate review of adult safeguarding by their integrated safeguarding team.

3.4 Theme 4: Care Practice

By the time of the incident on 11th June 2016, P1's care had for some considerable time, been provided whilst she was alone, lying down in bed. It does not appear that the care home sought expertise regarding room location, positioning, swallowing, nutrition, tissue viability, continence management, social needs and isolation. Other agencies do not refer to instructing the care home to access specialist advice, possibly indicating a lack of professional curiosity from ASC, CHC, the Hospice and the GP.

Both P1 and P2 were seen on a regular basis by GP's visiting the care home. There were twice weekly planned visits by doctors from the practice. In addition, patients could request to see a visiting doctor or staff could identify them to the GP, as needing medical attention, yet the GP IMR reports that all staff at the practice were aware of their safeguarding responsibilities, and that '**safeguarding is considered in line with guidance around (the) duty of care and the six principles of safeguarding. In care homes risk management, falls, pressure ulcers and medication are of particular concern.'** On 1st April 2016 the GP had referred P1 to the hospice for palliative care. On the day of the incident she was seen earlier by a GP as part of a palliative care review with her immediate medical needs noted and responded to.

The IMR notes that another GP (GP2) remembers that P1 was in a room near the nursing station. This is contrary to information provided by the care home to the SAR and different to the room shown to SAR Panel on their visit. GP2 described P1 as bedbound '**therefore had pressure mats on both sides of her bed which were intended to alert the care team if P1 attempted to get out of bed'**. This GP took part in the follow up SAR Panel interviews where this information was explored further, and they re-confirmed the location of P1's room. There are therefore, differences in information received about the location of P1's room.

The GP practice was involved with shared decisions about care for P1 and the IMR records that no one ever considered the placement to be unsuitable for P1. GP2 said his personal preference was that a nursing home may have been better suited to her personal care needs but there was general consensus (with the family) for her to remain at the care home. The GP IMR noted that there was evidence of good care in respect of P1 and in relation to risk identification, GP2 told the SAR Panel that: '**They accepted that a lower threshold to seek involvement with the CMHT would be appropriate for patients exhibiting aggressive or threatening behaviour'**. With regard to intervention, GP2 told the panel: '**Consideration should be given to involve safeguarding earlier to ensure the safety of other residents when agreeing care plans, medication changes, referrals and appropriateness of place of care'.**

The GP Practice were involved appropriately and there was evidence that they had, at times, advised on P1's management. There was a slight delay in the start of medication but GP2 told the SAR Panel, that they did not feel this would have prevented the incident.

GP2 advised that a Palliative Care Review involved '*anticipating people's needs, reviewing their pain and anxiety'* and that P1 was subject to such a review. Entries made in the GP IMR indicate that there was a focus on her medical needs and that safety and risk may not have been a wider consideration. They were not alerted to the volume of incidents involving P2 which may have prompted them to consider the impact on care practice.

The GP Practice told the SAR that P2 was discussed within Multi-Disciplinary Team (MDT) meetings (it is not known by the SAR, who attended) and as a result of this SAR, the Practice now holds weekly safeguarding discussions. There was recognition that the Practice could and should introduce measures to receive alerts from care homes. ASC recognised that if MDT's reached out to services, it may help to support improved case management.

The GP Practice said that an urgent referral was sent to the CMHT on 26 April 2016, and was marked accordingly, however it does not seem to have been followed up by the GP Practice. There was consideration given by the GP Practice and others, as to the suitability of the placement for P1, yet those involved in P2's care appeared to focus on sustaining his placement at the particular care home, without considering whether the home were able to meet his needs, or whether P2 would have benefited from an assessment from a psychiatric geriatrician.

3.5 Theme 5: Safeguarding Practice and Decision-Making

3.5.1 Pre-Incident

The adult safeguarding concern raised by the ambulance service for P2 in August 2015 was not responded to effectively and the ASC IMR concluded that a S42 enquiry should have been carried out. A report was made to ASC by the care home on 11th November that year, where P2 was experiencing **'unconfirmed dementia'** and he had a very low MMSE[8] score, indicating that he had serious problems, which had been recorded on 13 on 12th February 2015.

Police and ambulance were called on 11th November 2015 to an incident where P2 was lying on the floor and was aggressive, however this was not responded to effectively and no referral was made to mental health services. ASC again concluded that this incident should have led to an adult safeguarding enquiry. There does not appear to have been enough professional curiosity in relation to P2's mental health condition or its impact on himself or others and ASC apparently did not contact mental health services or the GP.

Following an incident with P2 on 23rd December 2015, ASC did not open a S42 Enquiry in relation to the other person involved and this was challenged by the care home. There seemed not to have been any consideration of the need to manage the risk P2 posed to others. Again, there was no referral to seek the support for him from mental health services.

On the 1st April 2016, ASC record a safeguarding concern relating to the incident on 30th March 2016, (regarding a reported assault on P2 by a staff member). The ASC risk assessment includes:

'**Hazard: Although [P2] has balance problems and walks with a frame he will use the frame as a weapon to hit people. He will also punch and hit out at anyone he feels has done him wrong. At these times he says he wants to kill that person and uses all of his strength to try to hurt them …'**

'What are the existing control measures: … [P2)'s whereabouts are monitored as far as possible by staff but this cannot always be guaranteed as he is very agile and moves around the community, entering other people's bedrooms and bathrooms …The residual risk rating is scored 12, though the risk matrix on the document shows a maximum score possible of 9 (which is where likelihood is 'Very likely' and impact is 'Extremely harmful major injury or death').

The incident should have led to a Best Interest Meeting, for P2 under The Mental Capacity Act 2005, regarding a decision about P2's overall future, given he was posing increasing risk to others, as well as a safeguarding referral regarding the other person. The numerous examples

[8] Mini Mental State Examination

of the incidents that had involved P2 showed poor management of risk by the care home, which had a direct impact on safe care provision for all of their residents.

The response from the care home was that a safeguarding investigation was recorded as having taking place and that the outcome was: **'for care home to review P2 risk assessment, and to refer to GP and CMHT memory clinic for a mental health assessment'.**

Given the nature of the allegation, the decision to allow the care home to carry out the investigation on ASC's behalf was flawed. The information about the serious risk that P2's behaviour posed was also not reflected in the GP's chronology, or that of the CMHT.

It is of note that the incident on the 30th March 2016 had been preceded by an accelerated volume of entries on P2's ABC charts, but this was not considered as part of the safeguarding information offered, or the response to it, and this was a missed opportunity where the prospect of a fatality could have been risk assessed as likely to have happened.

The ASC IMR identified that an impacting issue herein was that the safeguarding referrals from the care home that were made, had been sent to ASC locality team rather than to the Multi-Agency Safeguarding Hub (MASH), being the preferred route, which according to ASC's IMR, this may have meant that those referrals missed out on early intervention; early decision making; provisional planning with police and other agencies; timely sharing of information; identifying patterns of behaviour and escalating risk. Although it cannot be said for certain that it would have changed outcomes, it is likely that the impact of the referrals not being received by MASH, adversely may have affected the initial multi-agency safeguarding response.

3.5.2 Post Incident

The decision to carry out a s42 adult safeguarding enquiry in response to events of 11th June 2016 was correct, but the work that followed was flawed. The ASC IMR acknowledged that in the first adult safeguarding enquiry report ***'there was inadequate planning of the enquiry. It was focussed solely on what the care home had done and did not look at what the role of the mental health services. It might be that this was outside of the scope of a S42 enquiry regarding P1, as it would be about neglect of the other person'.***

Given the circumstances that had occurred up to 11th June 2016, as said, the decision on 13th to ask the care home to carry out their own safeguarding investigation was misjudged. A factor that may have contributed to this decision may have been an intention to apply the approach described in the "Responding to abuse and neglect in a regulated care setting" in the Care and Support Statutory Guidance[9]. However, there were factors in this case where the circumstance set out in paragraphs 14.70 and 14.71 of that guidance may have applied, which would indicate that this approach should not have been adopted because: investigation by the police was needed; there were indications that there may have been ineffective past enquiries and or serious multiple concerns; there was a previous incident of P1 being assaulted by a resident and there were many previous incidents of P2 posing a serious risk to others.

The decision from the Police not to fully investigate the incident on 11th June 2016 arguably should have been subject to challenge by ASC. The police accept, that their decision was based on the flawed belief about mental capacity and culpability of P2 for the reported assault on P1. Constructive partnership challenge from ASC of a police decision, may have prompted action to consider whether offences such as s44 of the Mental Capacity Act 2005 and s20 or s21 of the Criminal Justice and Courts Act 2015, or other legislation, may have applied. ASC knew from the former Police incident report that they had information of previous violent

[9] Care and Support Statutory Guidance - paragraphs 14.68 to 14.75

incidents involving P2, however it did not appear apparent, that a strategy or multi-agency meeting took place to explore the complexities of the case.

It was only after the incident on 11th June 2016 that ASC started to recognise the gravity and escalation of violence appertaining to the risk posed from P2, to others. Even then, case management did not capture the full extent of incidents, despite the information being available at the care home and in police reports, and it would appear that performance supervision of ASC staff failed to identify such omissions or consider the need for holistic social work assessment. As such, the quality of the S42 enquiry into the incident on the 11th June 2016 was not assured.

ASC advised the SAR Panel that the S42 Enquiry should have questioned if there was failure to ensure that P2 had support in place to manage the risks he posed to others, and if this was not the case, then it may have constituted neglect of P2 by a variety of agencies. In addition, in the absence of a police enquiry, the S42 process led by ASC, would have benefitted from improved planning, with mental health services having a pivotal role in contributing to decision making. The CCG also should have had a more proactive role as commissioners of CHC, and in consideration of the risks that P2 posed and P1 and others faced. The Trust's Datix Incident Recording System would normally trigger the Serious Incident Process, however a Datix entry was not made by Hospital 1 or CMHT, which meant that process was not initiated.

3.5.3 Second S42 Enquiry

When ASC was challenged by the family about the remit and independence of the first enquiry, the local authority arranged for a second S42 Enquiry to take place, carried out by a member of staff from a CCG. This request was consistent with S42(2) of the Care Act 2014 and paragraph 14.100 of the Care and Support statutory guidance, which gives local authorities the power to delegate others to make S42 enquiries whilst retaining oversight. However, the detail of the report was not sufficient to ensure that the shortcomings of the first Enquiry were addressed, and that the objectives set out in paragraph14.94 of the Care Act 2014 were met. In addition, paragraph 14.100 of the Care and Support Statutory Guidance is clear that where a local authority causes others to make enquiries, the local authority retains responsibility for oversight. If a safeguarding investigation does not meet requirements, then a local authority, should ensure that is addressed via their performance management policy and procedure. In this instance, again after further challenge by P1's family, ASC resumed role of undertaking the Enquiry, leading to a third S42 Enquiry.

