

Independent investigation report

Care and management of MR September 2013 to June 2014

25 November 2016



The **effective investigations** company

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Acknowledgements

This investigation would not have been possible without the input of the family of the deceased, FR, and the four agencies involved in the case management of MR between September 2013 and June 2014.

These agencies were:

- ❑ The care home provider
- ❑ The local authority safeguarding team
- ❑ The specialist mental health service
- ❑ MR's general medical practice

The family of MR were unable to meet with the independent author during the review process. MR was critically ill and their focus was on supporting him. They have however subsequently spoken with NHS England during the inquest process and were supportive of the review and its findings.

Key dates

Fatal incident date: 26 June 2014

Date independent investigation was commenced: The initial multi-agency telephone conference took place in July 2015. The first face-to-face meeting occurred on 14 August 2015. On this day the independent team took receipt of MR's care home records. The local authority records were provided later the same month. Mental health records had been provided in July.

Date provisional investigation report was issued in draft: 12 January 2016. A second draft was issued for consideration on 10 March 2016. All agencies met on 15 April 2016 to discuss the penultimate version of the report, and to agree the conclusions and recommendations made. All comments on the last draft of the report were required to be received by 6 May 2016, and this was achieved. Further amendments were undertaken and a further draft circulated to all agencies.

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EXECUTIVE SUMMARY

Incident overview

On 26 June 2014, an incident occurred between two residents (one male and one female) in a care home. As a consequence of this the female resident (FR) fell and hit her head. Despite emergency treatment, she subsequently died from a subdural bleed which occurred as a direct result of falling and hitting her head.

The male resident (MR) was arrested at the time of the incident and was then detained under the Mental Health Act and cared for by Tees, Esk and Wear Valleys NHS Foundation Trust in a medium secure service. This level of service was only required for him as a consequence of what had happened rather than his prevailing behaviour patterns in the period leading up to the incident. Although there had been three previous incidents involving MR, his day-to-day behaviours were not outside of the normal range of behaviours that occur in persons with dementia, and neither did they reach the threshold for 'challenging behaviour' per se.

MR was charged with manslaughter as a consequence of the incident, and since the instruction of the independent review process MR has himself died.

The independent advisers and independent author offer their condolences to both families affected by this incident. The independent team also wishes to be clear that there is no evidence that the incident that occurred was a planned or purposeful attack. Furthermore, it is likely that MR was unaware of what he was doing at the time the incident occurred. Nevertheless, understandably, the families of both residents have concerns about what happened and question whether or not the incident could have been prevented.

Purpose of the investigation

The terms of reference for independent investigations under HSG (94) 27/NHS England's Serious Incident Framework 2015 provide for investigators to "determine through reasoned argument the extent to which this incident was either predictable or preventable, providing detailed rationale for the judgement".

Main findings and conclusions

As a consequence of the investigation undertaken, the independent advisers and author consider that:

- Care home staff provided MR with attentive care. For example, they were persistent in their efforts to support MR as far as he would allow with his personal hygiene issues – a known trigger for agitated behaviour in MR. The care home records demonstrate that staff were sensitive to MR's needs and were able to judge his feelings about the support offered by subtle changes, as well as marked changes, in his behaviours.
- The care home records demonstrate timely and appropriate communications with MR's family where issues of concern arose.

- The care home records show that staff were aware of MR's wandering tendencies and that they took measures to be alert to this and to guide him out of other residents' bedrooms and back to communal spaces or to his own room. On the small number of occasions MR wandered out of the care home, the records clearly demonstrate appropriate and kindly support of MR and encouragement for him to return, which he did on each occasion.
- The care home records also show that staff invested considerable time and effort in monitoring MR's whereabouts, predominantly on an hourly basis. Monitoring increased to every 15 to 30 minutes following significant incidents for time-limited periods.
- There is clear evidence, in the care home records, that the care home staff were persistent in their efforts to achieve input and advice from specialist mental, health and social care services for MR. Unfortunately, the level of concern felt by the care home staff about MR once he had transferred to the elderly mentally infirm (EMI) unit (this unit provided a more intensive care service to persons with dementia) was not fully appreciated by the agencies working with them. These agencies considered that the concerns were not communicated in a way that enabled them to appreciate the level of concern felt by the care home's staff, even though the care home registered manager considers that they clearly articulated these.
- Although the care home did not receive the level of support and advice it was seeking from its partner agencies, the social work records demonstrate that MR's social worker maintained close communication with the care home and undertook to make periodic calls and visits to determine MR's wellbeing. There is also evidence of strategic communications between this practitioner and the care home manager prior to March 2014 in which options for managing MR's wandering habit, and the best care environment for him, were discussed. The social care records thereafter also demonstrate ongoing communications between the two agencies. The social worker assigned to MR recalls receiving differing messages from the care home staff at the time regarding their ability to manage MR, but did not receive any information he could interpret as the care home not being able to cope with MR. His observation of MR and his contacts with MR prior to MR's period of residency in the care home led him to the conclusion that MR's behaviour patterns were within the capability and competency of the care home staff.
- There were two high-risk incidents involving MR in March and May 2014. No serious detectable harm was caused by either of these incidents, but there was discernible potential for higher levels of harm if MR was to be involved in similar types of incidents again. Although the care home staff recognised that both incidents posed a risk to other residents, and reported both to the local authority by raising a safeguarding concern. The extent of the risk posed by MR was not fully appreciated by the Local Authority and consequently escalation procedures were not applied to the management of MR's behaviour as a result of the Safeguarding alert.
- However, a comprehensive risk assessment was conducted after the 30 May (2014) incident. This was conducted by an older persons' community

psychiatric nurse. It identified MR's potential risk of harm to others as a consequence of his unpredictable behaviour, as demonstrated by a small number of incidents, and his ongoing levels of agitation around staff's efforts to assist him with personal hygiene.

- In between the risk assessment taking place and the plan for a medical assessment for MR, a third incident occurred on 24 June. This involved MR and FR, and as far as can be gleaned from the care home records, MR and FR appear to have been equal contributors to a situation that resulted in MR pushing FR, who fell and landed on her bottom, experiencing no harm.
- The fatal incident, which again involved MR and FR, occurred on 26 June, two days later. This incident was not witnessed by staff, but the care home records suggest that MR had again pushed FR, who on this occasion fell and hit her head. The antecedent to the incident is not known.
- The first assessment of MR had been planned for 26 June, and was to be undertaken by an occupational therapist who was co-worker to MR's new community mental health nurse (the lead professional for this episode of care), but was then deferred to early July owing to the inability of the occupational therapist to attend at the care home on 26 June. It is very unlikely that this assessment would have made any difference to the sequencing of events had it occurred as originally planned.

Predictability of the incident of 26 June:

With regard to the question of incident predictability, the independent team wishes to highlight that incidents such as that which occurred on 26 June are not uncommon in communities where persons with cognitive impairment, such as dementia, are living in close proximity. Staff working with individuals with a diagnosis of dementia manage such occasions on a regular basis, and such incidents do not commonly result in life-threatening harm. Acknowledgement of this is important to correctly contextualise the circumstances of the incident.

Therefore:

1. Was it predictable that MR might push FR? Yes, it was, under the circumstance that FR was again within MR's physical space shouting or remonstrating with him. He had pushed her two days previously as a consequence of this.
2. Was it predictable that he would push her and that she would fall and suffer a subdural haematoma as a result of her fall? No, it was not. This is especially so if one considers the normal context of these occurrences within residential care and dedicated dementia care units.
3. Is it predictable that if an elderly person falls and hits the back of their head, they might suffer a subdural haematoma? Yes, it is. There are examples of this happening in the hospital and home environment, but it would not automatically feature as a core consideration in a falls risk assessment.
4. Was it predictable that MR might hurt someone as a consequence of his occasional aggressive outbursts that were not related to efforts to support

him with personal care? Yes, it was predictable that an unexpected incident involving him could result in significant harm to another resident.

The incidents that occurred on 4 March 2014 (found with his hands round the neck of another resident) and 30 May 2014 (punched another resident in the face, causing facial bruising and abrasion) demonstrated MR's capacity and capability for high-risk assaultive behaviour, whether or not he was himself aware of what he was doing.

Preventability of the incident of 26 June:

This question has been given careful consideration by the independent author, the independent advisers and all multi-agency panel members, two key front-line practitioners involved with MR at the time, (local authority and mental health trust), a regional manager for the care home provider and the care home manager in post at the time of the incident.

The bottom-line opinion as a consequence of these considerations is that

- had the information about the 4 March 2014 incident not been inadvertently overlooked by MR's social worker as a consequence of dealing with a backlog of communications on his return from annual leave, and had his manager not also overlooked the risk associated with this occurrence, and
- had the care home instituted one-to-one observations of MR in the immediate aftermath of the 4 March incident,

the following actions and activities are most likely to have occurred:

- negotiation with the local authority by the care home for a review of MR's residential care package
- notification to mental health services of the incident and an assessment of MR under the Mental Health Act (1983).

Although one cannot say what the outcome of these assessments and negotiations would have been, the clinical professionals involved consider that it would have been unlikely that MR's place of residency would have changed at this point because his behaviour settled back to normal and for the following 8-10 weeks there were no further high-risk incidents

Furthermore, from what the involved agencies and the independent team know, it is unlikely that MR would have been detained under the Mental Health Act at this time.

However, when the second incident occurred on 30 May 2014, all agencies are agreed that the response to this incident would have been much more assertive, if the suggested actions and activities had occurred as above, and would have included:

- closer observation in the care home along with the instigation of discussions with the local authority about placement and the funding of close observations until a more suitable placement could have been located
- assessment of MR by mental health services, under the Mental Health Act (1983)
- construction of a care/management plan involving all three agencies.

Had the immediately above occurred, it is unlikely that an alternative placement would have been found for MR in the three weeks preceding the incident of 26 June 2014. A period of three to four weeks and more is the usual experience of the agencies involved in this case. Therefore, on balance, MR would still have been a resident in the care home on 24 and 26 June 2014. However, with a more robust management plan there would have been much less opportunity for him to have become involved in altercations with other residents, or to have had physical contact with them. Therefore, the risk of future incidents would have been reduced to the lowest reasonable level by the care home and the other agencies involved.

However, the independent team highlights that the situation of 'no risk' was not achievable.

Primary contributory factors to MR's risks not being managed as assertively as they should have been:

- The care home records show that its staff did raise concerns about MR with its partner agencies following the incident of 4th March 2014. These agencies included the GP Practice, the Specialist Mental Health Service and the Local Authority Safeguarding Team. However, not one of the other front-line professionals recalled being informed about the 4 March incident. The reasons for this are understood as:
 - Although it is clear that the care home made contact with the GP, the GP surgery has no record of the detail of the communication and cannot therefore recall the depth of information provided. It is not uncommon for such conversations to be conducted via telephone and for key notes only to be made. It is not usual practice to follow up such communications in writing.
 - On 5 March the care home staff spoke to the community mental health nurse to request a meeting with the care coordinator at the Mental Health Trust about how to manage MR's needs. A message was left by care home staff to speak to MR's social worker to arrange a meeting to discuss MR's behaviour and ways to manage him. A safeguarding alert was logged by the care home. MR was moved to the EMI unit on the initiative of the care home. On 6 March 2014 the care home staff requested an emergency referral to the mental health team for MR. The care home was operating under the belief that the community mental health nurse knew about the incident of 4 March 2014; however, the community mental health nurse had not been informed about the incident detail at any stage. Had he been informed, his response to the requests for re-referral would have been different.
 - The social worker assigned to MR was on annual leave when the incident of 4 March occurred. Although the safeguarding alert had been forwarded to him by his manager, it was not flagged with an 'alert flag' and got lost within the backlog of emails that were waiting in his inbox on his return from annual leave. No dedicated time is provided to review and screen these before recommencing with front-line duties.

- There is no agreed communications system between the agencies, such as the 'SBAR' model advocated within healthcare organisations. Furthermore, there are significant obstacles to achieving this:
 - All agencies working within the geography of the county council borough would need to agree on a communication formulation, and possibly adopt this within their own agency community for it to be reliably utilised and understood.
 - Verbal communications using the agreed formulation would need to be followed up in writing. This is more likely to be facilitated by email. However, not all agencies are on a secure cross-agency email network.
 - It is not usual for senior carers within a care home to have a professional email account provided by their employer. They therefore would not be able to engage safely with an across-agency communications model without the engagement of all care home providers.
 - The dangers of 'e-communications' – this case highlights a recognised challenge posed by the digital age: the volume of emails falling into one's inbox.
- At the time, there was a lack of opportunity for a care home to directly refer to specialist mental health services. At the time, a care home was required to refer via the resident's GP. The impetus for this was an expectation that a GP would visit a care home resident and make his/her own assessment before a referral to specialist services was made. In this case, the GP assessment did not occur.
- At the time, there was no clear multi-agency escalation procedure for professional concern or disagreement
- Although some information communicated by the care home to its partner agencies was received and understood, up to 30 May 2014 there was a variability in the expressed levels of concern about MR depending on which member of staff at the care home was communicated with and depending on the behaviour being exhibited by MR at the time. This was the experience of the older persons' community mental health nurse and also the social worker assigned to MR.
- A reasonable expectation is that visiting professionals utilise the care home records and read them to inform themselves about the resident they have come to see. Apart from the isolated incidents on 4 March and 30 May, the content of MR's records does not indicate that there was any cause for concern. Furthermore, the design of the records in MR's care home at that time was not the easiest to navigate, largely because of the volume of records a care home generates per resident.
- Although the care home correctly took protective actions following the incident of 4 March 2014 by moving MR to the EMI unit and by raising a safeguarding alert, there was no structured risk assessment process in place in the care home at the time which would have flagged a follow up with other partner agencies to reach an agreement as to the risk potential associated with the incident that occurred.

- There were also a collection of system related issues within the local authority that also meant that more detailed conversations about risk and Mr MRs placement did not occur. These issues were:
 - the way the risk threshold tool utilised was applied – at the time, this did not include a separate and distinct assessment of perpetrator risk, where safeguarding alerts identified resident-on-resident assaults in local authority-funded care providers
 - the information being overlooked by MR's social worker as already identified
 - the social worker for the female resident (4 March 2014) not identifying the risk
 - the incident not being screened as an adult protection referral, which would have provided more focus on the potential risks for both residents involved in the March 2014 incident.

Recommendations

The independent author has four recommendations.

Recommendation 1: This incident has highlighted a situation where vulnerable adult risk was assessed only in relation to the victim, and perpetrator risk was not considered. It is accepted that the safeguarding framework and guidance is victim focused; however, it is also noted that neither the framework nor the guidance was developed with 'vulnerable adult on vulnerable adult' incidents in mind.

Therefore, the local authority is encouraged to review the design of its risk threshold tool and the documentation tools it provides to its staff to record their risk considerations, so that the tools themselves support the documentation of a structured assessment of risk across all of the domains set out in the threshold tool, and the consideration of risk in relation to situations in which both perpetrator and victim are vulnerable adults.

To achieve this, the independent author suggests consideration of:

- The narrative space in the current risk threshold: this could be more structured. An enhanced structure could drive active consideration of perpetrator risk where the perpetrator is also in receipt of care and is him or herself a vulnerable adult.
- A risk assessment process that is designed to include specific questions. Examples are:
 - What harm was caused by this incident to the victim?
 - What were the circumstances of the incident in terms of:
 - location of incident and 'line of sight' for care home staff
 - how the incident was discovered (for example by chance, or because of planned activities)?

In addition:

The independent author recognises that the local authority has made considerable investment in risk management and risk assessment training for its staff. However, the independent author encourages the local authority to ensure that sufficient emphasis is placed on the basic elements of how to conduct a structured risk assessment (that is, considering what has happened in terms of outcome, what could happen if this recurred tomorrow and what is the reasonable likelihood of this happening again) alongside the complex range of issues professionals within social care and related agencies are required to consider.

Recommendation 2: This case highlights the importance of having a clear and structured risk assessment and management process within a care home environment. MR's care home had an incident reporting system in place, as well as a process for reviewing reported incidents. However, the assessment of risk potential and how this was to be reduced was not documented on Datix as part of this process, and neither was there a requirement to do so. Registered care home managers recorded the outputs of any assessment and investigatory activities elsewhere. In this case, on review of the available documentation, the repetitive approach to documentation led to a lack of clarity about what was done. Consequently, the care home provider needs to achieve a situation where:

- All reported incidents are assessed using a structured and recognised risk assessment process that is integral to the Datix reporting system.
- Where a serious incident investigation and 'standalone' report document is not required the care home provider needs to implement an approach whereby the outputs of any investigation work conducted is captured on its Datix system. This risk management database has the capability and capacity to deliver this.
- Where a registered care home manager is concerned about the risk behaviour of a resident, and there is an underlying diagnosis of dementia, it would be prudent for the registered care home manager to seek the input and advice of the mental health provider in scoping the risk associated with the behaviour. The nearby mental health provider is a specialist organisation and risk assessing behaviour is a core competency for its staff acting in a medical or care coordinator capacity.

An embedded risk assessment process could incorporate a simple range of questions, such as:

- What risk behaviour was demonstrated in this incident?
- What was the impact of this risk behaviour?
- If the same behaviour is demonstrated tomorrow (even in a different location or with a different resident), what is the risk of a worse outcome?
- If you think the outcome could have been worse, what realistically could have happened?
- What safeguards or actions need to be in place to minimise the risk of this occurring again?
- Can this be achieved within current resources?

- Having answered these questions, is your overall perspective of risk very low/low/medium/high/catastrophic (i.e. carries a risk of death)?

As part of the risk assessment process which the care home provider may develop, it will be important to ensure that appropriate professionals are involved at an early stage to ensure that any risk assessment is conducted with the requisite skill and technical knowledge and that there are agreed direct lines of communication with specialist services – in this case, specialist mental health services – so that concerns can be logged if escalation does not take place. Partner agencies will have to work with the care home provider to develop effective lines of communication.

Recommendation 3:

This case highlighted an unfortunate situation where recorded communications made by one agency (the care home) to partner agencies did not result in the detailed assessment of risk that was required. The partner agencies (the GP, and social care and specialist mental health services) have reported that on occasion they:

- did not review and/or receive the information provided,
- considered – as a result of inconsistencies in MR's behaviour, and thus a variation in the messages being communicated to the visiting community mental health nurse and social worker – that there was not a 'constant' concern about MR's behaviour, and consequently when information was obtained from the care home during a 'settled' period there were no undue concerns reported and/or
- did not retrieve some of the available information and/or
- misinterpreted the information.

There is no simple or single solution to the above. Furthermore, the features set out have been reported as a consequence of other independent review processes. Therefore, the health and social care community in Durham needs to consider how it can achieve a more robust approach and, possibly, a common framework for enhancing the effectiveness and reliability of cross-agency communications. There are communication models already utilised in the health and social care domains that already have similar principles – a situation which suggests that agreeing on one model ought not to be unachievable.

Because this recommendation represents a sizeable piece of work, spanning all agencies and care homes and not only those involved in this incident, the Safeguarding Adults Board supported by the Clinical Commissioning Group(s) within the locality are asked to jointly convene a multi-agency working party to explore possible communication models and if possible to set up a pilot scheme so that the preferred models can be tested for usability and acceptability. Furthermore, because this issue is of equal relevance to safeguarding children, it is recommended that the Safeguarding Children Board is invited to be actively involved in exploring and finding a way to improve the consistency and thus the reliability of cross-agency communications.

Recommendation 4: This case highlights a fairly common situation where one agency did not feel empowered to escalate the fact that it considered that it was not receiving a satisfactory response to requests for assistance with a resident's management.

To provide for the mitigation and minimisation of this situation in future, the Safeguarding Adults Board, Safeguarding Children Board and Clinical Commissioning Groups are asked to explore the concept of, and develop and implement, a Multi-Agency Professional Disagreement Escalation Policy.

Such a policy must:

- operate across agency boundaries
- incorporate the need for clear local agency escalation policies that enable initial senior-management-to-senior-manager communications with the aim of local resolution
- provide for the independent adjudication of multi-agency case management disputes
- have a clear and understandable pathway
- have a well-designed document/email template
- be advertised and promoted across all agencies working with vulnerable adults and children.

Recommendation 5: This case identified a lack of knowledge about the facility within the local authority to fast track a request for adhoc additional funding for additional staffing cover where interventions such as one: one observation for a care home resident is required for a period of time to maintain a safe care and home environment for all residents.

Consequently the strategic manager for commissioning at the local authority is asked to explore at the first available care home managers forum how many care home managers are aware of the fast track process to secure a temporary uplift in a residents funding package following an incident that requires enhanced care or intensive observations to secure safe care and practice including 1:1 observations.

MAIN BODY OF THE REPORT

1.0 INTRODUCTION

On 26 June 2014, a male resident (subsequently referred to as MR) in the EMI part of a care home (referred to as 'the care home' from this point forward) assaulted a female resident (subsequently referred to as FR). As a consequence of this, FR fell and hit her head. An ambulance was called, as were the police. FR was taken to the nearest accident and emergency department, where she received treatment, but sadly she died on 28 June 2014 as a consequence of her injuries. The independent advisers, independent author and all agencies involved in this review offer their condolences to FR's family. Subsequent to this incident, MR has also died as a result of his vascular dementia and ill health. Condolences are also offered to his family.

During MR's period of residency at the care home (September 2013 to June 2014), there were large periods where he was documented as settled and amiable. However, as is not uncommon in persons with a dementia diagnosis, there were periods of time during which he displayed emotional stress and verbal and physical aggression. This was most commonly associated with efforts made by care home staff to assist him with his personal hygiene needs. Between 4 March 2014 and 24 June 2014, MR was involved in three separate incidents, none of which caused any lasting harm to the women he assaulted. However, two of the incidents carried a more serious risk of potential harm than is usually associated with resident-on-resident assault within the context of a care home. The first of these incidents occurred in March 2014 and the second on 30 May 2014. Although the initial incident of 4 March 2014 was attended to by the care home staff, and a safeguarding alert was raised, there was no subsequent structured assessment of any ongoing risk MR posed to himself or other residents by the care home or the local authority. Therefore, this raised the question of whether FR's tragic death could possibly have been avoided had MR been managed differently.

Thus the purpose of the investigation commissioned by NHS England North was to conduct an assessment of the case management of MR by all involved agencies:

- the care home
- the local county council – social care services
- the specialist mental health provider
- the GP practice

to determine the reasonableness of his case management in respect of his behaviours. The independent advisers and independent author were also tasked with forming a perspective about the predictability and/or preventability of the incident that occurred on 26 June 2014 and which proved fatal for FR.

The full terms of reference for this independent process can be found at section 2.0 of this report.

1.1 Relevant background and context

A brief overview of the agencies involved in the case management of MR is set out below. This is followed by an overview of MR's case management immediately prior to and following his admission to the care home. A more complete chronology is set out in Appendix 1 of this report.

The care home: In September 2014 the Care Quality Commission (CQC) described the care home as providing care treatment and support to older people. The home can accommodate up to 75 people. The care home received CQC inspections in April and September 2014 (the year of the incident) and on both occasions the care home was considered to be delivering a service that complied with CQC standards in most respects. The CQC report clearly shows that the residents and the families of residents it spoke with were satisfied with the care and service being provided.

The local authority: The local authority provided social care input to MR prior to and after his residency at the care home. It provides the statutory social care service in the locality in which MR and the deceased lived. The local authority is the lead agency in the implementation of policy and procedures for safeguarding adults. As such, it performs a coordination role in responding to allegations of abuse and neglect involving adults with social care needs.

The specialist mental health provider: The mental health service involved with MR provides a range of mental health, learning disability and eating disorder services.

The GP practice: The practice is a point of delivery for a range of primary medical services, including access to general practitioners, nurses and several specialist clinics. There are 12 doctors and eight practice nurses. They are supported by two healthcare assistants and a team of administrative staff.

1.1.1 MR

In July 2009, MR, who was 66 years old, was first referred by his GP for assessment by a psychogeriatrician. He was experiencing marked deterioration in memory function and self-care. However, at this time he had capacity and did not want to engage with mental health services for older people. Tees, Esk and Wear Valleys NHS Foundation Trust tried on three separate occasions between July and September 2009 to engage with MR, but without success.

Between January 2010 and mid-July 2013, a range of vulnerable adult concerns were raised about MR, which included:

- home fire risk
- financial exploitation.

However, MR was not agreeable to engaging with health or social care services and was able to demonstrate capacity on the occasions staff were able to meet with him.

This situation changed in August 2013. MR's cousin raised the concern with social services that he was wandering around Consett in an unkempt state, and she thought he had memory issues. For example, he didn't seem to know where he was.

On 23 August 2013, MR was visited at home, and blood samples and a urine sample were obtained from him to exclude a physical cause for his memory problems. At this visit it was clear that MR wished to remain in his own home.

