OLDHAM SAFEGUARDING ADULTS BOARD

Safeguarding Adult Review Overview Report: Miriam

Lead Reviewer
Allison Sandiford

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1 Introduction to the Case and Summary of the Learning from this Review.

1.1 This review is in respect of an 89-year-old lady, Miriam. Miriam moved into residential care in August 2016 as she required care, and support with daily living. Following several hospital admissions and a move to a care home in a neighbouring borough, she died in hospital in February 2017. A coronial inquest concluded that Miriam had *died of a naturally occurring disease, exacerbated by high levels of sedation and immobility in the months prior to her death which worsened her underlying frailty*.

2 Process.

2.1 The Safeguarding Adult Review Sub Group identified that the case met the criteria[1] for a Safeguarding Adult Review (SAR) as Miriam was in receipt of services within the Oldham borough for her care and support needs and lessons could be learnt regarding the way agencies had worked together to co-ordinate and oversee care.

2.2 The subgroup recognised that there had already been a significant number of investigations undertaken into concerns raised regarding the care that Miriam received and proposed that the SAR should collate all of the reviews, investigations, and single agency responses to the Coroner's Regulation 28 report to devise a multi-agency action plan to improve future care and practice.

2.3 The review sought to understand the following key lines of enquiries:

- Co-ordination of care/treatment – who was the lead professional.
- Communication between the GP/mental health services/the care home/family.
- Safeguarding processes/police procedures that have taken place for Miriam.

2.4 OSAB appointed an independent reviewer[2] who used a mixed method approach grounded in systems methodology and considered reports and chronologies provided by the agencies involved in Miriam's care, alongside previously completed safeguarding investigation files. Owing to the significant number of investigations that had already been undertaken into Miriam's care, the review was mostly a desktop exercise with additional clarification of events and discussions/analysis held virtually[3] with the panel.

2.5 The purpose of the review is to consider what lessons can be learned to guide better future practice and focus on opportunities for improvement within systems. It is not the purpose of the review to scrutinise the actions of, or apportion blame to, any agencies or individuals. In addition, the independent reviewer has attempted to complete the report without any hindsight influence.

2.6 Miriam's daughter was informed of the decision to commission a SAR and invited to contribute. In an attempt to ensure that her mother's voice be heard, she has contributed to the review and indicated that she would welcome the review to identify learning that would mean that no other adult in a care home would suffer as she watched her mother suffer.

2.7 The review has considered agency involvement with Miriam and her family from her admission into the residential home until February 2017 when she moved into a care home in a neighbouring borough. However,

[1] Section 44, the Care Act 2014 stipulates that Safeguarding Adult Boards must arrange a SAR when an adult in its area with care and support needs dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.
[2] The lead reviewer appointed was Allison Sandiford. She is an experienced reviewer and is entirely independent of the OSAB.
[3] Covid restrictions in force at the time of the SAR necessitated the use of virtual communication.

some safeguarding processes were undertaken after this timescale and have been included as they relate to agency involvement prior to February 2017.

2.8 Management of the Care Home has changed since the timeline of this review. The current manager was not in position at the time Miriam was resident but despite being limited in the level of detail she could provide, has contributed greatly to the review process and learning.

3 Brief Synopsis of Events.

3.1 In August 2016, following a period of hospital admission, Miriam became resident of a Residential Care Home in the Oldham area. Initially Miriam appeared to settle well but the care home soon reported a deterioration in Miriam's behaviour and episodes of agitation. Different medications were prescribed by the GP and psychiatrist to address this, some of which had sedative effects.

3.2 Following further deterioration of Miriam's health, it was decided on 16th December 2016 by the consultant, that she needed an elderly mental infirm (EMI) nursing bed. In the interim she remained in the home but on the 30th December 2016, Miriam was taken to hospital following consultation with a GP who said that her 'alert, verbal, pain, unresponsive' (AVPU) level was reduced, possibly due to her medication. She remained in hospital until an EMI bed was found on the 6th February 2017 in a neighbouring authority. On the 19th February 2017 Miriam was admitted to hospital where she remained and received palliative care until she passed away on the 28th February 2017.

3.3 Safeguarding enquiries were undertaken into the care that Miriam had received. None found evidence of neglect or ill treatment. But an inquest undertaken by Her Majesty's Coroner (HMC) later concluded that Miriam had *died of a naturally occurring disease, exacerbated by high levels of sedation and immobility in the months prior to her death which worsened her underlying frailty*.

3.4 In view of this, in July 2019 the Coroner sent a Preventing Future Deaths report under Regulation 28[4] to the GP, the care home manager and the Clinical Commissioning Group and asked that the police and ASC conduct further enquiries.

4 Family Experience

4.1 Miriam's daughter (hereafter referred to as K) has contributed to this review by means of telephone conversations, virtual meetings, and email. She has also met the reviewer in a socially distanced environment to share some documentation. K has been open about her experience of the services and support received by Miriam and herself. The reviewer recognises that this has not been easy for K and would like to thank her for her invaluable contribution and offer her and the rest of her family sincere condolences.

4.2 Whilst it is important to respect the privacy of Miriam and her family in this review, it is critical that she is kept central to the report to ensure distinct learning. K describes her mum as a beautiful and perfect lady. She was originally a wedding gown machinist; however, she went on to work as a teaching assistant in a socially deprived primary school where her care and compassionate nature helped to support the children and families of the local community. Miriam was an integral part of her parish community for 60 years; she was part of the social

[4] A Regulation 28 report is made under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

committee, read at mass on a regular basis and was a catechist for the children of the community. Miriam was highly respected and loved by all members of the church community, as well as her family. This was reflected by the large number of people who came to the church to pay their respects at her funeral.

4.3 The decision to move Miriam into a care home had been made a little easier for K because she knew that it was a temporary arrangement designed to offer her mum respite and rehabilitation before she moved back into independent living.

4.4 K has described how during the month of October she, her children, and some other people who visited her mother became concerned for Miriam as they noticed that she often appeared to be 'drugged up' and unable to communicate or walk. K raised these concerns with the care home manager on numerous occasions and was told that the care home was working with the GP practice. K recalled that the manager said that Miriam's state was a transient period until the balance of the drugs was right. K also raised her concerns with her mother's GP who advised that she would push for a diagnosis and would look into the drugs and their effects.

4.5 Over time, as K became more concerned about the changes becoming her mother, she also consulted her mother's social worker who was from a neighbouring borough, but she felt her safeguarding concerns went unheard. K reports that ASC only acted following a fall which caused K to raise concerns about insufficient staffing levels and her mother being 'drugged up'. Following the initial social worker stopping working the case, K and the hospital struggled for a while to establish who was now responsible for Miriam's case management and as a result felt unsupported. There was one subsequent meeting with the new social worker but K considers that this was retrospective as her mother's health had, by then, significantly declined. K has advised that she does not feel the social workers kept her updated of safeguarding enquiries, nor was she advised how to appeal any of their decisions. When K did raise concerns through the appropriate channels she said that she felt that her concerns were minimised and there was no appropriate action taken to safeguard Miriam or to investigate the concerns. K doesn't feel that the police investigations were thorough, and she doesn't feel that anyone has looked at the facts evidenced in the Coroner's Court - K reports that the findings from the Coroner's Court clearly state that Miriam was over prescribed medication which had been stopped and she has said that this was evidenced in court both on the MARs sheets and by the doctor who had stopped the medication.