3.5.4 Third S42 Enquiry

Whilst more comprehensive than previous reports, this was actioned almost a year after the date of the incident and made the process a significantly more challenging task than it would have been, had an effective Enquiry been conducted from the outset.

The third Enquiry report starts to address the issue of the role of the mental health services and their involvement with P2. The approach taken by the officer identified that this was a relevant issue that needed to be addressed, and identified it as an action to be taken, outside of the Enquiry. This seems to be a reasonable approach in the circumstances, in order to manage the issues of confidentiality, in addressing crossover of regarding the services that P2 received; how that affected the risk he presented to others, and what happened to P1.

An Enquiry is clearly less effective, if the range of issues are not recognised at the outset and such recognition in the approach would have been likely to have been more effective and given the P1's family assurance that the issues were being addressed. The fact that it took three attempts to complete the S42 enquiry reports raises a number of issues, such as:

that the S42 enquires lacked professional curiosity about existing risks; the quality of social work, its supervision; its performance management and managerial supervision. It also raises the unacceptable impact on P1's family, for a protracted amount of time, who were waiting for what could have been answered, had the first S42 enquiry been effective in delivery of outcomes.

Other issues existed such as: the lack of acknowledgement and family communication regarding delays in completion; why the S42 enquires were not unable to identify and rectify issues raised by the family, and again this brings into question the management and supervision of social workers, and the lack of systems oversight by senior management. Additionally, a clarified process for monitoring recommendations made from the first, second and third S42 enquiries, was not apparent.

The SAR considered whether there were system issues (other than the referral pathway) that contributed to the above. The SAR received information that suggested that an engrained culture regarding social work practice seemed to exist at that time. Contributing factors may have included, (prior to Care Act changes), legal advice to ASC teams was that the previous 'No Secrets guidance' did not give the local authority the mandate to investigate, which led to working practices compliant with such advice. Post Care Act implementation, whilst the local authority took a leadership role, in this case, they handed over the safeguarding investigation to the care home, which albeit was within its power to do so, this decision contributed to a 'hands off culture'. At the time, practice seemed to focus on identifying immediate risk and addressing it, but did not necessarily reflect on how or why the risk(s) had developed. Whilst some improvements have been made it is acknowledged by ASC the 'hands off' culture in safeguarding adult practice still needs to be addressed.

In addition, given that ASC was not the commissioner of the care, ASC Quality Assurance would not have had a contract monitoring role with the care home and responsibility for the contract monitoring would have sat with the Clinical Commissioning and CHC - but only after P1 was partly funded for Nursing Care. In addition, CHC had a responsibility during that period to provide a patient review.

Family Perspective

The family raised their concerns about safeguarding practice in an e-mail to ASC, shared with the CCG on 16th June 2016. They expressed concerns for their mother's safety, that of other residents, and about their frustration about the apparent delay from ASC and the care home in investigating the incident. This decision, in their view, did not fully reflect the content and gravity of the situation. The family's written concern represented a comprehensive summary of possible actions and observations and clearly set out their perspective. This was as follows:

- their concerns of ongoing risk to P1 and potentially others
- a request for urgent action to review risk and the need to instigate immediate protective measures.
- their concerns that their Mother could still have died as a consequence of the reported assault
- questions about the independence of the initial investigation
- challenging the robustness of the investigation (they describe the care home being given a sheet with pre-printed questions by ASC with seven days to respond).
- questions that relate to the previous Serious Case Review, (Mr J and Mr Y).
- a summary incident of the previous violence by P2, that they were aware of and queries about the role of psychiatric specialists when someone is a risk to themselves or others
- actions taken by the care home
- their trauma and feelings of guilt for their perceived failure to protect their mother.

On 17th June 2016, CHC recorded a conversation with P1's son where he expressed the family's wishes for their Mother to stay in the care home, as long as she was safe. The CHC team advised him to contact them if he had any further concerns about his mother's safety.

In relation to the S42 enquires, the family felt duty bound to challenge the independence and quality of reports, because in their view, key issues had failed to be addressed, given that they had requested the process be repeated to a satisfactory standard. They also queried supervision and quality assurance processes for S42 Enquiries and would like to see national standards, audited by external experts, to ensure that the same are met.

3.6 Theme 6: Making Safeguarding Personal (MSP)

The ASC IMR acknowledged inconsistencies in making safeguarding personal, the delivery of safeguarding enquiries and the outcomes[10]. This does not feature as part of ASC practice in their chronology to support safeguarding, nor was it evident in systems and process.

In relation to the safeguarding enquiry into the incident involving P1 on 26th February 2015, it was evident that the family were not included in the process as they ought to have been, and this remained unchecked, when the decision was made to end the Enquiry. The family should have been made aware of the outcome*s* and any recommendations, instead they were redirected to the care home by ASC. The outcome of that particular Enquiry concluded that hot food was being served to P1 and had been dropped on her chest and burnt her skin. ASC do not appear to have considered that if this was the case, or that had the food been placed in P1's mouth it would have had a similar outcome, i.e. a burn to mouth/lips/gums or her throat. There appears to have been be a missed opportunity to safeguard effectively in relation to care home practices, to prevent this happening again.

Key lines of enquiry were given by the family to ASC, which should have been followed up e.g. checking the sensor mat's activation in P1's room; scrutinising response times to these activations (including on the day in question) and whether the mats themselves were functional or defective. A consideration could also have been made regarding the alarm calls that had not been responded to, or if mats were actually in place.

On 11th June 2016 the family had raised a pertinent question to ASC, regarding the maintenance of the sensor mat in their mother's room, as they had observed frayed wiring. It seems according to the chronology this was dismissed on 7th September 2016 by the S42 Enquiry because the fraying had not been noticed by the care home. It is reasonable to conclude that ASC did not make any checks on whether the mat's wiring was checked after the incident on 11th June 2016 and the Chartcall sensor mat response sheet, may have proved useful in an investigative capacity to both ASC and Police.

The response report of activations was obtained by the family and made available to the S42 Enquiry, but the activity on the mat on the 11th June 2016 was not subject to scrutiny. The response report shows no activations between 14.00hrs and 16.12hrs, and the incident evidently happened between 15.00 and 15.20hrs. This did not prompt questions as to why it did not identify a person entering P1's room, whether the mat was working, whether it was in place or how effective for risk management.

[10] MSP -Making Safeguarding Personal - is a sector led initiative which aims to develop an outcome focus and a person-centred approach in safeguarding others and provides a range of responses to enable people to be supported in relation to improving or resolve their circumstances.

Family Perspective

The family were not advised from the outset about the safeguarding process itself, their rights, roles and responsibilities, furthermore, the family had tried to drive the process forward and were not heard. They had to seek updates and subsequently found themselves in dispute with ASC and the care home, in their own efforts to safeguard their mother.

There was conflicting information given to the SAR as ASC thought the family had a Lasting Power of Attorney in place on 13th April 2016, which they did not, whilst the Occupational Therapists said it was not in place on 16th June 2016. A reference however to a Deputyship Order was made within the family's report to the SAR, and that they had sought the Order post the June 11th incident.

The family were shocked that, after several attempts to complete a S42 Enquiry, a thorough examination of P1's and P2's records was not made, and that ultimately, they feel that their Mother's 'voice' was lost in the process.

3.7 Theme Seven - Statutory compliance

CQC had specific responsibilities for the regulation of the service and hence why an IMR was requested from CQC to assist with: information sharing about their involvement and to identify potential learning. CQC had conducted inspections on this care home and given that the CQC website states: **'We inspect and rate residential care homes and nursing homes. You can use our inspection reports and ratings to help you understand the quality of care'**, there is, arguably, a public perception that as a public facing organisation they provide assurance as to the safety and wellbeing of residents within care homes.

As part of the planning process in 2013 (to the present day) enquires received about or from a care home are reviewed. In 2013 this was manually done, whereas in 2016 onwards, systems produced a summary that identified information such as number of complaints, safeguarding referrals, accidents etc., that had been reported to CQC. This information could come from the service, its staff, family, service users, visitors, professionals, or the general public. CQC's practice was to look at the number and detail of statutory notifications of areas deaths, serious incidents, safeguarding and incidents reported to the police. Two inspections using non-ratings methodology in 2013 found that standards were met at the care home. An inspection in late 2016, rated the care home as Requiring Improvement in '**Responsive to people's needs'**,' with an overall rating of Good.

Analysis of the CQC care home records, showed a further incident where one service user hit another occurring in August 2016. No physical injury was reported, and the care home had seemingly recorded their action as an appropriate response to keeping the people safe. It is significant that there was a note within CQC records submitted to the SAR, advising the next inspection to consider assessment of risk and staff support for people whose behaviour may challenge others.

During a CQC inspection, the onus is on the care home to inform the Inspector of relevant incidents. CQC have acknowledged that since the incident in June 2016, they have been made aware of incidents documented herein that involved P1 and P2, which they were unaware of at the time. It has been evidenced that CQC (and other agencies) were not aware of all incidents that had involved P2 and CQC have advised, that if regulations have not been complied with, it will be addressed. CQC filed criminal proceedings in respect of a Breach of Regulation 12[11].

Should CQC wish to analyse the number of violent incidents that were recorded at the care home versus those that they were notified of, they would, for example, simply have to review

[11] Heath and Social Care Act 2008

the ABC Charts for P2, versus the lawful Notifications received. CQC have told the review that their analysis of this information within the ABC charts did not take place until outside the time limits for criminal action against the provider.

CQC guidance refers to inspectors talking to 'relevant' stakeholders and looking at 'relevant' records. This is apparently determined by the individual inspector using their professional judgement and their own expertise. In this particular case CQC, shared that sources of feedback information given to the 2016 inspection included Healthwatch, commissioners and the ASC safeguarding team. In addition, they advised that they had spoken to:

'23 people, two relatives and 17 staff as well as reviewing 10 care plans and associated records, 10 medicine administration records, five staff recruitment files, and the records of quality assurance checks carried out by the staff'.

CQC were made aware of the previous Serious Case Review in January 2016 and have advised that learning informed future inspections. Post June 2016, a further incident in August was reported to CQC, when a 'resident on resident' assault occurred and the inspector was made aware. CQC advise that the provider gave them assurances that measures were put in to place to reduce the risk of reoccurrence. CQC were unable to share information regarding the details of those measures, as the parties were not connected to this SAR, but did advise that the circumstances did not warrant an earlier inspection date.

The SAR is advised that CQC are now developing a more risk-based approach to regulation, both in terms of monitoring and inspection. Use of intelligence and other dashboards currently inform decision making and as part of developmental planning, (2020/21) the onus will remain on the care home to identify and share notifiable incidents to inform inspections, with reliance on other relevant sources. What may be less clear and articulated to this SAR, is how the identification and mitigation of potential gaps in the management of soft intelligence is to be managed.

