Safeguarding Adults Review Joint Report

Betty
Deceased 22 March 2016
Aged 84

Robert Lake
Independent Author

Section 1: Introduction

Section 44 of the Care Act 2014 places a statutory duty on Local Safeguarding Adults Boards (SAB) to undertake a safeguarding adult review (SAR) in certain circumstances as set out below:

(i) A SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if:

(a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

(b) condition 1 or 2 is met.

(ii) Condition 1 is met if:

(a) the adult has died, and

(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

(iii) Condition 2 is met if the adult has not died but the SAB knows or suspects that the adult has experienced serious abuse or neglect.

The purpose of a SAR is to gain, as far as is possible, a common understanding of the events that prior to death, to identify if partner agencies, individually and collectively, could have worked more effectively and to suggest how practice could be improved. A SAR is about learning, not blaming, and aims to improve future practice.

The Terms of Reference for this Review are given at Appendix 1. For the purposes of this report and in line with standard practice for Safeguarding Adult Reviews, the agencies and individuals providing information to the Review are not identified.

When a SAR is to be conducted, family members are invited to contribute to the report. I met with Betty's husband and sons, at the start of the Review process and again when the report was at final draft stage, and it is at their request that she is referred to as "Betty" throughout this report.

Betty had been resident at a local Care Home since 11th Feb 2013, as a result of needs associated with her dementia. On the 17th March 2016, Betty was sitting on a chair outside the treatment room when another resident, William, approached her and, allegedly[1], threw her off the chair onto the floor. He then sat in the chair. The incident was witnessed by a carer who alerted other staff members. Betty was unconscious on the floor and after treatment by ambulance staff, she was taken to

[1] The word "allegedly" is used because there has been no formal finding of guilt in relation to this matter. A Police murder enquiry was undertaken but William died before the Crown Prosecution Service made a final decision on whether to mount a prosecution, or not. The words "allegedly/alleged" will not always be repeated throughout the report (in order that the report can flow) but the reader must remain aware that there has been no prosecution nor formal verdict in this case.

the local Hospital where a brain haemorrhage was found. Betty remained in hospital until the 22nd March 2016 when she passed away.

Because of the Police investigation into Betty's death it was not until January 2017 that the Protection Sub Group of the Sandwell SAB was able to determine that the criteria for a Safeguarding Adult Review had been met. The SAR was to concentrate on the period 18th January 2016 to 23rd. March 2016, the date of her death.

I was appointed by the Sandwell Safeguarding Adults Board (BSAB) in January 2017 to assist them in the preparation of this Safeguarding Adult Review (SAR) report. [I am an independent social care consultant and a qualified social worker having previously been a Director of Social Services for fifteen years in large county local authorities. Subsequently, I have held senior executive and non-executive Board level positions in the NHS and as a non- Executive Director with a large voluntary housing association. I have authored several SAR's for different Local Safeguarding Adult Boards.]

When I and SSAB staff were scoping the report, we came to the realisation that the alleged perpetrator of the assault on Betty, William, could also be regarded as a "victim" in that the care afforded to him after the event may not have been to the high standards required by the Board and its partner agencies. It was therefore decided to commission an additional SAR to include a consideration of the care provided to William. The timescale for this SAR was to be the 17th March 2016 to 23rd August 2016, the date William was admitted to a specialist care home in Staffordshire. William passed away at that care home on 30th December 2016 – his death was due to natural causes.

In line with the Terms of Reference for the William SAR, two separate reports have been prepared.

This Safeguarding Adults Review primarily used an investigative, systems focus: relevant agencies were asked to provide an Individual Management Review (IMR) of their involvement. This ensured a full analysis by the IMR authors (and subsequently by the multi-agency Protection Sub-group) to gain a comprehensive overview and alignment of actions. In addition to the meetings with the IMR authors and the Protection Sub-Committee, a Practitioners Event was held which gave an opportunity for some of those directly involved in Betty's and William's care to comment on the factual accuracy of this report and to start the learning process.