4.6 On 16th December 2016 K had the opportunity to advise the consultant of her concerns that the drugs being administered to Miriam were causing her to deteriorate and leaving her unresponsive and comatose. She told him that when the drugs were wearing off, there was a window of opportunity to talk with her mother, as she was more lucid and able to communicate as she had always done. K recalled that the doctor said he was unsure why Miriam was on certain medications and their dosage and reassured her that he would look into it. He also said that Miriam needed an EMI nursing home, and he would draft a letter advising the care home, the doctors and social care of this. K considers that this is the first time she was listened to, but action wasn't forthcoming, and things moved too slowly. Within weeks her mother was in hospital following another fall.

4.7 K spoke of her mums juxtaposing presentations between the hospital wards and the care home, which she attributes to the lesser dosage of drugs. In contrast to the care home's reports of aggression and high agitation, hospital staff described Miriam as 'mildly wandersome', 'manageable' and 'coax-able'. During short stays in hospital, she often presented as alert and chatty, to the point where hospital staff questioned why she was being administered such a quantity of medication. It is clear that the hospital had concerns as ward round notes, dating from 31.12.16, remark that prior to discharge, Miriam should be subject to a safeguarding input due to a 'pattern of injuries needing further investigation – possibility of elderly abuse'. To K's confusion hospital staff do not appear to have raised these concerns with any other professionals and she has said that it was disclosed

at the Coroner inquest that this should have been shared with the nurse/sister and a safeguarding referral should have been completed.

4.8 K's weakest professional relationship was with the care home manager. K feels that this was primarily due to the manager trying to prevent her and her children, from taking Miriam out of the home for meals and rides out. K reports to have raised this concern with the social worker who advised he did not believe there should be an issue with Miriam going out. K has said that the care home manager made her feel irresponsible, and as if she was not putting Miriam's needs before her own. It came to the point where K's children would take Miriam back into the care home to prevent any further confrontation with the manager in the presence of Miriam. K considers that as, in her opinion, her mother's presentation deteriorated (in respect of her becoming more and more 'comatose' for longer periods of time) the manager became more avoidant of her. K did find some of the staff helpful and kind. One particular member of staff came forward after Miriam had died and told K that she had witnessed her mother being over sedated. K said others advised her that they were sorry and said they should have done more but they were concerned about repercussions.

4.9 In summary, K raised her concerns regarding the management of Miriam's care and her response to the medication administered, to several professionals but she continues to ask herself whether she did everything possible to safeguard her from harm. She is haunted by images of her mother unresponsive and unable to support her own weight and she sadly feels that she has let her mother down. Given that she knew and loved her mother better than anyone, she doesn't understand why professionals were not supportive of her when she raised concerns. K has since collected a wealth of information covering events leading up to her mother's death gleaned from organisational records and copies of the subsequent investigations and coroner enquiry, but still struggles to make sense of the situation.

4.10 K feels that the inquest is the only procedure that has answered any of her questions to date but cannot comprehend why when the coroner has said that Miriam's death was exacerbated by high levels of sedation, no individual or organisation has been held to account. Especially given that the Coroner exercised her powers under Regulation 28 and outlined her concern which specifically centred around a drug being administered that had been stopped by a consultant.

4.11 K understands that this review is about learning and improving future practice, and she welcomes the insight, but she has shown consistent determination throughout her contribution to this review to ensure that the care provided to her mother, that she believes to be criminal, is investigated thoroughly. The key specific questions that she seeks answers to, both for future practice and justice for her mother, are:

- *How could medication have continued to be administered when it had been stopped by a consultant?*
- *How can agencies ensure that in the future, medication being prescribed and administered is subject to regular multi-agency review?*

5 Analysis by Key Lines of Enquiries and Identification of Learning.

Co-ordination of care/treatment – who was the lead professional.

5.1 The care home that Miriam became resident of in August 2016 is registered with the Care Quality Commission[5] (CQC) as a residential home caring for adults with dementia, mental health conditions and sensory impairments. K has told this review that Miriam's admission to the care home had the intention of offering Miriam a period of recuperation following a sustained stay in hospital. K found that there was a limited availability of beds in care homes and agreed to this one when it became available, mostly due to its close proximity to her own home.

5.2 Towards the end of November 2016, whilst Miriam was a resident, the care home was subject to an unannounced inspection by the CQC. The inspection report[6] gave an overall rating for the service of 'inadequate' and the home was therefore placed in 'special measures'. The inspection had identified breaches *in relation to unsafe moving and handling practices, poor infection control, poor food hygiene practices, inadequate staffing levels, poor training, failure to work within the principles of the Mental Capacity Act 2005, poor record keeping, failure to handle complaints correctly and poor governance.* The home was kept under review and there was an expectation that significant improvements would be made within a six-month timeframe[7].

5.3 When Miriam first joined the care home community she was described as settling well but on the 15th September 2016 the home contacted the GP and requested a review as Miriam was showing signs of confusion and deterioration in her mental state. The GP consequently referred Miriam to the Memory Assessment Service with a view to establishing a diagnosis. Subsequently on the 18th October 2016 Miriam was seen by a memory liaison practitioner who conducted a memory assessment. The assessment concluded a deterioration within Miriam's cognitive abilities but noted that due to her level of impairment it was difficult to complete any formal memory testing. It was agreed in discussion with K that Miriam should see a consultant regarding a formal diagnosis and an appointment would be scheduled for her to attend the Older People's Specialist Mental Health Services.

5.4 The consultant attended Miriam on the 16th November and put forward a diagnosis of *delirium, possibly superimposed upon underlying dementia* but said that this needed confirming via a memory assessment. As current medication was not proving effective, he amended her prescription. However, unbeknown to the consultant, two days later following Miriam having broken a window, a GP attended and altered her medication again. Within a week, the manager of the home spoke to the social worker and requested that following an increase in aggressive behaviour, Miriam be moved.

5.5 Meanwhile, Miriam remained in the care home awaiting her memory assessment. She could not attend one arranged for the 29th November 2016 due to sustaining a fall and being unwell, and a further memory assessment did not go ahead on the 14th December due to a mix up with the records at the consultant's clinic. Two days later the consultant visited and recommended that, pending a nursing assessment, Miriam be found an EMI placement.

[5] The Care Quality Commission monitors, inspects and regulates services to make sure they meet fundamental standards of quality and safety.
[6] https://api.cqc.org.uk/public/v1/reports/704966b5-2e55-45b6-b3d5-a710bdea26d4?20200129163919
[7] The most recent inspection which was conducted in 2019 gave the care home a rating of 'requires improvement' but it should be acknowledged that the care home has been rated 'good' within the time period in-between the two inspections, implying that improvements have been made and sustained for a time.