During the information gathering for this SAR, a historic sexual assault in 2013, on P1 from another resident (known as P4) was identified both to police, and the SAR Panel, by the family, and their solicitors. It was established that the incident was recorded in P1's notes at the care home. Consequently, a police investigation and a further S42 Enquiry were carried out. However, police were legally unable to pursue the matter and both parties are now deceased. Agencies were unable to gather information from the care home because they decided to withdraw from the SAR process, owing to the intended CQC prosecution. Sufficient evidence could not be established to bring about charges. The S42 enquiry into this historic allegation concluded that on the balance of probabilities the abuse did occur. This information has been passed to CQC in relation to the possibility of regulatory breach.

Family Perspective

The family raised a number of concerns and comments about CQC's role, the incident involving their mother and how inspections are undertaken. These included how the December 2016 inspection afforded a '*Good*' rating shortly after the incident had occurred and how the public can make informed decisions about care home choice in the face of limited availability of information following serious incidents, and why learning from the previous Serious Case Review did not inform inspections. The family felt that comments could mislead the public about the safety of a care home e.g. erroneous assumptions that risk assessments were in place and that they were regularly reviewed. The family advised CQC of their concerns and regarding the use sensor mats and the monitoring of their activation.

This information was not received prior to the Inspection of the care home in 2016. Whilst the use of sensor mats was advisory in the December 2016 inspection, there was no reference to

how such information (or inconsistencies within it), contributed to 'holistic' risk assessment for those nursed in bed.

3.8 Theme Eight - Investigative Practice by Police, ASC and CQC

On reflection, police accepted that the initial investigation on 11th June 2016 held conscious bias: '**there did seem to be a mind-set 'conscious bias' from the start and throughout, and that as the incident had occurred in a care home and the victim and suspect were elderly residents where capacity had been identified as an issue, that there was no requirement to commence /carry out a rigorous investigation'.**

There was a lack of action from the police emergency call taker in not making enquires with the care home about the incident, and advice about crime scene preservation, securing evidence and details of potential witnesses. This 'conscious bias' may have impacted on the response at the scene, from the uniformed officers as they did not receive instruction on scene management or accessing specialist advice, such as whether CID[12] or a crime scene investigator, should be contacted.

Whilst one of the first response officers did take a few photographs, they told the SAR that they had consulted with their Safeguarding Investigation Unit (SIU) who had advised, as previously stated **'that due to the fact that the suspect in this case has health conditions and does not have capacity , the incident would be recorded as an assault (Grievous Bodily Harm) and finalised with no additional scene preservation or investigation'.**

There was not an appropriate response to this incident and a serious assault had occurred, and clear expectations and responses which are set out in the College of Policing Authorised Professional Practice document, should have been followed.[13]

Thus, primary aspects of investigation were missed on the 11th June 2016, impacting on any secondary investigative opportunities, including a decision to take the victim and suspect to the same hospital, potentially devaluing any potential forensic opportunities. No witness statements or evidence was obtained, to confirm the suspect's mental capacity to assess if he understood he consequences of his actions.

There is a subsequent supervisory entry in notes, that indicates that P1's injuries were not as serious as first thought, but there was recognition that the incident could have resulted in a more 'injurious' outcome. That being the supposition, it is reasonable to consider that this assessment should have prompted remedial investigation.

In similar circumstances injuries to a 92-year-old palliative resident, may have resulted in a murder enquiry which, as a direct result of the initial investigation and scene handling would be likely to have been severely compromised. There is an urgent need to address the existing conscious bias for the sake of future investigations. There should have been a comprehensive investigative process and a defensible rationale applied for closing this investigation.

The police held primacy when a serious assault had taken place and therefore had responsibility to both ensure an effective investigation was carried out; that a comprehensive risk assessment was undertaken and a proactive investigative approach made with partners, to gather evidence.

The initial post incident response demonstrated a lack of understanding by police in relation to multi-agency safeguarding and its interface with risk identification and risk management. As such, there was no initial meeting with partners, which resulted in agencies making decisions

[12] Criminal Investigation Department
[13] https://www.app.college.police.uk/app-content/investigations/?

in isolation, without understanding the holistic view of risks to P1, P2 and other residents at any future placement for P2.

A recent national report, 'The Poor Relation: The police and Crown Prosecution Service's response to crimes against older people' reflected that there are systemic investigative issues as seen in this review for policing responses to crimes involving older people.[14]

In order to fully investigate the incident on 11th June 2016, in early 2019, following the SAR interview, the Police decided to revisit their original investigation. As part of this, they made requests to the care home for relevant care records relating to P1 and P2. The care home questioned the status of the police investigation and the rationale for the request given that by this stage there had been several previous S42 Enquires. Following advice, the care home declined to assist with these requests, citing that both P1 and P2 were now deceased.

P1's family had previously secured copies of P1's care records which upon request were shared, however police sought to access their own independent evidence that would have necessitated access to P2's information and possibly that of others.

It had been their experience from previous investigations, that without consent from the care home, they could not access medical records and or care records, under a Section 9 Police and Criminal Evidence Act 1984 (PACE) application and warrant. The legal advice they received confirmed that records of this nature amount to personal records and are thus are considered as '*excluded material'* within s11 and s12 of PACE and the access condition in paragraph 3(b) of Schedule, could not be fulfilled. It was therefore not possible to apply for a Production Order. (This advice was supported by R V Cardiff Crown Court ex. p. Kellam (1993) 4 WLUK 77, The Times, May 3, 1993).

In relation to ASC, the practice of managing and deploying a S42 Enquiry was concerning, for example, in March 2015, efforts should have been made to assess what happened in a timely manner (i.e. not taking 12 days). There also should have been a healthy degree of scepticism about simply accepting the account of what had allegedly happened. Also, when a member of staff tried to remove P2 from a situation, ASC did not request an account of what had happened. This failed to ensure the application of natural justice principles, and his mental health needs were not considered.

ASC have acknowledged that at the time of the incident in June 2016, adult safeguarding concerns were not always leading to S42 Enquiries when they ought to have done, and when they did, ASC was unduly reliant on exercising the S42 discretion to **"cause others to make enquiries"** rather than undertake the Enquiry themselves, retaining legal responsibility for oversight.

In addition, where enquiries were made, in a significant number of instances they were not thorough. ASC report that practice has now changed (detailed at Appendices 2 and 3).

ASC were not aware of the alleged sexual assault in 2013 as it had not been reported to them police, or the family, and it was identified by research from family lawyers into care home daily notes. Albeit that that the alleged assault fell outside of the scope of this SAR, the Panel recognise the seriousness of the incident for P1, and the distress that P1 and her family experienced, the family having only discovered this information latterly. The lack of reporting such a serious incident by the care home to the police, ASC or CQC, appears to contribute to

[14] https://www.justiceinspecorates.gov.uk/hmicfrs/publications/crimes-against-older-people/

a culture of their 'under-reporting' , formed an inadequate response to a serious incident and failed to support P1, or avail to her, her lawful rights.

The revisited criminal investigation in relation to the physical assault of P1 on 11th June, 2016, concluded that there was insufficient evidence to pursue a criminal prosecution against the care home and police were unable to gather voluntary information from the care home, nor could they establish sufficient evidence to pursue any individual charges.

Without applying hindsight bias, it is not possible to attribute the missed opportunities herein to the inability of police being unable to prosecute, but what can be concluded is that the likelihood of securing a conviction in any investigation is maximised by ensuring that crime scene management; effective evidence gathering and risk management, occur from the outset.

However, CQC has the responsibility of ensuring service providers are providing quality care when carrying out regulated activities and during the SAR process, a parallel process was initiated where CQC undertook an investigation into the care home and as stated, CQC made the decision to prosecute for Breach of Regulation 12, regarding safe care and treatment[15].

Family Perspective

The family expressed concern that the investigation structure for any safeguarding enquiry needed to ensure that key evidence was not missed and that issues were identified at a very early stage. They queried why it took so long after a S42 Enquiry had taken place, to deal with what they consider to be **'criminal negligence'** and that this needed to have been specifically identified and questioned at the outset.

The family challenged the thoroughness of investigations, given what their lawyers had found in a note on their mother's file in 2013, stating that their mother had been sexually assaulted. They questioned why this incident did not come to light within the S42 enquires and felt that it should have done. They sought assurance that structures for S42 enquiries were robust and that going forward, that s42 Enquiries would not be left to professional and or individual interpretation, resulting in an inconsistent approach.

The family expressed concern that the care home was unable to co-operate with Police and the S42 enquiry, into the alleged sexual assault on 2013. They felt it was a significant concern that this could happen and that no apparent sanction could be applied - and others who continue to use and access the service are not made aware. In addition, the family were concerned that in their case, they believed information in care records had been kept and stored by the care home outside of the UK, and that this should be highlighted as a potential future barrier to an investigation.

The family would like to see an investigative framework agreed from the outset with all interested parties involved, setting out how an investigation will be conducted, ensuring that important evidence is not missed.

The family reflected that to date the 'process' has taken three and a half years, during which they have learnt a great deal about the Safeguarding Enquiry 'system' and their rights as a family. They feel it would have been enormously helpful and beneficial if they had received a guidance booklet explaining: process; the likelihood of what or may happen; who may be involved; contact details of relevant personnel; how a family can contribute; what to expect and, that they had the option to take a complaint to each service involved and the Local Government Health and Social Care Ombudsman Scheme.

[15] Health and Social Care Act 2008

There is recognition that some learning is not necessarily unique to this SAR as well as that each local Adult Safeguarding Board publish their own multi-agency safeguarding policy and procedures, approved by all Board Members from the local safeguarding partnership. which delineate process; identify roles and responsibilities; set out lawful compliance and family guidance. The family also felt that across agencies there was a need for much greater accuracy, planning, thoroughness, expediency, communication and professionalism.

The family have raised a concern regarding the CQC's methodology for assessing care home ratings and about the reliability of an assessment process that allowed for a 'Good' rating for safety to be given to a care home when a Section 42 enquiry had yet to report. However, recognition also has to be given to the fact that the home planned improvements following the incident of 11th June 2016, albeit the extent of those improvements is unknown to this SAR.

3.9 Theme Nine – Authoring an IMR

3.9.1 There was a consistent theme across many of the submitted IMRs, relating to gaps in information, relevant to the Terms of Reference. There was also, in some cases, a lack of reflection on practice and factual inaccuracy. The need to revisit the IMR outcomes owing to such issues, altered the proposed timeline of the SAR process. However, this process was agreed by the Panel as a necessary action, in order to deploy due diligence. It additionally brought increased learning for partners, particularly in relation to prevention, for example: when police re-assessed to see if a conscious bias had existed in their original IMR, they identified new factors that had contributed towards their original incident response. Police partners also recognised the need to deploy the Mental Capacity Act 2005 Statutory Code of Practice, when working with an incapacitated adult, and possible neglect. Police have proposed recommendations to address this, accompanied by a pro-active approach by their Safeguarding Lead, detailed in Appendices 2 and 3.