At the outset, I wish to record my thanks to all those who have assisted with and provided information for the review including the authors of the Individual Management Reviews (IMR's) and the members of the Protection Sub-group. Particular thanks go to the Sandwell Safeguarding Adult Board Business Manager and her staff who have provided excellent professional and administrative support.

Section 2: A Summary Chronology of Key Events: 18th January 2016 to 23rd March 2016

Some events which pre-date the review period are listed to aid a greater understanding of the matters under consideration. Any quotations used are taken directly from the IMR's. The details here are taken from the various IMR's and are listed without comment. Where quotes are given, the source is also given.

11th February 2013: Betty was admitted to the specialist, EMI, residential care home. During 2014 and 2015 there were four safeguarding alerts raised by the home all of which concerned a deterioration in other residents' behaviour and none of which involved Betty directly.

22nd February 2016: William was admitted to the home from the local hospital where he had been since the 18th January following a fall at home. There was no risk assessment in relation to William either by the hospital social worker or the care home manager. Almost immediately upon admission to the care home and over the next seventeen days, William displayed agitated and verbally aggressive behaviours towards staff on an almost daily basis. This extended to physical assaults on staff and residents. He also had a tendency to wander into other resident's rooms and, on one occasion, William had to be restrained from attacking another resident (not Betty).

11th March 2016: *"Betty was on [the] floor next to her favourite chair, screaming, and William was sitting where Betty was sitting moments before."* There were no witnesses to this incident but the records state *"[William] has knocked Betty onto [the] floor, suspected of pushing off chair"*. Betty was helped to her room but, as far as can be ascertained, there was no medical assessment or treatment undertaken.

11th to 15th March 2016: William continued to show aggressive and threatening behaviour.

16th March 2016: William went into another resident's room and attacked him, causing cuts to the face and neck. The community psychiatric nurse is contacted and told of this event and of the event involving Betty on the 11th March.

17th March 2016: William was visited by the community psychiatric nurse. He could not recall assaulting anyone and wants to go home. The nurse discussed progress with the home manager and was told that the home was equipped to care for William. The nurse agreed to contact the social worker to request a review of William's placement.
Later that day, *"At 15:30, [William] was walking up the corridor staff could see him from the lounge and [a staff member] seen him pick another resident off the chair - Betty - by treatment room before carers could get to them he threw the resident on the floor, he was asked why he had done it he said, he didn't do anything."* Betty was left unconscious. She was taken to the local hospital by ambulance where a brain haemorrhage was diagnosed. Betty died on the 22nd March 2016.

Subsequently, the police launched a murder enquiry but William died before the Crown Prosecution Service made a final decision on whether to mount a

prosecution, or not.

Section 3: Events Leading to William's Admission to the Care Home

It is necessary to give some detail of the circumstances and events leading to William's admission to the care home on 22nd February 2016.

William was admitted to the local acute hospital, from his home, on 18 January 2016 following a fall. He had been lying on the floor for some considerable time. While at home, William had been supported by a local, community based, domiciliary care service twice daily. He had also received support from a community psychiatric nurse as he was subject to a Care Programme Approach[2] as he was suffering from mental ill-health.

On admission to the acute hospital, it was noted that William's medical history included diabetes, dementia and bi-polar affective disorder. It was also noted that he had stopped taking his medication and that physical examination suggested that he had fallen on several occasions previously.

While in hospital, William received medical, physiotherapy, nursing and speech and language services. It was confirmed that he was at high risk of falls and that he had a tendency to choke on his food.

On the 29th January 2016, William was transferred to the pre-discharge ward within the hospital. It is recorded that his behaviour was non-compliant, agitated and aggressive but this settled for a few days.

On the 3rd February 2016, William was assessed by adult social care. He expressed a wish to go home. A mental capacity, decision specific assessment was completed and it was concluded that William lacked capacity to make informed decisions and that 24hour care is required. William's daughter was consulted and she agreed to the 24hour care plan.