By 27 August 2013, MR was assessed as lacking capacity. The Durham County Council social work record noted that MR was awaiting an assessment by a consultant in old-age psychiatry. This record also captures the sense of frustration in MR's family, in relation to their efforts to gain help and support for him.

On 28 August 2013, GP correspondence with the Older People's Service at Tees, Esk and Wear Valleys NHS Foundation Trust advised:

"He does have severe short-term memory loss and poor recollection. His situation is compounded by his poor self-care, but also recently has become a danger to himself and others with small house fires, and his cousin is concerned.

We have asked the district nurse to carry out some dementia screening blood tests. [MR's] insight is very poor and he himself feels he is well and denies having any problems such as the fires, etc."

Throughout the preceding months, MR had been supported by two of his cousins. However, in September 2013, they advised Durham County Council's social care team that they would not be able to sustain the level of input they previously had.

On 9 September 2013, a comprehensive assessment was conducted by a community mental health nurse at MR's home. Present were his two cousins and MR. A mental health clustering tool was completed, and MR was allocated to cluster 19¹ due to his level of complexity, history of self-neglect, apparent loss of functioning and history of alcohol abuse (cognitive impairment or dementia complicated – moderate need). The documented plan was to discuss MR in the next multidisciplinary meeting and liaise with social services. The liaison took place with social services on the same day as the assessment. The social care records say: "Advised that MR is not coping with self-care and is not drinking alcohol. He [the community mental health nurse] also discussed sheltered accommodation and MR is stating that this is something he would like to move to."

¹ "A Cluster is a global description of a group of people with similar characteristics as identified from a holistic assessment and rated using the MHCT."

Patients are assigned to a cluster at the end of their initial assessment, at CPA or planned formal care reviews, and at any other time when there is a significant change in their planned care.

There are four organic clusters (18, 19, 20 and 21). (see Appendix 3)

Two days later (11 September), a visiting social worker noted that if support services took over the role of the family, then MR would “be fine in his own home”. This is what MR was expressing a wish for then, and at the time his memory fluctuated. This meant that sometimes he was lucid and able to express his wishes and sometimes he was not.

On 25 September 2013, there was a discussion within specialist mental health services for older people about MR. The key points of the discussion were around the assessments conducted and the then situation for MR. The risks outlined at this discussion were falls and fire risk, self-neglect, financial abuse, physical decline, wandering and carer stress (cousins withdrawing their day-to-day support as a consequence). The plan agreed was that the social worker was to assess capacity and to use best interest if MR was found to lack it. The multi-professional meeting agreed that MR needed emergency respite under the Mental Health Act if necessary. Ward admission was to be used as a last resort.

On the same day, the social worker attended at MR’s home and conducted a capacity assessment. MR agreed to move to the care home. The local authority records noted that MR’s community mental health nurse arrived while the admission to the care home was being arranged. MR’s cousins were present and involved in the decision-making process and then accompanied MR to help settle him in.

Within a very short time following admission, it was evident that MR had:

- a tendency to wander, including into others’ rooms
- an erratic sleep pattern, with poor sleep
- lack of cognitive ability, for example he got locked in the loo and could not get out – staff assisted him
- a reluctance to wash or change his clothes.

On 3 October 2013, MR’s social worker attended to conduct an assessment to determine whether his placement at the care home could become permanent.

On the same day, a district nurse, supported by a senior care assistant in the care home, completed a Continuing Healthcare checklist.² Although MR was considered to have high needs in relation to cognition, his behaviour was at this stage not considered to be unpredictable, complex or challenging. It was therefore considered that that further assessment was not needed (DoH National Framework for CHC).³

2

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213138/NHS-CHC-Checklist-FINAL.pdf

3

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213139/Decision-Support-Tool-for-NHS-Continuing-Healthcare.pdf

Between this date and 12 November 2013, a number of behaviours were identified in MR. Below is a synopsis:

- MR expressed that he was being held under “false pretences”. This occurred on one occasion only as far as the independent author could determine.
- Wandering into others’ rooms was a permanent feature. On one occasion he fell asleep on another resident’s bed, suggesting that he was not aware of where he was, and he also tried to get other residents out of their beds.
- Assistance with personal hygiene required.
- A small number of instances of agitation. These were contained to verbal outbursts and ripping up his own cigarette. (These behaviours are not unusual in persons with a dementia diagnosis.)
- MR’s family were regular visitors.

On 13 November, MR’s placement at the care home was confirmed as permanent. At this stage his placement in the general residential part of the care home was considered appropriate, and, even with the benefit of hindsight, the local authority and care home consider that this was the correct placement for MR at the time.

After 13 November MR was a general resident within the care home until 6 March 2014.

Between November 2013 and 3 March 2014 MR is noted within the social care and care home records to have been relatively content and settled. He did have occasional periods of agitation and frustration, but these were most usually in relation to efforts staff were making to encourage and assist him with his personal hygiene needs. There was an occasion at the end of January 2014 where care home staff were noted by the community psychiatric nurse not to be coping, but subsequent information revealed that this was not a persistent issue at that time, and that the expected approach to de-escalation, including distraction techniques, worked reasonably well with MR. At this time tests were also performed to exclude a physical cause for his perceived changes in behaviour. The only other behaviour of note during this period was a tendency to wander into other residents’ private bedrooms, thinking they were his own, and to pick up their possessions as though they were his own. As a consequence of this, dialogue between social care and the care home did occur regarding whether or not MR ought to be in the EMI part of the care home facility. A decision was made that this would not be appropriate, as the general residents, although possibly finding MR a nuisance, did recognise that he was not purposefully wandering into their rooms. Furthermore, in an EMI environment MR’s behaviours may have been less well tolerated, thus introducing an unnecessary level of risk for MR and the other EMI residents in relation to unpredictable behavioural responses.

A detailed summary of MR's chronology from January 2014 to 26 June 2014 is provided in Appendix 1 of this report. It is based on the aggregated information gleaned from all agencies' records and its purpose is to provide a more in-depth picture of the sequencing of events than is appropriate to include in the main body of the report. It is not a full and unabridged factual recount for each agency and neither is it intended to constitute this.

2.0 TERMS OF REFERENCE

The terms of reference for this investigation were as follows.

To undertake an investigative process that establishes:

- A chronology of fact.
- What the acknowledged policy and procedures and/or recognised good practice required were in relation to:
 - MR's deteriorating behaviours and especially his incidents of assault on others
 - the safeguarding alerts raised on behalf of the victims of MR's behaviours
 - requests for mental health input and assessment
 - mental capacity assessment
 - consideration of an appropriate place of residence.
- To assess MR's chronology and management across all three agencies against what at minimum ought to have been delivered and to identify where standards were met, and where they were not.
- Where standards were not met, to determine the magnitude of any acts of omission or commission, and to form an opinion of the link between the lapses and the incident that subsequently occurred.
- Where any lapse constituted a serious breach of safe practice procedure, to conduct an analysis of this with the staff involved using recognised human factors methods and/or other analytical investigatory methods so that the core contributory factors can be identified within and across the involved agencies.
- To devise uni- and multi-agency recommendations to address the core contributory factors to identified serious lapses.
- To form an opinion on the preventability of the incident that occurred leading to the death of FR taking into account the situational context of a residential care home.
- To deliver to NHS England North, setting out the investigation's findings, conclusions and recommendations (the design of which must lend itself to measuring impact once implemented).

In delivering the above terms of reference, it is assumed that the investigation will take account of:

- the appropriateness, clarity and delivery of care plans
- MR's diagnosis and treatment plan, where it is relevant to do so
- risk assessments conducted and risk management plans
- inter-agency communications and their effectiveness
- safeguarding considerations
- the needs of the victim's family and the family of the perpetrator.

3.0 PROCESS OF THE INVESTIGATION

A decision was made by Consequence UK (CUK) and NHS England North to conduct this review process based on a multi-agency round-table review, supported by independent advisers, whose role was to assure a good level of professional discussion, debate and check-and-challenge. The independent advisers were representative of the main agencies and disciplines involved with MR.

The rationale for this was:

- The number of agencies involved.
- The unusual nature of the case. Both MR and the deceased FR had dementia, and it is highly unlikely that MR meant any harm to FR when he pushed her, or had any real awareness of what he was doing. His behaviours are recognised as being a consequence of advancing vascular dementia.
- Optimal learning is likely to occur where agencies are active participants in the review process rather than passive recipients.

This process required the agencies to:

Provide to CUK detailed chronologies of their contact with MR between 2013 and June 2014. These were then collated into a seamless chronology for MR.

This chronology was reviewed by the independent advisers and CUK. The independent advisers were:

- Ms Sarah Pilkington – Specialist Vulnerable Adult Practitioner, Worcestershire County Council
- Charlotte Potter – Registered Care Home Manager
- Mary Mellor – Senior Mental Health Nurse, Older People's Services, recently retired from South West London and St George's Mental Health Trust, London.

In addition to the above, a factual accuracy meeting was convened on 14 August 2015, which allowed for all agencies to meet on a face-to-face basis, and for each agency to review the initial chronology, provide additional information and engage in healthy exploration and check-and-challenge with regard to the case management of MR.

At the end of this meeting it was clear to the independent team that the primary lines of enquiry for the independent process were:

Issues that appeared to be of specific relevance to the case management of MR leading to the fatal incident between MR and FR, which included:

- i. The appropriateness of MR's placement in the care home, initially as a temporary resident and then as a permanent resident.
- ii. Risk assessment, specifically the risk assessment of the incidents of physical aggression MR was involved in between January 2014 and the death of FR.
- iii. Inter-agency communication, and the systems and processes in place to support effective communication.
- iv. The level of observation and support provided to MR, with a particular focus on how this was conducted after each incident.
- v. The decision by the older persons' mental health services not to accept MR for assessment following his referral in March 2014.

Once the chronology and context of care was better understood, the appropriateness of MR's placement at the care home became of less significance because:

- It was a reasonable placement.
- The move to EMI on 6 March was reasonable.
- The key learning opportunities emerging centred on the recognition and management of the risk potential as a consequence of the incident that occurred on 4 March 2014.
- Overall MR's behaviours were not notably challenging, were within the normal range of those experienced by persons with dementia and were manageable within the skill set of the care home staff.

Therefore, the independent author and the agencies involved agreed that the inclusion of a section dedicated to this subject would detract from the areas delivering optimal learning and reflection opportunity.

In addition to the above, the independent advisers considered the issue of Deprivation of Liberty Safeguards. There were features of MR's behaviours that raised the question in the minds of the independent advisers as to whether consideration of Deprivation of Liberty Safeguards should have been evidenced within the care home records. A review of the legislative requirements and guidance in situ locally and nationally at the time suggests that except on two occasions, MR's behaviours did not reach the threshold for such consideration. Now (2016) MR's admission to the care home would reach this threshold.

Following the meeting of 14 August 2015, CUK was provided with all outstanding case management records for MR from the three primary agencies involved. This meant the independent team had access to the records from the care home provider, the local authority and the specialist mental health provider. However, because the

specialist mental health provider records were originally created electronically, the printed copies proved difficult to work with. Therefore, the clinical lead for Older People's Services agreed to double-check any area of uncertainty regarding the sequencing of events against the electronic record to ensure accuracy in the timeline created. This was valuable support for the independent team.

On completion of the chronological timeline, 165 questions were identified by the independent team. These were sent to all agencies, with a clear indication regarding which agency needed to respond to which question. The questions comprised:

- questions of fact
- questions about standards of practice or process
- questions of context
- questions about possible acts of omission or acts of commission.

All agencies engaged positively with this process and responded to all questions asked.

NHS England North was apprised of all developments and considerations throughout the independent process and provided its agreement and support for these.

Hindsight bias/counterfactual thinking

Whenever an incident such as this occurs, it is always easy to be wise after the event, and to see the past history differently to how it was perceived or experienced at the time. This case in particular carries a significant risk of hindsight bias, and the independent team has worked hard to ensure that it does not have an impact. Great care has been taken to try to view the facts as they were 'on the ground' at the time, and to consider carefully what would have been reasonable in terms of actions and responses based on what was known at the time. Because the independent team was not able to meet with front-line professionals involved until a late stage of the independent process (see below), maintaining a strong sense of discipline in avoiding hindsight bias was essential.

Challenges in conducting the independent process

At the time this independent process was commissioned, the criminal justice process was not complete. MR had not been tried in court and had not been convicted. Furthermore, because of what happened, South Yorkshire Police held under consideration whether or not a referral to the Health and Safety Executive was warranted and whether or not there should be a charge of corporate manslaughter against one or more of the agencies involved.

This created a challenging backdrop for the review and, understandably, the situation increased the vulnerability for all agencies. It also presented a barrier to the normal process of meeting, at an early stage, the front-line professionals involved in the case and care management of MR. Consequently, for the greater part of the

independent process the independent team worked exclusively with the identified panel members and, in the case of one agency, its legal advisers.

Consequently, exploring the systems and processes in place at the time, as well as the contemporary practice situation for each agency, was not as straightforward a process as CUK has normally experienced in its 13-year history of conducting independent reviews.

The threat of a possible corporate manslaughter charge was not removed until February 2016, after consideration of the first draft of the independent report by South Yorkshire Police. This then enabled the independent author to meet with the front-line professionals across two of the involved agencies who knew MR and remained within the employ of the agencies involved. Neither the GP surgery nor the care home provider were able to send involved professionals to this meeting because they reported staff no-longer being in post. This was an important meeting and provided some of the missing context to MR's placement and case management. Subsequent to this meeting CUK was able to meet with the registered care home manager and the additional information she was able to provide was helpful.

3.1 Contact with the family of FR and the family of MR

NHS England and the independent author communicated with the families of MR and FR early in the independent process.

MR's family were not able to actively engage in the process as their time and attention was taken with supporting MR during his critical illness and then attending to family matters. They would have otherwise met with the independent author.

Written communications occurred with the family of FR on 16 July, 22 July and 14 September 2015. The independent author also spoke with FR's grandson in the early stages of the review process. The main issue for the family was how the incident could have been allowed to happen. They saw MR as a stronger and fitter man than other residents in the part of the care home FR lived in, and they were aware of his wandering tendency. They considered that if he happened to be aggressive he could inflict harm on a fellow resident purely because of his younger age and vitality (by comparison with residents such as FR).

On 23 September 2016 the independent author made email contact with FR's grandson to advise him that the review process was almost completed and to find out if he wished to meet with her and NHS England to go through what had been found during the review process.

4.0 FINDINGS OF THE INVESTIGATION

As section 2.0 sets out, the terms of reference for this review required that due consideration was given to:

- the appropriateness, clarity and delivery of MR's care plans
- MR's diagnosis and treatment plan, where relevant
- risk assessments conducted and risk management plans
- inter-agency communications and their effectiveness
- safeguarding considerations.

Section 3.0 highlights how the issues of greatest importance to

- the potential for a different outcome, and
 - opportunity for practice, quality and safety improvements
- emerged as
- risk assessment and risk perception
 - observation management
 - communication.

This section of the report therefore concentrates on the following key questions that enable the meaningful consideration of the predictability and preventability of the tragic incident that occurred.

- i. Risk assessment, specifically the risk assessment of the incidents of physical aggression in which MR was involved between January 2014 and the death of FR.
- ii. Inter-agency communication, and the systems and processes in place to support effective communication.
- iii. The level of observation and support provided to MR, with a particular focus on how this was conducted after each incident.
- iv. The decision by mental health services not to accept MR for assessment following referral of MR to older persons' mental health services in March 2014.

4.1 Risk assessment, specifically the risk assessment of the incidents of physical aggression in which MR was involved between January 2014 and the death of FR

“The aim of risk assessment is to consider a situation, event or decision and identify where risks fall on the dimensions of ‘likely or unlikely’ and ‘harmful or beneficial’. The aim of risk management is to devise strategies that will help move risk from the likely and harmful category to the unlikely or beneficial categories. An enlarged idea of risk management based around the concept of ‘safeguarding incidents’ introduces the idea of professional and organisational learning from near misses” (Bostock et al., 2005).⁴

In the context of a care home setting that provides a home for persons with dementia, the assessment and management of risk can be challenging. Care home, social care and mental health professionals are required to:

- conduct a balanced assessment of risk, taking into account the circumstances of the incident, its actual impact and any residual associated risk for the resident and/or other residents
- implement a risk minimisation plan, taking account of the needs of the resident(s) involved in this incident and the needs of other residents as well as the possible impact on them
- ensure that they do not unnecessarily restrict the liberty of any resident in the development and delivery of their risk management plan
- embrace the concepts of positive risk taking to optimise independence, and not to only apply a risk-avoidance strategy.

For a care home facility, there is an added complexity posed by the agreed and funded care package negotiated with the local authority at the time a resident is placed at the care home. Where the risk assessment and risk management plan requires interventions that are more than the care package originally funded, an application needs to be made to the local authority to support and fund the interventions. In the intervening period, a care home has to balance the risks associated with implementing the unfunded plan, for example one-to-one observations, and the negative impact that this may have on the other residents living in the same environment, for instance less staff resource to support their needs while one-to-one observations are delivered.

MR’s case embraces all of the above issues. Furthermore, MR did not display frequent episodes of physical aggression towards others. Most of his aggression was contained to verbal outbursts and a small number of incidents where he hit either himself or inanimate objects, such as a wall. In this respect he posed a risk of harm to himself.

4

This section of the report concentrates on the risk assessment and risk awareness in the agencies involved following eight incidents concerning MR. The analysis concentrates on whether or not the risk assessments were sufficiently cognisant of risk potential and whether or not the risk management plans were reasonable based on the risk that needed to be managed in the context of a care home environment.

4.1.1 Relevant chronology pertaining to the assessment of risk as posed by MR

From the time MR became a temporary resident in the care home up to and including the date of the incident with FR, he was involved in nine incidents, three of which had the potential to cause serious harm to others. These were:

Date	Incident description	Detail of incident	Outcome	Risk score ⁵
5 January 2014	MR punching walls and setting off alarm	MR had wandered into another part of the care home, and into another resident's room, from which he was removed.	No harm caused	Low future harm potential ⁶
28 January 2014	MR had a verbal altercation with a resident (female)	No specific detail available. However, the care home records and the mental health records demonstrate that staff were struggling with MR's aggressive behaviour. The records show that on two occasions he had entered rooms and screamed at the residents. Also he had smeared faeces in the toilet. Staff seemed to feel that the residential unit was no longer appropriate for him. They were also querying the need for medication. The community mental health nurse is noted to have asked the care home staff to complete behaviour charts and to arrange a physical review for MR, including a midstream urine specimen to rule out delirium given this sudden change in behaviour.	No harm caused	No harm potential

⁵ The risk score assigned to any incident should take account of the outcome of the incident, the circumstances and situational context of the incident, the likelihood for recurrence of the incident type, and the realistic potential for harm.

⁶ This incident was likely to recur with similar consequences. In terms of harm magnitude, at this stage it was likely to be low physical harm to MR or the environment.

Date	Incident description	Detail of incident	Outcome	Risk score ⁷
19 February 2014	Pushed over a chair in the lounge area	MR was noted to have been agitated because he believed people were in 'his' house. He did, however, retire to bed and settle.	No harm caused	Low to moderate harm potential ⁸
4 March 2014	MR found with his hands round a resident's neck. (female)	The safeguarding referral informs that care home staff heard a commotion and found MR with his hands round the resident's neck. MR admitted laying hands on her, but she said he had hit her.	No physical harm	High harm risk potential ⁹
4 March 2014	MR punched his own face and banged his head on the walls	One of the witness statements collected by the care home reported MR as saying: "I can't believe what I have done, hurt a lady in a wheelchair.' He started getting more and more agitated with himself and started punching himself in the head and in the face. When staff tried to calm MR down, he said, 'I'm not right in the head and I'm going to hurt myself.' He then punched the wall a few times and started pacing	No harm caused	Some risk of harm but most likely low harm

⁷ The risk score assigned to any incident should take account of the outcome of the incident, the circumstances and situational context of the incident, the likelihood for recurrence of the incident type, and the realistic potential for harm.

⁸ This incident type had a higher risk potential because of the nature of the incident. MR had vascular dementia and his behaviour was therefore unpredictable. On this occasion there was no one in the way when he pushed over a chair. This might not have been the case if he had repeated the behaviour at a time of the day when other residents were present. There was, therefore, some potential for future harm. Likelihood of recurrence = possible. Likelihood of harm = possible. Magnitude of harm = ? almost impossible to guess at. More than likely low to moderate.

⁹ This incident could only be viewed as high risk. In risk management terms it was 'by chance' that staff intervened because they heard a commotion. Any incident involving hands round the neck carries with it an accidental risk of semi-asphyxiation or death.

		the floor.”		
Date	Incident description	Detail of incident	Outcome	Risk score¹⁰
5 March 2014	MR was found shouting at another resident (female)	A request was made for GP review – most likely to have been related to the 4 March incident.	No identifiable harm	Low harm potential
30 May 2014	MR punched a resident (H) in the face	<p>The alert says: “Cleaner on duty Hoovering past H’s bedroom and she heard a commotion. Cleaner saw MR in H’s room and she saw MR punching H in the face. Staff came and intervened; asked MR to leave the room, which he did straight away”</p> <p>The social worker (SW) noted: “Due to the injuries above being noted, it would be beneficial to request GP to check over H and advise SCD [Social Care Direct] if there are any more substantial injuries.”</p> <p>Incident recorded as a safeguarding alert because it was considered an isolated incident between two residents lacking in capacity.</p>	A small cut to left side of her lip and redness to left cheekbone. Also bruise/swelling to outside/inside of lower lip.	Moderate to high harm potential

¹⁰ The risk score assigned to any incident should take account of the outcome of the incident, the circumstances and situational context of the incident, the likelihood for recurrence of the incident type, and the realistic potential for harm.

Date	Incident description	Detail of incident	Outcome	Risk score ¹¹
24 June 2014	MR thought to have pushed FR	The records indicate that FR was in MR's personal space, shouting in his face. It appears that MR pushed FR away and she fell backwards to the floor.	No harm caused	Under the same conditions this incident most likely had a low harm potential. However, small changes, such as the mechanism of the fall and how a resident might land on the ground, would result in this incident carrying at least a moderate harm potential.
26 June 2014	MR appears to have hit FR again	FR fell as a consequence of the assault and hit the back of her head, which is a high-risk injury in elderly persons. She suffered a subdural haematoma.	Fatal injury	

4.1.2 Commentary

Most of the incidents listed did not result in a safeguarding alert being generated and neither should one have been generated. The care home records show that on an event-by-event basis, those incidents that did not meet the threshold for generating a safeguarding alert were managed 'on the ground' using a range of supportive de-escalation and distraction techniques that the staff had found worked with MR. The care home also utilised a local incident report system to capture incidents. Reported incidents were reviewed by the care home manager on a daily basis, and the care home provider advises that all care home managers were expected to use this review process to prompt quality discussions with the staff and institute local improvements where indicated.

Although the care home provider had invested in a tried-and-tested incident-reporting system (Datix), a structured risk assessment was not a core component of this at the time MR was a resident in its facility. Furthermore, training in incident management and risk assessment of incidents had not been provided for its staff: a not uncommon situation in care homes.

¹¹ The risk score assigned to any incident should take account of the outcome of the incident, the circumstances and situational context of the incident, the likelihood for recurrence of the incident type, and the realistic potential for harm.

The care home system did however provide an alert to the home manager who could then intervene and escalate as appropriate. At the time there was not an expectation that care home staff would carry out a risk assessment or implement any incident management interventions, other than immediate safety considerations, without reference to the care home manager.

It is CUK's direct experience that many care home managers and senior care staff are required to deliver effective risk assessment and risk management practice in the care environment with no specialised training in how to do this. However, the incidents pre-dating March 2014 all constituted low-risk incidents, and the strategies employed by the staff working in the care home appear to have been reasonable based on the analysis of the home's care records.

Between 4 March and 24 June 2014, there were four incidents that resulted in low to no harm, although three of them had a higher risk potential for harm to another resident. These three incidents were correctly reported by the care home via the local authority's safeguarding processes as safeguarding alerts, and they were assessed by local authority staff who regularly conducted the initial assessment of such cases.

The three incidents reported via the safeguarding process were all identified by the local authority as isolated low-risk events, and no further safeguarding actions were instituted by the local authority. This meant that no further detailed assessment of them occurred. It is important to note that the care home provider did not, at the time, consider the incidents as low risk.

The care home did not at the time have a structured risk assessment process in place, and therefore there was no trigger to initiate the development of a specific 'in-house' risk management plan for MR. The staff, however, did institute what they believed to be appropriate actions, including:

- moving MR to a more intensive care setting (6 March 2014)
- approaching mental health services for specialist input and advice regarding MR's ongoing care and management (after the March, May and June 2014 incidents)
- increasing the level of visual observations for MR to between 15- and 30-minute intervals as opposed to the hourly observations that were often in place for him as a consequence of his wandering tendencies
- approaching the local authority and voicing concerns about the challenges they were experiencing in managing MR (after the March, May and June 2014 incidents)
- contacting MR's GP.