A contributory factor to the quality issues noted in some of the IMRs received, could be the lack of understanding by agencies with regard to their lawful obligations to a SAR, and how IMR good practice is crucial in learning lessons; the delivery of a positive approach in safeguarding practice and future prevention.

For the purpose of this review the Kent and Medway Safeguarding Adults Board is thanked for sharing their SAR Methodology, which was adopted as an interim arrangement, whilst SSAB continue to review, and further develop their documentation and associated processes.

Family Perspective

The family have commented about the length of time taken to produce the Safeguarding Adult Review and are aware that the quality of some of the IMR reports caused the Panel to apply due diligence, also that there was a need to establish views from CQC and, that parallel processes impacted on the timeline.

The family would welcome positive change to ensure that when opportunities are presented to professionals to provide information, that it is accurate and comprehensive and submitted in a timely manner.

4 Conclusions

The SAR Panel produced a themed analysis, resulting in the production of a range of systemic factors that met the requirements of the Terms of Reference. These are as follows:

1. The care home's policy and practice relating to managing violent residents focused on post incident response, not on prevention or holistic risk assessment. The risk assessments and care plans in question, for individuals did not explicitly address risk from or to, other vulnerable residents, and did not effectively recognise changes in health, or in the living

environment which could increase risk. The increased risk posed by P2, and the escalation of his aggression and violent behaviours were ineffectively monitored, and not accumulatively or holistically assessed, and a 'tracker system' left the GP uninformed of urgent concerns and risk levels. However, the latter may have been reduced if an effective mental health medication review for P2 had regularly taken place.

This was added to by poor understanding of how to deploy the Mental Capacity Act 2005 and its Statutory Code of Practice, by the care home, which rendered ineffective Best Interests Decision Making, particularly concerning family involvement, advocacy, change in accommodation and care and health decision making. There was also a lack of sharing important information with, and seeking assistance from, relevant agencies and professionals, along with an absence of their holistic risk assessment, causing a negative impact on resident welfare. In addition, and where mitigation may have been possible via access to specialist internal advice**,** this did not occur.

2. ASC and Police (holding primacy for the investigation) failed to adequately or effectively deploy the Mental Capacity Act 2005 and its Statutory Code of Practice, which also affected Best Interests Decision Making for P1 regarding her health, welfare and accommodation. ASC and the care home, also failed to recognise that a Deprivation of Liberty issue did not exist in relation to the use of a stairgate for protection, and failed to recognise that what did exist was in fact a disputed Best Interest Decision, which could have been remedied at the Court of Protection, or possibly if effective practice had been in place. This meant that the family did not receive correct information, and there were unacceptable delays, before family wishes were implemented.

3. Investigation and S42 enquires did not always reveal or explore the experiences, history or previous risk that P1 faced and serious safeguarding concerns were also not always reported to ASC, police or CQC, which added to that risk. A subsequent new S42 Enquiry concluded that on balance of probability that abuse took place and CQC may consider if this constitutes a regulatory breach, in relation to notification.

4. There was a lack of professional curiosity and scrutiny, from all agencies, where opportunities existed to mitigate and explore shared multi-agency risk assessment and management.

5. The CCG did not adequately monitor CHC provision, and did not deploy regular reviews, and it would appear that adequate resources were not available to meet their obligations and responsibilities which added to missed opportunities to assess P1's healthcare needs and the associated risk she faced.

6. The care home reported various incidents to CQC regarding other residents and we are advised that this informed inspections, but it is not possible to conclude if measures were effective in preventing harm, or if missed opportunities could have been mitigated. Whilst CQC express confidence that lower level incidents that do not form part of the requirement to notify under Regulation 18 Health and Social Care Act 2008 would be identified, the SAR has concluded that this may be unlikely. CQC systems and their new intelligence led approach, may need to be tested to see if 'lower level' incidents or patterns and trends in similar cases are identified, particularly where providers may 'under report' concerns. In addition, CQC may benefit from deciding how they can demonstrate that the learning from this and other SAR'S are considered in their regulatory inspections.

7. When families provide information to agencies regarding risk to loved ones, their views should be listened to, valued and recorded, and when there are grounds for their concerns, appropriate action taken. The SAR concludes that all agencies and providers involved in care and health provision, should ensure that where the law permits, accurate,

proportionate and transparent information is shared with a family, regarding risk to their relative, when that person lacks capacity.[16] The family consider that not advising other families with incapacitated relatives at the care home, with regard to the risk posed, may also represent a breach of candour to others.

The family's experience regarding the first allegation, has led them to conclude that a S42 Enquiry requires a different structure, aimed at achieving outcomes. In relation to the allegation from 2013, (outside of scope of this SAR), the family believe that if former negligence exists, access to records should be legally allowed. There is clear frustration on their part, in relation to this, and that the same may represent a significant concern to other families, who place loved ones in care. In addition, the family also believe that if a care home store records outside of the UK, this can act as a barrier to any investigation. The timeline of the safeguarding process was clearly exhausting for this family, and their experience tells us they had to learn about the process as it developed, rather than having information from the outset.

8. Issues identified with the ASC Out of Hours Emergency Duty Team suggest that adult safeguarding arrangements with the Multi-Agency Safeguarding Hub (MASH) require review.

9. ASC and the CCG did not record, respond to, or monitor adult safeguarding concerns appropriately and formal s42 Enquiries lacked effective supervision.

10. The SAR concludes that Making Safeguarding Personal was lacking in both cases of P1 and P2.

11. The poor quality of some IMRs had an adverse impact on the timeline and follow up enquires were needed to establish clear facts, where gaps existed.

[16] Health and Social Care Act (Regulated Activities) Regulations 2014: Regulation 20.

5 Recommendations

It is important to note that all agencies involved in this SAR have made their own recommendations (found in Appendix 2) and described improvement and planning. It is advised that those Appendices are read before the following, which adds recommendations from the activity of this SAR.

5.1	**ASC**
1.	**That ASC audit a sample of not less than 50 cases adult safeguarding cases from January 2019 to December 2020, and conduct a deep dive to establish that risk was effectively assessed and acted on; that adult safeguarding policy and procedure was adhered to and that the Mental Capacity Act was, where necessary correctly applied and that the views of the service user and family are evident and that safeguarding is personal.**
2.	**That ASC utilise the results of the above to inform** **a) ongoing improvement plan** **b) to devise a risk assessment framework which is consistently applied to all adult safeguarding cases** **c) develop a system which offers a clear family/ representative perspective in S42 Enquiries re process and purpose of various stages; and that keeps families appraised and updated.**
3.	**That if and where ASC have, or do, commission placements for service users at the care home in question, their Quality Assurance team monitors outcomes for those service users for at least the next 12 months or until the Team is satisfied that any concerns that may exist, have received any necessary intervention and, where or if, a notifiable incident has occurred, a referral has been made by the Care Home to CQC.**
4.	**That during information sharing meetings with CQC, that ASC Adult Safeguarding regularly request to be advised of any recent notifiable incidents and that if gaps in identifying 'relevant information 'are established, they are challenged by either organisation.**
5.	**That ASC redesign their safeguarding referral form and their safeguarding adult process so that when a referral is made, receiving officers have an awareness of contextual and historical risk to enable a holistic approach to information gathering and assessment and that the overarching value of holistic assessment is embedded into safeguarding practice.**
5.2	**Clinical Commissioning Groups (CCGs)**
1.	**That the CCG audit a sample of not less than 50 CHC reviews (to include a focus on those receiving care in bed and/or displaying distressed/aggressive behaviour) from January 2019 to December 2020, and conduct a deep dive to establish that risk was effectively assessed and acted on; that correct policy and procedure was adhered to and that the Mental Capacity Act was, where necessary correctly applied according to the decision specific issue and that the views of patient and family were evidenced.**
2.	**That the CCG ensure there are clear processes of monitoring of CHC that includes reviews being undertaken in line with prescribed timeframes, effective risk management and supervisory oversight.**
3.	**That should a backlog of reviews exist at CHC, then the CCG establish effective plans to manage this which includes resource, system and service monitoring.**
4.	**Commissioners of the CMHT service are to seek assurance of the timeliness of responses to mental health referrals in line with the Service Level Agreement and a monitoring system is put into place to provide oversight intelligence to management.**
5.	**That NHSE consider developing clinical prescribing guidelines for GPs who are facing the management of violent patients in the community.**
6.	**That KPIs are put into place for a Trust response to urgent mental health referrals, and good practice guidelines are made regarding GP response to urgent requests for a mental health referral of a cared for person who lacks capacity.**

5.3	**Mental Health Services and The Trust**
1.	**That the Trust audit a sample of not less than 50 mental health reviews from January 2019 to December 2020 (to include a focus on those receiving care in bed and/or displaying distressed/aggressive behaviour). To conduct a deep dive to establish that risk was effectively assessed and acted on; that correct policy and procedure was adhered to, that and that the Mental Capacity Act was, where necessary correctly applied correctly applied according to the decision specific issue and that the views of patient and family are evident and outcomes contribute to improvement planning.**
2.	**That the Mental Health Trust conduct a scoping exercise to identify patients in the community who may represent a risk to others and check if these patients have received a review within correct timescales, and if not to provide a review. This exercise should shape development of an ongoing monitoring system to improve future risk management**
3.	**That the Trust set up a monitoring system to ensure timely reviews take place.**
4.	**That Trust Policy regarding the management of potentially violent patients in the community be reviewed and that associated guidance be shared with the SSAB for circulation (to commissioned and or independent provider services) and it should include guidance on: the necessity for multiagency contributions; the need for contextual information; the value medication reviews; advice on the prevention of risks to others, particularly if they are receiving care in bed and the framework for monitoring arrangements.**
5.4	**GP Practice**
1.	**That systems are reviewed to ensure all urgent referrals to mental health services are flagged clearly as urgent and that they are subject to a timely administrative follow up, in accordance to CCG expectations or KPIs.**
5.5	**Ambulance Service**
1.	**That Ambulance staff are fully conversant with how to undertake a verbal mental capacity assessment and are trained accordingly.**
2.	**That if two people are to be conveyed to Hospital that consideration is made to if they could attend different hospitals, where there is a victim and a suspect.**
5.6	**Police**
1.	**That a multi-agency audit of a sample of crime reports takes place, where an allegation of crime has been made, and where the mental capacity of the victim and /or suspect is a factor.**
2.	**That an internal training programme is set up for all officers to refresh learning on the practical and lawful deployment of The Mental Capacity Act and The Statutory Code of Practice; Multi-Agency Adult Safeguarding Procedures and Policy and relevant learning derived from within 'The Poor Relation: The police and Crown Prosecution Service's response to crimes against older people'[17].**
3.	**When seeking access to medical notes in this case, and after a voluntary request for documents had been declined by the care provider as part of an ongoing criminal investigation , Police (having sought legal advice) felt unable to legally utilise powers under Section 9 of Police and Criminal Evidence Act in order to seize relevant material; as the personal records involved could be considered 'excluded material'. The impact of receiving this legal advice has wider implications for Police when carrying out Safeguarding investigations.** **The SAR acknowledges that there are opportunities for information sharing between partner agencies. This includes the sharing of relevant and proportionate information with the Police e.g. it is the public interest to do so or where there is a legal mandate such as the Data Protection Act 2018 legislation or a relevant court order in place e.g. power of attorney. It is therefore recommended that this issue is highlighted to Safeguarding Investigators and shared with other Police Services via the NPCC lead, in consideration of lawfully obtaining records in support of thorough investigations.**