5.6 During these months, Miriam had a GP and a consultant planning and delivering her medical care and prescribing her medication. Subsequently she was under primary and secondary care services simultaneously and as a consequence, the transfer of information between these two professionals was extremely important, especially regarding any alterations to the medication plans. Their communication and the effect of poor communication is considered in the next section of this report, but just as important as their communication was the co-ordination of their roles, both with each other and with the other agencies/practitioners involved in Miriam's overall care

5.7 Co-ordination is vital as the GP and the consultant, being responsible for Miriam's healthcare, had common purpose but separate objectives. The GP is a person's first point of contact and has a management role over a person's health. They develop and share an agreed plan with a patient which may include a course of action or medication, or a referral to a specialist department. A consultant's role is distinctive in that it provides high-level care and oversees a patient's care pathway within a specialist department. Both of the roles are of equal importance to the patient and subsequently any difficulties or misunderstandings between the clinicians will influence the standard of care provided.

5.8 As a result of the deterioration in Miriam's health, multiple professionals/organisations[8] became involved in Miriam's care within a short period of time. Whilst it is recognised that each organisations' primary relationship was and should have been with Miriam as their patient, working in partnership with each other was essential. Particularly as when a person is unable to understand and/or communicate their own care needs, it is imperative that time be taken to ensure that the correct overall care is being administered to help that person and to improve their quality of life.

5.9 An overview of who was supporting Miriam and how, was achievable by way of a central co-ordination contact record at the care home. It is especially important that the care home manager ensures that this record contains accurate and up-to-date information regarding contacts and observations from every professional who has contact with a resident, regardless of the external procedures of the agencies that those professionals work for. Although such documentation has not been seen by the reviewer, this review has been told that all professionals visiting Miriam were asked to document in the care notes, but most had their own records which they completed instead. Subsequently it was the senior staff members on duty at the time who documented the visit and detailed the findings in the daily notes which were then kept on file. This appears to be common practice but does not come without risk of misinterpretation which can only be minimised by use of a checking procedure. A visiting professional could be asked to read and sign the notes made by staff prior to leaving the building. Or when a consultation has been undertaken by telephone, the notes could be checked verbally prior to the call ending and both parties could confirm on their own platform.

Learning Point 1

Handheld or electronic notes, completed by staff on behalf of another, must be confirmed by the attending professional.

Recommendation: The OSAB should seek assurance that partner agencies ensure that a protocol is produced/available which offers clear guidance for all professionals, including care home staff, completing handwritten and/or electronic notes/records, on behalf of another professional.

[8] The Care Home Liaison Service (CHLS) and the Intensive Home Treatment Service (IHTS) were involved to help monitor the effectiveness of the prescribed medication

5.10 All of the individual agencies involved in Miriam's care would have held individual care plans regarding Miriam's identified needs, assessment processes and the support that their service was offering. The challenge in a person's care, is making sure that all of the individual plans can work together without conflict. A single overarching plan is needed to co-ordinate disparate individual plans and to make sense of what is happening.

5.11 What is clear when considering the care provided to Miriam is that the care home was unquestionably the central point of contact for all professionals working with Miriam and for her family. The care home monitored Miriam continually and had the opportunity to acknowledge everyone who visited and supported her. This review has not had sight of any live care plan that consistently reflected Miriam's ongoing needs, but one should have been in place. This would have affected joined up working by means of an accurate and communal record which is non-disputably an absolute must when caring for any adult with needs.

5.12 However, the effectiveness of such record is wholly dependent upon the quality of its review and distribution, thus a lead professional is necessary to co-ordinate the content and distribution of plans. Interestingly none of the safeguarding enquiries undertaken into Miriam's care, have identified a lead professional and when the question *'who did you consider to be the lead professional in Miriam's care?'* was posed to participants of this review, the response alternated between social worker and care home manager. Upon reflection, the answer is understandable as care managers and social workers both have a responsibility to ensure that service users receive individual centred care tailored to meet their needs.

5.13 The social worker, under the professional code of practice was the voice of Miriam, the vulnerable adult, and therefore had a statutory role in the co-ordination of services around her. Even when a person is settled in a residential home, when that placement is funded by social care, their case will always remain open to the social care team and any concerns will not require a re-referral to the assessment team.

5.14 A registered manager of a care home has legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the care service is run. By definition, the registered manager is the person in day-to-day charge of the regulated services provided by the home. In 2013 the Social Care Institute for Excellence published the document, *GP services for older people: a guide for care home managers*. The guide suggests that *the care home manager can take a lead role in identifying the health care needs of residents and discussing preferences with residents and/or family members and GPs*. It goes on to say that the *manager acts as an advocate for residents and takes a leadership role in relation to medical plans.*

5.15 Miriam needed an advocate to ensure that her care plans adapted in conjunction with her changing needs, that the plans were understood by all who supported her and that they were without conflict. Neither the social worker nor the care home manager, undertook any advocate role holistically, although there is evidence of discussion between them.

5.16 It was good practice that when the care manager recognised that Miriam required specialist care she communicated this directly to the social worker. This was on the 24th November but there is no evidence of any subsequent multi-agency meeting to plan the next steps and/or to discuss an ongoing care package for Miriam in the interim - until the 30th December when a social worker attended the home. Subsequently, the nursing assessment wasn't planned until this time, when the social worker then informed the home that it couldn't be done until the New Year.

5.17 Good practice would have been for a social worker to attend the home in a timely manner, and meet with the care home manager, Miriam, and her family, to discuss what needed to be done. The review recognises that

the process of rearranging care for a person is a complicated process that involves much planning, but the initial discussions need to be prompt.

Learning Point 2

When care does not suit an individual and a home is unable to assist with a development of care to improve a person's quality of life, timely co-ordination of a plan to ensure that the individual is placed somewhere where they can receive the care and support they need, is crucial.

Recommendation: The OSAB should seek assurance that care homes within their authority understand their responsibilities and have access to policy regarding the procedure to follow when a care home can no longer meet a resident's needs. The policy must recognise that when such a situation arises the care home must contact the commissioning authority to convene an MDT meeting and review the situation in a timely manner.

5.18 Miriam's social worker was from a neighbouring local authority. This was unavoidable (and not uncommon) as Miriam's care was funded by a different council to the one that provided the services. However it is recognised that this served to increase delays as it added an extra layer of communication into decision making. Oldham ASC have spoken of the challenges of waiting for people from the neighbouring authority to respond before action could be taken.

Learning Point 3

Cross-boundary working will have its challenges, but authorities should work together to minimise the impact upon the service user.

Recommendation: The OSAB should share this SAR with the neighbouring authority who commissioned Miriam's care and should ask GM to consider reviewing/producing a policy regarding cross-boundary working and ensure that it incorporates an escalation policy in the event of poor communications. Once the cross-boundary protocol has been agreed, the OSAB should seek assurance from the Care Home Commissioning Team that cross-boundary training has been delivered within all of the borough's care homes and that clear guidance is available.

5.19 As mentioned, the care home should have developed a fluid care plan for Miriam upon admission that would have been adapted to meet Miriam's needs with time. This should have been reviewed monthly by senior staff at the care home, but Miriam would have benefitted from the care plan also being considered regularly by all the professionals involved in Miriam's care, Miriam herself and Miriam's family. The review panel have discussed how this could be done by way of a video conferencing platform to accommodate busy professionals who may be subject to tight time restraints. This procedure would ensure that a care home plan accommodated and co-ordinated all the professional care plans.