On 10th February 2016, liaison between the hospital social worker and William's Community Psychiatric Nurse established that William had a diagnosis of schizoaffective disorder rather than dementia/bi-polar affective disorder. The nurse advised that William would not accept a 24hour placement.

On 11 February 2016, William was transferred back to an acute ward suffering from cardiac problems. On the 12th February, a pacemaker was fitted. William was also assessed by the psychiatric service and appropriate medication prescribed.

On 12th February 2016, the social worker requested funding approval for a residential "Elderly Mentally Infirm" placement for William, noting (as stated in the IMR) that he was entitled to after care services under Section 117 of the Mental Health Act. Approval was given on 16th February. William's daughter was given assistance in choosing a placement for her father.

[2] The Care Programme Approach (CPA) is a way that services are assessed, planned, co-ordinated and reviewed for someone with mental health problems or a range of related complex needs.

On 20th February 2016, nursing records show that William was displaying increased aggression and he had hit another patient. An incident form was completed but there is no evidence to suggest that the hospital's "violence and aggression policy had been followed appropriately" (Hospital IMR/Root Cause Analysis).

On 21st February 2016, it is recorded that "a staff member was in the bay at all times due to [William's] aggression".

On 22nd February 2016, William was transferred to the care home by ambulance. His daughter was present. This followed a pre-admission assessment by the care home manager but this did not include a formal risk assessment.

Section 4: Areas for Consideration

Within the Terms of Reference for this Review, there are four areas listed for consideration. These are:

- How the agency upheld "Making Safeguarding Personal"[3];
- How and when the Mental Capacity Act and Deprivation of Liberty Safeguards were applied and documented;
- How self- neglect guidance was applied;
- How multi-agency working was demonstrated at times of critical decision making.

Of these, only two are relevant to Betty's care:

A Mental Capacity Assessment and Deprivation of Liberty Safeguards for Betty had been completed on 28th August 2015.

There was little if any effective multi-agency working demonstrated in the critical period of 22nd February 2016 to 17th March 2016. [This will be discussed further below.]

There is one further particular issue to consider – one which was raised by Betty's husband and sons when I met them at the start of this Safeguarding Adult Review process. They asked if the care home's decision to accept William was because they were experiencing high vacancy rates and needed to accept referrals, for monetary reasons, irrespective of the appropriateness of the referral. I have made specific enquiries on this point and have found that the home was running at almost full capacity at the time of William's admission and, therefore, it would not be reasonable to conclude that William's admission was for monetary reasons.

[3] Making Safeguarding Personal (MSP) is a sector led initiative which aims to develop an outcomes focus to safeguarding work, and a range of responses to support people to improve or resolve their circumstances

Section 5: Analysis: Areas of Concern

There are seven main areas of concern:

(i) that the detail given to the care home in the original care enquiry from the social worker and on the care home manager's pre-assessment visit to the hospital was not fully accurate and could not, therefore, constitute effective inter-agency working [Note: neither the social worker nor the CPN were asked to take a view on the suitability of this particular care home]

- the initial enquiry form from the social worker reportedly stated the sole mental health condition as dementia, albeit the social worker's support plan did mention schizoaffective disorder but not William's symptoms, behaviors, early warning signs or triggers. Also, no mention was made of William's likely aversion to 24hour care (a probable contributory factor to his aggressive behaviour);
- the hospital informed the care home manager that William's medical history included diabetes, bi-polar affective disorder, glaucoma, a pace maker having fitted and dementia but no mention of aggression or the apparent triggers for such behaviour;
- the assault on another patient by William while still in hospital, on 20th February, was not reported to the care home by the hospital or social worker [Note: It is probable that the social worker had not been informed of this incident by the hospital];
- it should also be noted, with concern, that information held by the hospital – that William had assaulted a patient at the hospital - was not shared with the care home for the first week of William's stay.