[17] https://www.justiceinspectorates.gov.uk/hmicfrs/publications/crimes-against-older-people/

5.7	**Care Home**
1.	**Based upon the report's findings regarding the management of vulnerable residents in a safe environment, that the SSAB seek assurance from the Care Home owners, that they have/are developing a performance management framework which is embedded into practice, to improve how managers and care staff are managed and led, and that this process can be evidenced as effective in ensuring robust individual risk management and escalation from staff and managers, in the home for all residents.**
2.	**To co-produce a policy with primary care, regarding mental health referral management, to particularly consider risk from violent residents posed to isolated and or immobile residents and family involvement.**
3.	**Within the next 6 months, a training programme is delivered to Managers on how to deploy the Care Standards;[18] The Mental Capacity Act 2005 and its Statutory Code of Practice; The Surrey Safeguarding Adults Board Multi-Agency Adult Safeguarding Policy and Procedures; accurate recording and the lawful and valuable involvement of families and advocacy for mentally incapacitated or mentally impaired residents.** **That care staff are trained on the relevant components of (4) and the practicalities of referral processes for services; response times, escalation and out of hours services offers and that any proposed training is submitted to SSAB for quality checking.**
4.	**Directors ensure that managers regularly check SAB websites on learning from published cases.**
5.8	**Surrey Safeguarding Adults Board (SSAB)**
1.	**That the SSAB seek evidence and assurance on all recommendations made in this SAR and on the agencies own recommendations and pay attention to the former consider recommendations regarding Mr J and Mr Y.**
2.	**That the SSAB provide IMR Training and or they provide written guidance on best practice for the same and include any necessary guidance in the Multi-Agency Safeguarding Adult Policy and Procedures.**
3.	**That learning from this SAR is shared locally and nationally and that learning is maximised and includes multi-agency responsibility in both risk assessment and its management; how the latter is improved by inclusion of contextual and historic risk-based information and accessing systems access and sharing information.**
4.	**That the SSAB co-produce a guidance booklet with Person 1's family (if it is their wish) and others, to advise on the SAR process, roles, responsibilities, contributions, rights, escalation and concerns and that this available on the SSAB website.**
5.	**That the SSAB seek assurance from the care home, CCG, CHC, The Trust, GP Practice and ASC on how their recording systems identify and monitor risk and that reviews and outstanding are flagged.**
6.	**That the Independent SSAB Chair writes to:** **a) Surrey Care Home Association - to agree a communications loop with local learning.** **b) CQC National Safeguarding Lead - to request:** **i. the need for a national outward facing approach taken by CQC on how to respond to SAR requests** **ii. how SAR Terms of Reference can be shaped to support learning for CQC practice to improve inspections** **iii. whether notifiable incidents should include safeguarding referrals and if not why not** **iv. to ascertain if the latter applies to resident on resident incidents, particularly in high risk cases and when people pay for their own care** **v. a view if current inspection arrangements may represent a system failure regarding 'a safe service' standard, if a care home fails to make relevant notifications**

[18] Care Standards Act 2000

	vi. how the learning from this SAR could impact on family involvement in the inspection process in future and help to raise public confidence in care home ratings and **vii. that care home managers evidence their understanding of both The Care Standards Act 2000, during regulatory inspections, as well as the Health and Social Care Act 2008.** **c) ADASS[19] Local Government Association and the National Adult Safeguarding Board Chair's Network – to engage discussion about the need for national guidance on writing Individual Management Reviews and opportunities for developing standards for completing S42 Enquiries.** **d) Department of Health and Social Care - to engage discussion on issues related to the duty of candour and how all agencies and providers involved in care and health provision, should ensure that where the law permits, accurate, proportionate and transparent information is shared with a family, regarding risk to their relative, when that person lacks capacity. Specifically, to consider how S81 of the Care Act 2014 updated S20 of the Health and Social Care Act 2008 in relation to the provision of information in a case where an incident of a specified description affecting a person's safety occurs in the course of the person being provided with a service.** **e)The National Police Chief's Council Safeguarding Lead - to request that the implications of this SAR are nationally considered to improve the quality in similar police investigations and to share the considerations posed with CQC, and the implications of the legal advice provided to police to when trying to secure access (without consent) to medical and care records from a care home, given the direct impact on the potential for a revised police investigation and the significant implications for investigation of all offences, where this evidence needs to be sought.**

[19] Association of Directors of Social Services

Appendix 1: SAR Panel Terms of Reference

1. Background

1.1 Person1, aged 93, lived in a care home and was receiving palliative care. She had been diagnosed with 'end stage' dementia. Cared for in bed, the Review is informed that Person 1 was unable to move, speak or communicate her needs in any way. Whilst in bed, in her room on 11th June 2016 at 15:20, the Review is informed that Person 1 was assaulted, which involved her being beaten with a Zimmer frame, by a male resident, who also had dementia and a recorded history of violence and aggression (this person will be referred to as Person 2). As a result of the assault, the Review is informed by Person 1's daughter's, and how their Mother sustained injuries, and experienced considerable pain and suffering in the last four months of her life. It is important to note that Person 1's family experienced distress because they witnessed their mother in pain, at the last stages of her life, and also because they did not know how to manage this very difficult matter and its consequences. In addition, Person 1's family very much wanted to ensure their mother was properly safeguarded, for the remaining months of her life.

1.2. On 11th June 2016, Person 1 was alone in her room in bed, with the door open and staff reported that Person 2 was seen coming out of Person 1's room, claiming that he had killed Person 1. Further detail appertaining to the incident will be determined by the Review.

1.3 Following the incident Person 1 was taken to Hospital 1. Her daughter was called and attended the care home and accompanied her mother to the hospital. Person 1 stayed in hospital until she was discharged at 01:00 on 12th June. It was noted that during the admission process, Person 1 was in the vicinity of Person 2. When she returned to the care home Person 2 was no longer resident at that establishment. In the following months Person 1 experienced pain and distress and sadly passed away on 22nd November 2016.

1.4. A referral requesting a SAR was submitted by Adult Social Care to the Surrey Safeguarding Adults Board on 5th December 2017 and on 11th December the SAR sub-group of the SAB (including representatives from the Clinical Commissioning Group, Surrey and Borders Mental Health NHS Foundation Trust, Surrey County Council , the Acute Trust, Police and Surrey Fire and Rescue Service) met and decided that the case of Person 1 met the criteria for a SAR.

1.5. On 6th March 2018 Maria Dunmore Gray was appointed as the Independent SAR Author and on the 19th July 2018, she met with family members. As a result of that meeting and subsequent discussions with the family it is acknowledged that: a) following the incident Person 1's family witnessed their mother's pain and distress and b) have struggled to understand how such a violent assault could have happened in an environment where they believed their mother was receiving the very best care and c) have struggled to manage their mother being effectively safeguarded post the assault. It is also acknowledged that there are four family members, all children of Person 1. The Independent Chair of the Review, Deborah Stuart-Angus, has sought and received written confirmation from the family, which states that they do not all wish to take part in the Review, and have delegated their authority to two of their sisters to represent them.

2. Meeting SSAB duty to conduct a Safeguarding Adults Review

2.1 The SSAB will take the lead for conducting a SAR when:

a. An adult at risk dies and abuse or neglect is known or suspected to be a factor in their death
b. An adult at risk has sustained any of the following: a life-threatening injury through abuse or neglect; serious sexual abuse; serious or permanent impairment of development through abuse or neglect or,
c. Where there are multiple victims
d. Where the abuse occurred in an institutional setting
e. A culture of abuse was identified as a factor in the Enquiry and,

f. The case has given rise to concerns about the way in which local professionals and services worked together to protect and safeguard the adult at risk

The reason a Safeguarding Adults Review is held is to enable to the members of the SSAB to:

a. Establish the lessons to be learnt from Person 1's case in terms of how professionals and organisations worked both individually and together to safeguard those in their care.
b. Identify what those lessons are, both within and between agencies, how and within what timescales that they will be acted on, and what is expected to change as a result.
c. Prevent harm and apply these lessons to service responses for all adults at risk who need safeguarding support through intra and interagency working.

SSAB are in the process of refining their procedure for Safeguarding Adult Reviews and so this SAR will be carried out in accordance to the procedure set out in the document Kent and Medway Safeguarding Adult Board (KMSAB) Procedure for Safeguarding Adults Review (revised 2017), as a good practice model and following a formal request to the KMSAB.

3. Purpose of a SAR

3.1 On 10th September 2018, a SAR Panel was held by SSAB and chaired by an Independent Chair. It was decided that the SAR would consider both provider and agencies' involvement with Person 1 and with Person 2, in so far as it was relevant to the safeguarding of Person 1. Prior to circulation of the Terms of Reference, The Independent Chair will contact agreed family members to make an introduction and attest how information from the SAR will be shared and with whom.

3.2 In accordance to the Care Act 2014, and the associated statutory guidance, the purpose of this SAR is to:

a. establish lessons to be learned from the case of Person 1, in terms of how professionals and organisations work, both individually and together, to safeguard adults at risk and prevent harm
b. identify required improvements and the timescales in which they will deployed, identifying how and what is expected to change as a result, and agreeing required monitoring systems
c. deploy a mechanism for the SSAB to apply lessons learned to service responses for adults at risk across Surrey and to share these lessons at a national level

4. SAR Methodology

4.1 The Independent Chair of this SAR Panel will oversee the review process. An overview report and an executive summary will be produced and presented to SSAB as soon as is possible, post enquiries and completion. Both reports will be based on information gathered from agencies identified as having had contact with Person 1 and Person 2, but the latter only being regarded as is relevant to the safeguarding of Person 1.