5.20 In summary, the coronial inquest uncovered that Miriam had been administered a damaging dosage of medication. At the time, this conflict went unnoticed despite the care home records and despite concerns being raised by K regarding Miriam's demeanour. This can only be because the health care plans of Miriam had not been co-ordinated with enough robustness to draw attention to the discrepancy.

5.21 Relatives and carers partaking in the learning report: *Making care safer*[9], in 2011, suggested that there *was a need to clarify lead responsibilities for particular areas such as medication and communication* and suggested that care home managers or particular members of staff should take the role of 'medication champions'. Whilst such oversight of an individual's medication could reduce the risk of prescribing or dispensing errors in a care home, it should be acknowledged that neither the care home manager or the staff will be medical professionals

[9] https://www.health.org.uk/sites/default/files/MakingCareSafer.pdf

and it is not within the scope of their work to identify unsafe prescribing of medications. However, there is no doubt that a 'key person' monitoring an individual's care could greatly assist with the co-ordination of their plans and that the care home, being central witness to a resident's routine, contacts, and wellbeing, is in the best position to assume such role.

5.22 It is important to draw attention to the fact that a 'key person', or a 'lead professional' is not responsible for all the services and/or support delivered to a service user from other agencies, nor do they replace other practitioners.

Learning Point 4

There must be an identified lead professional to co-ordinate a resident's care and impart information effectively. Appointment of a lead professional should be considered on a case-by-case basis.

Recommendation: The OSAB should consider the production of a lead professional handbook which will describe the role, its functions and advise professionals re appointment.

5.23 To conclude, a lack of overall senior oversight, leadership, and direction in the care of Miriam resulted in a disjointed multidisciplinary team with no co-ordinated plans. This effected poor monitoring of Miriam's overall health.

Communication between the GP/mental health services/the care home/family.

5.24 Poor communication between professionals always risks detriment but the inadequate communication between professionals with regards to Miriam's medication resulted in erroneous administration which led to a decline of her quality of life and a deterioration of her health. Confusion over reduction and changes to her medication were the result of a lack of clarity in exchanges between professionals that went unnoticed, largely due to weak co-ordination of her care.

5.25 Each service had its own remit. The consultant was responsible for identifying the most effective medications. The GP practice was responsible for prescribing the medication but would also identify medication as and when required. And the care home was responsible for ensuring that Miriam received the prescribed medication as directed. Thus, communication between all of these agencies/professionals was crucial to the co-ordination of Miriam's medicinal care plan.

5.26 In accordance with care home policy, the review has been told that the consultant's instructions were written in the care notes, though they were written by senior staff as the consultant had his own records. And as per good practice, the consultant dictated important information to be sent to the GP in the form of a letter. However, perusal of these letters evidence that they weren't typed until between four and seven days after the visit. This delay in communication has already been recognised by agencies and it has been acknowledged that it could prove detrimental to a patient's care. A new IT system (Graphnet) is being developed to address the problem which will enable a system-wide electronic approach and in the meantime, the care home has agreed to ask visiting specialists to update the surgery the same day of any changes to controlled drugs and sedatives.

5.27 The review has established that the GP would attend Miriam upon the care home's request, or if a face-to-face meeting was not thought necessary, would arrange a telephone consultation through the care home staff. The GP did not routinely visit the care home to see Miriam, but the practice did have regular practice meetings where certain patients would be discussed. (It has not been possible to ascertain whether Miriam was discussed

at any of these meeting or not.) Instruction to the care home from the GP was usually verbal, but the medications were dispensed from the chemist with printed instruction.

5.28 The GP relied wholly upon information from another prescriber to be updated of any changes to Miriam's medication and as such was reliant on the consultant's letters. (The new aforementioned IT system will serve to improve this situation.) However, there was no mechanism in place to communicate any changes to medication made by a GP back to the consultant. This was a huge communication gap.

5.29 To review, the consultant communicated with the GP by letter and communicated with the care home during visits. The GP communicated with the care home directly, either during visits or by telephone. But there was no communication from the GP to the consultant.

Learning Point 5 & 6

A robust procedure is required to communicate variations in medication to a care home.

A robust mechanism is required to assist primary care keep secondary care updated of changes to a person's care.

(The GP Practice has already created a new policy to ensure prompt and effective communication between the practice, the care home, and clinical colleagues. Communication is also expected to be improved once 'Graphnet' is implemented – a national data-sharing strategy which will allow all clinicians oversight of prescriptions and dosage.)

5.30 Any chain of communication is not infallible and thus it is important that care be reviewed regularly. Section 1.8 of the NICE guidance: *managing medicines in care homes* recommends that GPs should work with other professionals to identify a named health professional who is responsible for medication reviews of care home residents. A review should include communication with the *resident (and/or their family members or carers, as appropriate and in line with the resident's wishes)* to discuss any problems and/or side effects the resident is having. There is no evidence of such a review having taken place with Miriam, but medication reviews were conducted by the consultant when he visited. However as already identified, communication from primary care to secondary care is flawed and it is likely that the consultant would not have had full knowledge of primary care actions and/or concerns regarding any aspect of Miriam's care.

5.31 In addition, the GP practice conducted some medication reviews when a prescription was requested by the home, but this did not always include speaking to the care home directly. It often relied solely upon what had been recorded on the system. But as we know, due to the time taken to dictate, send, receive, and input, letters dictated on behalf of an attending consultant would not have been reflected upon the system with immediate effect. Therefore, the GP was not always able to review medication using the most up to date communications. The actions identified above at Learning Point 4 and 5 will assist to address this issue.

5.32 A true medication review can only be completed by consultation of a record of all medicines administered. Hence why the care home, being the final receiver of medication instruction, must ensure that robust safeguarding procedures are in place recording their involvement. The NICE[10] Guidance for Medication in Care Homes[11] stipulates that all health and social care practitioners should ensure that records about medicines are accurate and up to date by following the process set out in the care home's medicine policy and that the process in the policy should cover

- recording information in the resident's care plan
- recording information in the resident's medicines administration record

[10] National Institute for Health and Care Excellence

[11] Section 1.4 Managing medicines in care homes. Published: 14 March 2014

- recording information from correspondence and messages about medicines, such as emails, letters, text messages and transcribed phone messages
- recording information in transfer of care letters and summaries about medicines when a resident is away from the home for a short time
- what to do with copies of prescriptions and any records of medicines ordered for residents.

5.33 This review has had sight of a care home medication policy and can confirm that it contains some correct direction. However, the review is unable to confirm its availability at the time that Miriam was resident at the home and the MARs, daily logs and care plans viewed during the course of this review suggest that the guidance was not always strictly followed. For example, there is no evidence of a witness checker when controlled drugs have been administered and there is no clear indication of the verbal changes to medication directed by a doctor being verified by a doctor within 24 hours. Also, the daily logs make no reference to the consultant visiting suggesting that some professional visits may have gone unlogged.