(ii) That contrary to expected practice, there was no multi-agency discharge planning meeting held, a meeting which should have involved, at least, the social worker, the Community Psychiatric Nurse and acute hospital staff;

(iii) that there is no record of a Care Programme Approach Care and Risk Assessment being shared with the care home and no arrangements were made for a Care Programme Approach handover. We have no evidence of a Care Plan being in existence. With William's history, and as the community psychiatric nurse was to provide continuing care to William, transfer of information was essential. Again, this is poor inter-agency working;

(iv) that the regular verbal and physical aggression towards staff and residents, displayed by William from the moment he was admitted to the care home, appears to have not been reflected in updated risk assessments and care plans. This is particularly true of the response to

the incident on the 11th March 2016 when Betty was found screaming on the floor and it was concluded that William had knocked her to the floor. It was only after the incidents on the 16th and 17th March that actions were initiated to safeguard other residents. The care home should have been updating individual risk assessments and care plans on a regular and possibly, daily, basis when faced with the behaviours William was exhibiting.

(v) A formal Safeguarding Alert should have been raised after the incident involving Betty on the 11th March – the care home states that such alerts were raised for the incidents on the 16th and 17th March, which demonstrates that the care home management were aware of the procedure so it is difficult to understand why an alert wasn't raised earlier;

(vi) that no medical assessment or treatment was afforded to Betty after the incident on 11th March – this is unacceptable;

(vii) that the care home manager failed to escalate incidents to appropriate professionals (social worker, GP) albeit she did speak to the community psychiatric nurse on the 17th March but stated that she was of the opinion that the home could care for William. We were told, by the police, that they would have expected the home manager to have reported the various assaults (both assaults on staff and on other residents) to them and they would have kept a log of the incidents and, possibly, intervened. The home manager also failed to escalate matters to her own line management. Had more assistance been sought from other professionals, then the tragedy that befell Betty (and indeed William) may not have occurred.

[It should be noted that the care home manager has subsequently been dismissed by her employer, but that, at the time of writing, there is an appeal against dismissal pending.]

Section 6: Recommendations for Action

One of the objectives of a Safeguarding Adult Review is, in considering the details of the case, to make recommendations for actions to improve future practice. Recommendations may apply to single agencies or to the Safeguarding Adult Board in relation to inter-agency policies, procedures and practice.

(i) Individual Agency Recommendations and Action Plans

There were four agencies directly involved in these events: the local acute hospital, the mental health trust, adult social care and the care home. Some of the

recommended actions which follow were identified by the agency concerned but are included here for completeness.

For the Acute Hospital

- The hospital should ensure that discharge summaries are accurate on the day of discharge and fully comprehensive. Summaries should not just concentrate on medical issues: they should include details of the patient's behaviour, symptoms, trigger factors etc.
- The hospital should ensure that the violence and aggression policy is known to all staff and fully complied with.

For the Mental Health Trust

- The trust should ensure that Care Programme Approach Care and Risk Assessment are completed and shared with care home providers and ensure that arrangements are made for a Care Programme Approach handover and multi-disciplinary discharge planning meeting

For Adult Social Care

- Adult social care should ensure they have a clear understanding of information sharing procedures with other agencies and of other agencies procedures and thresholds
- Adult social care should establish closer line management of case recording ensuring that the content is accurate, appropriate and completed in a timely manner. (The IMR identified some gaps/insuffiencies in recording but these had no direct bearing on this case.)

For the Care Home

- The care home should ensure pre-admission assessments are as comprehensive as possible and are fully current at the point of admission.
- The care home should review their admission criteria and ensure that these are fully known and applied in practice.
- The care home to ensure that all staff receive training in the importance of communication and documentation of individual incidents.
- The care home to audit recording and instigate follow up action/training accordingly.
- The care home to audit staff training and ensure that regular supervision is provided.
- The care home to ensure that other professionals are kept fully briefed.
- The care home to ensure that there is an active approach to risk assessments and care planning and build in an initial review at day 7 of placement.