4.2 Information will be gathered from Independent Management Reports (IMRs) submitted by agencies having been identified as having relevant contact with Person 1 or Person 2. Currently the KMSAB template will be utilised by the SSAB. Additional documentation may also be requested by the SAR Author if relevant.

4.3 Each IMR will be researched and written by a person working for the agency making the submission and it will be assumed that they will possess the appropriate skills and seniority to analyse and question actions taken by their organisation. However, they must not: have had any direct involvement with Person 1 or 2, nor be an immediate line manager of any member of staff whose actions are, or may be, subject to review within the IMR.

4.4 Each IMR will include a chronology and analysis of the service provided, during the denoted period covered by the SAR. The IMR will highlight both good and poor practice, and if appropriate, make recommendations for improvement in either agency, or multi-agency working. The IMR will include context relating to issues such as resourcing/ workload/ supervision/ support and training /experience of staff involved.

4.5. Each agency must include the circumstances of their first recorded contact with Person 1 and Person 2, if affects the safeguarding of Person 1, in the chronology of their IMR, regardless of the date. Any significant incidents that occurred outside the period of the review should also be noted. The chronology must include all information about contact in the denoted period.

4.6 Each agency's IMR must contain a comprehensive summary of all information that is relevant to the safeguarding of Person, during the period covered by the SAR and must include:

a. narrative and analysis of their organisation's involvement with Person 1
b. identification of any lessons learned
c. challenges and opportunities
d. recommendations for their own organisation

4.7 Any issues relevant to equality, for example disability, sexual orientation, culture and/or faith should also be considered by the IMR writer. If none are relevant, a statement to the effect that these have been considered must be included.

4.8 The completed IMR must meet the submission date agreed by the SAR Panel. Each agency must ensure that sufficient time is available for the IMR to be signed off by a senior manager in the organisation, including return to the author for any amendments or addition required.

4.9 Completed IMRs will be considered at a meeting of the SAR Panel. If members of the panel have queries arising an IMR, a meeting will be convened and individual IMR authors will be requested to attend so questions from the Panel can be raised and answered.

4.10 If necessary, the SAR author or members of the panel may seek to request further research/ information to supplement an IMR, to enable better supported independent conclusions about the lessons to be learned from the case of Person 1

4.11 When the IMR information has been agreed by the SAR Panel, the Independent SAR Chair will ask the Independent Author to produce a draft Overview Report. The SAR Chair will retain independence of agencies subject to SAR and will use their independence and will discuss the recommendations with the author and provide rigor to the recommendations made (if required).

5. Agencies who will be asked to submit reports

- Adult Social Care
- Care Home
- CCGs
- Continuing Health Care
- A General Hospital
- A Trust
- An ambulance service
- A hospice
- Police
- Person 1's GP
- Person 2's GP

In addition to the above, Person 1's family wish to submit a report of their own, which will be received in due course.

6. Action to be taken if there is a failure by agencies to cooperate with a SAR request

6.1 Any failure to co-operate with this SAR will be reported immediately and directly to the Independent SAR Chair, who in the first instance will report any apparent lack of co-operation to the Independent Chair of the SSAB.

7. The Overview Report

7.1 This will outline:

- A summary of the incident and the risks faced by Person, being cared for in bed, on a daily basis
- A summary and analysis of the contact and involvement that the provider and each agency with had with Person 1 in relation to the risks she faced
- A summary and analysis of the way the provider and agencies worked together to safeguard Person 1
- A summary and analysis of how the provider and agencies worked together, in relation to the risks faced by Person 1 from Person 2.
- Other areas considered identified as relevant by the author
- Conclusions about the way in which agencies acted, singly or together, to safeguard both Person 1 and Person 2, and whether policies and procedures require change to ensure improved safeguarding in future.
- Recommendations for action that should be taken to improve the safeguarding of adults at risk, and what must be learned either by a single agency or by agencies working together.
- Lessons learned from agency involvement from all of the above, and how such lessons can be applied and deployed to safeguarding adults in future.
- The outcomes of a consultation meeting with Person 1's family in relation to their views

The overview report will assist the panel on completing:

- An action plan setting out how agencies will implement recommendations, including: required action, who will be accountable, the timescale in which actions will be completed and what will be different as a result.

7.2 A first anonymised draft will be submitted two weeks prior to a further meeting of the SAR Panel, following which agreed changes will be made to the draft. If it is necessary to make any changes, a second draft will be submitted to the Independent Chair of the SAR Panel, after which a decision will be made whether or not to submit the potential second draft as a 'final' draft to the Independent Chair of the SSAB for consideration by the SSAB.

7.3 Following feedback by the SAR Panel, an Executive Summary can be produced, which will not contain any personal or sensitive data.

8. Specific Issues to be Addressed (see further document for details of questions from SAR Panel and family)

8.1 Risk Management

- What was the risk management methodology, deployment and quality assurance regime within the care home's management system (including human resourcing, management, supervision, training and qualifications) in relation to:
  a) management of potential violence and aggression, and
  b) its impact when caring for individuals receiving end of life healthcare in isolated circumstances?
- What impact did the outcomes of the above have on the risk management for Person 1 and Person 2, staff, management, partners, family and visitors?
- What knowledge of Person 1 and Person 2, assisted organisational and partnership responsibilities to contribute to risk assessment in providing social and healthcare, and the delivery of statutory safeguarding responsibilities, including Making Safeguarding Personal?

8.2 Post Incident

- How did the post incident response contribute to the effectiveness of risk management for Person 1 and Person 2 and other residents within the environment?
- How were Person 1's former wishes represented and how were her views advocated,
- particularly given that Person 1 was subject to an approved Deprivation of Liberty Safeguard application?

- How were Person 1's family enabled to contribute to their Mother's risk and social needs assessment and enabled to understand the ramifications of the Mental Capacity Act and the DoLS Amendment?
- What monitoring and review requirements from the regulator (CQC) and service commissioners (CHC and ASC) contributed to effective safeguarding?
- How did the Section 42 Safeguarding Enquiry enable understanding of key issues?

8.3 Information sharing and confidentiality

- How were the family advised of the risks their mother was facing in relation to being cared for in bed and from other residents?

8.4 Previous Safeguarding Adult Reviews

- Are their connections to any previous SARs held by SSAB?

8.5 Particular issues relating to ethnicity, disability, sexual orientation or faith

- Are there any of the above that might have bearing on this review?

8.6 Known research that may contribute

- Is there any known research that may contribute to the learning from this Review?

8.7 Participation of the Family

The SAR Panel identified names and details of Person 1 's daughters who have been contacted and advised of the SAR and its purpose, how it will be conducted and how they may be involved. Their views have been sought by the Independent Author. The Independent Chair will meet with agreed family members at an early stage if required to do so and will contact agreed family members, following the completion of the final draft of the Overview report, to discuss findings and recommendations.

9. SAR Governance

9.1 The Independent Chair of the SAR Panel will advise the Independent Chair of the SSAB regarding emerging findings that require action by agencies prior to SAR completion, so as to enable the deployment of change/ or organisational systems improvement at the earliest point.

9.2 The Draft Overview Report will be sent to the Independent Chair of SSAB prior to listing it as a confidential Board agenda item, in order to ascertain the Independent Chair's views, a consequence of which, may be that the Independent Chair of the SAR Panel, may request a redraft.

9.3 Once agreed by the SAR panel, the Overview Report and Executive Summary Report will be presented to the next SSAB for sign off.

9.4 The SSAB will be responsible for the co-ordination of any media management in relation to the SAR in line with an agreed media strategy.

9.5 The SSAB will make the decision about publication of either the Overview Report and or the Executive Summary Report, having already received family input via either the Independent SAR Chair/Author, at the final presentation of both to the SSAB.

10. Period the Safeguarding Adults Review will cover and report completion

The review will cover the period from when Person 1 moved into the Dementia Unit at the care home (January 2013), up to the conclusion of the adult safeguarding enquiry. It is expected that the Independent Author will have completed the report, 6 months following commission date.

11. Parallel Processes

There were no known parallel processes in relation to this Review, however this changed over time and two parallel processes occurred, one from CQC and one from Police.

12. Media Strategy

The SAR Panel and its Chair will advise SSAB on a media strategy.

13. Legal Advice

Legal advice from SCC may be sought, at any point during the Review given their position as the host authority.

Deborah Stuart-Angus, The Independent SAR Chair for SSAB in the case of Person 1.

Appendix 2: Agency Recommendations (Including Action Taken)

1.1 ASC

- Complete work to implement its revised Safeguarding Policy and Procedure
- Revise adult safeguarding workflow on its client recording system so that it reflects the ways of working set out in the current ASC Safeguarding policy and procedure
- Work with Police and Trust to improve ways of working in MASH so that: a) non-adult safeguarding referrals from the Police are dealt with efficiently and effectively, so that the MASH as a whole has capacity to deal with referrals of adult safeguarding concerns and b) adult safeguarding referrals are responded to effectively by MASH, with timely and good quality decisions regarding a S42 Care Act Enquiry and, if so, initial decision making about what and who that will involve.
- Work with SSAB and providers of services to ensure that all initial safeguarding referrals are made to or referred through the MASH. This will need to include how the Emergency Duty Team link with MASH in relation to out of hours referrals.
- Identify and implement improvements needed in the application of the Mental Capacity Act in practice by ASC
- Emergency Duty Team to review its work to ensure there are no systems, policy or practice barriers to ensuring a proactive response to situations when they are aware of a person in need of a Mental Health Act Assessment
- Social Care Staff to be reminded to be clear with family members and or people's representatives, regarding the purpose of a S42 Enquiry and to keep people appraised and updated at key points in time.
- Social Care staff to be clear with family members, and or, the person's representative(s) with regard to co-ordinators and or key contact people, for the duration of the s4 enquiry.
- S42 enquiries will have clear Terms of Reference, to ensure they fully cover all aspects, particularly preventative and background circumstances.
- When a SAR is published this will be disseminated to ASC staff.

1.2 CCG and CHC

- CHC to develop operational guidance describing the process to be followed on receipt of a safeguarding concern and/or serious incident.
- CHC to ensure that patients in receipt of NHS fast track funding receive a 3-month care review in accordance with the National Framework (NHS Continuing Healthcare and NHS-funded Nursing Care)
- Safeguarding & CHC team to continue to work together to strengthen clarity regarding specific roles and responsibilities and the interface between safeguarding and CHC.
- CHC to ensure information relating to the health and care of patients is recorded in appropriate health record and information received is attached to the health record in line with local and national record keeping standards
- Safeguarding team to ensure that safeguarding advice and ad hoc supervision is recorded in line with local and national record keeping standards.
- Following publication of the Adult Safeguarding: Roles and Competencies for health care staff Intercollegiate Document (2018) safeguarding leadership team to undertake an analysis of team member's appraisals to ensure that staff have achieved and are maintaining safeguarding competences appropriate to their role.