5.34 The review is unable to confirm whether the visiting professionals consulted the homes daily logs or MARs[12] to check Miriam's medication regime and/or consider her overall presentation but it is clear that the logs were a missed opportunity to diarise Miriam's care and medication in one record for Miriam, Miriam's family, and professionals to see.

5.35 In addition, there is little reflection of Miriam's voice within any of the care home documentation and the review is left with a distinct sense that Miriam's voice was not heard. Was Miriam happy with the care afforded to her? How did she feel? How did the medication make her feel? In the absence of Miriam being able to communicate her own wishes and feelings then those of the people closest to her should have been sought, yet K feels that when she tried to speak on her mother's behalf, she wasn't listened to and her opinion was spurned.

Learning Point 7

Residents of care homes and their families must be consulted and listened to.

Recommendation: The OSAB should seek assurance that work is undertaken with professionals to ensure that a Care Home's resident's voice is being heard and reflected in their care.

5.36 It would be difficult for a member of Miriam's family or a concerned friend to raise any concerns or observations they had about Miriam to every professional involved in her care, although to her credit, K raised her concerns to multiple professionals. It is unacceptable that a person who is concerned for a loved one feels unheard, and as such a facilitator would be beneficial in such situations. The Nice guidelines: *Managing medicines in care homes*[13] published in 2014, suggest that all *care home providers should ensure that residents can use advocacy and independent complaints services when they have concerns about medicines*. The current manager of the care home has assured the review that there is now an independent complaints policy for everyone to see and that any concerns and complaints raised are thoroughly investigated and taken seriously.

5.37 There would also be benefit from care homes alerting residents and their families to the independent body Healthwatch. They champion for people who are in receipt of health and social care services (including nursing homes and care homes) and are unhappy with the service.

[12] Medicine Administration Records

[13] 1 Recommendations | Managing medicines in care homes | Guidance | NICE

5.38 This review has seen no evidence of the GP practice, care home, psychiatric consultant, Miriam, and Miriam's relatives ever coming together in one meeting to review and plan the care afforded to Miriam. Besides offering an opportunity to discuss Miriam's medication, such a meeting could have helped the family and the care home to understand management of Miriam's behaviours reducing the need for sedation. The panel have discussed whether a regular 3-monthly meeting involving a resident, a resident's family, the care home, and all key professionals could be scheduled into a care homes agenda, and the care home's response has been positive. Such a meeting would not replace regular updates, or ongoing communications, but it would afford a regular overview into a person's care and an opportunity to ensure that the voice of the individual has been listened to by all involved.

Safeguarding processes/police procedures that have taken place for Miriam.

5.39 The care that Miriam received leading up to her death has been subject to multiple safeguarding investigations and a Coroner's Inquest. It is the intention of this review to provide analysis of their findings and to identify themes and lessons that are related to the key lines of enquiry. It is not the intention of this review to revisit or reinvestigate their forensic nature.

Table of investigations

Safeguarding Investigation/Enquiry	Lead Agency	Start Date	Concern/Findings
S42[14] Safeguarding Investigation (1st)	ASC	December 2016	K raised concerns regarding staffing levels and the home's ability to meet Miriam's needs. They were unsubstantiated.
Police Investigation/Strategy meeting/ ASC Safeguarding Enquiry (2nd)	Police	March 2017	K raised concerns to the police about the care afforded to her mother and the levels of medication administered to her. Their investigation concluded that there was no evidence of wilful neglect or ill treatment.
Coronial Investigation	HMC	March 2017	A coronial investigation commenced.
SAR Referral	Police	January 2018	The SAB concluded that the criteria for a SAR had not been met at this time.
Section 42 Safeguarding Enquiry (3rd)	ASC	April 2018	After police advised K that there was no evidence of criminality, she requested a transparent enquiry. This enquiry progressed as a local authority led investigation, with K's concerns of neglect and over prescribed medication being considered on the balance of probabilities rather than the police threshold. The enquiry concluded that the care home had sought and relied upon advice from medically trained professionals.
Coronial Inquest	HMC	29 April 2019 – 2 May 2019	The inquest concluded that Miriam had died of a naturally occurring disease, exacerbated by high levels of sedation and immobility in the months prior to her death. As a result, the coroner sent a Regulation 28 report to agencies and requested that GMP and ASC reopen investigations.
Police Investigation	Police	May 2019	The investigations concluded that the threshold had not been met to approach the Crown Prosecution Service.

[14] Section 42 of the Care Act 2014 applies where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there)—(a)has needs for care and support (whether or not the authority is meeting any of those needs), (b)is experiencing, or is at risk of, abuse or neglect, and (c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it. The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case (whether under this Part or otherwise) and, if so, what and by whom.

S42 Safeguarding Investigation (4th)	ASC	Jan 2020 (this investigation could not begin until the police investigation had concluded)	The enquiry focussed on specific lines of enquiry related to allegations of neglect and acts of omission on the part of staff at the care home regarding medication management. In addition, the report considered specific lines of enquiry raised by Miriam's family and substantiated neglect and acts of omission on the part of the care home regarding the management and administration of PRN medication, mal administration of medication and, the medication contributing to, and worsening Miriam's frailty. The report unsubstantiated unqualified staff administering medication. The completed report identified several findings and recommendations.
SAR Referral	Oldham Cares	18 October 2019	The SAR was commissioned.

5.40 Whilst resident in the care home, Miriam's mental state deteriorated. The care home reported that she began to display some aggressive behaviours and signs of confusion and there was an increase in incidents reported in the quality monitoring monthly logs. However, the incidents were all classed as level 1 or 2 which, in line with the local safeguarding levels of harm, do not necessarily require a safeguarding investigation.

5.41 On Christmas Day 2016 Miriam suffered a fall and was taken to hospital. She returned to the care home the following day but on the 30th December 2016, she was taken back to hospital. Following this, K raised concerns with both the care home manager and the social worker as she did not consider that the care home had adequate staffing levels when Miriam had fallen, and she was worried that the staff who were on duty did not have enough experience to manage the circumstances of the day. Given the deterioration in Miriam's health she also had concerns as to whether the care home had continued to meet her needs.

5.42 ASC investigated the concerns and concluded that the number of staff on shift the night that Miriam fell was adequate given the residents dependency levels. It acknowledged that the number of staff was down from three to two on this occasion due to staff shortages but stated that this was still acceptable. This was confirmed by the Quality Monitoring Officer. It was noted that the staff had responded according to policy, which states that when a fall is unwitnessed, staff should call for an ambulance and contact the family. The investigation also considered whether the care home could meet Miriam's needs given her deterioration of health. It reported that when the deterioration began staff involved external agencies to support Miriam such as the Mental Health Care Home Liaison Team and the Intensive Home Treatment Service. A diagnosis was sought, and various attempts were made to manage the deterioration by medication. Thus, the investigation concluded that the home had responded to Miriam's deteriorating health appropriately and that allegations of neglect[15] were unsubstantiated.