Unfortunately, despite the care home's well-intended efforts, a clear plan for how best to manage MR and an assessment of whether or not his needs could be managed within the context of the care home's resources did not take place after the incident in March 2014. Following the incident in May, a detailed assessment by specialist mental health services did take place which identified MR's ongoing risks to others, and the intent was for this assessment, conducted by MR's community

psychiatric nurse, to be discussed at the multidisciplinary meeting and for a plan to be devised, including the assessment of MR by a consultant in older people's psychiatry. Although there was a plan for occupational therapy input for MR, a psychiatric assessment had not happened by the time the third incident occurred on 24 June 2014. This was closely followed by the fourth and fatal incident on 26 June 2014.

The key questions emerging were:

- How was the ongoing potential risk of harm to others posed by MR missed by the involved partner agencies following the incident on 4 March 2014?
- Why, following the identified risk of harm to others by specialist mental health services on 6 June 2014, was a clearly formulated management plan not generated between mental health, social care and the care home and led by mental health (as the specialist service and experts in risk management and dementia care)?
- Why, when it was identified on 6 May that a psychiatric assessment might be required, did the care home have to chase this up 18 days later when it became clear that this had not been progressed? At what stage ought a psychiatric assessment to have occurred based on the risk assessment conducted by MR's new community mental health nurse on 6 June?

Under optimal investigatory conditions, the independent team would have met with the front-line staff engaged in each of the three incidents that held the higher potential for future harm. However, because at the time this review was conducted the criminal prosecution case had not been concluded and there were concerns in the local constabulary that there may be indicators present necessitating a corporate manslaughter charge against one or more of the agencies involved, it was not possible to meet with the front-line staff from any agency.

Therefore, the independent team reviewed the records of all three agencies and also met with representatives of each agency to discuss the case and then posed a wide range of questions to them individually and collectively. The independent team took receipt of the written responses to all of these 165 questions and based its analysis and considerations on its assessment of and reflections on the data made available to it.

4.1.2.1 How was the ongoing potential risk of harm to others posed by MR missed by the involved partner agencies following the incident on 4 March 2014?

To consider this question, the three significant incidents prior to the fatal event on 26 June 2014 need to be considered.

The first serious incident involving MR – 4 March 2014

This incident involved MR being found with his hands round FR's neck. It occurred in March 2014.

The sequence of events relating to the incident of 4 March, its consequences and actions taken

Date	What was happening
4 March 2014 at 8.49pm	<p>The care home records show that MR was found with his hands round the neck of a 94-year-old female resident of the care home. The care home manager reported this incident to the local authority safeguarding team on 6 March 2014. The referral form noted that staff heard a commotion and found MR with his hands round the resident's neck. MR, it is reported, admitted laying hands on her, but she (the resident) said he had hit her. The care home record noted that, "MR's recent behaviour was very disruptive on the unit as he wanders into others' rooms and disturbs their belongings. It was agreed that he should move to the EMI unit."</p> <p>The referral form stated:</p> <p>"A resident named MR was found shouting at another female resident. He has dementia and she has learning difficulties. He said he had his hands on her neck and later became distressed at what he believed he had done. She said he hit her. Her neck was reddened, according to staff. No permanent marking or distress later. Immediate action – both residents were calmed down, MR accepted 1:1 support and supervision and distraction therapy was used successfully. MR is on hourly observations during the day and half-hourly at night. Action today: CPN/SW contacted. MR will be moved to [the EMI unit] tomorrow when disruption due to contractors has finished. Staff are to use distraction techniques to manage his behaviour."</p>
4 March 2014 at 9pm	<p>The incident form completed at the care home reveals that MR punched his own face and banged his head on the walls. He was offered and eventually accepted one-to-one support, and distraction techniques were used to successfully manage his behaviour.</p> <p>The action component of this form identified that the care home's registered manager spoke with Social Care Direct. The form noted that Social Care Direct was to "review the file and arrange a meeting between Social Worker, the Community Psychiatric Nurse, Care Home Manager, and themselves as a matter of urgency. [Home Manager] contacted for advice." (Note: It is not Social Care Direct's remit to arrange meetings. Its role was and remains to pass messages on the request for a meeting to the responsible social worker.)</p> <p>One of the witness statements reported that MR said:</p> <p>"I can't believe what I have done, hurt a lady in a wheelchair.' He started getting more and more agitated with himself and started punching himself in the head and in the face. When staff tried to calm MR down, he said, 'I'm not right in the head and I'm going to hurt myself.' He then punched the wall a few times and started pacing the</p>

	floor.”
Date	What was happening
5 March 2014	The care home record noted that a staff member made MR’s relative aware of what had happened and of the decision to move MR to a different unit in the care home site, and that the care home staff member shared with MR’s relative two witness statements from the night staff and explained his self-harming.
5 March 2014	The care home’s incident form and the Safeguarding Adults Inter-Agency Partnership notification form was completed by the care home. The partnership form repeated what was set out in the referral form completed on 4 March.
5 March 2014	The care home record shows that its staff left a message for the social worker to arrange a meeting for MR in order to look at the way they could manage him.
5 March 2014	The records also show that the care home contacted the specialist mental health provider and spoke with a mental health support worker, leaving a message asking MR’s community mental health nurse to ring the care home about arranging a meeting to discuss the management of MR’s needs.
5 March 2014	The care home records show that MR’s cousin (who was also his next of kin) was contacted to inform her of what happened and of MR’s move to the EMI unit.
6 March 2014	<p>A social worker (the independent team believes) contacted the care home. The notes made at the time by the care home show that:</p> <ul style="list-style-type: none"> ▪ The local authority acknowledged the information reported regarding the incident. ▪ The local authority was informed about steps the care home had taken to reduce recurrence – that is, moving MR to the EMI unit and observations. ▪ The local authority is noted to have suggested that the care home should liaise with mental health (that is, the community mental health nurse). <p>The care home records also noted that the care home had advised the local authority that MR had been discharged from mental health and that it had made numerous attempts to raise concerns about MR. The local authority advised the care home to try again. “Passed to senior carer ... to action.”</p>

Date	What was happening
6 March 2014	<p>The care home record and the Social Care Direct record show that community mental health nurse input had been requested. The care home records say the community mental health nurse said:</p> <p>“He couldn’t do anything as MR had been discharged, so I have rung MR’s GP to do an emergency referral. Still waiting for GP to ring back. GP rang and he is going to do an emergency referral to the community mental health nurse straight away.”</p> <p>The incident form says the community mental health nurse advised that:</p> <p>“MR is no longer on his books as he has previously seen him and left a care plan. He advised we must send a new referral via the GP. ... Social Care Direct contacted, she will notify case manager ... on holiday ... locality manager has contacted home and asked that the home refer MR to a community mental health nurse. Social Care Direct has decided not to invoke the incident as [it] is being appropriately managed by care home. MR is being moved to [EMI] this afternoon along with a member of staff who he is comfortable with ... no further episodes of aggressive behaviour.” (Observations continued over this period for MR.)</p>
6 March 2014	<p>The care home record noted that it had requested that the GP make a mental health referral.</p> <p>The GP record states:</p> <p>“History: req CPN input. States unable unless another letter provided by GP. Vascular dementia, slapped another resident. SS has been involved to consider upgrading care. OK to put CPN in contact again. Will do letter.”</p>
7 March 2014	<p>The GP referral letter, marked urgent, said: “[MR] was diagnosed with vascular dementia and was discharged from your clinic last month. Unfortunately, there have been a few incidents in the home and they are in the process of trying to upgrade his care. However, in the meantime I wondered if there was anything you could do to help with regard to his behaviour.”</p>

Date	What was happening
10 March 2014	<p>Letter from mental health services to MR's GP declining referral (received in surgery on 12 March 2014):</p> <p>"The care home have been in contact to say this man is wandering into other residents' rooms, which annoys them, but there are no other difficulties. The discharge plan included a contingency plan of moving him to EMI residential care, which is done via Social Services. We would not be involved in this process, but if you have assessed him and have further information please get back in touch."</p>

4.1.2.2 In addition to the above sequencing of events, the independent team understands that:

- An incident form was completed by care home staff which identified the incident type: "strangulation/ligature/asphyxiation/drowning". The care home records also stated that the risk assessment for MR had been reviewed. However, the independent team could find no documentary evidence of a structured risk assessment having been conducted. The incident form design does not include a section of assessing risk.

Discussion with the registered care home manager, in post at the time, revealed that there was no structured risk assessment process in place but that she undertook her own risk assessment and investigation which would have been recorded in management files as the risk management database purchased by the care home had not been set up to accommodate this information at the time. The registered care home manager advised that she applied the 'what happened' and 'why did it happen' questions as a matter of routine when reviewing incidents.

The care home manager also advised the independent author that the categorisation of "strangulation/ligature/asphyxiation/drowning" possibly overstated what she and her team believed may have happened at the time. MR, was known to put his hands on people's shoulders, but this behaviour was not regarded as an act of aggression by the care home staff. The care home manager had herself experienced him doing this, and had not felt threatened. There was no aggression or threat associated with the act.

- The care home manager, also advised the independent author that the female resident also involved in this first incident (4 March 2014), often made a '*wailing sound*' and there was not necessarily a trigger for this. There was a care plan in place to deal with this. It was a noise other residents found distressing at the time, and could be challenging to manage. The care home manager advised the independent author that at

the time of the 4 March incident, staff considered it possible that the female resident had started to wail which may have prompted Mr MR to place his hands on her neck in an effort to placate her. The incident reporting system in place at the care home at the time only had a limited number of incident description choices, which is how it came to be logged as a strangulation incident. The care home manager recalled that other residents who witnessed the incident, described MR as putting his hands around the other female resident's neck, but no-one used the word strangulation. Nevertheless, the then care home manager appreciates that no one can be certain about what exactly took place and taken at face value the incident required treating as a high risk incident, which she considered she and her staff did at the time.

- The care home manager recalls contacting another manager colleague at a nearby care home run by the same provider and asking for advice as this colleague had more dementia experience than she did and managed a care home which was PEARL accredited¹². She also recalls contacting the quality assurance lead for the care home provider at the time, who also had specialist knowledge and experience with dementia care. Both colleagues attended at the care home in the immediate aftermath of this incident to observe MR and to provide advice. Mr MR was observed for the remainder of that day from a dementia care mapping perspective and this exercise was used to inform the ongoing management plan for him.

Consequently, the staff in MR's care home were asked to keep him under constant supervision, and the entire team (including domiciliary staff) engaged with this activity as they did not have the manpower resource to place a dedicated member of staff to this task. It was also as a direct consequence of her colleague's advice and support that the registered care home manager made the decision to move MR to the EMI unit.

- The care home manager also recalled making contact with the local authority regarding the incident and discussing the need for one to one supervision for MR. When the care home manager was advised that the case worker was on annual leave she recalls insisting on speaking to the social workers manager. She then recalls that she did follow this up with MR's social worker when he returned from annual leave. At this time she understood that closer observation of MR could only be achieved via a multi-agency review and a review of MR's continuing health needs. It was because of this that she contacted her regional manager (see below). The care home manager was not aware that there was a fast track process for securing immediately required and short term interventions for MR that were not funded via his pre-existing care package. This fast track process required the case holding social worker to discuss the issue with their team manager who then could seek permission from the (or a) Strategic Manager. The Strategic Manager - Safeguarding, Practice Development &

¹² <http://www.fshc.co.uk/specific/pdf/fshc-pearl-dementia-care-brochure.pdf>

Access advised the Independent Author that it is a process that works and ensures that immediate decisions can be made where required.

- The care home manager, also reported to the independent author that she contacted, via telephone, the regional manager for the care home provider at the time, to ensure that this individual was aware of what had happened and the plan she had implemented. She also told the independent author that she asked the regional manager if she could have an additional member of staff to facilitate the supervision of MR. The care home manager's recollection is that she was advised that Mr MR's care package was not funded for the cost of additional staff, and that his care package would require a review to achieve this. The care home manager did not make a record of this discussion and she recognises that she should have made a more complete record of how she had her staff set out to manage this event, and the advice and input she sought and was given from colleagues and managers within the organisation.
- The independent author asked the registered care home manager why she did not simply institute one:one observations in any event, and to address the funding issue as a secondary issue. The registered care home manager told the independent author that in 2014 it was her perception at the time that there was an emphasis on cost efficiency and staff to resident ratios and this was monitored on a daily basis.

Note in relation to the above two bullet points: The independent author shared the above information with the care home provider who advised that at the time MR was resident there was a process in place whereby, if additional (agency/bank or otherwise) staff were required in the view of the home manager, a request would be made by email to the regional (or sometimes area) manager. Emails provided to the independent author by the care home provider evidenced regular proactive requests for usage of qualified agency staff to cover the staff rota, and it appears that these requests were regularly agreed to.

Between March and May 2014 additional qualified nurse hours per week purchased by the care home provider were:

Date	Hours
2 March 2014	22
9 March 2014	33
16 March	44
23 March 2014	33
30 March 2014	44
6 April 2014	44
13 April 2014	0
20 April 2014	22
27 April 2014	44

Date	Hours
4 May 2014	11
11 May 2014	11
18 May 2014	22
25 May 2014	44

With regards to the care home manager's recollection that in March 2014 her request for additional help was not agreed to, the situation was different. It was not a planned request.

The care home manager advised the independent author that she made her request in the course of a conversation she was already having with the then regional manager about the incident which had occurred. It was not customary practice for her of the regional manager to make a file note of all of their communications, or of their supervisory meetings.

The care home manager also recalled that although there was a structured approach to how requests for additional staff to cover the staff rota were progressed this did not, in her experience, apply to adhoc requests for additional care assistant staff, in circumstances such as that posed by MR, where the request was for a specific resident who required enhanced care or observation input for an unspecified period of time. She also supported the care home providers position that where formal requests were made for additional staff to cover the staff rota her experience of these being agreed to was good. The then care home manager again reiterated her personal learning of accurate and complete contemporaneous documentation in such circumstances.

The overall position of the registered care home provider is that where additional cover is require to preserve the safety of the care environment then this should be provided. In this circumstance it does not know why it was not funded.

- In addition to the partnership form which the independent team understands was faxed to Social Care Direct by the care home, the care home manager telephoned Social Care Direct (on 6 March 2014), who logged the concern as a safeguarding alert. Social Care Direct routinely uses the local authority's risk threshold tool to ensure that the correct information has been gathered from the provider making the enquiry. The independent team has been informed by the local authority that providers all have copies of the risk threshold tool.
- On assessment of the information provided by the care home to Social Care Direct (using the local authority's risk threshold tool), a decision was made that this incident did not meet the threshold for a formal investigation. It was recorded as a safeguarding alert. There was therefore no requirement for this incident to be reviewed by the safeguarding lead officer. This was in line with the local authority's procedures at the time.

- The care home expected the local authority to identify and advise it of any risk issues that it needed to pay attention to, and to validate that it was taking the right actions as a consequence of the incident that had occurred. It also expected that any specialist mental health services involved would have been invited to the multi-professional forum.
- The independent team is advised by the local authority that it is the responsibility of a care home to develop its own specific risk management plans where needed, in line with its contractual requirements and CQC registration requirements. The independent team is also informed by the local authority that in this specific case MR's social worker was reassured that MR's care home had a plan in place – that is, the enhanced observations. However, it accepts that the social worker should have satisfied himself that the level of observations was sufficient to manage the risk, which they were not.
- The information about the incident was subsequently passed to MR's line manager by Social Care Direct, as MR's social worker was on annual leave at the time. The line manager, the independent team understands, did forward the information to MR's social worker by email, but no 'red flag' was put against this email and it got lost in the volume of emails waiting in the social worker's inbox on his return to work.
- MR's social worker was initially surprised by MR's move to the EMI unit. This we now know is because he did not learn about the precise nature of the incident that had occurred. His experience of MR, and what he had understood from the care home, up until that time was that MR's main issue was 'wandering' and that he mostly came across as an unassuming and 'bewildered' man. The social worker told the independent author that he did not associate MR with characteristics of aggression in the day-to-day context of living. However, he was aware that MR could become notably agitated when care home staff tried to assist him with personal hygiene. In this context, what he had seen of MR, and what he had heard from the care home, led him to consider that MR was manageable within the care home environment.
- MR's social worker also advised the independent author that the totality of information about MR he read in the report had come as a shock, as he had not appreciated the range of MR's moods and behaviours (leaving the care home, throwing over furniture, acts of potential self-harm caused by frustration). On discussion it became clear that it would not be usual for a care home to inform a social worker or community mental health nurse of all the behaviours a dementia client exhibited, and that this would happen only when a care home was concerned, could not manage or considered the placement to no longer be appropriate. In the case of MR, most of his behaviours would not have met the threshold for onwards communication to a social worker.
- With regard to the social worker's lack of knowledge about the 4 March 2014 incident, the reasons for this seem to have been:

- He did not see the specific email setting out the detail. Although he did screen the backlog of emails in his inbox on return from annual leave, there was nothing in the header of the email sent to him to alert him to its significance. His practice was to scan emails and to read carefully those that were flagged, as there simply was not time to read all with the same degree of attention. He returned from annual leave to an active caseload and client visits that had to be made. This left little time for reviewing large numbers of emails, many of which were of little consequence to his work or his client caseload.
- The care home staff, not unreasonably, thought that MR's social worker was fully aware of what had happened in light of the information it had provided to the local authority; therefore, in conversation with him the detail was not recounted.
- Similarly, the community mental health nurse contacted by the care home is clear that he did not know the detail of the 4 March incident. He knows that both he and MR's social worker did discuss MR, the incident and MR's EMI placement, but there was no detail as such associated with the incident. The community mental health nurse recalled that he and his social work colleague agreed that the range of behaviours they were aware of were within the capacity of a residential care home.

At the time these discussions were taking place, MR was not on the community mental health nurse's caseload, as he had previously been discharged from the mental health service on 14 February 2014 because the behavioural charts completed by the care home did not evidence any behaviours or any challenges with MR's day-to-day care and management that required the input of a specialist mental health service. Had the community mental health nurse been aware of the incident detail, as set out in the care home record, he told the independent author and the clinical director for the Older People's Service that he would have wanted to have sought advice and input from senior mental health colleagues. This would have represented optimal practice. Under the known-about circumstance, and in keeping with the system and process of re-referral at the time, the care home was advised to re-refer MR to the mental health service via his GP. The expectation within specialist mental health services was that the GP would visit and assess MR before making the referral.

- Although MR's GP practice did make a referral for specialist mental health input, a visit to the care home to assess MR before doing so did not take place. The independent author understands from the GP practice that it would be normal practice to do so, and it is not known why this did not happen in March 2014. Neither the GP record made at the time, nor the letter of referral to specialist mental health services, conveyed an accurate appreciation of the seriousness of the incident between MR and FR. The GP who attended the panel meeting on 15 April 2016 advised the

independent author and other panel members that communications between care homes and GPs are often verbal via telephone, and not followed up in writing. This established approach introduces opportunity for the mishearing and misinterpretation of information provided. It is only in cases such as this that the misinterpretation is revealed.

- At the time this incident occurred, there was no prescribed or agreed cross-agency communication process to optimise the consistency and robustness of communications.

4.1.2.3 The independent team's observations and comments

It is clear to the independent author that MR's care home was concerned about the incident that occurred on 4 March 2014 and that it undertook to manage this situation for the benefit of MR and the other residents he was living with. It is also clear on reading MR's records that the care home staff had a continuing level of concern about MR and his ongoing management during the period following the incident.

Social Care Direct staff correctly processed the care home's notification through the local authority's risk threshold tool, and the community psychiatric nurse gave the care home the correct advice regarding how to achieve a situation of re-engagement of specialist mental health services for MR. Unfortunately, the correspondence sent by the GP practice to achieve this did not.

The following question therefore remains: given that the multi-agency staff involved were taking what they thought were reasonable and corrective actions, and that the incident had been assessed via an established risk threshold tool, how was it that a suitably robust multi-agency care plan for MR was not developed as a consequence of this incident?

To try to answer this, the independent author and the independent advisers undertook a careful review of the risk threshold tool in use at the time.

The output of this consideration is set out below.

4.1.2.4 The risk threshold tool

The independent team considered it important to double-check the risk assessment of the incident of 4 March against the risk threshold tool in use by the local authority and its partner agencies at the time.¹³ The independent team based its assessment

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<http://www.safeguardingdurhamadults.info/SiteCollectionDocuments/RISK%20THRESHOLD%20TOOL%20March%202012.pdf>

on the facts recorded about this incident at the time it occurred, and is confident that it has not been influenced by the subsequent course of events.

This risk tool has four levels of risk:

Red = Critical

Amber = High

Yellow = Moderate

Blue = Minimal/Low.

The areas for consideration posed within the tool are:

1. The vulnerability of the victim
2. Type and seriousness of abuse
3. Pattern of abuse
4. Impact of abuse
5. Impact on others
6. Impact of alleged perpetrator
7. Illegality of actions
8. Risk of repeated abuse – victim
9. Risk of repeated abuse – others.

If one takes each of the above and benchmarks them against the incident that occurred on 4 March 2014, the following emerges:

1. Level of vulnerability of the victim: The resident was female, 94 and wheelchair-bound. She therefore had residual vulnerability if she were assaulted by the same or another resident. Her ability to defend herself and/or to seek help would be limited. The risk tool has two choices: less vulnerable or more vulnerable. The resident would meet the criteria for more vulnerable or the same level of vulnerability she had at the time of the 4 March incident.

2. The type and seriousness of the abuse: The risk threshold tool sets out a detailed description of what constitutes the type and level of abuse and what constitutes minimal, low, moderate, high and critical risk levels.

This incident involved MR placing his hands round a resident's neck. We do not know his intent and we do not know what would have happened had a member of the care home staff not been nearby to investigate the noise coming from the resident's bedroom. However, the act of placing hands round the neck is generally considered to be a high-risk activity and generally, unless consensual, would constitute assault. Because there are a range of unknowns, the independent team considers that caution requires the type and seriousness of abuse to be classified as high; however, a moderate score of "potential serious consequences" would also have been reasonable for this incident.

3. Pattern of abuse: This was, at the time, an isolated incident. It was the first incident of dangerousness displayed by MR towards this victim or any resident. A rating of 'minimal/low' risk was not unreasonable.

4. Impact of incident on victim: The choice range in the risk tool is 'low impact' to 'seriously affected'. Owing to the condition of dementia, this would have been difficult to judge. There was no identifiable lasting physical consequence, but psychological impact was unknown. It is not unreasonable to suggest that, rather than opting for low impact, moderate impact would have been a proportionate choice.

5. Impact on others: This incident impacted on the assaulted resident and MR. MR was very distressed afterwards and was physically abusive to himself in a way that he could have harmed himself. A risk score of 'moderate' would have been reasonable for this criterion.

6. Intent of alleged perpetrator: From the information contained in the care home records, in the immediate post-incident period it is clear that MR was unlikely to have had any intent in terms of 'pre-meditation' or 'pre-planning', such was his distress once he realised what he had done. Because of the dementia diagnosis, 'intent' was possibly not the best criterion to use in the assessment of this incident. In this case, the combined factors of his diagnosis, the circumstance of the incident and its out-of-sight location would have been factors to promote a more grounded consideration of risk at this stage of the assessment process. These factors mean that, although 'intent' may be considered low risk, a repeat without intent had a reasonable chance of happening again. Therefore, a rating of 'high' seems reasonable.

7. Illegality of actions: This criterion includes 'bad practice' by agencies, from criminal acts through to serious criminal acts. MR was a resident and a vulnerable adult and it is difficult to see how these categorisations can easily be translated to a resident-on-resident incident, especially where cognitive functioning is impaired. However, looking at what happened from a broad spectrum perspective, MR's actions constituted common assault and were therefore technically criminal. Using the risk threshold's scoring, this criterion met the threshold for 'moderate' risk.

8. Risk of repeated abuse of victim: In this case, because MR was being moved to a different unit, it was unlikely to occur again for this victim. So 'low risk' was a reasonable assessment.

9. Risk of repeated abuse of others: The features of this incident are such that a repeat of the same or similar behaviours can be predicted as likely to occur. The levels of risk set out in the risk tool are: "Others not at risk; Possibly at risk; Others at risk; Others at serious risk." Taking into account that rarely do resident-on-resident incidents result in serious harm but that harm ranging from low to moderate (for example, a broken bone) is possible, the risk score for this criterion must at least be 'moderate', but could also reasonably be classed as 'high'. In risk management terms either could be justified, but the cautious practitioner would assess the risk as 'high'.