I would recommend to the Sandwell Safeguarding Adult Board that the Board agrees the issues listed as requiring action by the agencies and asks each agency to complete action plans accordingly and submit these to the Board for approval. The Board will wish to ensure that these plans are then audited to be assured that the desired outcomes have been achieved.

(i) Recommendations for the Sandwell Safeguarding Adults Board itself

In this case, I did not identify any shortcomings in the Board's policies and procedures.

The only **Recommendation** I would make to the Board is that they should audit compliance, among partner agencies, with the policy and procedures relating to the raising of Safeguarding Alerts. This should include reminding all agencies, especially care homes, that they have a duty to report all assaults to the Police.

Section 7: Closing Remarks

On the day that Betty received the fatal injuries, she did nothing to warrant the attack that was made upon her. A combination of a lack of accurate up-to-date information being given to the care home and the lack of pro-active intervention by the care home manager, over a period of twenty-four days, led to the situation where Betty's assailant was effectively out of control with no protection plans in place for other residents or staff. Betty's death was preventable.
We can only hope that valuable lessons will be learned from these sad events – sad for many concerned – and that practice and the safeguarding of people like Betty will be better in the future.

Robert Lake.
Independent Author.

APPENDIX 1

Safeguarding Adult Review
Betty

TERMS OF REFERENCE

Supporting Framework

The Care Act 2014, which came into force in April 2015, places a statutory duty on Safeguarding Adults Boards (SAB) to undertake case reviews in certain circumstances as set out below.

Section 44, Safeguarding Adult Reviews:

(i) A SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if:

(c) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

(b) condition 1 or 2 is met.

(ii) Condition 1 is met if:

(b) the adult has died, and

(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

(iii) Condition 2 is met if the adult has not died but the SAB knows or suspects that the adult has experienced serious abuse or neglect.

Circumstances of Incident

Betty had been resident at a local Care Home since 11th Feb 2013, as a result of needs associated with her Dementia. On the 17th March 2016 Betty was sitting on a chair outside the treatment room when William approached her and threw her off the chair onto the floor, he then sat in the chair. The incident was witnessed by a carer who alerted other staff members. Betty was unconscious on the floor and was then treated by ambulance staff and taken to Sandwell Hospital where a brain haemorrhage was found Betty remained in hospital until on the 22nd March 2016 she passed away. William arrived at the care home on the 22nd February 2016 after being taken there from City Hospital following a fall at home. William's diagnosis required him to have monthly depot injections, and, he had a long history of mental ill health spanning 36 years of interventions. After the incident, William was sectioned under the Mental Health Act and taken to a local Psychiatric Hospital.

On the 2nd August 2016, a Post Mortem report detailed that Betty died as a consequence primarily of her injuries with contributions from underlying natural disease. Cause of Death given as 1a) Bronchopneumonia, 1b) Blunt Head Injury and Fractured Neck of Femur, 2) Alzheimer's disease, Amyloid Angiopathy and Osteoporosis (aplastic bone disease).

There were several other reported incidents during the period that William was resident at the care home, including one incident against a member of care staff on the 25th February;
On the 11th March, Betty was found slumped on the floor next to her favourite chair, William was sitting in it. **There were however no witnesses to this incident.**
On the 16th March William was found in another resident's room with his hands around the resident's neck.

Methodology

The Safeguarding Adults Review will primarily use an investigative, systems focus and Individual Management Review (IMR) approach. This will ensure a full analysis by the IMR author or multi-agency Protection Sub-group to show comprehensive overview and alignment of actions

Scope of Safeguarding Adult Review:

Adult Betty Date of Birth 17.06.1931 Date of Death 23.03.16

Timeframe

The scope of the SAR will be from 18.01.16 to 23.03.16

Agency Reports

Agency Reports will be commissioned from:
Adult Social Care
The Local Hospital
The Mental Health Foundation Trust
The Care Quality Commission
The GP/Clinical Commissioning Group
The Care Home Provider

Agencies will be expected to complete an Individual Management Review (IMR) with chronology, template and guidance attached.