5.43 In March 2017, following the death of Miriam, her daughter contacted GMP as she still had concerns over the treatment Miriam had received whilst at the care home. A multi-agency strategy meeting convened, and it was established that that although there had already been an investigation into the staffing levels of the home and its ability to meet Miriam's needs, the administering of the medication had not been considered. Police led the enquiry, but as toxicology[16] hadn't ever been taken when Miriam was in hospital there was no evidence that

[15] Neglect and acts of omissions are defined under the Care Act 2014 and include *'ignoring medical, emotional or physical care needs, failure to provide access to appropriate health, care and support or educational services, the withholding of the necessities of life, such as medication, adequate nutrition and heating'*.

[16] Clinical toxicology is undertaken to guide a clinician's treatment. It was not required in this case as clinician's knew how to respond to Miriam.

could prove the levels of drugs in Miriam's system and therefore no evidence of any wilful neglect or ill treatment[17].

5.44 The fact that K raised concerns again so soon after the ASC investigation, suggests that from Miriam's family's perspective, the initial investigation by ASC hadn't given them enough clarity or reassurance. It is important that professionals remember that safeguarding procedures, which are familiar to them, can feel complicated to family members who may become confused and frustrated by the process. Families should be supported throughout and reminded of any further support available. Although it is not clear from the documentation how much contact was maintained with the family during the safeguarding investigation, discussions with K evidence that she did not feel included in the process. However, this review has seen timelines of attempted contacts with members of Miriam's family by ASC at the end of the enquiries. It is recognised that there are occasions where communications between a family and a professional may become difficult. Families could on occasion benefit from the provision of an advocacy person to help with difficult conversations.

Learning Point 8

Professionals undertaking safeguarding enquiries should ensure full involvement of the subject and their families (where appropriate) and do everything possible to ensure that they understand the process and result.

Recommendation: The OSAB should produce a safeguarding leaflet to be provided to subjects/families (as appropriate) at the beginning of all safeguarding enquiries. The leaflet must explain the safeguarding process, how a subject/family is included and how a decision can be appealed.

5.45 Concerns were raised to HMC who then referred the concerns to GMP (GMP act on behalf of the HMC to provide evidence in relation to the circumstances of a person's death to assist the enquiry). HMC subsequently decided that an investigation was needed. The coronial investigation considered statements and evidence from family members and care home employees. To clarify, a coroner's investigation is different from a criminal investigation but the two can run parallel to one another. If a coroner investigates, it does not mean there is suspicion of a criminal act or of any wrongdoing - the coroner's investigation is to establish who has died, and how, when, and where they died.

5.46 Following the Pre-Inquest Review Hearing, HMC asked GMP to refer to a SAR panel. The panel concluded that the criteria for a SAR had not been met as there were no concerns about how agencies had worked together to safeguard Miriam. The panel noted that if any further information was discovered as part of the coronial investigations, then the information would be reviewed.

5.47 At the end of April 2018, a multi-agency strategy meeting convened at which it was agreed that although the criteria for a police investigation had not been met, ASC would lead an investigation[18] into a possible medication dosage error administered to Miriam on the 30th December 2016. The subsequent investigation included recognition that on the 30th December, a social worker had attended the care home and had witnessed Miriam to be sat in a chair in an unresponsive state. The care home had called for a GP who had attended and suggested halving the Promazine tablet and reducing the number of times it was administered. The investigation reports that the MARs were consulted to confirm Miriam's medication, but this review has not had sight of any overview of that day's administration - the MARs provided to the review do not record any medication being administered that day but do reflect the GP's verbal changes.

[17] It is an offence under Section 20 of the Criminal Justice and Courts Act 2015 for an individual who has the care of another individual by virtue of being a care worker to ill-treat or wilfully to neglect that individual.

[18] An ASC investigation is considered on the balance of probability whereas a police investigation has a threshold of beyond reasonable doubt.

5.48 The local authority investigation concluded that an allegation of neglect relating to the overuse of sedatives was unsubstantiated and that the home was relying upon the knowledge and expertise of the medical professionals responsible for Miriam 's care.

5.49 In 2019 K made a formal complaint regarding the safeguarding enquiries into her mother's care and a subsequent investigation[19] found that the scope of this third safeguarding enquiry had not been fully addressed as specialist professionals were not consulted as part of the enquiries. This result concedes that it would have been better practice if the investigation had sought additional advice regarding any possible over-sedation. This could have been done by way of a clinical professionals meeting with the GP, psychiatrist, and any other significant medically trained professionals in attendance.

5.50 When conducting and concluding safeguarding enquiries such as these, good practice is for any professional to ask him or herself, 'Would this be good enough for members of my own family?' And it is important to include in the conclusion, evidence that the circumstances have been considered in detail and full rationale of the investigation's decisions.

5.51 In 2013, social care in Rochdale investigated a similar situation when the son of a resident in a care home alleged that his mother was regularly 'drugged' by staff giving her repeated overdoses of sedatives. Her medication had been prescribed on a similar basis as that prescribed to Miriam - to be used as and when needed, but not always on a regular basis. Their investigation established that the drug had been given on a near-nightly basis and a subsequent case conference found that the allegation of physical abuse was substantiated by a majority vote. As a result, the care home introduced a policy whereby it would notify the GP when any resident had been given 'as required' medication for five consecutive days and it also implemented extra training for staff regarding PRN medication. This review must ask the question, 'what was done differently in that investigation to unearth the prescription discrepancy?' A difference that has been uncovered is that none of Miriam's safeguarding enquiries were concluded with case conferences. A case conference would have provided an opportunity to review the findings of the enquiry.

5.52 According to OSAB's document, *Operational Procedures for Safeguarding Adults at Risk*, a case conference meeting will ordinarily be required where:

- *a multi-agency perspective is required to review the findings of the Enquiry and contribute to the Safeguarding Plan.*
- *a Large-Scale Enquiry has been undertaken*
- *there are concerns about the safety of the service or organisational abuse*
- *formal actions may be required in relation to a 'person in a position of trust' e.g., Referral to professional regulatory body or the Disclosure and Barring Service.*
- *the Enquiry findings are detailed or complex or indicate a significant difference of opinion about the outcome*
- *a Case Conference Meeting will assist the adult at risk/representatives to reach resolution and recovery from his/her experiences*
- *a serious crime has occurred.*

Given that the concerns raised in Miriam's enquiries had included matters regarding the safety of a service (a care home dispensing medication) and a person in a position of trust (care home manager) it would have

[19] As a result of the investigation a full review of Oldham's Adult Safeguarding arrangements has been undertaken and a multi-agency response to specific concerns around medication is now being implemented, and progressed, monitored and reviewed

been advisable to hold a case conference. It would also have been beneficial to Miriam's representative (K), who was and still is trying to understand her mother's experience.

Learning Point 9

There are benefits to concluding a safeguarding enquiry with a case conference or meeting.

Recommendation: ASC should assure the safeguarding partnership that a case conference will always be considered when dealing with any complex safeguarding enquiry and where a decision is made not to convene, rationale will be documented.

5.53 Following the coronial investigation, the Coroner decided it was necessary to hold an inquest. On the inquest's final day, the independent expert, had sight of additional information that had been requested by the police Coroner's Office. Upon reviewing the new information, he provided evidence contrary to the initial findings and the inquest concluded that Miriam had *died of a naturally occurring disease, exacerbated by high levels of sedation and immobility in the months prior to her death which worsened her underlying frailty*. As a consequence of this alternative conclusion, the Coroner requested that GMP and ASC re-open their investigations.