1.3 Community Health Services and The Trust

- raise awareness of professional curiosity and effective documentation
- review care of all patients in residential homes cared by community nursing services to establish if their views of their care, and needs, have been documented.
- healthcare professionals should advise the adult social care team so that a Care Act assessment can be offered or completed to determine level and appropriateness of care input required regardless of funding arrangements for care and support needs for patients in the community, especially when a patient lacks capacity to make a decision regarding these needs,
- ensure safeguarding incidents from community settings are recorded in A&E
- review why there was a delay in responding to referrals and to establish if this is more widespread, and if so, what needs to be done about this.

1.4 GP Medical Practice

- Prompt identification and referral of patients with aggressive or threatening behaviour (ATB) will be made to the CMHT
- Regular review of care home patients with potential safeguarding concerns to be scheduled within the Practice

1.5 Surrey and Borders Partnership Trust

- CMHT to review why there was a delay in responding to these referrals and if this is more widespread and if so, what it needs to do about this.
- Commissioners of the CMHT service to seek assurance of the timeliness of responses to referrals and consider reviewing the monitoring arrangements of the timeliness of response to referrals in line with the Service Level Agreement.

1.6 Ambulance Service

- Crew attended P2 a total of 11 times before the incident took place. A Falls referral had not been completed for this patient and there is the option to make falls referrals via the IBIS system.

1.7 Police

- Police Chief Officers should raise the profile and standard of safeguarding adult's investigations using methods similar to those that have been used on a force-wide basis to improve the police response and investigations in child protection, domestic abuse, modern slavery and hate crime.
- Police Chief Officers should use appropriate internal communications and existing training programmes address the culture that exists amongst officers and staff when responding to incidents occurring in care settings to one of positive action and wider consideration of offences relating to possible abuse and neglect.
- The Head of Public Protection should remind all front-line and secondary investigation teams using appropriate internal communications of the requirement to initiate a strategy discussion and what this entails at the earliest opportunity with ASC when attending incidents within care settings.
- The Head of Public Protection should remind all front-line and secondary investigation teams using appropriate internal communications of the requirement when responding to allegations of abuse in care settings to carry out a rigorous investigation as they would when responding to any allegation of a crime having been committee outside of a care setting.
- The Head of Public Protection should remind all front-line and secondary investigation teams using appropriate internal communications of the investigative requirement to obtain formal evidence from an appropriate mental health professional in cases where a suspect has been deemed to lack capacity.

- Repeat Recommendation. When investigating serious incidents that have taken place in residential or nursing home settings, police should consider whether criminal offences have been committed by agencies as well as by individuals, e.g. they should collect evidence to inform decisions about health & safety practices in the home and investigate whether there are grounds for considering charges of corporate negligence or corporate manslaughter (where appropriate). This is in addition to considering whether neglect by individual staff as defined within MCA s44 has been a feature of the case.
- The Head of Public Protection should remind all front-line and secondary investigation teams using appropriate internal communications of the statutory requirement under the Code of Practice for Victims of Crime to afford close relatives (nominated family point of contact) of a victim of crime who lacks capacity of the services that must be provided by the police.
- The Head of Public Protection should carry out a review of the current Adults at Risk policy and procedure to ensure that it includes sufficient guidance around the investigative standards expected when staff investigate incidents in care settings where neglect and/or abuse are suspected and where mental capacity is an issue.
- This incident and report and the learning and recommendations should be cascaded and adhered within all the relevant organisations

1.8 Care Home

- An urgent need was identified following the incident on 11th June 2016 for more of the team in the Dementia Unit to have lessons and input in their practice through a Dementia Pathway Training Course which includes:
- Dementia Awareness Training (Types of Dementia)
- Person Centred Care
- Communication in Dementia
- Cognitive Stimulation and Reasoning
- Record Management in Dementia and in Care Services
- Virtual Dementia Tour
- This will equip staff with the skills to identify, manage and refer as appropriate, any needs that they cannot meet in a timely manner. Most of the staff in the Dementia Unit Neighbourhood should take a step further in their training and complete a Level Three Distressed Behaviour Training Course.
- Training Dementia Unit Team on correct documentation of ABC charts and ensuring that this is reflected on Behaviour tracker.
- following this incident, the outcomes will be shared with other General Managers via Clinical Governance news brief.
- the organisation needs to focus more on training and compliance and regional tracking of the use of behaviour trackers through our auditing process and add the findings to the key performance indicators which will be monitored regularly.
- the organisation will benefit from carrying out a Post Incident Analysis to improve system performance and help equip staff with the skills for incident management procedures. For the organisation to have guidance on strategies to ensure people nursed in bed have regular checks in place and where appropriate specialist equipment is used to monitor and keep them safe and engaged as part of the Neighbourhood.

Appendix 3: Partner improvements and lessons learnt

1. ASC

The learning from this case outlined above is in line with what we had already identified about how adult safeguarding work in Surrey was being done. We have already taken steps to address these issues, but this case reinforces how ingrained these ways of working were in the culture of the organisation, which should give pause for thought about the scale of the challenge in changing that culture and what we must do to meet that challenge.

Changes we have made include:

1) Revisions to the policy and procedures for adult safeguarding work in Surrey:
   a. The policies and procedures for Surrey Safeguarding Adults Board and for ASC have been separated, which helps make clearer the distinctions between the role of the local authority and the multi-agency elements of adult safeguarding work
   b. The current policies and procedures set out clear expectations of what is good practice in adult safeguarding work. In particular, they include a method for adult safeguarding enquiries which will help reduce the likelihood of the problems seen in the work done with P2 and P1
2) ASC has revised its training arrangements regarding adult safeguarding, and the content of the new courses reflects the new ways of working
3) ASC has improved its arrangements for quality assurance auditing of our adult safeguarding work so that it has a better understanding of whether the work being done meets the expectations set out in the revised policy and procedures
4) ASC has produced Good Practice Guidance on adult safeguarding enquiries to help its staff apply in practice the approach set out in the revised policies and procedures

However, these are relatively recent changes and we cannot yet be confident that there has been the change in our practice that there needs to be. The ways of working seen in these cases reflect a culture of practice that has been widespread across the organisation, and it will take time and effort to shift this.

Work we have underway or planned to carry us forward on this journey are:

1) To complete the roll-out of the new policy and procedure. This involves a series of workshops in each of our localities to inform staff of the changes being made and to support local leadership with implementation
2) To revise the adult safeguarding workflow on our client recording database, to help support our staff to work in line with the model outline in the revised policy and procedures
3) To ensure that all adult safeguarding initially goes through the MASH
4) The effectiveness of these changes will be monitored and reviewed by the Head of Safeguarding.

2. CCG

CCGs are required to demonstrate that they have appropriate systems in place for discharging their statutory duties in terms of safeguarding. The integrated safeguarding team undertook a review of the adult safeguarding governance and assurance processes on behalf of all the CCG's. The learning from this case outlined above is in line with what the CCG had already identified and measures have already been taken to address these issues. In particular, work has commenced to strengthen clarity regarding specific roles and responsibilities and the interface between safeguarding and the CHC team.

The CHC team did respond to the fast track referral from the district nursing team within the specified time frame outlined in national guidance. Furthermore, there is evidence the CHC team liaised with the clinical networks involved in P1's care to discuss various care options to ensure P1 remained in her preferred place of care, the home she had lived in since 2007.

Changes made include:

1) The Associate Director of Continuing Healthcare and CHC senior managers undertook a review of CHC services and team structure. This included recruiting more practitioners to

the team to prioritise and manage the backlog of initial and review care assessments resulting in referrals being managed with the time frames specified in the National Framework for CHC.

2) The Associate Director of Continuing Healthcare reviewed and updated the duty system and function resulting in the recruitment of 3 permanent senior clinicians with the required level of knowledge in safeguarding, and a clearer escalation process to ensure sufficient priority is given to urgent cases received by the duty team.
3) The CCG integrated safeguarding team reviewed and updated the guidance and flowchart outlining the process to be followed on notification of a safeguarding and / or serious incident including the requirement to notify Executive Leads for safeguarding and senior managers within the relevant team.
4) The CCG integrated safeguarding team have developed a joint CCG safeguarding adult and children policy which clearly outlines the roles and responsibilities of all staff members of the CCG in relation to safeguarding adults and children.
5) The CCG integrated safeguarding team have developed a joint CCG safeguarding supervision policy that includes a template for recording a supervision session and advice given and a process for auditing the quality of safeguarding supervision.
6) Designated nurse and lead nurse for safeguarding adults provide regular quarterly supervision with CHC and other clinical staff in the CCG and Care home organisations.
7) Adult safeguarding governance systems and processes have been updated to reflect the Care Act (2014) and associated Statutory Guidance and NHS England's Accountability & Assurance Framework and aligned to existing arrangements for those of safeguarding children. This includes a joint adult and children assurance, accountability and supervision framework used with care homes to measure compliance with safeguarding statutory duties.
8) Designated nurse for safeguarding adults receives regular supervision in line with the requirements of the Adult Safeguarding: Roles and Competencies for health care staff Intercollegiate Document (2018).
9) Lead nurses for safeguarding adults receive regular supervision in line with the requirements of the Adult Safeguarding: Roles and Competencies for health care staff Intercollegiate Document (2018).
10) The CCG integrated safeguarding team regularly reviews training material to ensure it reflects current local and national changes to safeguarding including recommendations and learning from serious case reviews and partnership reviews.

3. Community Health Services

1) The investigation has highlighted the importance of raising awareness of professional curiosity. Responding to concerns requires the ability to recognise (or see the signs of) vulnerabilities and potential or actual risks of harm. Reported isolated issues or concerns within the DN team must prompt further discussion but provide intelligence to decide whether the concerns should have been raised to the Multi-Agency Safeguarding Hub.
2) P1 was cared for in the residential home and her needs were met by community nurses and other professionals in a regular basis.
3) Upon reviewing her care, it raises question whether she would have been benefited from being cared for in a nursing home rather than a residential home due to her needs. The nursing home would have provided her with care and support she required without any delay due to availability of nurses and other professionals on site. Living in an environment with residents with similar needs could have potentially reduced the risk of harm from others.

   On the 26th November 2012 it is documented on RIO that a CNS was asked by the home to assess P1 for a Nursing Home (NS) placement. There was no further information supplied by the DN team of the outcome of the assessment. There was no documented evidence to show whether it was person1's choice to stay in the home.