Matrix of the risk scores that the independent team considers would have been reasonable in relation to the 4 March 2014 incident

Criterion	Minimal/Low	Moderate	High	Critical
Level of vulnerability of the victim				
Type and seriousness of the abuse				
Pattern of abuse				
Impact of abuse – victim				
Impact of abuse – others				
Intent of perpetrator				
Illegality of actions				
Risk of repeated abuse of victim				
Risk of repeated abuse of others				

Setting out the scores assigned against each criterion makes clear that the incident of 4 March was not a low/minimal-risk incident. All agencies agree with this. Importantly the registered care home manager told the independent author that she never considered this incident to be a low risk incident. She also considers that having a graph such as that set out above would have been a useful part of the safe guarding alert process. She considers that such an approach to recording one's risk considerations might mitigate against the subjectivity that arises when a client is a known individual to the reporting agency. The independent author concurs.

The author of the risk threshold tool was at the multi-agency panel meeting on 15 April 2016, and he advised the independent author and professional colleagues present that it had been his original intent that staff using the tool mapped their risk considerations in line with the above. However, the tool was (and is) made widely available to all agencies working within the boundaries of the local authority. This has meant that its range of use has expanded and that the rigour of application also varies. The independent author is advised by the care home provider that no training was provided to its staff on the use of the risk threshold tool at this time. In the specific context of Social Care Direct, a custom and practice had emerged whereby staff would look at the guidance notes on the back of the form and the scenarios set out. This in itself was not problematic, as the idea of the guidance notes was to support a proportionate risk formulation. However, the reality of the situation was that as this was an isolated resident-on-resident incident between those specific residents and there was no harm, 'low harm' would automatically be assigned.

To appreciate how local authority staff assessing safeguarding alerts did not apply a broader risk management perspective, one needs to appreciate what was driving the response from the local authority in March 2014.

This was driven by the inter-agency safeguarding policies and procedures in place at the time. They were based on the Department of Health document "No Secrets",

which remained the guidance document nationally until 31 March 2015. The “No Secrets” definition of a vulnerable adult was:

“An ‘adult at risk’ is someone aged eighteen or over, who is or may be eligible for community care services and whose independence and well-being would be at risk if they did not receive appropriate health and social care support.”

The risk threshold tool in use at the time reflected this definition and was designed to provide guidance on whether the concern met the criteria for formal multi-agency safeguarding referral or not.

The safeguarding alert referral was introduced in 2012 for victims to try to ensure an appropriate and proportionate approach to incidents which appeared to be non-complex, low risk and resulted in no or minimal harm – this included low-level incidents between service users. While such incidents would be screened to determine the appropriate response – that is, follow up via a case worker – they would not usually lead to invoking the inter-agency procedures.

Changes to the inter-agency policies and procedures were implemented as a result of the 2014 Care Act on 1 April 2015. This included a revision of section 42, which is the mandate for undertaking a social care investigation.

The 2015 section 42 definition states that if

- 1) 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, then
- (2) 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.

If this definition had been in place at the time of this incident, a similar screening judgement may have been made about whether the incident was serious enough to warrant multi-agency formal procedures or not. This is because the legislation does not set out specific procedures but is based on a set of principles which emphasise the need for proportionate and appropriate responses.

The Care Act has resulted in significant changes to the policies, procedures and practice in this local authority. The safeguarding referral is now an adult protection referral, and the safeguarding alert is now a section 42 safeguarding enquiry. This change to the safeguarding alert is deliberate to reflect the Care Act section 42 definition. The intention, reinforced by ongoing training, is to ensure a more proactive approach to concerns about, and the management of risks for, victims and perpetrators. If the adult protection threshold is not met, all relevant agencies are required to cooperate with these section 42 enquiries.

Independent author's comment:

Although it seems plain with the benefit of hindsight that the risk potential associated with MR's behaviour on 4 March 2014 ought to have been identified, the above information aids insight and understanding as to how it was not. For clarity and to summarise:

- Vulnerable adult policies per se have never been designed to provide for a holistic assessment of risk following resident-on-resident incidents.
- MR was not 'abusing' the resident he assaulted in the way we think about abuse in relation to vulnerable adults.
- The risk threshold tool being used by the local authority, and by its partner agencies, was not designed to assess or consider the incident in question outside of the abuse/safeguarding matrix.
- The risk threshold tool in use by the local authority at the time (and now) did not and does not require its assessors to set out its consideration against each assessment criterion in a structured format. Neither did it require assessors to set out the score assigned to each criterion, as the table above does. There is space in the risk threshold tool for notes, but this space is not structured.
- Incidents of verbal and physical aggression with no significant harm attached are reportedly commonplace in care homes where there are residents with a diagnosis of dementia. Staff managing and assessing such events, it is acknowledged, can become desensitised to the risks these incidents pose, and thus no longer appreciate the risk potential associated with them. Comments made to the independent team by the local authority at panel meetings during the course of the review process suggested to the independent author that some degree of desensitisation may have prevailed during the assessment of the safeguarding alert made following 4 March incident.
- There was no system in place at the Care Home to escalate "outside" the risk assessment process used by the Local Authority. The Care Home was unaware of the specific system requirements of the risk assessment tool being used at the Local Authority.

All of the above factors influenced the under-assessment of risk in this case.

Effective risk assessment of any incident requires the assessor to:

- Have a grounded understanding of how to conduct a risk assessment.
- Have a complete understanding of the incident. In this case this included:
 - what happened (that is, the incident – found with hands round the neck)
 - how it happened (MR is able to wander freely into another resident's room unobserved, as all residents are able to do)

- the impact in terms of harm (marks around the victim's neck – also, it can in this case be assumed that there would ordinarily be some degree of psychological trauma)
- the risk-containment measures implemented.
- Have the skill and knowledge to consider the facts and the situational context and determine:
 - the likelihood of recurrence with this or another resident
 - the likelihood of the harm being 'the same', 'less than' or 'more than' what happened this time should it recur under similar circumstances, even with a different resident.

Activities undertaken to enable local authority and multi-agency staff to deliver a reasonable risk assessment:

The local authority had been delivering a one-day risk management and awareness workshop to social workers, social work assistants, community nurses, occupational therapists and occupational therapy assistants as part of a two-year programme between 2010 and 2012 to assure their ability to conduct meaningful and defensible risk assessments. In addition to the one-day session, a workbook was developed which mirrored the training and was aimed at the in-house provider service.

The aims of the 2010-2012 training were:

To provide participants with skills and abilities to assess and manage risk which they may encounter within their work setting and to examine aspects of accountability and the challenges faced when working in high-risk situations. The workshops were intended to give participants an assessment tool for use in the work setting.

The session content was designed to:

- Define risk – its positive and negative aspects and those which professionals would want to promote/avoid in the work setting.
- Examine professional accountability: the duty of care and what the law says in terms of training, standards and transparency.
- Consider the Health and Safety Executive's five steps to risk assessment and their hierarchy of risk reduction, and to look at how these should be applied in practice.
- Balance likelihood against acceptability. The use of assessment tools to evidence decisions.
- Ensure familiarity with service documentation and relate to Durham County Council policies and procedures.

Following these sessions, risk training was then incorporated into the transformation/cultural change sessions for front-line staff within the local authority. These sessions were delivered from April 2013 to December 2013 and included the topic of defensible decision-making and concise recording.

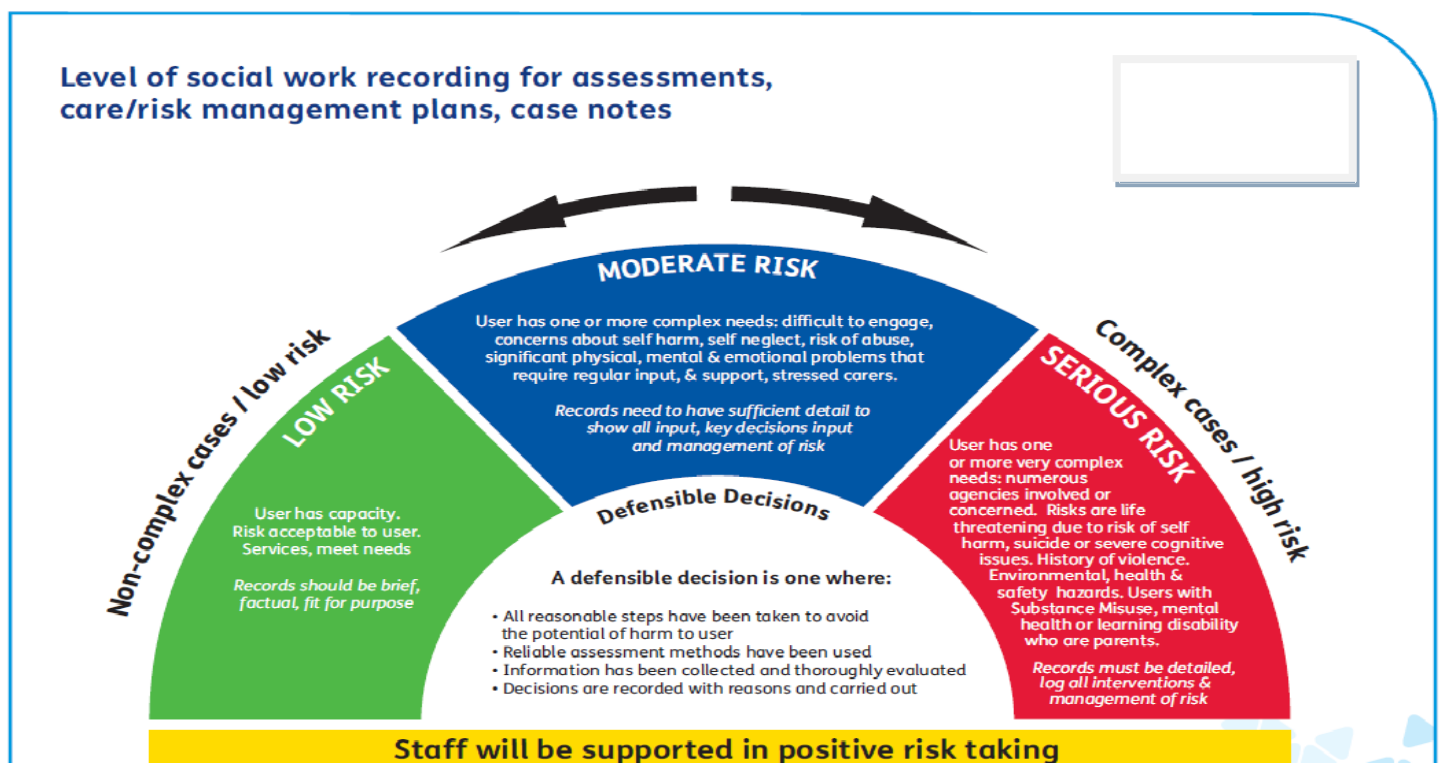
The aims and content are documented below:

Aims: To provide participants with the skills and abilities to complete their assessments, care plans and case notes in line with procedures which reflect defensible decision-making.

The session will enable participants to:

- explore the elements of good recording
- include a record of decisions taken and the reasons for these decisions
- separate fact from opinion
- incorporate assessment, including risk assessment where appropriate
- consider information-sharing in line with the Data Protection Act
- explore some case examples to practise recording skills and translate the theory into practice.

The following is an example of a slide utilised in the 2013 workshop session:



The local authority had therefore taken reasonable steps to ensure that its staff, and those acting on its behalf, knew how to conduct a balanced and defensible risk assessment.

4.1.2.5 In summary and to answer the question of how MR's risk potential was not known or understood

It is the contention of the independent team that:

- The care home staff had a level of risk awareness, and retained a level of concern about MR. This is demonstrated by:
 - moving MR to a more intensive unit
 - raising a safeguarding alert
 - seeking the input of professionals trained and experienced in risk assessment and dementia management
 - maintaining a close level of observation with MR immediately prior to and following his transfer to the dementia unit, until they felt it was safe to reduce this.

However, at the time it appears that via health and safety training registered home managers would have received some element of risk assessment training. The care home manager recalls this being relatively brief and not in-depth. She also recalled that risk assessment training for care staff was particularly limited (this is no longer the case). Only two places had been made available and that training had focussed on positive risk taking and appropriate risk avoidance with clients in relation to aspects of care such as falls management. The care home manager did not recall it encompassing a wider perspective of risk. What the care home manager also considered to be missing was a structured, and consistent way of recording risk assessment made post adverse incident (such as that which occurred on 4 March and 30 May 2014). Furthermore, there was no algorithm for the local and management actions that were required depending on the risk score arrived at. The standard at the time was that all incident reports were reviewed by the registered care home manager.

- Social Care Direct utilised the risk threshold tool in place at the time, but did not contemplate the wider issues associated with MR's diagnosis or the situational context of the incident and the residual risks this highlighted.
- The design of the risk threshold tool did not require the systematic recording of the risk considerations per criterion. Neither did it require the assessor's assigned risk score per criterion to be set out so that the collective picture could be considered and an overall risk score assigned.
- Resident-on-resident incidents are 'shoe-horned' into an assessment process that they do not fit into easily. Although many of the criteria set out in the local authority's risk threshold tool apply to the assessment of such incidents, they do not completely encompass the risk considerations required.
- The communications with specialist mental health services resulted in a recommendation that MR be re-referred via the established process at the time, which was via the GP. Unfortunately, neither the specialist

mental health service nor the GP practice was aware of the precise detail of the incident. This contributed to a GP referral that did not meet the threshold for the specialist mental health service in terms of referral acceptance and a request for further information. Unfortunately, there is no evidence of any further actions being taken by the GP practice as a consequence of the response received from specialist mental health services.

4.1.2.6 The impact of the underrated risks posed by MR in March 2014

The independent team considers that the management of this incident represented the first 'stop' point in the subsequent sequence of events. Had this episode been risk-assessed and managed more appropriately, then the following should have occurred:

- the institution of close observations for MR (that is, within eyesight at all times)
- a specialist mental health assessment under the Mental Health Act
- careful consideration of the scope of MR's care package.

Had this occurred, even if there was no material alteration to his residential care package, over and above the change that did occur – that is, admission to the EMI unit – when subsequent incidents arose they would have been looked at more carefully and with a mental health component to the assessment process.

4.2 The second incident where 'higher harm' was predictable if the incident type occurred again – 30 May 2014

The second incident where all agencies ought to have been alerted to the seriousness of risk MR posed to others occurred on 30 May, some two months after the first incident.

On 30 May 2014, MR punched another resident in the face.

Immediate sequence of events following this incident:

Date	What was happening
30 May 2014 at 7.25am	<p>MR was involved in another incident – recorded as a safeguarding adults alert only. SW 1 notified by email.</p> <p>The alert says: “Cleaner on duty hoovering past H’s bedroom and she heard a commotion. Cleaner saw MR in H’s room and she saw MR punching H in the face. Staff came and intervened, asked MR to leave the room, which he did straight away. H was sitting in the chair in her room. Staff noticed her set of drawers was open and H would not have been able to do this herself as she cannot walk independently. ... MR admitted hitting H but unable to say why. Staff stated there were no marks visible at the time. ... [At] 8.30am staff noticed a small cut to left side of her lip and redness to left cheek bone. At 9.50am staff have noticed bruise/swelling to outside/inside of lower lip.”</p> <p>The SW noted: “Due to the injuries above being noted, it would be beneficial to request GP to check over H and advise SCD if there are any more substantial injuries.</p> <p>Incident recorded as a safeguarding alert only at this time – isolated incident between 2 residents lacking capacity.”</p> <p>On the same day, SW 1 contacted the care home. The SW records say: “I asked what they were doing to safeguard further from this incident and they have kept MR away from the victim ... family have been informed but are not taking the issue further; also GP has been informed.</p> <p>Outcome: Asked for advice from a [social care professional] who stated [that the] safeguarding team will deal with incident. I have also asked the home to refer to CPN office to have MR assessed from MH Team.”</p>

Date	What was happening
30 May 2014	<p>GP requested to make a referral to the mental health team by the care home.</p> <p>The care home records say:</p> <p>“Safeguarding informed. They advised to get GP for MR and they will take no further action. [Social worker] informed of incident and is seeking advice, waiting for him to call back. At 14.00 [Social worker] phoned and the only advice he could give me is to phone the GP to be referred back to the Mental Health Team as soon as possible for a CPN involved with MR. Observation chart recommenced. [GP] phoned and we spoke about the incident and he said that he was going to write to the Mental Health Team for a referral for him urgently.”</p> <p>The GP’s notes confirm this: “Incident this am reported to safeguarding and his social worker required referral to the Mental Health Team – safeguarding not taken further – assaulted resident this am – hit in face – temper frustration issues in past – has threatened to hit staff and residents in past – has h/o vasc dementia on EMI unit – no alcohol now in EMI 4/12.”</p>
2 June 2014 at 11.19am	<p>GP referral faxed to consultant psychiatrist.</p> <p>The GP referral was marked ‘routine’ but asked “for early review”, stating: “BC have reported an incident to safeguarding which occurred on Friday 30th and MR’s social worker has requested a Mental Health Team review as MR had assaulted a resident, actually hitting her in the face. MR has a long history of temper issues and frustration in the past. He has threatened to hit staff and residents in the past but has not acted on these threats previously.”</p>
3 June 2014	<p>The community mental health nurse contacted the care home to assess urgency of referral. (This was a new community mental health nurse for MR)</p> <p>After discussion about the incident, the community psychiatric nurse agreed to visit on 6 June rather than on the same day as there had been “no further worrying displays of aggression”. The carer had also reported that “the other resident was likely to have verbalised quite strongly and staff would normally have been more observant in managing a potential difficulty; with MR they seem to be quite familiar with changes in his mood”.</p>

Date	What was happening
4 June 2014 at 1.32pm	<p>Entry by the care home manager following a conversation she had with the local authority social worker:</p> <p>“This is not an isolated incident. A request for a visit from the challenging behaviour team was made following an earlier incident. This still hasn’t happened in spite of asking for support from GP and social worker to progress matters. GP has been asked to make an urgent referral for the second time. Home Manager spoke to social worker on 3 June 2014 and asked him to progress this with mental health services. MR commenced on 15 min observations. Staff already do a walk-around hand-over to ensure they remain on the floor during hand-over.”</p>
6 June 2014	<p>MR’s new community mental health nurse visited the care home.</p> <p>Key facts gleaned from the mental health records: “CPN conducted comprehensive assessment (pp108-122), including a risk assessment – FACE. Risk assessment indicated MR’s behaviour posed risks in terms of physical harm to others, 2 recent incidents. It also identified MR is intolerant of female residents and that staff (care home) have been concerned about the recent aggressive response and have alerted services. Mental Health clustering tool allocated MR to cluster 20 (cognitive impairment or dementia complicated high need¹⁴). MR was placed on Standard CPA, summary of CPA, recent aggression to female resident, can be confrontational, sometimes will hold head and facial expressions indicate his tolerance is not good, intolerant of women’s conversation and irritation. New care co-ordinator identified. The records include mention of MR hitting a staff member. The notes also say - ‘referral sparked by an incident that included MR hitting a female resident – no other associated agitated or aggressive behaviour, although there is significant evidence of cognitive decline’.</p> <p>CPN reviewed the care home’s case notes and found no consistent or major changes to his presentation, care home staff according to CPN’s note describe MR as being ‘generally very amenable’. Plan to discuss at MDT and, given detailed explanations of low/anxiety, discuss the possibility of anti-depressant medication.”</p>

¹⁴ See appendix 3 for explanation. Also MR’s cluster score had changed from 19 to 20.

4.2.1 In addition to the above sequence of events, the independent team understands that:

Note: The independent author has only set out below information that relates to this incident that has not already been accommodated in the setting out of the issues pertaining to incident one (4 March 2014). There is no value in repetition for its own sake.

In addition to the information gleaned from the multi-agency case records relating to MR, the independent team also learned that:

- The registered care home manager has reflected on this incident and cannot explain why the police were not contacted as a consequence of this incident. The care home has done so following similar type events.
- With regards to the 15 minute timed observations instituted for Mr following this incident, the registered care home manager told the independent author that they simply did not have the man power capacity to conduct 'within eyesight' observations for a prolonged period for one resident. However, they instituted a system whereby they could maintain regular surveillance of him. The issue of no 1:1 observations reflected the situation already presented in relation to the 4 March 2015 incident. (page 41). Unlike March 2014, steps were taken following this incident to ensure that a detailed mental health assessment was conducted of MR.
- MR's social worker rang the care home the same day to discuss the incident with care home staff to ensure that appropriate measures had been taken by the providers to ensure the safety of the victim and other residents. He felt that they had.
- This incident was a more clear-cut case of assault than the incident of 4 March 2014. The care home was specifically asked: "What is the position of [the care home provider] regarding physical assault and harm? Some care homes report to the police, as it is assault; how does [this care home provider] assess risk in this type of circumstance now, and is this the same approach as in 2014 or different?" The response elicited was: "If an individual is felt to be at risk or it is felt a crime has been committed, alerting staff have a duty to ensure the alleged victim(s) are comfortable and safe. In these circumstances the police should be contacted immediately and medical attention sought if appropriate." The police were not contacted on this occasion.
- MR was placed on 15-minute observations following this incident.
- The GP correspondence did not convey the accumulating risks associated with MR. This was because the detail associated with the 4 March incident was not interpreted as the care home intended, or the information was not heard. Furthermore, although it was the intention of the GP practice to make an urgent referral after this May incident, it was actually marked 'routine' by the GP.
- The mental health records say:
"Telephone call made to [the care home] to assess the need for urgency with regard to the referral made for involvement. Letter from GP

indicates that MR had hit someone last week and there may be an increased need for urgent involvement.

On speaking to senior carer (at the EMI unit) she said that last week MR had entered another resident's room and had started to go through her drawers; she had protested and he [MR] had hit her. [The senior carer] thought that the other resident was likely to have verbalised quite strongly and staff would normally have been more observant in managing a potential difficulty; with MR they seem to be quite familiar with changes in his mood. [The senior carer] thought MR would benefit from Formulation to further assist them with management of the situation; however, I have arranged to visit next Friday rather than respond urgently today. There does not appear to be the necessity for immediacy as there is no other worrying displays of aggression."

MR's new community mental health nurse would have had no knowledge of the incident of 4 March unless this was specifically shared with her by the care home. However, because it seems most likely that the care home was operating under the reasonable assumption that both agencies were aware of what happened on 4 March, there would have been no real trigger for them to have recounted this information again.

- The independent team sought clarification with regard to the timeliness of the response from the specialist mental health service. Was six days post incident reasonable?

The team manager at the time told the independent author that on receipt of the GP referral she recognised that a more urgent response was required and that the incident did not constitute a routine referral. MR's new community mental health nurse was therefore asked to visit MR and conduct an assessment. It is the perspective of the team manager that the 6 June 2014 was a reasonable timeframe to have conducted this in.

The clinical director for the Older People's Service also advised the independent team that:

"It appears from [the community mental health nurse's] PARIS^[15] entry that the senior carer did not voice any objections to the plan for a visit in 3 days' time, implying that they were content with this response. There was an opportunity here for the carer to say that they needed a response that day, but that did not happen.

The following day (4th June) a member of the admin team contacted the care home to confirm the CPN visit on 6th – this was another opportunity for the care home staff to say that the situation was more urgent and that they required an earlier response."

¹⁵ PARIS is the electronic record-keeping system in use at the Mental Health Trust.

The independent team agrees that the actions of the team manager were appropriate and also that the actions of the team manager evidenced an appropriate assessment of the situation.

- The independent team was interested that the care home manager recorded in the care home records her concern that this was not an isolated incident and that she had communicated this to MR's social worker. The independent team was therefore interested to know why the local authority had not also started to see this incident as a further indication of MR's increasing ill health and risk to others. The local authority informed the independent team that:
"There is no record of the contact between care home and SW on 3-6-14. SW did, however, contact the care home on 30-5-14 to discuss the incident that day and asked the care home to refer to the CPN office to request assessment from mental health team. This is done via the GP. It was reported by the social worker that there was no indication from the care home during the telephone discussion on 30-5-14 that they had concerns about the intensity or frequency of MR's behaviours increasing. SW (mistakenly) understood at this point that the incident had been reported as a Safeguarding Referral (it wasn't – it was a Safeguarding Alert) and that the Safeguarding Team were dealing with it accordingly."

The above response does not explain what the social worker understood by the concern raised by the care home manager. Neither does it provide any illumination about how this professional responded. Although there is no record made by the social worker about the specifics of the communication, the record made by the care home was contemporaneous.