Learning Point 10

All available information must be passed to the Coroner as early as possible in proceedings.

A protocol is being produced by Rochdale, Oldham and Bury safeguarding adult boards with the North Manchester's Coroner office to establish effective and consistent notification and information sharing between agencies and HMC Office. It reminds agencies of their duty to assist the Coroner's Court and of the Coroner's right to see all material which they consider relevant unless there is an application for public interest immunity. There would be benefit from the protocol being shared with other Coroners within Greater Manchester.

5.54 The police investigation considered whether the treatment of Miriam, or a lack of treatment, by any professional organisation who cared for her in the time leading up to her death amounted to circumstances which would render individual staff or an organisation criminally culpable of an offence. The Detective Inspector (DI) considered the offence of Corporate Manslaughter[20]. Corporate Manslaughter is a criminal offence where a business or organisation is found to have caused a person's death. Alongside Corporate Manslaughter the DI also considered the two lesser offences of ill-treatment and wilful neglect which both fall within the ambit of Sections 20-25 of the Criminal Justice and Courts Act and Section 44 of the Mental Capacity Act, and state that *it is an offence for an individual who has the care of another individual by virtue of being a care worker, to illtreat or wilfully to neglect that individual*. The investigation consulted the expert witness who had been called to the coroner's inquest, to assist to identify whether any management of any organisation who cared for Miriam was the direct cause of her death and whether Miriam was ill-treated or neglected by means of a deliberate conduct or reckless act by a staff member who cared for her. The expert is a barrister and professor emeritus[21] of geriatric medicine with over 20 years' experience as an expert witness. He found no neglect of significance to meet the required threshold for the police to approach the Crown Prosecution Service (CPS) with regards to a charge for any of the aforementioned offences. Subsequently the investigations were closed.

5.55 Best practice, given the complexity of the situation, is to seek early investigative advice from the CPS. This review is unable to regard any rationale regarding consideration of early investigative advice taken, but guidance at the time[22] noted that *'Prosecutors may provide guidance and advice in serious, sensitive or complex*

[20] Corporate Manslaughter is an offence created by Section 1 of the Corporate Manslaughter and Corporate Homicide Act 2007

[21] The title is awarded to retired Professors who have made an exceptional contribution in academic leadership terms, including dedicated achievement to his or her field of study.

[22] Charging (The Director's Guidance) 2013 - fifth edition, May 2013 (revised arrangements) | The Crown Prosecution Service (cps.gov.uk)

cases and any case where a police supervisor considers it would be of assistance in helping to determine the evidence that will be required to support a prosecution or to decide if a case can proceed to court'. Updated Director's Guidance on Charging (6th Edition)[23] notes similar at 7.2 where it states that *'Advice may be sought before a charging decision is requested or may be given as part of the charging process'* and that *'investigators must consider seeking early advice in serious, sensitive, or complex cases.'* There is a strong recommendation at Annex 6 that all cases resulting in death, access the provision of early advice. Note that this provision for obtaining investigative early advice is distinguishable from a request for a charging decision.

5.56 Early consultation with the CPS in the investigation, prior to the expert being tasked with the legal questions, can result in the CPS suggesting different avenues for the expert to consider. The review recognises that this may not alter an outcome, but it will result in a more robust conclusion and offer reassurance to living victims that a thorough investigation has taken place.

Learning Point 11

The consideration/use of early CPS advice in complex cases is critical to a thorough investigation.

5.57 As can be realised in the Table of Investigations above, the final ASC safeguarding enquiry concluded differently to previous enquiries. When asked how this could happen, ASC told the review that initial enquiries hadn't utilised expert evidence; this latter enquiry had received substantial input from an expert pharmacist who presented as the objective person.

5.58 ASC did recognise similarities to the previous enquiries that could be improved upon - namely that the family of Miriam could have been included more. In recognition of this, and the hardships that the family have been/are going through, K is to be offered a de-brief session. The panel also discussed how helpful advocacy could be for a family involved in an enquiry and suggested that it should always be considered. However, it is acknowledged that many family members will not meet the threshold for advocacy support under the Care Act as they may not have care and support needs of their own and alternatives may need to be explored.

5.59 The Social Care investigation was not completed until May 2021 and as such this review explored timescales. It was established that the enquiry had been unable to commence until the police investigation was finalised, subsequently, it wasn't allocated until January 2020. Its progress was then quickly impacted upon by the Covid-19 pandemic which caused social care's priorities to shift elsewhere. This interruption was unprecedented and unavoidable, but ASC did identify that a strategy meeting at the start of the investigation would have been beneficial to timescales. In particular because the amount of information to be reviewed was immense, the number of key lines of enquiry was substantial and a strategy meeting could have assisted to identify relevant material thus saving time in due course.

5.60 It was good practice that on this occasion, a case conference did convene at the end of the investigation but as previously mentioned, the care home by this time was under new management and the old management (to whom many of the key lines of enquiries were directed) did not attend. Discussion was had by the panel regarding this, and it was agreed that this was correct as it is the director of a care home who is accountable for a managers actions and it is for them to act upon any subsequent concerns post discussion.

5.61 K has said that she found this meeting quite difficult because she struggled to understand the fairness of the process when the people under scrutiny are given a vote to substantiate or unsubstantiate lines of enquiry that relate to their own actions or the actions of colleagues within their own agency.

[23] Charging (The Director's Guidance) - sixth edition, December 2020 | The Crown Prosecution Service (cps.gov.uk)

5.62 The coroner went on to exercise her powers under Regulation 28, which states that *'where a Senior Coroner has been conducting an investigation into a person's death, anything revealed by the investigation which gives rise to a concern that circumstances creating a risk of other deaths will occur or continue to exist in the future, and in the Coroner's opinion action should be taken to prevent the occurrence or continuation of such circumstances or to eliminate or reduce the risk of death created by such circumstances, the Coroner must report the matter to a person who the Coroner believes may have the power to take such action'*. The coroner addressed the document collectively to the GP, the manager of the care home and the CCG. The concern being that *Promazine was sought by the home manager at XXX and prescribed by the GPs at XXX after XXX (Psychiatrist working in the Memory Clinic (part of Pennine Care NHS Foundation Trust) had advised that such medication be stopped on the 16th November 2016 and, again on the 16th December 2016. On both occasions, promazine continued to be prescribed by the GP and continued to be administered under the control of the manager at XXX Residential Home. In the event, I found that Miriam had been over-sedated during her time as a resident at XXX Residential Home. The psychiatrist had recommended alternative sedative and antipsychotic medication, which was also being administered to Miriam. It was clear that the GPs and psychiatrist were not aware of decision being made by each other in October to December 2016, which led to unsafe prescribing of sedatives and antipsychotic medication.*

5.63 The coroner requested that actions be identified and taken by the single agencies to prevent future deaths. The responses are summarised in the table below:

Single Agency	Improvements Identified within the Regulation 28 Response:
GP	• A new policy has been created to specifically address the issue of sedative medication for dementia patients in care homes. • Care Homes have been asked to ensure that they have appropriate guidance in place regarding PRN medicine and that they request all visiting specialists/psychiatrists to update the surgery the same day that they visit of any changes to sedatives and/or controlled drugs.
CCG	• The use of more expedient communication methods will be looked at to consider how these can be maximised in these circumstances. • A new IT system is in the process of being commissioned which will enable a system wide electronic approach – this is in the early stages and will be some time before it is in place and operational. • A new policy has been developed which outlines processes for maintaining safety for individuals living with dementia in care homes and receiving sedative medication. • The Quality and Assurance team are reviewing the use and application of protocols in place in care and residential homes for the administration of PRN medication.
Manager of the Care Home	• Policy amendment for the monitoring of medication. • Updates to Administration of Medication, Covert Medication and Controlled Drugs Policies.