4. The Trust

1) Recording safeguarding alerts on should be a high priority in A&E for patients presenting with injuries which have occurred as a result of assault in the community or hospital settings.
2) There is evidence of good practice in the partnership working with both individuals, their families, friends and the other agencies involved. Additionally, there is evidence that both P1 and P2 were seen within or more frequently than the assessed timescales.
3) Some records are unclear there are others that are clear, comprehensive and enable the reader to easily follow the path taken by the clinician in supporting the patient, in particular P2. This includes a holistic approach.
4) Although there is evidence of good practice there are still lessons to be learnt in terms of communication, evidencing that safeguarding procedures are followed and reporting and recording for some staff.

5. GP Practice

1) As a result of discussing this care within our Significant Events Meeting all doctors have a lower threshold to involve The Mental Health Team in patients where aggressive or threating behaviour is involved.
2) Safeguarding concerns and considerations should be highlighted with all concerned (Care homes, GP practice doctors, other relevant agencies) discussed earlier, documented in the medical notes and specifically discussed within the practice.
3) Complex cases where the combination of risk magnifies the potential for harm should be highlighted and advice sought early. For example, the combination of vulnerability in one resident with the threat of aggressive behaviour from another resident.
4) The safety of other residents should be explicitly considered when agreeing / discussing care plans, medication changes, referrals and appropriateness of place of care.
5) With hindsight, a possible delay in the communication of a report of an assessment (of the resident reported as assaulting P1) by the Advanced Practitioner (Mental Health, CMHT) may have reduced the risk of harm to P1. It appears from the medical notes that there was direct verbal communication between the assessor and Care home and communication was not only made in writing. It is not clear whether the suggested plan ‘to increase 1:1 Dementia Unit time’ would have helped to prevent the incident.

6. Ambulance

1) Both crews that attended the care home in June 2016 acted efficiently treating the patients, their needs and transporting them to hospital.
2) Safeguarding Referrals were completed for each of the patients detailing the crews concerns from the incident that took place on the 11th of June 2016.
3) Upon checking there have been no falls referral relating to patient P2. P2 had over 11 referrals which were mainly related to falls. Good practice would suggest that the crews who attended complete a falls referral form if one had not already been completed by the care home.

7. Police

1) Individual learning has been identified and accepted by a supervising officer in this SAR.
2) Organisational learning in respect of practice and procedure and culture have been identified in this IMR and are detailed as recommendations below.

Appendix 4: Chronology

2007
March
P1 moved to care home and paid for her care in the residential unit.

2013
January
P1 moved to RU.
April
P1 subject to reported sexual assault
September
P2 moved to the care home and paid for care in the residential unit.

2014
P1's has poor health and provided with end of life care

2015
February
Burn mark on P1's chest, ASC a Police notified. No criminal intent was established. Section 42 Enquiry conducted. ASC safeguarding team concluded she been fed hot food which had spilt whilst she was being fed.
March
Adult safeguarding referral made for P2 to ASC over with bruising to his hand. S42 enquiry initiated and police made aware. P2 considered being able to decide whether or not he takes the matter further.
5th August
Ambulance Service attend at 7am and raise a safeguarding concern to ASC having found P2 on the floor since a fall at 5am, after having been verbally aggressive to staff and refusing to get up.
October - November
P1 seen by GP Practice for palliative care. P2 continues to have falls, sustaining injuries. Police called by the Ambulance service when P2 found on the floor. Police make referral to ASC and Mental Health. ASC record that ABC charts are in place and P2 awaits an assessment by CMHT but do not contact them and no further action is taken
23rd December
P2 noted as assaulting another resident in residential with a Zimmer frame causing bruising to resident's arm. ASC notified, but no S42 Enquiry instigated. Decision challenged by care home. ASC document activity to seek a DoLS for P2. GP receives a request from) the care home to prescribe medication to calm P2. Police made aware of incident but do not attend.
Concluded that P2 did not have mental capacity to form criminal intent. Noted that there is an intention to move him to the RU. No further police action taken. GP refers P2 to CMHT and he is moved to the RU.
2016
5th February
P2 moved to RU
End of February
Start of significant increase in the use of ABC charts for P2. Monthly reviews in place to monitor behaviour.
25th February
Two records relate to verbal aggression, directed towards other residents.
28th February
P2 noted as verbally aggressive towards other residents
9th March
P2 Noted as angry and verbally aggressive.
13th March
ABC chart completed for P2

15th March
P2 noted as verbally aggressive towards other residents.
16th March
P2 noted as shouting and trying to hit other residents.
17th March
Noted that P2 was walking behind another resident and their visitor, and said he wanted to kill the visitor. Trying to hit out with Zimmer frame
18th March
P2 was shouting and trying to hit another resident with a Zimmer frame
25th March
P2 found with bruising to wrist. He names a member of staff and alleges assault. Police informed but do not attend. ASC informed.
26th March
Two incidents recorded where P2 was shouting and swearing.
30th March
P2 found with bruising to his wrists, cause unknown, noted he has fluctuating mental capacity, registered blind, misinterpreting his environment and going into other residents' rooms. ASC informed but take no S42 action but refer P2 to the CMHT for a mental health assessment.
April
P1 becoming increasingly frail, being nursed in bed and hospice conduct first palliative care assessment. GP records Best Interest assessments in respect of her future hospital admission and medical treatment. P1 referred and accepted for fast track for Continuing Heath Care Assessment. Risk assessment from care home shared with ASC outlining serious risks that P2 posed to others. S42 Safeguarding Enquiry starts and advises care home to revise P2's risk assessment, refer him to GP and CMHT memory clinic for a mental health assessment.
3rd April
P2 is recorded as being verbally and physically aggressive towards other residents.
7th April
ASC talked to P2 and concluded by he has mental capacity.
10th April
P2 noted as arguing with other residents and trying to pinch them.
18th April
Noted that P2 was trying to strike another resident.
19th April
Two ABC entries stating P2 is trying to hit staff with Zimmer frame.
21st April
P2 pulls the hair of a female resident and tries to hit another resident with a Zimmer frame. GP advises the care home to contact CMHT directly.
29th April
P2 attempts to hit a female resident and is very aggressive
30th April
ABC chart records that P2 was verbally aggressive.
3rd May
P2 noted to be verbally aggressive and threatening people with his Zimmer frame.
8th May
Recorded as being verbally aggressive.
11th May
P2 state of undress and described as 'upset 'towards a female resident.
21st May
Recorded as being verbally aggressive.
22nd May
P2 shouting and wanting to hit a resident.
2nd June
P2 reviewed by CMHT.

4th June
Incidents recorded of verbal aggression; trying to hit a resident and a member of staff. Later noted as trying to slap another resident. Incident is reported to ASC who note that they are satisfied with how the incident was managed.
5th June
P2 noted shouting at a resident during supper and trying to hit another resident with a Zimmer frame.
6th June
P2 found semi-naked and physically aggressive
7th June
Three entries on the ABC charts regarding verbal and physical aggression towards staff; trying to hit a female resident with Zimmer frame and having had a fall was initially aggressive towards a paramedic.
11th June
Member of staff saw P2 coming out of P1's room, and when asked what he was doing said he had "just killed the lady in there and put her out of her misery". P1 was found to have cuts to her arms legs and hands. P2's Zimmer frame was found in her room and had blood on it. It was believed it was used to assault her whilst she was in bed. Paramedics and police were called and both were conveyed to hospital. Limited police investigation commenced and no further criminal action was taken against P2 due lacking mental capacity. CQC notified of the by the care home. Following treatment for her injuries, P1 returned to the care home. In the days following incident there was limited interaction with P1's family who were looking to identify measures to safeguard their mother in her room. The use of a stairgate was explored and initially considered as a Deprivation of Liberty Standards (DoLS) issue and the family's request was declined. (After a lengthy and complex process, a stairgate was put in place in August 2016).
13th June
ASC request that care home carry out investigation as part of a S42 enquiry into the assault on 11th June.
14th June
CCG make a retrospective entry indicating that the Safeguarding Lead was informed of the incident. An e-mail marked as high importance was sent to the CHC, raising questions about the incident. No response received.
15th June
Care home meeting re health and safety implications of the use of a stairgate
16th June
Discussion by ASC Occupational Therapy Assistant Team Managers on issues appertaining to P1. Family now aware of a previous Serious Case Review where risk management options, including use of a stairgate, in a similar circumstance, were explored. A Best Interests Decision document records them as the decision maker with the family expressing differing views over arrangements to ensure their mother's safety. The family send an extensive e-mail to CCG, who were not involved in the Best Interest Decision, to voice their immediate concerns. They also contact ASC.
21st June
Safeguarding meeting held, but family of P1 not present.
24th June
A further meeting takes place in care home to discuss outcome from the meeting held on 21st June. This is held with P1's family and care home staff. An option was given to the family to return P1 to the Residential unit which is declined.
30th June
First S42 enquiry shared with a senior social worker who concludes that the care home responded appropriately to address P2's needs and contacts them for further clarification and to assure them of this. The care home is contact with CQC in relation to this S42 enquiry and other notifications that have recently been sent. P1 remains at the care home. Following concerns raised by the family about the first S42 Enquiry, a second S42 Enquiry is undertaken with CCG managing investigation and ASC oversight.

2017

11th May

CCG complete the S42 Enquiry and following a meeting with the family, it was agreed by ASC that the Enquiry fell short in relation to its quality.

11th June

A third and final S42 enquiry was initiated

7th July

Third Enquiry completed

September

Family meet with the care home and ASC discuss the final S42 enquiry report.

November 22nd 2016

P1 passes away at the care home.

December 2017

Decision taken to refer the case for a Safeguarding Adult Review to SSAB agreed and SAR Panel set up.

2018-19

Following consultation and advice at the SAR Panel, the Police revisited the original criminal investigation to consider if there was any criminal liability by the care home in respect of the circumstances surrounding the incident on the 11th June 2016. The revisited investigation resulted in no further action. CQC commenced criminal proceedings with the care home.

A historical sexual assault allegation on P1 from 2013, was also subject to a criminal investigation, which also resulted in no further police action being taken and it was subject to S42 enquiry which concluded on the 13th June 2019.

Appendix 5: Glossary of abbreviations

ASC	Adult Social Care	CHS	Community Mental Health Services	PACE	Police & Criminal Evidence Act
BI	Best Interests	DoLS	Deprivation of Liberty Safeguards	Res & DU	Residential and Dementia Unit
CCG	Clinical Commissioning Group	EDT	Emergency Duty Team (ASC)	SSAB	Surrey Safeguarding Adults Board
CHC	Continuing Health Care	IMCA	Independent Mental Capacity Advocate	SCR SAR	Serious Case Review Safeguarding Adult Review
CID	Criminal Investigation Department	IMR	Individual Management Review	SI	Serious Incident
CMHT	Community Mental Health Team	MASH	Multi-agency safeguarding hub	SIU	Safeguarding Investigation Unit
CQC	Care Quality Commission	MSP	Making Safeguarding Personal	Trust	Mental Health Trust