- The independent team wanted to understand more fully what happened as a consequence of the FACE risk assessment conducted in relation to MR. The Mental Health Trust informed the independent team that:
"The referral was received at 3.20pm on Monday 2nd June 2014. It was responded to the following day (Tuesday 3rd June 2014) by phone call, during which [MR's new community mental health nurse] spoke to a senior carer [at the care home] and established the urgency of response that was needed. [The understanding of the current Clinical Director for the Older People's Service is that the community mental health nurse agreed the visit date with the senior carer she spoke to.] The standard response time to routine referrals was and remains within 4 weeks. The Mental Health Trust's expected response time to urgent referrals is agreed with the referrer – and is sometimes (but not necessarily) the same day. Therefore, it is the perspective of the Mental Health Trust that the visit on 6 June 2014 was a quick response for a routine referral, and appears to have been appropriate given the phone conversation that took place."

The Mental Health Trust also advised that “at that time (June 2014), the consultant psychiatrist who was providing input to the Care Home Liaison Team was allocated to do so on Wednesday afternoons and all day Thursday”. In the period immediately after the community mental health nurse’s assessment, the “consultant psychiatrist was on annual leave from 16th – 20th June 2014 inclusive. In the assessment documented by this community mental health nurse, the needs and actions identified included ‘review with consultant’. There is no evidence that this was arranged at the time. Unfortunately, since this community mental health nurse has left her post the Mental Health Trust have been unable to ask her recollection of this. The Team Manager however, reports that the MR’s case was discussed by the community mental health nurse at the team meeting on 10th June 2014, and an Occupational Therapist was allocated to him ... who planned to visit the Care Home on 26 June 2014. The consultant psychiatrist was not present at this meeting as it was not her working day. The team manager also reports that in 2014, staff were not recording all team discussions about patients in the health record. It is not known whether the community mental health nurse discussed MR with the consultant psychiatrist at a later date. It is known that on 24 June 2014, records made by the community mental health nurse state that she will ‘arrange review with the consultant next week’. This occurred after contact was made by the care home”.

Reflective Observation by the Mental Health Trust:

“Having looked again at the Crisis and Risk Management Plan (which is recorded at the end of the FACE risk assessment document), the Trust does not consider that it addresses the risks that the community mental health nurse had identified and therefore would not have helped guide her colleagues’ actions had a crisis arisen and she was not at work.”

4.2.2 The independent team’s observations and comments

As already indicated, the independent team does not consider it helpful to repeat much of its observations in relation to the first serious incident that occurred on 4 March 2014.

This section therefore confines its commentary to those features that are different, or that need to be restated because they did not present so dominantly in March.

First and foremost, as with the March event, all four agencies undertook a range of reasonable actions following this incident:

- The care home completed a safeguarding alert.
- The care home instituted 15-minute observations for MR.
- The care home requested help from the local authority and the mental health trust.

- The care home requested a referral to mental health services via MR's GP, as was the process at the time.
- The specialist mental health service responded to the GP referral by attending at the care home to conduct a risk assessment and to agree a plan of action.
- The care home chased up the actions being implemented by mental health services with the community mental health nurse.
- The care home raised its concerns with MR's social worker about MR's risks and mentioned that this second incident was not 'isolated', as Social Care Direct considered it to be.

However, although the risk assessment undertaken on 6 June highlighted MR's ongoing risks to others, and the documentation across the three agencies demonstrates that the plan was for

- discussion at the multi-disciplinary team meeting
- assessment by a psychiatrist
- occupational therapy input,

not all of these activities had occurred by the time MR assaulted FR on 26 June 2014. The occupational therapists' input was planned for mid-June, but had to be postponed until the first week in July. The referral for psychiatric assessment did not take place until the week of 24 June, and thus the assessment had not occurred by 26 June.

With regard to the lack of a psychiatric assessment:

It is difficult to say what the outcome of a consultant psychiatrist visit to the patient might have been. The Mental Health Trust considers it is unlikely that medication would have been prescribed for the behaviour that is described in this report – furthermore, there is very little evidence to support the use of medication for such reasons. It is likely that a consultant would have discouraged the use of alcohol for this patient. It is possible that a formulation meeting would have been requested and arranged. It is likely that a consultant would have had further discussions with the care home staff, reinforcing the advice that the community mental health nurse had given about ways to manage his difficult behaviours. It is also possible that consideration might have been given to the appropriateness of his care home placement.

4.3 The third incident where ‘higher harm’ was possible, but not necessarily predictable, if the incident type occurred again – 24 June 2014

The interval between significant incidents one and two was almost two months; however, between incidents two and three there was just less than one month. Furthermore, the circumstances of this incident were markedly different to the previous two. In the first two incidents there had been no known provocation for MR’s behaviours. In this incident, MR seems to have responded to provocation from FR, as the following chronological extract sets out. FR was known to be a forthright character within the care home, and the scenario that arose between her and MR was not uncharacteristic.

At the time of this incident, the multi-agency organisations involved were already mustering to achieve a consultant psychiatric assessment, and occupational therapy interventions were also planned. The care home had also maintained an increased level of observation of MR and at a level it deemed appropriate in light of his behaviour.

As with the previous two analyses of MR’s aggressive acts, the table below builds on what has already been articulated and does not repeat it.

Date	What was happening
24 June 2014	<p>Telephone contact between the care home and the Mental Health Trust:</p> <p>A senior carer at care home wanted to know what plans had been put in place for MR. The community mental health nurse confirmed that Occupational Therapist (OT) assessment would take place the following week. She also said she would give MR an appointment for a review with one of the medical staff the following week. The senior carer reported that MR was refusing all personal interventions. His behaviour seemed confined to this, apart from his irritation with the women on the unit. The community mental health nurse made suggestions for managing personal care, which were: i) ask relatives about MR’s previous self-care, ii) obtain background information on MR’s habits, iii) try to engage MR in other activities, iv) not to confine personal contact to only when a shower is needed, v) consider a strip-wash, as MR being resistive towards having a shower had been identified as a trigger.</p>

Date	What was happening
24 June 2014 at 2.30 pm	<p>A senior carer made a safeguarding referral on 26 June, after the event. The safeguarding alert says:</p> <p>FR was seen by staff “up in MR’s face shouting about wanting a policeman. MR must have become agitated and staff saw FR stumble backwards and fall to the floor.” Staff did not have time to get to her before she fell and they were unsure if MR had pushed her or she had stumbled backwards, as they did not have a direct line of sight.</p> <p>The alert notes: “When asking the residents about the incident, MR said he knows he did it and FR said that ‘he pushed me’.”</p> <p>The alert also noted that: “FR was a little shocked but not injured. She was mobilising as usual and not complaining of pain. She had had a settled night.”</p> <p>The alert form noted that: “The referrer advises that this is the second incident with MR as instigator but not towards FR. He was now on 15-min obs when in the communal areas” and he had an appointment with a psychiatrist the following week.</p> <p>The local authority worker noted that: “The home appears to have taken appropriate action and describes it as a low risk physical incident between 2 residents with dementia.” It was recorded as a safeguarding adult alert, and allocated workers were advised.</p>
25 June 2014	<p>The care home made a statutory notification to CQC. This document stated:</p> <p>“The alleged perpetrator is already being reviewed by mental health services as he has previously abused residents on twice [sic]. He has an appointment with consultant psychiatrist next week and is already on 15 minute observations.”</p>
25 June 2014	<p>Telephone contact between the local authority and the care home.</p> <p>The SW recorded: “Only pushed a resident and no harm. MR knows he has done this and took himself off to his room.</p> <p>Outcome: FR is unharmed and only shocked – No issue to follow up today. [GP] (XX to visit MR I was informed by [senior carer]).”</p> <p>There was also contact between a social worker from Social Care Direct and MR’s social worker to advise of the safeguarding alert.</p> <p>A social work assistant was also noted to have contacted ‘D’ at the care home to find out how FR was. No concerns noted and 15-minute observations continued.</p>

In addition to the above sequence of events, the independent team understands that:

- This incident, as with incident two, was considered to be an isolated incident because the victim, FR, had not been involved in an incident previously. However, MR had, and the safeguarding referral highlighted this point. From the analysis of incident one (4 March 2014), the independent team gained insight into how Social Care Direct may have underrated the three individual incidents that occurred to this point. Consequently, the independent team was interested to understand better how patterns of incidents involving residents such as MR were identified via the risk threshold assessment. The local authority advised the independent team that:

“[The local authority] recording system enables [Social Care Direct] staff to easily recognise patterns relating to victims of abuse, but it is less easy to identify patterns relating to the perpetrator. MR’s [social worker] was aware of this pattern. He again contacted the care home to discuss the incident and was assured that there were no ill effects suffered by the victim, that MR was being observed by care home staff at 15-minute intervals, and that MR was to be assessed by a psychiatrist the following week.

The incidence of MR’s aggressive behaviours towards women could have been coincidental and the population within the care home at the time had a higher proportion of women than men.”

- The independent team also wanted to know what the local authority expectations of its social workers were at the time in relation to risk assessment when a vulnerable adult on their caseload had been involved in multiple incidents.

The local authority advised the independent team that:

“[Social workers] receive formal Risk Management Training and regular briefing notes relating to specific areas of practice. Risk Management Plans are expected to be produced by SWs where there are risks which cannot be managed adequately within the existing care plan. At the time of this incident, MR was awaiting further assessment by a psychiatrist and [the social worker] (being a generic Adults Social Worker, and not having a Mental Health background or specialism) was reliant upon the expertise of his mental health colleagues.

The [social worker’s] last formal reassessment of MR’s needs was April 2nd and there are a number of risks identified within this document regarding risk to self and others.

There is also evidence that he has sought advice from his line manager.

The [social worker] was focussed on risks to MR – rather than potential risks to the wider population within the care home.

[The local authority] is currently addressing this issue with all [adult social workers] so that awareness is raised of risk management in relation to victims and perpetrators.”

- Across all three incidents it is clear to the independent team that the care home staff undertook what they considered to be the correct actions to safeguard their other residents and also to support MR. However, although an increase in the level of observations of MR was achieved on all occasions, including this one, there is nothing to suggest that ‘close’ or ‘within-eyesight’ observations were considered. The independent team was therefore interested in:
 - How the care home determined levels of observation for its residents (see the next section of this report).
 - How it guarded against and/or managed the situation of ‘risk tolerance’. (Risk tolerance is a situation that can arise where one or more persons is continually exposed to a level of risk to the extent that one’s perspective of risk is diminished. For example, if one continually breaks the speeding limit and nothing ‘bad’ ever happens, one’s awareness of risk and the dangers associated with it diminish.) The care home at the time of the incident did not have a strategy for risk tolerance, and would not have been expected to have had one. It is something that is difficult to quantify, and case study work is possibly one of the more effective ways of raising its profile with staff.
- The local authority was also asked: “How did the SW continue to see MR as ‘low risk’ when at least two previously reported incidents posed an ongoing real threat to safety?” (The issue here is not frequency, but the possible impact if or when the behaviour was repeated.)

The local authority provided an open and candid response:

“Unfortunately, these types of incidents are not unusual in any given EMI unit and SWs must weigh up their intervention within the context of the incident and the individuals involved in order to provide a proportionate response. SWs are also reliant upon the providers who have the day-to-day care and management of the client to advise us on the level of risk.”

The independent team considers the above to be a reasonable response. However, frequency of event-type occurrence in a subset of the population is not the best determination of risk. It is possible to drive too fast on a motorway for significant periods of time over many journeys and not have an accident or get caught for speeding. That ‘nothing bad’ happens does not diminish the risk of harm. It remains a prevailing risk; it just hasn’t happened yet. But when it does, there is a clear potential for high harm.

- The independent team also asked the care home provider: “With regard to risk assessment and risk management strategy with clients such as MR, what are the expectations of senior carers and registered care home managers in [your care home] in terms of risk management, and what training and competency assessment is undertaken for both groups

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of staff (in 2014 and now in 2015)?" The care home provider advised the independent team that "they were unable to find any specific training regarding Risk Management in 2014". This is not an unusual situation in the care home community. However, the lack of training means that staff do not have the knowledge to conduct an appropriate level of risk assessment in incidents such as this, and those of March and May. Independent sector staff are invited to the safeguarding training provided by the local authority; however, this training does not focus on how to risk-assess incidents in the way this independent team is suggesting.

4.4 Inter-agency communication, and the systems and processes in place to support effective communication

In this case, and as the previous sections demonstrate, there was no lack of communication about MR between:

- the care home and the local authority
- the care home and mental health services
- the care home and the GP.

There was also regular evidence of communication between:

- MR's social worker and the care home
- MR's social worker and mental health services
- the GP and mental health services
- mental health services and the care home and social care.

However, despite all of these communications, the majority of which were generated as a consequence of concerns about MR,

- the level of concern held within the care home was not appreciated
- there was no effective joint professionals meeting to develop a clear plan to enable the care home to optimise its management of MR's behaviours (wandering, and the escalation in his assaultive behaviour from verbal expression to physical assault)
- the GP practice, MR's first community mental health nurse and MR's social worker all report not being aware of the detail of the incident that occurred on 4 March 2014 until after the fatal incident on 26 June 2014.

What is particularly frustrating for individual agencies in this case is:

- The care home manager considers that the social worker and community mental health nurse were consistently supportive. She considers that the care home was well supported in the decision to transfer MR to the dementia care unit. The only thing that caused frustration for the care home manager was the lack of formal multi-agency meeting to enable a detailed and structured round table discussion about MR including risk assessment. The care home manager at no time appreciated that the care home concerns were not being understood by the other agencies. Had she known this she may have felt able to be more assertive in achieving its delivery.
- The mental health service considers that it would have acted and responded more assertively had it been aware of the detail of what had been happening from 4 March 2014.
- The GP practice considers that if it had known in more detail the events of 4 March 2014, it could/would have written different letters of referral.
- The social care records demonstrate follow-up communications with the care home to find out how things were progressing with MR and to encourage the care home to persist in its attempts to engage MR with

mental health services. However, none of these communications resulted in more accurate situational awareness for MR's social worker.

A key factor for the independent team and particularly the independent author is the fact that there is no agreed structure or process for cross-agency communication. For example, at the time there was no expectation that verbal communications followed a structured formulation so that key information could be followed up via secure email or fax.

Learning opportunity

There are evidence-based handover communication tools that have been demonstrated to improve the robustness, reliability and consistency of inter-team and across-team handover of information. One of these is referred to as SBAR¹⁶ (situation, background, assessment and recommendation).

This single case, and the findings of numerous serious case reviews that highlight communication issues across agency boundaries as a significant contributory factor, means that the local Safeguarding Board for Vulnerable Adults needs to promote and support the exploration of tried-and-tested communication tools that are known to minimise the opportunity for information loss as occurred in this case. Consideration of the piloting of a selection of such tools would be a worthy consideration as a component of this.

¹⁶ WIHI: SBAR: Structured Communication and Psychological Safety in Health Care: <http://www.ihl.org/resources/Pages/AudioandVideo/WIHISBARStructuredCommunicationandPsychologicalSafetyinHealthCare.aspx>

4.5 The level of observation and support provided to MR, with a particular focus on how this was conducted after each incident

It is clear from reading through MR's care home records that he received considerable support from the care home staff during the period of his residency. It is also evident that he was a resident who was subject to the care home's supportive observation policy for significant periods of time. The supportive observation policy (c&c/031) was implemented in May 2013.

The policy document describes the level of observations that were required for use within the care home provider group. These were:

- Level 1: General supportive observations (this is cited as the minimum acceptable level of supportive observation for all care home residents. It requires staff to "positively engage with the person to assess their mental state". The outcome of this must be recorded in the person's care record.)
- Level 2: Intermittent supportive observations (this is for occasions where people receiving care and support are potentially but not immediately at risk).
- Level 3: Within-eyesight supportive observations (for persons considered to be at immediate risk of harming themselves and others. A specific observation chart is required to be completed.)
- Level 4: Within-arm's-length supportive observation (this is for people considered to be at the highest levels of immediate risk of harming themselves or others. A specific observation chart is required to be completed.)

A review of MR's care home records to explore how supportive observations were delivered and conducted revealed:

Date	Observation level or frequency	Reason for observations	Adequacy of observation level
12 November 2013	Ranges from 15 to 30 minutes	MR was persistently going into others' rooms.	Not unreasonable
27 January 2014	Hourly observations	MR found in another resident's room. Left and returned to his own on being asked – between this date and 2 February 2014, wandering into others' rooms was a significant issue for the care home.	Monitoring MR's whereabouts with respect to his wandering behaviours would have been challenging. Given the irritation MR appears to have caused other residents, one wonders if intermittent observations and 30-minute intervals may have been more effective. However, such frequency may not have been practical.
28 January 2014	General observations of behaviour	The community mental health nurse asked the care home staff to complete behaviour charts and to arrange a physical review and midstream sample of urine to rule out delirium given this sudden change in behaviour.	
		Adequacy of Observation Level: Despite the encouragement of the care home manager there was a lack of 'behavioural' information recorded and the observation records predominantly capture a resident's whereabouts. Behavioural training was being offered but not all staff could be educated at once. Although staff were placed on the programme opportunity was limited as each participating organisation had a small number of places.	

13 February 2014	Not clear	<p>MR is wandering at this stage – into others’ rooms, but no violence or aggression.</p> <p>Care home manager is noted in the SW records to have agreed with the SW that MR was “in himself difficult to place as, if he were in EMI unit, the people in there have no understanding of his behaviours, which are harmless”.</p> <p>Care home unable to confirm if observation charts were utilised.</p>	
5 March 2014	Hourly observations during the day and half-hourly at night	<p>“A resident named MR was found shouting at another female resident. He has dementia and she has learning difficulties. He said he had his hands on her neck and later became distressed at what he believed he had done. She said he hit her. Her neck was reddened, according to staff.”</p>	
		<p>Adequacy of Observation Level:</p> <p>From an immediate risk management perspective, the multi-agency panel and specialist advisors are agreed that a period of Level 3 observations (within eyesight at all times) would have been prudent. These could then have been reduced once it was clear that MR’s behaviours had settled and he was behaving in keeping with his normal pattern of behaviour.</p> <p>Although the care home manager reports that she requested additional staffing to enable formalised close observations to occur, the care home provider has no record of this request as it was not followed up in writing as was the expected process at the time. The care home manager advised that as a consequence she and her team all worked together to maintain a close surveillance on MR in the immediate aftermath of the incident.</p>	
10 March 2014	?	MR walked out of the care home, but was persuaded to return. An observation chart was commenced.	Appropriate actions were taken in the specific context of this event. Please see the foot of this table.

Date	Observation level or frequency	Reason for observations	Adequacy of observation level
13 March 2014		MR left the care home again. "At lunchtime MR walked briskly out of the main entrance in full view of staff. He was accompanied by the manager and a care assistant. He walked down the street, and turned right down another. He was displaying signs of stress 'fight-or-flight' mechanism. The home manager and the care assistant talked to him and distracted him with conversation about family that he knew and persuaded him to calmly return to where he had started to collect his wallet. He was put on an observation chart."	Not required the staff were with him at all times

Date	Observation level or frequency	Reason for observations	Adequacy of observation level
30 May 2014	15-minute observations	Second instance of physical assault against another resident – ‘observation chart’ recommenced.	As with previous incidents. The multi-agency panel and specialist advisors are agreed that a period of Level 3 observations (within eyesight) at all times could ideally have been implemented which could then have been stepped down once the situation had been assessed as safe to do so. The care home staff worked together to maintain a close surveillance on MR in the immediate aftermath of the incident.
4 June 2014	15-minute observations	Observations continue. The care home manager recorded: “This is not an isolated incident. A request for a visit from the challenging behaviour team was made following an earlier incident. This still hasn’t happened in spite of asking for support from GP and social worker to progress matters. GP has been asked to make an urgent referral for the second time. Care home manager spoke to SW on 3 June 2014 and asked him to progress this with mental health services. MR commenced on 15-min observations. Staff already do a walk-around hand-over to ensure they remain on the floor during hand-over.”	
24 June 2014	15-minute observations when in communal areas	MR thought to have pushed FR over.	

With regards to 10 May 2014: The registered care home manager has advised the independent author that on this day all residents in the EMI unit were being managed in the foyer in the conservatory. This was considered the safest space for them as renovation works were being conducted. The reason for this was that it was a contained space and all residents could be observed by the staff. The front doors were also locked. At the time there were two sliding doors on a sensor. However, when visitors came the doors needed to be unlocked to allow them in. Both doors opened and it was not possible to limit this. This was a recognised risk issue for the registered manager at the time as it provided opportunity for a resident to simply wander through the door. On 10 May 2014 the registered care home manager watched MR ‘wander’ through the door and followed him. It was definitely a ‘wander’ and not a purposeful leaving of the unit. When the care home manager directed MR

back inside he did not resist or voice objection. The care home manager told the independent author that MR did not like to be in close proximity with people and she was not surprised that when 'space' became available he moved into it. She did not, and does not, consider that this incident warranted close observations, or any more than they were doing at the time. The independent author, now apprised of the context of the situation, concurs.

With regards to 30 May 2014: The care home manager advised the independent author that MR was not the only resident with challenging behaviour, and as the manager it was her responsibility to maintain safety for all residents and to ensure that all residents had their needs met as far as this could be achieved. Ideally, she agreed that one:one observation of MR was required, but this simply was not achievable so they did what they could, as they did in March 2014. (Please note that the information on page 41 applies)

Because a significant activity for the care home staff had been to curtail MR's entry into other residents' rooms, an activity they had achieved success with, it meant that the focus of their observation activities was when MR was in communal areas.

4.5.1 Observations of the independent team

There were four drivers for observing MR:

- his wandering behaviour
- his habit of going into other residents' rooms, invading their privacy and meddling with their possessions
- to monitor his patterns of behaviour towards other residents and staff
- to maintain safety for MR and other residents following incidents of assaultive behaviour.

Of the above reasons, the most frequent for observing MR was not assaultive behaviour, but his wandering behaviours. It is a testament to the staff at the care home that on no occasion did MR manage to leave the care home without staff observing and following him. This suggests that he was a resident they maintained a close and supportive eye on and that they were generally aware of his whereabouts much of the time. In this respect the care home's commitment to a baseline standard of general observations was successful.

Similarly, in respect of MR being found in locations within the home (namely other residents' rooms), where he would be encouraged to return to a communal space or his own room, this demonstrates that staff were aware of i) his wandering tendencies and ii) his whereabouts. That the records show they were mostly able to encourage him to return to communal or his own personal space also suggests effective use of the principles of the care home's 'Distressed Reactions' policy (P5/001/DC), which had not been implemented at the time MR was a resident, but contains clear guidance for managing sensitive situations safely and with minimal risk of startling a resident.

With regard to the observation levels undertaken following the incidents MR was involved in on 4 March, 30 May and 24 June, in the first two incidents, given what actually happened and the known and unknown context of these incidents, a closer level of dedicated close observation could have been instituted for a longer period of time than was possible for the care home given its capacity in terms of staff to resident ratio at the time. The independent author recognises the limitations on the care home in terms of the funding for each resident and the limitations that posed in this specific case whatever the rights or wrongs of the way in which the then care home manager made her request for additional staffing. However, the independent author also asserts that it is predictable in a care home environment, and especially in a unit dedicated to residents with a diagnosis in the dementia spectrum, that from time to time periods of within eyesight observations will be required for some residents. Therefore, the independent author asserts that all providers of care home services, and all commissioners of care home services need to ensure that in circumstances where short periods of enhanced observation, or enhanced care, are required that there is complete clarity about how this can be achieved with the minimum of delay so that safety can be maintained for all residents.

Setting the funding issue to one side, the independent team also noted that the description of observation levels and the review of them as required by the care home policy at the time was not reflected in the care home records. The language of the policy document was, more appropriate for a specialist mental health provider than a care home at the time, and did not represent a standard of practice that was achievable by care home staff. The independent author asked a representative from the care home provider on the review panel about the delivery of supportive observations. This panel member was not able to provide specific information about these or about MR's case but she was able to confirm that MR's care package was not funded to cover Level 3 (within eyesight) or Level 4 (within arm's length) observations, and to deliver this to him without additional funding (to enable an increase in staffing) for any substantial period of time would have been challenging and potentially disadvantageous to other residents. The care home provider is however, clear in its assertion that consideration is given to all requests made by care home managers for additional staffing support and if this is required to maintain safety for a specific resident and/or residents in a care home then this is usually agreed to while further assessment of the resident's care package is undertaken. In this case it is not possible to understand why this did not happen as there is no document trail to enable any decisions made and why they were made to be considered.

The care home's supportive observation policy (2013) provides no guidance for its staff about what to do should a situation arise where a higher level of observation is required than that accommodated within the funding and care package agreed with the commissioning authority. In fact, much of the wording in the care home's supportive observation policy (2013) reads as though it was intended for implementation in a specialist mental health provider rather than a care home environment, where the vast majority of staff do not have a professional health or mental health qualification. Although the principles espoused in the policy may have

relevancy and application, its content needs to reflect the reality of a care home environment and the skills and competencies of the staff working in a care home.