5.64 Although the number of safeguarding enquiries that have been undertaken with regards to Miriam's care suggests a good system of monitoring processes, it is a concern that following Miriam's death, K was approached by a former employee of the care home who admitted to having had concerns regarding residents being prescribed drugs that weren't required, especially Miriam. The resource, *Commissioning care homes: common safeguarding challenges*[24] acknowledges the *widespread issues regarding the misuse of sedatives to control challenging behaviour* and states that *such issues are extremely serious and should be referred through safeguarding procedures.* The care home has confirmed that all staff would have been trained on

[24] https://www.scie.org.uk/publications/guides/guide46/files/guide46.pdf

whistleblowing in the staff induction training programme and would have signed to say that they agreed with and understood the whistle blowing policy, but staff approached by the reviewer have not felt able to contribute to the review and discuss further.

Learning Point 12

Care home staff need to be confident to challenge poor practice and must have a good understanding of the whistle blowing procedure.

Recommendation: The OSAB should seek assurance that a piece of work is undertaken with care home staff to identify the barriers staff face when they want to challenge poor practice.

5.65 K has raised her concerns repeatedly, opening investigations but she has told this review that she wasn't ever made aware of her rights to appeal either ASC decisions or police decisions at the time, although she was provided with complaints procedure information on later dates.

Learning Point 13

Families should be aware of the appeal procedures available if they are unhappy with the outcome of a safeguarding enquiry or police investigation.

This will be addressed within the recommendation at learning point 1

6 Good Practice

6.1 Examples of good practice have been evident within the information provided for this review:

- The consultant has communicated to the GP by letter after every contact.
- K recalls that the police officers who attended her mother following an incident in the care home treated her mother with respect and were reassuring to both Miriam and the family.
- Single agency responses to the Regulation 28 notice have demonstrated that changes have already been considered and implemented, and evidence the agency's willingness to support future learning.
- Since October 2020, the care home has introduced a new management team and has worked hard to ensure the home has a more open culture. Local authority action plans have been completed and they are happy with the home as are the CQC following a recent inspection. A new electronic medication administrative system is proving able to assist with effective management and is ensuring that concerns are dealt with professionally and swiftly.
- The investigation undertaken as a result of Miriam's daughter's complaint in 2019 identified breaches and poor practice and issued practice guidance.

7 Conclusion and Recommendations

7.1 Miriam's family bereavement process has been deeply impacted upon by the circumstances that exacerbated Miriam's deteriorating health. K's narrative expressed shock and guilt about the medication that her mother was administered and frustration that it went unnoticed by professionals despite her personal efforts to bring attention to her mother's changing demeanour. She cannot understand why subsequent enquiries and investigations have not unearthed how such mistakes were made and how they went unnoticed. The reviewer hopes that the report might assist her understanding of the processes which affected her mother's care and reassure her that any failings are being addressed.

7.2 Review processes such as this one, are an essential part of safeguarding but their effectiveness is dependent upon agency participation and their responses to learning points and recommendations. The reviewer would like to thank agencies for their engagement. Their information has allowed the reviewer to identify the organisational learning points which can be grouped into 4 main themes:

1. Fractured communication - Because care homes rely heavily upon medical care afforded by multi-agency teams who are not based on site, it is vital that communication methods are robust and up to date to track changes.

2. Co-ordination – A service user must have a key point of co-ordination to ensure that their needs are continually met in the best placement and when a service no longer meets the needs of a person, assessment and referral of new services must be owned and timely.

3. Whistleblowing – This review recognises that caring for residents who suffer with memory loss/dementia and display behavioural changes within a care home, offers significant challenges systemically and for individual staff. Staff must feel able and confident to highlight failings, negligence, or poor practice in order to address the situation and improve the care provided.

4. Care Home Family relationships – A resident's care decisions should always be made on the basis of what works best for the resident, not the care home and therefore a care home and a resident's family should be in partnership. Family observations/concerns should not be dismissed as a key information giver is not always a professional. Likewise, family should be utilised during safeguarding enquiries/investigations and kept in the loop, where appropriate.

7.3 13 individual Learning Points have been identified - commendably, some of the learning is already being addressed and this has been acknowledged within the report. The following **recommendations** adopt the outstanding learning:

1. The OSAB should seek assurance that partner agencies ensure that a protocol is produced/available which offers clear guidance for all professionals, including care home staff, completing handwritten and/or electronic notes/records, on behalf of another professional.

2. The OSAB should seek assurance that care homes within their authority understand their responsibilities and have access to policy regarding the procedure to follow when a care home can no longer meet a resident's needs. The policy must recognise that when such a situation arises the care home must contact the commissioning authority to convene an MDT meeting and review the situation in a timely manner.

3. The OSAB should share this SAR with the neighbouring authority who commissioned Miriam's care and should ask GM to consider reviewing/producing a policy regarding cross-boundary working and ensure that it incorporates an escalation policy in the event of poor communications. Once the cross-boundary protocol has been agreed, the OSAB should seek assurance from the Care Home Commissioning Team that cross-boundary training has been delivered within all of the borough's care homes and that clear guidance is available.

4. The OSAB should consider the production of a lead professional handbook which will describe the role, its functions and advise professionals re appointment.

5. The OSAB should seek assurance that work is undertaken with professionals to ensure that a Care Home's resident's voice is being heard and reflected in their care.

6. The OSAB should produce a safeguarding leaflet to be provided to subjects/families (as appropriate) at the beginning of all safeguarding enquiries. The leaflet must explain the safeguarding process, how a subject/family is included and how a decision can be appealed.

7. ASC should assure the safeguarding partnership that a case conference will always be considered when dealing with any complex safeguarding enquiry and where a decision is made not to convene, rationale will be documented.

8. The OSAB should seek assurance that a piece of work is undertaken with care home staff to identify the barriers staff face when they want to challenge poor practice.

Glossary of Terms

Abbreviation/Acronym	**Full Title**
ASC	Adult Social Care
AVPU	Alert, Verbal, Pain, Unresponsive
CCG	Clinical Commissioning Group
CPS	Crown Prosecution Service
CQC	Care Quality Commission
EMI	Elderly Mentally Infirm
GMP	Greater Manchester Police
GP	General Practitioner
HMC	Her Majesty's Coroner
MAR	Medicine Administration Records
NICE	National Institute for Health and Care Excellence
OSAB	Oldham Safeguarding Adults Board
SAR	Safeguarding Adult Review