Any references to the adult, their family or individual members of staff must be in a consistent format, e.g. by Initials, and for Professionals, identity such as Health Visitor- HV1 or Social Worker SW1.

Any reasons for none cooperation must be reported and explained, this also applies to timescales which should be strictly adhered to.
All Agency Reports must be quality assured and signed off by a senior manager within the agency prior to submission

It is requested that any additional information requested from agencies by the SAR Independent Author is submitted on an updated version of the original IMR in red text and dated.

Agencies will be asked to update SSAB on any actions identified in section 8 of the IMR prior to the completion of the SAR which will be fed into the final report. Updates will then be requested until all actions are completed.

Areas for consideration:

How the agency upheld Making Safeguarding Personal
How and when MCA and DoLS were applied and documented
How self- neglect guidance was applied
How multi-agency working was demonstrated at times of critical decision making

Parallel Process

E.G any Domestic Homicide Reviews or Crown Prosecution Service considerations?

Engagement with the individual/family

While the primary purpose of the Safeguarding Adult Review is to set out how professionals and agencies worked together, including how learning and accountability can be reinforced both in and across agencies and services, it is imperative that the views of the individual/family and details of their involvement with the SAR are included in this.

In doing so it ensures that this enshrines the principles and practice of Making Safeguarding Personal, a core value signed up to by all agencies working as part of the Sandwell Safeguarding Adults Board.

All IMRs are to include details of any family engagement that has taken place or that is planned. The Independent Reviewer will be the single point of contact with the family in relation to the SAR

Media Reporting

In the event of media interest all agencies are to use a standard no comment approach until the report is approved for publication.

Publishing

It should be noted by all agencies that the SAR report will be published once

complete unless it would adversely impact on the adult or the family.

Consideration should be given by all agencies involved in regard to the potential impact publishing may have on their staff and ensure that suitable support is offered and that staff are aware in advance of the intended publishing date.

Administration

It is essential that all correspondence with identifiable information is sent via secure methods only.

Specific Questions for Agencies to Consider

Although the subject of this SAR is Betty, we are collectively aware that in order to maximise the learning from the circumstances of her death, we need to explore antecedent factors that may have contributed to the incident from the perspective of the person accused of causing harm, which is William.

Accordingly, please consider:
William was variously reported as suffering from a schizoaffective disorder and/or a bi-polar disorder. At what stage did you become aware of either or both of these diagnoses? What implications were there for any care plan?

William was reported to have had some history of behaviours that could be described as challenging - what did you understand by this and how did it inform any risk assessments you may have made?

What was your understanding about William's mental ill health history, including any entitlements for 117 aftercare?

What was your understanding of William's views on being accommodated in a care home?

<u>Additional Question for the Care Home Provider</u>

After the events of the 11 March, when Betty was knocked to the floor, what specific actions were taken?

<u>Additional Question for Adult Social Care/the Hospital/the Care Home Provider</u>

Thinking about the principles of MCA 2005, what was your understanding and contribution to William being accommodated under a Best Interests arrangement and what steps were taken to address any Deprivation of Liberty?

Timetable for Safeguarding Adult Review	DATE
Scoping Meeting to agree on agencies to be involved, terms of reference, methodology etc. Letter to IMR agencies to identify authors and secure documents	20.1.17 6.2.17
First introduction and discussion with the individual / family	15.2.17
IMR Authors' briefing	27.3.17
Completion date for IMRs	3.5.17
Review of IMRs	18.5.17
Draft report and recommendations circulated to Panel members Protection Sub Group Individual/ family	13.6.17
Date for final amendments to draft report and recommendations	5.7.16
Date for final report submission to board with all partners of SSAB -presented by author with recommendations	27.7.17
Date for final report amendments and recommendations	TBC
Date for final board ratification of report and recommendations Feedback to individual and /or family	TBC
Date for Protection Group to determine multi-agency action plan from the SAR recommendations	TBC
Date for learning events	TBC
Date for publication on website	TBC
Closure latter to individual and/or family	TBC