Behavioural observations:

On 28 January 2014, MR's community mental health nurse asked the care home staff to conduct behavioural observations, because they were reporting challenges in managing MR's behaviours.

MR's records suggest that the staff considered that residential care was no longer appropriate for MR and queried why he was not on medication.

In addition to the request for a period of behavioural observations, the community mental health nurse asked the care home staff to arrange a physical review and urine specimen to rule out delirium, given MR's sudden change in behaviour.

At the time this consultation occurred, a decision had already been made to discharge MR from the mental health service. (This decision, which was made on 22 January 2014, was in fact postponed until 14 February 2014.)

The care home staff appropriately liaised with MR's GP to ensure that the physical health checks requested were conducted.

On 31 January 2014, MR's community psychiatric nurse [1] attended at the care home to review the situation. The records made of this review revealed that:

- "There have been no further aggressive incidents, although MR is still going into others' rooms and picking up things he believes are his own.
- The member of staff on duty believed MR was manageable on the residential unit, although contact has been made with the social care review team regarding transfer to the EMI unit.
- Care home staff were advised by the community mental health nurse that no medication will help divert MR from wandering and that staff should engage with him and divert him by other means.
- That MR's cousins have requested that MR is given a small amount of alcohol in the evening and that staff will do this. MR was also noted to be using 'e' cigarettes. [Although the care home records record that it was MR's family's request, it is the understanding of the care home manager that it was a senior carer who had the initiating thought about alcohol, and that it is unlikely that MR's cousins would have suggested it, or considered it a good idea. To the best recollection of the care home manager she strongly remonstrated with the senior carer about this and instructed that alcohol was not to be given.]
- The plan was noted to await bloods and liaise with Social Services."

Subsequent to this, care home records reveal:

- 5 February 2014: Some agitation. Context was around being asked to go for a shower, which he did, but “then he became very agitated, punching himself and attempted to hit the picture on the wall”. Staff tried calm-down techniques but had to abort the shower.
- 15 February: “Fantastic duty today, laughing and joking with staff.”
- 16 February: “Remains in high spirits.”
- 19 February: Agitated at midnight because “people were in his house. He pushed a chair over in the lounge area. Then he retired to his bedroom and settled down.”
- 19 February at 4pm: MR agitated in shower – settled afterwards.

These are good-quality observations regarding MR’s behaviours. However, they were recorded in the daily records maintained by the staff and were not captured in a dedicated behavioural observation chart. This meant that when the community psychiatric nurse attended at the care home to review the behavioural charts he had asked to be completed, there was little data in them.

The independent team understands that at the time MR was a resident the care home did not have a specific approach to observing and recording ‘behavioural’ observations as opposed to supportive observations. This goes some way to explaining why the many observations charts reviewed by the independent team were not especially illuminating from a behavioural management perspective. It is, however, important to note that the community psychiatric nurse did take the care home staff through the requirements of behavioural observations and show them how to use a behavioural chart. The specialist mental health service also provided training to this care home in the management of challenging behaviour, which included behavioural observations. At the time of MR’s residency, 19 staff members had been trained.

MR’s community mental health nurse had deferred discharge at the end of January to mid-February. When he attended on 14 February 2014 to reassess the situation, he found that the main issues continued to be MR wandering into others’ rooms and MR’s personal hygiene. The community psychiatric nurse noted that MR was now:

- Sleeping in his bed three nights a week on average. However, MR sleeps in the lounge if staff are unable to persuade him to go to bed.
- MR seemed relatively kempt.
- Two behavioural charts had been completed, both detailing minor altercations: one being MR shouting at a staff member giving him tea, and the other being MR swearing at a resident who asked him to leave her room. In the opinion of the community mental health nurse, the charts indicated that care home staff had successfully de-escalated the situations.

The community mental health nurse noted in his records that he advised on options to minimise disruption to residents by MR, such as closed or locked doors, diversion by staff, or a sensor pad on MR's door. The care home staff considered the institution of a sensor pad but concluded that it would not be helpful for MR as he was more often than not out of his room than in it. Furthermore, when MR was in his room the strategy was to leave him to be quiet as it caused him distress when staff checked on him. They therefore maintained a level of vigilance for when he emerged from his room. With respect to closed and locked doors this would have posed a deprivation of liberty issue and was not considered appropriate for the living environment. Also, at this visit the community mental health nurse updated MR's care plan and closed his case to mental health services. The Mental Health Trust has spoken with the community mental health nurse who recalled that at this time he did not form the impression that the care home was unable to meet MR's needs. Although some care home staff had differing perspectives, the overall impression he formed was that the care home staff were able to manage. It was because of this context that he proceeded with the discharge.

On 2 March, care home staff noted in their records variability in MR's mood, ranging from happy to annoyed. The care home records noted that staff contact with MR was limited, as he was agitated quite often. The records suggest that staff did not consider him to be in pain or discomfort, but that there was an undercurrent of emotion. The independent team could not find any clear evidence of any specific behavioural observations continuing over this time, but the day-to-day records do contain regular and clear accounts of MR's behaviours.

Reflective learning opportunities

1: ABC observations are an established method of behavioural observations utilised in care home and older persons' care settings, and the National Institute for Health and Care Excellence contains a wealth of literature on the usage of ABC charts; a simple Google search also reveals an extensive list of informative literature extolling the benefits of the ABC approach.

The ABC method of observation and recording of the behaviours is:

- **Antecedent** – the events, action or circumstances that occur before a behaviour
- **Behaviour** – the behaviour
- **Consequences** – the action or response that follows the behaviour.

For example:

Resident X is 75 and suffers from dementia and wanders constantly. When it is intrusive, he is guided by care home staff. When confronted in this supportive way, Resident X can become aggressive.

A = Antecedent event – Resident X wanders into co-resident's room. Co-resident asks X to leave.

B = Behaviour – Resident X responds aggressively (verbally or physically).

C = Consequence – care home staff speak with X in a calm, reassuring manner. Techniques of diffusion are utilised such as distraction techniques. X calms down and agrees to return to his own room.

This type of approach to behavioural observations with clearly laid-out documentation tools may have been supportive to the care home staff trying to capture the challenges they were having with MR's behaviours. Such documents may also have been useful for visiting professionals to review.

2: The independent team asked the care home provider how its staff are trained in observation.

The care home advised the independent team that: "Observation is judged on an individual basis. This is determined by the reasons for the observation and management of the client." However, the care home provider also advised the independent team that: "There is currently no specific training in observation; however, the observational charts used are provided by the community mental health nurse and they indicate the areas of observation and level of intervention to be recorded."

Whilst there may have been no corporate training for staff, there was a local training initiative in which MR's care home participated. The then care home manager recalls supporting the care home staff to attend at the time, and that her aim was to enable all staff to attend the behavioural observation training as it was useful to their ability to optimise their supportive management of their residents, as well as their ability to capture useful information for the visiting mental health professionals.

Furthermore, the specialist mental health provider advised that a community mental health nurse will instruct a care home to commence a behavioural chart, and that:

"Some care homes have their own behavioural charts, but some do not and the [community mental health nurse] would then offer a template behavioural chart to a member of the Care Staff and check that they understood how to complete it. It would then be necessary for the care home staff to share this information with each other. We believe that this care home had their own 'Distressed reaction' form in place. We do not recall whether these, or charts we had provided, were being used for MR (sometimes care homes copy charts that they have been using for other residents)."

Note: The distressed reaction policy utilised in the care home was not implemented until November 2014, so did not apply to the observation practice of the care home staff at the time MR was in receipt of care and support.

In the context of a care home environment, supported timed and behavioural observations require:

- staff to understand what they are doing and why
- a suite of documentation tools that are consistently accessible, easy to use and stored in the resident's records in a way that ease of access is provided to visiting professionals who need to be able to review the information gathered, discuss this with care home staff and plan any future management strategy with those staff
- policies and procedures that reflect the reality of what is deliverable within the constraints and skill range of the staff
- a clear escalation process for those occasions where it is not possible to deliver required levels of supportive or behavioural observations for an individual resident without compromising the safety and quality of management for other residents (that is, the level and scope of observations required is outside of the care package funded by the commissioners of that package)
- an internal system for the review of practice and procedural compliance so that issues relating to any practice development needs can be attended to in a timely manner as a team as well as to meet the needs of individual members of staff.

3: Consideration needs to be given as to what constitutes a reasonable length of time over which behavioural observations should be conducted. Is it at all possible to set a minimum period of time for this activity to enable the full range of resident behaviours to be captured? The consideration of this is especially important where a care home has raised significant concerns about a resident and is contemplating the suitability of the resident for the care package and environment for which he/she is funded.

It is notable in this case that within two weeks of being discharged from the community mental health nurse's caseload, MR displayed a dramatic divergence from his usual pattern of verbally aggressive/hostile behaviour with occasional attacks on his own person, by assaulting a fellow resident. Also notable over this two-week period is evidence that care staff were keeping their distance from him in advance of this date owing to MR's hostility.

The independent team is left with a sense that mental health services ought not to have withdrawn quite so quickly, but it cannot guarantee that it is not being influenced by the subsequent course of events in contemplating this. The mental health service has also contemplated this discharge and agrees that, with the benefit of hindsight, it could appear as premature; however, at the time the decision was made, there was no reason not to discharge MR from the community mental health nurse's caseload.

4.6 The decision by mental health services not to accept MR following referral of MR to older persons' mental health services in March 2014

The information set out in sections 4.2 and 4.3 relates equally to this section.

It is clear in retrospect that there were opportunities for mental health services to have been more actively involved with MR's management than they were. However, for this to have occurred they would have had to have been informed about the detail of MR's behaviours, and the behavioural charts requested from the care home would have had to have been completed correctly. However prior to the independent team being able to speak with the frontline professionals involved with MR, and before the the significance of the information loss between and within agencies was appreciated by all agencies, the local authority and the care home, had questions they considered important for the mental health trust to respond to. These were:

- Why was MR discharged from the community mental health nurse caseload on 14 February 2014?
- Why, when the incident occurred on 4 March 2014, was MR not automatically taken back onto the community mental health nurse's caseload, given the short passage of time following discharge?
- Why, given the community mental health nurse's knowledge of what had been happening, was the GP referral refused?
- Why, following the incident on 30 May 2014, and following a detailed assessment, including a risk assessment, by a community mental health nurse, was there no comprehensive plan instituted for MR, including a consultant psychiatric assessment?

These were all reasonable questions that any agency would ask in a case such as this and the independent author was content to request a response from the mental health provider.

Why was MR discharged from the community mental health nurse caseload on 14 February 2014?

The records maintained by the community mental health nurse and MR's social worker in February 2014 (that is, around the time the community mental health nurse discharged MR from the community mental health nurse caseload) make clear that:

- On 14 February 2014, the record of a conversation between MR's social worker and his community mental health nurse (made by the social worker) gives a clear impression that:
 - He had always found MR to be easy to divert and was reluctant to move him to EMI, where his behaviour would have been the same and he could have been at risk of assault from other residents who were more impaired.
 - Care home staff were reporting problems in managing MR's behaviour of wandering into other residents' rooms. However, the social worker considered that this behaviour was "a minor management problem".

The social worker also documented:

“[Community mental health nurse] feels as I do that MR’s behaviours are only a management problem and not any bad behavioural problem that pose any threat. We discussed that a move to EMI seems unnecessary but [community mental health nurse] will assess this possibility this am.”

This record, combined with that of the community mental health nurse set out earlier, makes clear that neither professional considered that there was an issue of concern at this time that required the input of either agency and that the care home ought to be managing the situation. The term “minor management problem” was not an accurate descriptor for what the care home was experiencing.

Why, when the incident occurred on 4 March 2014, was MR not automatically taken back onto the community mental health nurse’s caseload given the short passage of time following discharge?

At the time this incident occurred, MR had been discharged from the mental health caseload, and the system in place at the time was that individuals had to be re-referred via the GP pathway.

The case management records show that the community mental health nurse had a number of conversations with the care home over this period and provided them with accurate advice on how to achieve a re-referral.

The issue here was not one of the mental health services not acting appropriately. The issue was that the letter of referral (as already identified) was insufficient in its content to enable mental health services to take MR back onto their caseload.

The mental health service explained why they could not accept the referral for assessment and asked for more detailed information, if any was available, to enable a reconsideration of this decision. No additional information was provided to the consultant psychiatrist by MR’s GP practice to facilitate a reconsideration of the decision. Neither did the care home assertively pursue this via the GP practice.

The reasons why there was no assertive follow-up by either agency (GP and care home) are not clear, and at this length of time after the fact it is unlikely that any explanation will be forthcoming.

Reassuringly, the contemporary situation has changed since 2014 and a care home can now make a direct referral to specialist mental health services without going through a resident’s GP. This seems to be a much better situation, as a care home will now be in control of the information communicated and able to more actively pursue it if the response is not what was hoped for.

Why, following the incident on 30 May 2014, and following a detailed assessment, including a risk assessment, by a community mental health nurse, was there no comprehensive plan instituted for MR, including a consultant psychiatric assessment?

As previously noted earlier in this report, in the assessment documented by MR's new community mental health nurse, the needs and actions identified included 'review with consultant'. There is no evidence that this was arranged at the time. The community mental health nurse assigned to MR in May 2014 is no longer in the employ of the Trust and it has not been possible to explore the reasons for this with her. Then, on 24 June 2014, records made by this same community mental health nurse state that she was going to "arrange [a] review with the consultant next week". The independent team understands that the impetus for this was a call from the care home to find out what had happened with MR's psychiatric referral. The Mental Health Trust has reviewed the Crisis and Risk Management Plan (which is documented at the end of the FACE risk assessment document). As a consequence, they were able to advise that it did not address the risks that the community mental health nurse had identified and therefore would not have helped to guide her colleagues' had she not been at work and a crisis had arisen, which is the whole purpose of the crisis plan. Furthermore, the community mental health nurse did not create a care plan for MR following her assessment. However, in view of the fact that the original plan was for MR to be assessed by the occupational therapist (co-worker to the community mental health nurse who was the lead professional for this episode of care) on 26 June 2014, this did not particularly fall below acceptable professional standards.

4.7 Case management reflections about practice issues not directly related to the incident that triggered the independent review process

In undertaking the analysis of MR's case management across the agencies involved, the independent author and the independent advisers identified a range of occasions which prompted a discussion about the application or non-application of Deprivation of Liberty Safeguards (DoLS) and whether or not this would have made any material difference to MR's chronology as well as a reflection on acceptable standards of practice in relation to DoLS.

Overall the team determined that there was no requirement for a DoLS application to be made, but there were some occasions where it would have expected evidence of consideration of the DoLS issue, even though this case occurred prior to Cheshire West's judgement¹⁷ where the Supreme Court ruled that "all people who lack the capacity to make decisions about their care and residence and, under the responsibility of the state, are subject to continuous supervision and control and lack the option to leave their care setting are deprived of their liberty"

The two occasions where the independent author and the independent advisers initially considered that DoLS ought to have featured as a consideration were on 10 and 18 (13th?) March 2014. These incidents both related to MR leaving the care home. However, now that the independent author has been able to speak with the then care home manager it is clear that the incident of 10 March 2014 did not constitute a DoLS incident. Furthermore two weeks later, when we left the care home, the care home manager was able to describe how MR opportunistically went to the pub as they came across it whilst walking. He, she recalled, met an old friend in the pub, and then decided that he was staying in the pub. Consequently, the care home manager considered that they ought to notify the police of the situation in case they could not persuade MR to return. In the event MR's friend took him back to the care home in his car and the care home manager, and carer accompanying her, walked back. By time they returned all residents had been returned to their own unit which was a safe environment. This incident also occurred as a consequence of the renovation works being conducted at the time. As a direct consequence of this incident the care home manager was able to submit a bid to have the doors to the care home changed.

¹⁷ <http://www.communitycare.co.uk/2014/03/19/supreme-court-ruling-heralds-sharp-rise-deprivation-liberty-safeguards-cases/>

5.0 ACTIONS ALREADY TAKEN BY ALL AGENCIES FOLLOWING THIS INCIDENT

The incident involving MR and FR occurred in June 2014. The independent process took place between August 2015 and July 2016. As is expected, all agencies have instituted practice and policy changes in the intervening period. Some of these changes would have occurred in any event and some have been directly influenced by this case.

The care home:

Since the incident in 2014, a number of significant changes have been introduced within FSHC and Brockwell Court. New care documentation has been rolled out across the organisation which has standardised and streamlined record keeping. Documents are easier to follow for the organisation's own teams but also for visiting professionals. Information is simple to update improving accuracy and encourages staff to make changes in a timely fashion. This has included new communication record format in the care documentation and the re - introduction of Daily Notes booklets. The Resident Experience Team have worked with the home managers to reinforce the importance of recording information and to add clear review and audit. This has then been cascaded to care home staff who are supported by the management team. A care plan tracker system and audit tool has been developed which encourages active participation as regards completion monitoring and rectification of actions highlighted. The new documentation has been followed by the introduction of the FSHC "Quality of Life" programme. Purpose designed software systems are accessed via iPads which provide immediate opportunity to provide feedback. Each care home uses iPad technology to audit and evaluate the resident experience on a daily basis. This feedback from residents, staff and visitors informs and enables the organisation to take action to correct issues as and when they arise. The iPad also enables the organisation to monitor and change resident dependencies as their condition dictates and this helps to highlight changing care needs and develop care planning accordingly.

In addition each home manager has been provided with an iPhone which is connected not only to the "Quality of Life" programme but also to the organisation's internal incident reporting system, "Datix". Now every Datix entry appears as an alert on the iPhone for instant 24 hour access and is escalated throughout the higher management team as indicated by its severity. This has assisted with openness and transparency at every level.

The organisation has also reviewed a number of its policies and in particular it's Observation Policy and Clinical Handover Policy. It has developed a Violence and Aggression Policy and a Delirium Prevention and Management Policy. Staff have guidance about how to seek assistance in a timely manner and how to deal effectively with evaluation of risk.

In September 2016 "Serious Incident and Effective Investigation" training is being rolled out for key team members, in order to provide further support and insight to the care homes and to facilitate the investigation of incidents in a timely and thorough manner.

In addition to the above the care home:

- now works to the principle of ABC (antecedent, behaviour and consequence) in how it carries out its observation of residents when there are behavioural concerns. The standards and approach expected by care home staff are set out in a policy document entitled the Distressed Reaction Policy. The documentation form that accompanies this embraces the principles of ABC observation but also includes additional information including:
 - exact location of reaction
 - staff members involved
 - how the distressed reaction was resolved
 - how the person appeared at the time of the reaction
 - possible causes including a pain assessment using the Abbey Pain Assessment
 - a depression rating scale using the Cornell Depression Scale
 - assessment of how the individual appeared after the event
 - a prompt for staff to consider anything the team could do that would prevent the distressed reaction from occurring again

The new form has been designed to facilitate the findings and formulations made following a 'distressed reaction' being followed through into any necessary alterations to a residents care plan. The care home provider advised that the Distressed Reaction Form was developed following the principles of the Newcastle Challenging Behaviour model and monitoring charts used by the service. This model of care, the provider asserted, encompasses the principles of viewing the individual holistically rather than by each separate incident of distress that perhaps a generic ABC chart does not capture.

With regards to the training of its staff in this new approach the care home provider advised that is currently in the process of designing this. It is intended that its in-house training will supplement but not replace local training initiatives provided by specialist mental health providers to which it encourages its staff within the geographical locality to attend. Furthermore the in-house developments do not replace the need for multi-agency case assessment should the behaviour of a resident significantly change.

- has sent messages to its care home managers reminding them they can challenge decisions made by other agencies about a care home resident if they do not think the response is sufficient
- has also advised all of its care home managers that where they are trying to engage with a partner agency and are unable to elicit a reasonable response then this is to be escalated via the line management arrangements
- has worked with the local authority to enable further awareness-raising activities with regard to risk assessment
- is now able to refer directly to specialist mental health services.

Finally as a consequence of the MR case the care home is going to consider whether or not it needs a more prescriptive and specific policy statement in relation to managing safely where incidents of dedicated observation of a resident are identified as required.

Mental health trust developments

In addition to the change to the Trust's referral system:

- Consultant input to the care home liaison team has since changed, and is now managed by sector consultants who work in that geographical area. Although not all of them are full-time, it does mean that there is better accessibility for care home staff.
- The Trust has recently completely revised its risk assessment framework and is retraining its staff in a new narrative approach to risk. It expects the new process and documentation to be operational from 1 April 2016.
- Front-line staff have been reminded to record all phone calls received in PARIS.
- Front-line staff have been reminded that patients can be re-referred by any agency, themselves or carers.
- Since the incident, a 'Behaviours that Challenge Clinical Link Pathway' (referred to as a CLiP) has been developed and implemented. Requests for behaviour charts start at a much lower level of challenging behaviour than they did prior to this case. However, the problem of poor completion of charts remains a challenge for staff who go into care homes and is a fairly widespread issue. Furthermore, the specialist mental health service cannot insist that care homes use its preferred documents, and some care homes require their staff to only utilise the corporate documentation provided.
- A meeting recently took place between the specialist mental health service managers and local authority managers and an agreement to share low-level (pre-safeguarding) concerns about care homes was reached.
- The care home liaison team meets weekly to discuss caseloads and share concerns with one of the senior clinical leads, using a supervisory discussion to agree any further action required in individual cases, or at a whole care home level.
- As far as is practical we are allocating nurses to named Care Homes to enhance consistency of professional 'going in', improve communications, and situation awareness. The specialist mental health services hope that this will enable it to better identify trends of concern.
- The specialist mental health service is considering developing a formal written request for completion of behavioural charts (that would be copied to the Home Manager) and a follow up letter to use if request is not acted upon. We think that formalising the request might be helpful.

Local Authority

- Since October 2015, the Local Authority have put considerable effort into briefing staff and raising awareness regarding this case and the consequences of not paying enough attention to the risks caused by a service user who is the perpetrator. These “Safeguarding Care Act and You” sessions have been led by Senior Managers to ensure that the message is delivered in a clear and consistent way. It continues to roll out these sessions to ensure that all staff are aware of the need to strengthen risk management in respect of perpetrators who are service users.
- Adult Care Management Team have approved a new protocol from the April 6th 2016 whereby those staff screening “user on user” incidents can make a referral to the Emergency Duty Team or Social Care Direct for an assessment of need for the perpetrator in cases where the perpetrator’s behaviour appears to be causing harm and risks are escalating. This is a ‘belt and braces’ approach so that no one falls through the net.
- The local authority is considering the recommendations arising from this review regarding the risk threshold tool and how it can be used to better identify the risks to the victim posed by perpetrators. However, the local authority will be running further training sessions later this year and will use the opportunity to improve and embed better use of the risk threshold tool in the way described in this report.
- A new safeguarding training and development officer has recently taken up post and will embed the learning from this case when delivering safeguarding and adult protection training to ensure that a proper focus is given to the perpetrator as well as the victim.
- As a result of a recent restructure, the local authority now has a strategic manager who oversees both the safeguarding and access services. This means that the strategic manager is now responsible for both Social Care Direct and adult protection and is in a key position to influence the work of Social Care Direct to ensure that there is proactive screening for ‘user on user’ incidents to improve risk management of perpetrators as well as victims.

6.0 CONCLUSIONS

As a consequence of the investigation undertaken, the independent advisers and author consider that:

- Care home staff provided MR with attentive care. For example, they were persistent in their efforts to support MR as far as he would allow with his personal hygiene issues – a known trigger for agitated behaviour in MR. The care home records demonstrate that staff were sensitive to MR's needs and were able to judge his feelings about the support offered by subtle changes, as well as marked changes, in his behaviours.
- The care home records demonstrate timely and appropriate communications with MR's family where issues of concern arose.
- The care home records show that staff were aware of MR's wandering tendencies and that they took measures to be alert to this and to guide him out of other residents' bedrooms and back to communal spaces or to his own room. On the small number of occasions MR wandered out of the care home, the records clearly demonstrate appropriate and kindly support of MR and encouragement for him to return, which he did on each occasion.
- The care home records also show that staff invested considerable time and effort in monitoring MR's whereabouts, predominantly on an hourly basis. Monitoring increased to every 15 to 30 minutes following significant incidents for time-limited periods.
- There is clear evidence, in the care home records, that the care home staff were persistent in their efforts to achieve input and advice from specialist mental, health and social care services for MR. Unfortunately, the level of concern felt by the care home staff about MR once he had transferred to the elderly mentally infirm (EMI) unit (this unit provided a more intensive care service to persons with dementia) was not fully appreciated by the agencies working with them. These agencies considered that the concerns were not communicated in a way that enabled them to appreciate the level of concern felt by the care home's staff, even though the care home registered manager considers that they clearly articulated these.
- Although the care home did not receive the level of support and advice it was seeking from its partner agencies, the social work records demonstrate that MR's social worker maintained close communication with the care home and undertook to make periodic calls and visits to determine MR's wellbeing. There is also evidence of strategic communications between this practitioner and the care home manager prior to March 2014 in which options for managing MR's wandering habit, and the best care environment for him, were discussed. The social care records thereafter also demonstrate ongoing communications between the two agencies. The social worker assigned to MR recalls receiving differing messages from the care home staff at the time regarding their ability to manage MR, but did not receive any information he could interpret as the care home not being able to cope with MR. His observation of MR and his contacts with MR prior to MR's period of residency in the care home led him to the conclusion that MR's behaviour patterns were within the capability and competency of the care home staff.

- There were two high-risk incidents involving MR in March and May 2014. No serious detectable harm was caused by either of these incidents, but there was discernible potential for higher levels of harm if MR was to be involved in similar types of incidents again. Although the care home staff recognised that both incidents posed a risk to other residents, and reported both to the local authority by raising a safeguarding concern. The extent of the risk posed by MR was not fully appreciated by the Local Authority and consequently escalation procedures were not applied to the management of MR's behaviour as a result of the Safeguarding alert.
- However, a comprehensive risk assessment was conducted after the 30 May (2014) incident. This was conducted by an older persons' community psychiatric nurse. It identified MR's potential risk of harm to others as a consequence of his unpredictable behaviour, as demonstrated by a small number of incidents, and his ongoing levels of agitation around staff's efforts to assist him with personal hygiene.
- In between the risk assessment taking place and the plan for a medical assessment for MR, a third incident occurred on 24 June. This involved MR and FR, and as far as can be gleaned from the care home records, MR and FR appear to have been equal contributors to a situation that resulted in MR pushing FR, who fell and landed on her bottom, experiencing no harm.
- The fatal incident, which again involved MR and FR, occurred on 26 June, two days later. This incident was not witnessed by staff, but the care home records suggest that MR had again pushed FR, who on this occasion fell and hit her head. The antecedent to the incident is not known.
- The first assessment of MR had been planned for 26 June, and was to be undertaken by an occupational therapist who was co-worker to MR's new community mental health nurse (the lead professional for this episode of care), but was then deferred to early July owing to the inability of the occupational therapist to attend at the care home on 26 June. It is very unlikely that this assessment would have made any difference to the sequencing of events had it occurred as originally planned.

Predictability of the incident of 26 June:

With regard to the question of incident predictability, the independent team wishes to highlight that incidents such as that which occurred on 26 June are not uncommon in communities where persons with cognitive impairment, such as dementia, are living in close proximity. Staff working with individuals with a diagnosis of dementia manage such occasions on a regular basis, and such incidents do not commonly result in life-threatening harm. Acknowledgement of this is important to correctly contextualise the circumstances of the incident.

Therefore:

5. Was it predictable that MR might push FR? Yes, it was, under the circumstance that FR was again within MR's physical space shouting or remonstrating with him. He had pushed her two days previously as a consequence of this.

6. Was it predictable that he would push her and that she would fall and suffer a subdural haematoma as a result of her fall? No, it was not. This is especially so if one considers the normal context of these occurrences within residential care and dedicated dementia care units.
7. Is it predictable that if an elderly person falls and hits the back of their head, they might suffer a subdural haematoma? Yes, it is. There are examples of this happening in the hospital and home environment, but it would not automatically feature as a core consideration in a falls risk assessment.
8. Was it predictable that MR might hurt someone as a consequence of his occasional aggressive outbursts that were not related to efforts to support him with personal care? Yes, it was predictable that an unexpected incident involving him could result in significant harm to another resident.

The incidents that occurred on 4 March 2014 (found with his hands round the neck of another resident) and 30 May 2014 (punched another resident in the face, causing facial bruising and abrasion) demonstrated MR's capacity and capability for high-risk assaultive behaviour, whether or not he was himself aware of what he was doing.

Preventability of the incident of 26 June:

This question has been given careful consideration by the independent author, the independent advisers and all multi-agency panel members, two key front-line practitioners involved with MR at the time, (local authority and mental health trust), a regional manager for the care home provider and the care home manager in post at the time of the incident.

The bottom-line opinion as a consequence of these considerations is that

- had the information about the 4 March 2014 incident not been inadvertently overlooked by MR's social worker as a consequence of dealing with a backlog of communications on his return from annual leave, and had his manager not also overlooked the risk associated with this occurrence, and
- had the care home instituted one-to-one observations of MR in the immediate aftermath of the 4 March incident,

the following actions and activities are most likely to have occurred:

- negotiation with the local authority by the care home for a review of MR's residential care package
- notification to mental health services of the incident and an assessment of MR under the Mental Health Act (1983).

Although one cannot say what the outcome of these assessments and negotiations would have been, the clinical professionals involved consider that it would have been unlikely that MR's place of residency would have changed at this point because his behaviour settled back to normal and for the following 8-10 weeks there were no further high-risk incidents

Furthermore, from what the involved agencies and the independent team know, it is unlikely that MR would have been detained under the Mental Health Act at this time.

However, when the second incident occurred on 30 May 2014, all agencies are agreed that the response to this incident would have been much more assertive, if the suggested actions and activities had occurred as above, and would have included:

- closer observation in the care home along with the instigation of discussions with the local authority about placement and the funding of close observations until a more suitable placement could have been located
- assessment of MR by mental health services, under the Mental Health Act (1983)
- construction of a care/management plan involving all three agencies.

Had the immediately above occurred, it is unlikely that an alternative placement would have been found for MR in the three weeks preceding the incident of 26 June 2014. A period of three to four weeks and more is the usual experience of the agencies involved in this case. Therefore, on balance, MR would still have been a resident in the care home on 24 and 26 June 2014. However, with a more robust management plan there would have been much less opportunity for him to have become involved in altercations with other residents, or to have had physical contact with them. Therefore, the risk of future incidents would have been reduced to the lowest reasonable level by the care home and the other agencies involved.

However, the independent team highlights that the situation of 'no risk' was not achievable.

Primary contributory factors to MR's risks not being managed as assertively as they should have been:

- The care home records show that its staff did raise concerns about MR with its partner agencies following the incident of 4th March 2014. These agencies included the GP Practice, the Specialist Mental Health Service and the Local Authority Safeguarding Team. However, not one of the other front-line professionals recalled being informed about the 4 March incident. The reasons for this are understood as:
 - Although it is clear that the care home made contact with the GP, the GP surgery has no record of the detail of the communication and cannot therefore recall the depth of information provided. It is not uncommon for such conversations to be conducted via telephone and for key notes only to be made. It is not usual practice to follow up such communications in writing.
 - On 5 March the care home staff spoke to the community mental health nurse to request a meeting with the care coordinator at the Mental Health Trust about how to manage MR's needs. A message was left by care home staff to speak to MR's social worker to arrange a meeting to discuss MR's behaviour and ways to manage him. A safeguarding alert was logged by the care home. MR was moved to the EMI unit on the initiative of the care

- home. On 6 March 2014 the care home staff requested an emergency referral to the mental health team for MR. The care home was operating under the belief that the community mental health nurse knew about the incident of 4 March 2014; however, the community mental health nurse had not been informed about the incident detail at any stage. Had he been informed, his response to the requests for re-referral would have been different.
- The social worker assigned to MR was on annual leave when the incident of 4 March occurred. Although the safeguarding alert had been forwarded to him by his manager, it was not flagged with an 'alert flag' and got lost within the backlog of emails that were waiting in his inbox on his return from annual leave. No dedicated time is provided to review and screen these before recommencing with front-line duties.
 - There is no agreed communications system between the agencies, such as the 'SBAR' model advocated within healthcare organisations. Furthermore, there are significant obstacles to achieving this:
 - All agencies working within the geography of the county council borough would need to agree on a communication formulation, and possibly adopt this within their own agency community for it to be reliably utilised and understood.
 - Verbal communications using the agreed formulation would need to be followed up in writing. This is more likely to be facilitated by email. However, not all agencies are on a secure cross-agency email network.
 - It is not usual for senior carers within a care home to have a professional email account provided by their employer. They therefore would not be able to engage safely with an across-agency communications model without the engagement of all care home providers.
 - The dangers of 'e-communications' – this case highlights a recognised challenge posed by the digital age: the volume of emails falling into one's inbox.
 - At the time, there was a lack of opportunity for a care home to directly refer to specialist mental health services. At the time, a care home was required to refer via the resident's GP. The impetus for this was an expectation that a GP would visit a care home resident and make his/her own assessment before a referral to specialist services was made. In this case, the GP assessment did not occur.
 - At the time, there was no clear multi-agency escalation procedure for professional concern or disagreement
 - Although some information communicated by the care home to its partner agencies was received and understood, up to 30 May 2014 there was a variability in the expressed levels of concern about MR depending on which member of staff at the care home was communicated with and depending on the behaviour being exhibited by MR at the time. This was the experience of the older persons' community mental health nurse and also the social worker assigned to MR.

- A reasonable expectation is that visiting professionals utilise the care home records and read them to inform themselves about the resident they have come to see. Apart from the isolated incidents on 4 March and 30 May, the content of MR's records does not indicate that there was any cause for concern. Furthermore, the design of the records in MR's care home at that time was not the easiest to navigate, largely because of the volume of records a care home generates per resident.
- Although the care home correctly took protective actions following the incident of 4 March 2014 by moving MR to the EMI unit and by raising a safeguarding alert, there was no structured risk assessment process in place in the care home at the time which would have flagged a follow up with other partner agencies to reach an agreement as to the risk potential associated with the incident that occurred.
- There were also a collection of system related issues within the local authority that also meant that more detailed conversations about risk and Mr MRs placement did not occur. These issues were:
 - the way the risk threshold tool utilised was applied – at the time, this did not include a separate and distinct assessment of perpetrator risk, where safeguarding alerts identified resident-on-resident assaults in local authority-funded care providers
 - the information being overlooked by MR's social worker as already identified
 - the social worker for the female resident (4 March 2014) not identifying the risk
 - the incident not being screened as an adult protection referral, which would have provided more focus on the potential risks for both residents involved in the March 2014 incident.

7.0 RECOMMENDATIONS

The independent author has four recommendations.

Recommendation 1: This incident has highlighted a situation where vulnerable adult risk was assessed only in relation to the victim, and perpetrator risk was not considered. It is accepted that the safeguarding framework and guidance is victim focused; however, it is also noted that neither the framework nor the guidance was developed with 'vulnerable adult on vulnerable adult' incidents in mind.

Therefore, the local authority is encouraged to review the design of its risk threshold tool and the documentation tools it provides to its staff to record their risk considerations, so that the tools themselves support the documentation of a structured assessment of risk across all of the domains set out in the threshold tool, and the consideration of risk in relation to situations in which both perpetrator and victim are vulnerable adults.

To achieve this, the independent author suggests consideration of:

- The narrative space in the current risk threshold: this could be more structured. An enhanced structure could drive active consideration of perpetrator risk where the perpetrator is also in receipt of care and is him or herself a vulnerable adult.
- A risk assessment process that is designed to include specific questions. Examples are:
 - What harm was caused by this incident to the victim?
 - What were the circumstances of the incident in terms of:
 - location of incident and 'line of sight' for care home staff
 - how the incident was discovered (for example by chance, or because of planned activities)?

In addition:

The independent author recognises that the local authority has made considerable investment in risk management and risk assessment training for its staff. However, the independent author encourages the local authority to ensure that sufficient emphasis is placed on the basic elements of how to conduct a structured risk assessment (that is, considering what has happened in terms of outcome, what could happen if this recurred tomorrow and what is the reasonable likelihood of this happening again) alongside the complex range of issues professionals within social care and related agencies are required to consider.

Recommendation 2: This case highlights the importance of having a clear and structured risk assessment and management process within a care home environment. MR's care home had an incident reporting system in place, as well as a process for reviewing reported incidents. However, the assessment of risk potential and how this was to be reduced was not documented on Datix as part of this

process, and neither was there a requirement to do so. Registered care home managers recorded the outputs of any assessment and investigatory activities elsewhere. In this case, on review of the available documentation, the repetitive approach to documentation led to a lack of clarity about what was done.

Consequently, the care home provider needs to achieve a situation where:

- All reported incidents are assessed using a structured and recognised risk assessment process that is integral to the Datix reporting system.
- Where a serious incident investigation and 'standalone' report document is not required the care home provider needs to implement an approach whereby the outputs of any investigation work conducted is captured on its Datix system. This risk management database has the capability and capacity to deliver this.
- Where a registered care home manager is concerned about the risk behaviour of a resident, and there is an underlying diagnosis of dementia, it would be prudent for the registered care home manager to seek the input and advice of the mental health provider in scoping the risk associated with the behaviour. The nearby mental health provider is a specialist organisation and risk assessing behaviour is a core competency for its staff acting in a medical or care coordinator capacity.

An embedded risk assessment process could incorporate a simple range of questions, such as:

- What risk behaviour was demonstrated in this incident?
- What was the impact of this risk behaviour?
- If the same behaviour is demonstrated tomorrow (even in a different location or with a different resident), what is the risk of a worse outcome?
- If you think the outcome could have been worse, what realistically could have happened?
- What safeguards or actions need to be in place to minimise the risk of this occurring again?
- Can this be achieved within current resources?
- Having answered these questions, is your overall perspective of risk very low/low/medium/high/catastrophic (i.e. carries a risk of death)?

As part of the risk assessment process which the care home provider may develop, it will be important to ensure that appropriate professionals are involved at an early stage to ensure that any risk assessment is conducted with the requisite skill and technical knowledge and that there are agreed direct lines of communication with specialist services – in this case, specialist mental health services – so that concerns can be logged if escalation does not take place. Partner agencies will have to work with the care home provider to develop effective lines of communication.

Recommendation 3:

This case highlighted an unfortunate situation where recorded communications made by one agency (the care home) to partner agencies did not result in the detailed assessment of risk that was required. The partner agencies (the GP, and social care and specialist mental health services) have reported that on occasion they:

- did not review and/or receive the information provided,
- considered – as a result of inconsistencies in MR's behaviour, and thus a variation in the messages being communicated to the visiting community mental health nurse and social worker – that there was not a 'constant' concern about MR's behaviour, and consequently when information was obtained from the care home during a 'settled' period there were no undue concerns reported and/or
- did not retrieve some of the available information and/or
- misinterpreted the information.

There is no simple or single solution to the above. Furthermore, the features set out have been reported as a consequence of other independent review processes. Therefore, the health and social care community in Durham needs to consider how it can achieve a more robust approach and, possibly, a common framework for enhancing the effectiveness and reliability of cross-agency communications. There are communication models already utilised in the health and social care domains that already have similar principles – a situation which suggests that agreeing on one model ought not to be unachievable.

Because this recommendation represents a sizeable piece of work, spanning all agencies and care homes and not only those involved in this incident, the Safeguarding Adults Board supported by the Clinical Commissioning Group(s) within the locality are asked to jointly convene a multi-agency working party to explore possible communication models and if possible to set up a pilot scheme so that the preferred models can be tested for usability and acceptability. Furthermore, because this issue is of equal relevance to safeguarding children, it is recommended that the Safeguarding Children Board is invited to be actively involved in exploring and finding a way to improve the consistency and thus the reliability of cross-agency communications.

Recommendation 4: This case highlights a fairly common situation where one agency did not feel empowered to escalate the fact that it considered that it was not receiving a satisfactory response to requests for assistance with a resident's management.

To provide for the mitigation and minimisation of this situation in future, the Safeguarding Adults Board, Safeguarding Children Board and Clinical Commissioning Groups are asked to explore the concept of, and develop and implement, a Multi-Agency Professional Disagreement Escalation Policy. Such a policy must:

- operate across agency boundaries

- incorporate the need for clear local agency escalation policies that enable initial senior-management-to-senior-manager communications with the aim of local resolution
- provide for the independent adjudication of multi-agency case management disputes
- have a clear and understandable pathway
- have a well-designed document/email template
- be advertised and promoted across all agencies working with vulnerable adults and children.

Recommendation 5: This case identified a lack of knowledge about the facility within the local authority to fast track a request for adhoc additional funding for additional staffing cover where interventions such as one: one observation for a care home resident is required for a period of time to maintain a safe care and home environment for all residents.

Consequently the strategic manager for commissioning at the local authority is asked to explore at the first available care home managers forum how many care home managers are aware of the fast track process to secure a temporary uplift in a residents funding package following an incident that requires enhanced care or intensive observations to secure safe care and practice including 1:1 observations.

Appendix 1: MR's chronology from January 2014, two weeks prior to the first recorded instance that care home staff were struggling with MR's behaviour

This chronology is distilled from the aggregated information provided by all involved agencies. It is intended to give the interested reader a more complete picture of the sequencing of events in the six months preceding the fatal incident of 26 June 2014. The rationale for a distilled chronology is to provide the necessary information without an unnecessary increase in the density of this report.

Note: The community mental health nurses are mostly referred to as CPN in this chronology as this was the most prevalent descriptor used in MR's clinical, care home and local authority records

Date	What was happening	Context/detail
17/01/14	Home visit by the community mental health nurse subsequently referred to as CPN	<p>Care home record stated "CPN has visited today" and that MR had walked corridors and had a good diet and fluid intake.</p> <p>CPN record stated: "MR's wandering behaviour is continuing and other residents are increasingly frustrated. Care staff do not feel move to EMI section warranted but discuss medication to settle him. CPN discusses diversion and de-escalation techniques with the staff." CPN records acknowledged the problem caused by wandering into rooms, but indicated the main management issue was around his personal care. CPN recorded that staff maintained a reasonable standard of care by a mixture of assisting and prompting. He noted verbal aggression but no physical aggression.</p>
17/01/14	Home visit by CPN 1	Care home record also noted that CPN visited to check medication and do some memory testing, but no record of outcome.
20/01/14 to 21/01/14		Nothing of note in BC progress notes.
20/01/14	Discharged from CPN service	CPN felt no further intervention required.
22/01/14	Diagnostic discussion between consultant and CPN 1	Both cousins attended meeting with consultant and CPN. They would feed back diagnosis of dementia to family in Australia. They now wanted to withdraw from MR's care. The plan now was to discharge MR from the caseload.

Date	What was happening	Context/detail
27/01/14 to 02/02/14		<p>On 27 January: Found in others' rooms, but directed to his own room, and went.</p> <p>Record noted he had become reclusive about meals because he was ashamed that he could not afford to pay and therefore was taking his meals in his room.</p> <p>Hourly obs: Still being done, but no concerns.</p> <p>7.26pm: MR found in another's room, shouting and threatening her while she was asleep. MR removed. Obs continued.</p>
28/01/14		<p>Unsettled, in and out of others' rooms, causing "great stress". Had a verbal altercation with a female resident. While 'downstairs' – faeces incident.</p> <p>Was requiring regular reminders that other residents' rooms were not his.</p>
28/01/14	<p>CPN 1 asked to review MR</p> <p>Care home made initial contact with CPN according to its communication record</p>	<p>Staff struggling with MR's aggressive behaviour; he had on two occasions entered rooms and screamed at the residents. Also, he had smeared faeces in the toilet. The staff felt that the residential unit was no longer appropriate for MR and queried why he was not on medication. The CPN asked the care home staff to complete behaviour charts and to arrange a physical review and MSU to rule out delirium given this sudden change in behaviour. Note: MR was already identified as for discharge following last week's CPN visit and family meeting with his consultant.</p>
29/01/14	GP visit	<p>GP asked to complete a physical health check following on from CPN. GP records noted: "History: staff struggling with patient's aggressive behaviour."</p> <p>Following her examination, the GP asked the district nurse to check routine bloods and the care home staff to dipstick urine.</p>
29/01/14		<p>Home phoned Social Services Department, explained situation and asked for a social worker to be appointed. Told that a SW would contact when appointed.</p>

Date	What was happening	Context/detail
30/01/14		The care home record stated: "Spoke to MR's cousin about maybe bringing some alcohol in for MR as he has been asking quite a lot for some. Cousin quite happy to do this and for MR to have <u>one</u> drink before bed." Staff were to monitor closely. MR reported as telling staff that he had given up cigarettes and that he felt he was being stopped from having a drink; this made him feel frustrated and like a child.
31/01/14	Blood tests: district nurse	Blood tests had been requested by the GP.
31/01/14	Review: CPN 1	There had been no further aggressive incidents, although MR was still going into others' rooms and picking up things he believed were his own. The member of staff on duty believed he was manageable on the residential unit, although contact had been made with the review team regarding transfer to the EMI unit. Staff were advised that no medication would help divert MR from wandering. Staff were told to engage with him and divert him by other means. The incident with the faeces could just have been a loose stool, given his difficulties with personal care. Cousins had requested that MR was given a small amount of alcohol in the evening and staff would do this. He was using e-cigarettes. Plan to await bloods and liaise with social services.
01/02/14 to 02/02/14		No concerns noted; nothing different.
03/02/14	Blood test results entered into GP record	All results appeared to be "Normal, No Further Action".
03/02/14 to 09/02/14		Points of note: 1. Some agitation on 5 February. Context was around being asked to go for a shower, which he did, but "then he became very agitated, punching himself, and attempted to hit the picture on the wall". Staff tried calm-down techniques and aborted the shower.
10/02/14 to 16/02/14		15 February: "Fantastic duty today; laughing and joking with staff." 16 February: "Remains in high spirits."

Date	What was happening	Context/detail
13/02/14	SW spoke with the residential care home manager about MR	Care home manager is noted in the SW records to have agreed with the SW that MR was “in himself difficult to place, as if he were in EMI unit the people in there have no understanding of his behaviours, which are harmless, whereas where he is in general residential these residents have understanding of MR. We agreed to keep an open mind about this situation at this time.”
14/02/14	CPN 1 telephoned MR’s social worker	<p>Social worker had visited MR and reviewed the case with care home staff. SW had always found MR to be easy to divert and was reluctant to move him to EMI, where his behaviour would be the same and he could be at risk of assault from other residents who were more impaired. Care home staff reported problems managing MR’s behaviour of wandering into other residents’ rooms. The social worker felt this behaviour to be “a minor management problem”.</p> <p>Local authority record says: “CPN feels as I do that MR’s behaviours are only a management problem and not any bad behavioural problem that pose any threat. We discussed that a move to EMI seems unnecessary but [CPN] will assess this possibility this am.”</p>
14/02/14	Home visit: CPN 1	Issues continued to be wandering into others’ rooms and personal hygiene. MR now slept in his bed three nights a week on average; he slept in the lounge if staff were unable to persuade him to go to bed. He seemed relatively kempt. Two behavioural charts had been completed, both detailing minor altercations: shouting at a staff member giving him tea, and swearing at a resident who asked him to leave her room. The charts indicated staff had successfully de-escalated the situations. CPN advised on options to minimise disruption to residents: closed or locked doors, diversion by staff, a sensor pad on MR’s door. A new call system was being fitted.
15/02/14	MR discharged from MHSOP caseload. CPN (TEWVFT)	Care plan documentation completed and case closed.

Date	What was happening	Context/detail
17/02/14 to 23/02/14		<p>19 February: Agitated at midnight because “people were in his house. He pushed a chair over in the lounge area. Then he retired to his bedroom and settled down.”</p> <p>19 February at 4pm: MR agitated in shower – settled afterwards.</p>
24/02/14 to 02/03/14		<p>Noted to be light-headed on 24 February. Physical observations done, BP 151/100 P 82 T 36.5. Plan for community matron to review.</p> <p>2 March: Variability in MR’s mood noted between happy and annoyed. Staff contact was limited as agitated quite often. Staff did not consider he was in pain or discomfort, but there was an undercurrent of emotion.</p>
24/02/14	Home visit	<p>Staff concerned, as MR had had a “funny turn” that morning. Vague, light-headed, BP 151/100. On examination, MR said he felt well and had no symptoms particularly associated with transient ischaemic attacks. He’d had vasovagal episodes in the past.</p> <p>As written in chronology - ? this was another BP 116/69, pulse 88, o2 sats 95% Temp 36.8.</p> <p>GP noted not clear who had written letter to GP and letter not included in copies. However, details from the examination had been added to the record.</p>

Date	What was happening	Context/detail
04/03/14	MR found with his hands round the neck of a female resident.	The care home manager reported this incident to Durham County Council (DCC) safeguarding team on 06/03/14. See section 4 of this report for the detail of the 4 March 2014 incident.
05/03/14		Care home left message for the social worker to arrange meeting for MR to discuss the way it could manage him.
05/03/14		Care home spoke to a community mental health nurse to ask MR's community mental health nurse to ring back about arranging a meeting about how to manage MR's needs.
05/03/14		Care home rang MR's cousin to inform her of what had happened the previous night and also informed her that MR was going to move to the EMI unit.
06/03/14	Phone call received from SW team to the care home.	Key notes extracted from the care home record: Local authority: <ul style="list-style-type: none"> - acknowledged information report regarding incident on 4 March- was informed about steps taken to reduce recurrence - was informed of move to EMI unit and observations. - suggested that the care home provider should liaise with mental health (that is, the CPN). - was advised that MR had been discharged from mental health and that the care home had made numerous attempts to raise concerns about MR. Local authority advised to try again. "Passed to senior carer ... to action."

Date	What was happening	Context/detail
06/03/14	CPN input requested by: care home staff Social Care Direct	<p>The record stated: “[CPN] said he couldn’t do anything as MR had been discharged, so I have rung MR’s GP to do an emergency referral. Still waiting for GP to ring back. GP rang and he is going to do an emergency referral to the CPN straightaway.”</p> <p>The incident form stated: “He advises MR is no longer on his books as he has previously seen him and left a care plan. He advised we must send a new referral via the GP ... Social Care Direct contacted, she will notify case manager ... on holiday ... locality manager has contacted home and asked that the home refer MR to a CPN. Social Care Direct has decided not to invoke the incident as [it] is being appropriately managed by care home. MR is being moved to [the EMI unit] this afternoon, along with a member of staff who he is comfortable with ... no further episodes of aggressive behaviour.” (Observations continued over this period for MR.)</p> <p>Mental health records: These do not contain any record of this conversation.</p>
06/03/14	GP asked to write referral letter to mental health services by care home staff	Entry stated: “History: req CPN input. States unable unless another letter provided by GP. Vascular dementia, slapped another resident. SS has been involved to consider upgrading care. OK to put CPN in contact again. Will do letter.”
07/03/14	Referral to mental health by GP	Referral letter, marked ‘urgent’: “[MR] was diagnosed with vascular dementia and was discharged from your clinic last month. Unfortunately, there have been a few incidents in the home and they are in the process of trying to upgrade his care. However, in the meantime I wondered if there was anything you could do to help with regard to his behaviour.”

Date	What was happening	Context/detail
10/03/14	Letter to GP from consultant psychiatrist declining referral (received in surgery 12/03/14)	"The care home has been in contact to say this man is wandering into other residents' rooms, which annoys them, but there are no other difficulties. The discharge plan included a contingency plan of moving him to EMI residential care, which is done via Social Services. We would not be involved in this process, but if you have assessed him and have further information, please get back in touch."
10/03/14	MR walked out of the home	He was persuaded to stay by the home manager and another member of care staff. He was placed on an "observation chart".
10/03/14		Care home spoke with the consultant's secretary about request from GP. She said they had notification from the GP, and care home were waiting for arrangements.
10/03/14	MR's cousin made contact with MR's social worker	MR's cousin was asking if the SW could speak to the care home manager about MR and his move to EMI, a move the SW professed not to be aware of, even though his manager was informed on 6 March 2014.
12/03/14	Telephone conversation between SW and CPN 1	<p>CPN 1 stated that the "case had been reopened to CPN 2. CP explained that he had started some behavioural charts with staff at the care home and they had not proved any difficulty with MR; only two mentions of him wandering into other people's rooms, which staff had dealt with in a calm manner and did not think MR was a problem. CPN 1 had therefore discharged MR at the end of February 2014."</p> <p>Plan – CPN 1 to ask CPN 2 to call SW and update him.</p>

Date	What was happening	Context/detail
13/03/14	MR left the care home building	<p>“At lunchtime MR walked briskly out of the main entrance in full view of staff. He was accompanied by the manager and a care assistant. He walked down C. Street, turned right down [another]. He was displaying signs of stress ‘fight-or-flight’ mechanism. The home manager and the care assistant talked to him and distracted him with conversation about family that he knew and persuaded him to calmly return to where he had started to collect his wallet. He was put on an observation chart.”</p> <p>Context: At the time of this incident the residents of the EMI unit were being managed in the conservatory and the foyer while carpet fitters were in. It seems that MR became anxious/frightened and quickly went out of the door.</p>
18/03/14	MR left the building	MR went to the pub. The care home staff followed him to ensure his safety. They also went into the pub with him. The police had been called. However, MR returned to the care home with the care home staff.
18/03/14	Phoned CPN as requested	CPN assistance requested – the care home records show that they were informed that CPN 2 had not received request for referral. The care home manager was informed. This scenario was repeated on 27 March, also with the same information – no referral received.
18/03/14	CPN 2 and consultant psychiatrist	Care home rang CPN about input. CPN 2 advised that a referral from the GP had been requested and that the consultant psychiatrist had written back to the surgery to say she had seen MR and felt his needs were being met in the EMI unit. The CPN also said that if the care home felt it was necessary, it could phone and request support/intervention via the CPN nurses and they would try to advise.

Date	What was happening	Context/detail
18/03/14	SW spoke to senior carer and to CPN 1	<p>Purpose of call – to arrange a joint meeting with CPN 2 regarding MR because MR on EMI with no apparent authorisation.</p> <p>Note: CPN 2 was on annual leave at this time until 14/04/14.</p> <p>Note: At this stage SW noted that CPN 1 advised that MR had no allocated CPN, as the consultant psychiatrist had not accepted the referral and had written to the GP stating why not.</p> <p>Plan: SW asked for a copy of the GP letter and the consultant psychiatrist's letter, as it was his understanding that EMI was part of a contingency plan, and also he understood that CPN 2 had been allocated.</p>
24/03/14 to 27/03/14	Follow-up with mental health services	<p>24 March: CPN 1 advised that GP referral had been refused and that GP had been sent a letter.</p> <p>27 March: Care home phoned the CPN's office and spoke to a CPN assistant regarding a referral for MR. Advised to contact consultant psychiatrist. The care home noted in its records that it did this. The consultant's secretary was reported as saying she "has recorded our conversation regarding MR and she will present it to the team for their attention A.S.A.P" and that she would make the referral that day. The notes indicated that a CPN would contact the care home that day once the multidisciplinary team meeting was completed.</p>
31/03/14 (received in surgery 02/04/14)	Letter to GP declining request for assessment from consultant psychiatrist	<p>The letter highlighted that the behaviour charts were not being completed, raised concerns about access to alcohol given MR's past history and finally reported conflicting information from staff about how easily they were managing his difficulties. The letter, copied to the SW, ended: "I am unclear if there is a more difficult behavioural problem with this man or whether the home feels there are safeguarding or DOLS issues to raise. As he is currently closed to us, perhaps his GP and SW could discuss if he warrants a further assessment from the care home liaison team here or has moving him to EMI resolved the difficulties which were seen in the open residential unit? We will see him, if the reasons are outlined and the reports are more consistent."</p>

Date	What was happening	Context/detail
31/03/14	The Carers Centre asked the SW to make contact with them	<p>MR's relative had apparently raised a concern that they had no involvement in MR's move to EMI. SW noted that he had not been involved in the move as he had been on holiday, but that he had been in touch with MR's cousin about it and was putting in a panel application.</p> <p>MR's family requested a meeting between the care home manager and the SW so it could be explained to them why MR was in EMI.</p> <p>SW also informed by MR's family that MR's son would be visiting from Australia from 23 April.</p>
08/04/14	EMI bed funding	Funding for MR's EMI placement agreed and paperwork from panel received by SW.
09/04/14		Contact with MR's cousin regarding appointeeship and Deputy Order.
16/04/14	SW visited care home	The purpose of this visit was to monitor MR's welfare and placement. The record stated: "MR still happy and content and looking very well and very tidy. Now showering with better frequency and compliant."
14/05/14	Assessment of capacity forms returned to local authority by GP	The assessment forms which had originally been passed to Dr A had been passed to Dr O, who did not feel he knew MR well enough to complete them.

Date	What was happening	Context/detail
30/05/14	MR involved in another incident – recorded as a safeguarding adults alert only. SW 1 notified by email	<p>The alert stated: “Cleaner on duty hoovering past his bedroom and she heard a commotion. Cleaner saw MR in [another resident’s] room and she saw MR punching H in the face. Staff came and intervened, asked MR to leave the room, which he did straight away. [The resident] was sitting in the chair in her room. Staff noticed her set of drawers was open and [the resident] would not have been able to do this herself as she cannot walk independently. ... MR admitted hitting [the resident], but unable to say why. Staff stated there were no marks visible at the time. ... [At] 8.30am staff noticed a small cut to left side of her lip and redness to left cheek bone. At 9.50am staff have noticed bruise/swelling to outside/inside of lower lip.”</p> <p>The SW noted: “Due to the injuries above being noted, it would be beneficial to request GP to check over [the resident] and advise SCD if there are any more substantial injuries.</p> <p>Incident recorded as a safeguarding alert only at this time – isolated incident between 2 residents lacking capacity.”</p> <p>On the same day, SW [1] contacted the care home. The SW records stated: “I asked what they were doing to safeguard further from this incident and they have kept MR away from the victim ... family have been informed but are not taking the issue further; also GP has been informed. Outcome: Asked for advice from a social worker who stated safeguarding team will deal with incident. I have also asked the home to refer to CPN office to have MR assessed from MH Team.”</p>

Date	What was happening	Context/detail
30/05/14	GP requested to make a referral to mental health team following liaison with a senior carer	<p>MHT records: "Letter from GP indicates that MR had hit someone last week and there may be an increased need for urgent involvement."</p> <p>The care home records said: "Safeguarding informed. They advised to get GP for MT and they will take no further action. Social Worker informed of incident and is seeking advice, waiting for him to call back. At 14.00 Social Worker phoned and the only advice he could give me is to phone the GP to be referred back to the Mental Health Team as soon as possible for a CPN to be involved with MR.</p> <p>Observation chart recommenced. GP phoned and we spoke about the incident and he said that he was going to write to the Mental Health Team for a referral for him urgently."</p> <p>The GP's notes confirmed this: "Incident this am reported to safeguarding and his social worker required referral to the mental health team – safeguarding not taken further – assaulted resident this am – hit in face – temper frustration issues in past – has threatened to hit staff and residents in past – has h/o vasc dementia on EMI unit – no alcohol now in EMI 4/12."</p>
02/06/14	GP referral faxed to consultant psychiatrist	The GP referral was marked 'routine' but asked "for early review" and stated that the care home had "reported an incident to safeguarding which occurred on Friday 30th and MR's social worker has requested a Mental Health Team review as MR had assaulted a resident, actually hitting him in the face. MR has a long history of temper issues and frustration in the past. He has threatened to hit staff and residents in the past, but has not acted on these threats previously."
03/06/14	CPN 2 called the care home to assess urgency of referral	After discussion about the incident, CPN 2 agreed to visit on 6 June rather than on the same day, as there had been "no further worrying displays of aggression". The carer had also reported that "the other resident was likely to have verbalised quite strongly and staff would normally have been more observant in managing a potential difficulty with MR; they seem to be quite familiar with changes in his mood."

Date	What was happening	Context/detail
04/06/14	Entry by care home manager, following a discussion with the social worker	<p>"This is not an isolated incident. A request for a visit from the challenging behaviour team was made following an earlier incident. This still hasn't happened in spite of asking for support from GP and social worker to progress matters. GP has been asked to make an urgent referral for the second time. Care home manager spoke to SW on 3 June 2014 and asked him to progress this with Mental Health Services. MR commenced on 15-min observations. Staff already do a walk-around hand-over to ensure they remain on the floor during hand-over."</p>
06/06/14	CPN visit	<p>CPN conducted a comprehensive assessment, including a risk assessment: FACE. Risk assessment indicated that MR's behaviour posed risks in terms of physical harm to others (two recent incidents). It also identified that MR was intolerant of female residents and that staff (care home) had been concerned about the recent aggressive response and had alerted services. Mental health clustering tool allocated MR to cluster 20 (cognitive impairment or dementia complicated high need). MR was placed on Standard CPA. Summary of CPA: recent aggression to female resident, can be confrontational, sometimes will hold head and facial expressions indicate his tolerance is not good, intolerant of women's conversation and irritation. Documentation difficult to follow – new name as care coordinator, and as past assessments included, not easy to see what was current. The records included mention of MR hitting a staff member. The document Summary of Assessment and risk "referral sparked by an incident that included MR hitting a female resident – no other associated agitated or aggressive behaviour, although there is significant evidence of cognitive decline". CPN reviewed the care home's case notes and found no consistent or major changes to his presentation; care home staff, according to CPN's note, described MR as being "generally very amenable". Plan to discuss at MDT and, given detailed explanations of low/anxiety, discuss the possibility of anti-depressant medication.</p> <p>Note: The source of information that informed the community mental health nurse's assessment of MR and his reported 'intolerance' of women is not stated. Furthermore the Independent Author spoke with the registered care home manager at the time MR was</p>

		resident and she could not recall MR having an issue with women. This was not her experience nor that of her team. She recalled MR having a good relationship with his cousins who were women. She advised the Independent Author that MR was one of two men in the dementia unit (EMI) most were female. The three women with whom incidents occurred all had behavioural issues as MR did. Because none of the incidents were witnessed it is not possible to say whether or not some of their behaviours triggered MR's actions in relation to these incidents.
06/06/14	Appointment for OT assessment made. OT (TEWVFT)	P112 of CPN assessment noted: "OT reassessment to look at meaningful activity."
10/06/14	OT appointment rearranged	Appointment rearranged for Wednesday 2 July due to personal circumstances of OT.
24/06/14	Telephone contact between care home and the mental health trust Senior carer and CPN	Senior carer at care home wanted to know what plans had been put in place for MR. CPN confirmed that OT assessment would take place the following week. She also said she would give MR an appointment for a review with one of the medical staff the following week. Senior carer reported that MR was refusing all personal interventions. His behaviour seemed confined to this, apart from his irritation with the women on the unit. CPN made suggestions for managing personal care, which were: i) ask relatives about MR's previous self-care, ii) obtain background information on MR's habits, iii) try to engage MR in other activities, iv) not to confine personal contact to only when a shower is needed, v) consider a strip-wash, as MR being resistive towards having a shower was identified as a trigger.

Date	What was happening	Context/detail
24/06/14	An incident involving MR and a resident, FR	<p>A senior carer made a safeguarding referral on 26 June, after the event. The safeguarding alert said: FR was seen by staff “up in MR’s face, shouting about wanting a policeman. MR must have become agitated and staff saw FR stumble backwards and fall to the floor.” Staff did not have time to get to her before she fell, and they were unsure if MR had pushed her or she stumbled backwards, as they did not have a direct line of sight.</p> <p>The alert noted: “When asking the residents about the incident, MR said he knows he did it and FR said that ‘he pushed me’.”</p> <p>The alert also noted that FR was a little shocked but not injured. She was mobilising as usual and not complaining of pain. She had had a settled night.</p> <p>The alert form noted that: “The referrer advises that this is the second incident with MR as instigator, but not towards FR. He was now on 15-min obs when in the communal areas”, and he had an appointment with a psychiatrist the following week.</p> <p>The DCC worker noted that: “The home appears to have taken appropriate action and describes it as a low-risk physical incident between 2 residents with dementia.” It was recorded as a safeguarding adult alert and allocated workers were advised.</p>
25/06/14		<p>Home made statutory notification to CQC. “The alleged perpetrator is already being reviewed by Mental Health Services as he has previously abused residents on twice [sic]. He has an appointment with consultant psychiatrist next week and is already on 15-minute observations.”</p>

Date	What was happening	Context/detail
25/06/14	Telephone contact between DCC and care home provider, SW [1] and care home manager	<p>The SW recorded: "Only pushed a resident and no harm. MR knows he has done this and took himself off to his room. Outcome: FR is unharmed and only shocked – No issue to follow-up today. Dr G (MH to visit MR, I was informed by D)."</p> <p>There was also contact between the SW-SCD and SW [1] to advise of the safeguarding alert.</p> <p>A social work assistant was also noted to have contacted a senior carer at the care home to find out how FR was. No concerns noted and 15-minute observations continued.</p>
26/06/14	Incident between MR and FR	<p>The referral form said: "FR was said to be walking up the corridor and the MOS states that the next thing he knew there was a thump and FR was on the floor, having been hit on the back of the head by MR. FR is said to have injuries including a cut to the back of the head and the bleeding is said to be significant. At the time of the call ambulance crew were said to be at the scene and FR in the ambulance with the medics trying to stop the bleeding. ... MOS will provide update later today once it is known what plans can be put in place to manage risks from MR and once it is known how long FR will be in hospital. ... MR was arrested on suspicion of attempted murder and is in custody. ... FR's condition is critical and she is not expected to recover. ... There has also been an increase in night-time falls of other residents and this has been attributed to MR waking people up during the night. People who would normally sleep right through."</p> <p>This statement about increased falls has not been substantiated and was refuted by data held by the care home provider.</p>

Date	What was happening	Context/detail
30/06/14	<p>Strategy coordination meeting at the Mental Health Trust.</p> <p>Approved MH practitioner</p>	<p>Key points from record made:</p> <ul style="list-style-type: none"> - Lengthy discussion about the incident. - FR had a broken nose, bump to left eye, laceration to head which was consistent with frontal punch to face and then a fall. Post-mortem and forensic examination confirmed 'blunt force trauma' to FR's face. - Police family liaison officers were supporting the family of FR, and another individual was supporting MR's family. - Previous safeguarding alerts discussed, and noted one recent alarm from previous week involving FR and MR – however, unable to determine any real trigger or pattern to such incidents.

Appendix 2: Technical information relating to Deprivation of Liberty Safeguards

The Department of Health national archive says:

“The Mental Capacity Act Deprivation of Liberty Safeguards

The Mental Capacity Act Deprivation of Liberty safeguards (formerly known as the Bournemouth safeguards) were introduced into the Mental Capacity Act 2005 through the Mental Health Act 2007 (which received Royal Assent in July 2007).

The MCA DOL safeguards apply to anyone:

- aged 18 and over
- who suffers from a mental disorder or disability of the mind – such as dementia or a profound learning disability
- who lacks the capacity to give informed consent to the arrangements made for their care and/or treatment, and
- for whom deprivation of liberty (within the meaning of Article 5 of the ECHR) is considered after an independent assessment to be necessary in their best interests to protect them from harm.

The safeguards cover patients in hospitals, and people in care homes registered under the Care Standards Act 2000, whether placed under public or private arrangements.

The aim is to implement the safeguards in April 2009. The safeguards are designed to protect the interests of an extremely vulnerable group of service users and to:

- ensure people can be given the care they need in the least restrictive regimes
- prevent arbitrary decisions that deprive vulnerable people of their liberty
- provide safeguards for vulnerable people
- provide them with rights of challenge against unlawful detention
- avoid unnecessary bureaucracy.”

Article 5 of the Human Rights Act states that “everyone has the right to liberty and security of person. No one shall be deprived of his or her liberty [unless] in accordance with a procedure prescribed in law.” The Deprivation of Liberty Safeguards (DoLS) is the procedure prescribed in law when it is necessary to deprive of his/her liberty a resident or patient who lacks capacity to consent to his/her care and treatment in order to keep him/herself safe from harm (<http://www.scie.org.uk/publications/ataglance/ataglance43.asp>).
<http://www.hscic.gov.uk/dols>

Contemporary guidance about Deprivation of Liberty Safeguards and the forms that are required can be found at:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/437661/Final_DoLS_Guidance_2015.pdf

MR had essentially lost his ability to be self-determining about his life at the point he was offered/taken into respite care in September 2013. From that point onwards, it is important that the staff who engaged with him discharged their responsibilities in respect of MR's deprivation of liberty.

These occasions included:

- his initial admission to the care home
- a few occasions where he expressed the view that he did not wish to be at the care home and when he either attempted to leave or actually left the care home
- the introduction of timed observations for MR.

The Social Care Institute for Excellence website, in its guidance for professionals, says:

"If someone is subject to that level of supervision, and is not free to leave, then it is likely that they are being deprived of their liberty. But even with the 'acid test' it can be difficult to be clear when the use of restrictions and restraint in someone's support crosses the line to depriving a person of their liberty. Each case must be considered on its own merits, but in addition to the two 'acid test' questions, if the following features are present, it would make sense to consider a deprivation of liberty application:

- frequent use of sedation/medication to control behaviour;
- regular use of physical restraint to control behaviour;
- the person concerned objects verbally or physically to the restriction and/or restraint;
- objections from family and/or friends to the restriction or restraint;
- the person is confined to a particular part of the establishment in which they are being cared for;
- the placement is potentially unstable;
- possible challenge to the restriction and restraint being proposed to the Court of Protection or the Ombudsman, or a letter of complaint or a solicitor's letter;
- the person is already subject to a deprivation of liberty authorisation which is about to expire.

Restraint and restrictions

The Mental Capacity Act allows restrictions and restraint to be used in a person's support, but only if they are in the best interests of a person who lacks capacity to make the decision themselves. Restrictions and restraint must be proportionate to the harm the care giver is seeking to prevent, and can include:

- using locks or key pads which stop a person going out or into different areas of a building;
- the use of some medication, for example, to calm a person;
- close supervision in the home, or the use of isolation;

requiring a person to be supervised when out;
restricting contact with friends, family and acquaintances, including if they could cause the person harm;
physically stopping a person from doing something which could cause them harm;
removing items from a person which could cause them harm;
holding a person so that they can be given care, support or treatment;
bedrails, wheelchair straps, restraints in a vehicle, and splints;
the person having to stay somewhere against their wishes or the wishes of a family member;
repeatedly saying to a person that they will be restrained if they persist in a certain behaviour.

Such restrictions or restraint can take away a person's freedom and so deprive them of their liberty. They should be borne in mind when considering whether the support offered to a person is the least restrictive way of providing that support.

Care providers don't have to be experts about what is and is not a deprivation of liberty. They just need to know when a person might be deprived of their liberty and take action.

Final decisions about what amounts to a deprivation of liberty are made by courts."

A contemporary Mental Capacity Law Guidance Note¹⁸ entitled "Deprivation of Liberty after Cheshire West: key questions for social workers and medical practitioners" says of the 'acid test' that there are two questions that must be asked:

- Is the person subject to continuous supervision and control?
- Is the person free to leave (this is not about a person expressing a desire to leave, but on what those with control over the care arrangements would do if they sought to leave)?

For a person to be deprived of his/her liberty, he/she must be subject to both continuous supervision and control, and not be free to leave.

In all cases, the following are not relevant to the application of the test:

- the person's compliance or lack of objection
- the relative normality of the placement (whatever the comparison made)
- the reason or purpose behind a particular placement.

Readers of this report may wish to access this guidance note and the information on the Social Care Institute for Excellence website to formulate a more in-depth understanding of the complexities of Deprivation of Liberty Safeguards. The following CQC briefing may also be of interest:

http://www.cqc.org.uk/sites/default/files/20140416_supreme_court_judgment_on_deprivation_of_liberty_briefing_v2.pdf

¹⁸ http://www.39essex.com/docs/newsletters/deprivation_of_liberty_after_cheshire_west_-_a_guide_for_front-line_staff.pdf

Appendix 3: Severity of dementia as defined by the mental health clustering tool (MHCT)

“A Cluster is a global description of a group of people with similar characteristics as identified from a holistic assessment and rated using the MHCT.”

Patients are assigned to a cluster at the end of their initial assessment, at CPA or planned formal care reviews, and at any other time when there is a significant change in their planned care.

There are four organic clusters (18, 19, 20 and 21).

Care Cluster 18: Cognitive impairment (low need)

People who may be in the early stages of dementia, who have some memory problems, or other low-level cognitive impairment, but who are still managing to cope reasonably well. Underlying reversible physical causes have been ruled out. Some memory and other low-level impairment will be present. ADL function will be unimpaired, or only mildly impaired. There may be changes in ability to manage vocational and social roles.

Care Cluster 19: Cognitive impairment or dementia complicated (moderate need)

People who have problems with their memory and/or other aspects of cognitive functioning resulting in moderate problems looking after themselves and maintaining social relationships. Probable risk of self-neglect or harm to others and may be experiencing some anxiety or depression. Impairment of ADL and some difficulty with communication and in fulfilling social and family roles. May lack awareness of problems.

Care Cluster 20: Cognitive impairment or dementia complicated (high need)

People with dementia who are having significant problems in looking after themselves and whose behaviour may challenge their carers or services. They may have high levels of anxiety or depression, psychotic symptoms or significant problems such as aggression or agitation. They may not be aware of their problems. They are likely to be at high risk of self-neglect or harm to others, and there may be a significant risk of their care arrangements breaking down. Significant impairment of ADL function and/or communication. Significant impairment of role functioning. Unable to fulfil social and family roles.

Care Cluster 21: Cognitive impairment or dementia (high physical or engagement)

People with cognitive impairment or dementia who are having significant problems in looking after themselves, and whose physical condition is becoming increasingly frail. They may not be aware of their problems and there may be a significant risk of their care arrangements breaking down. Significant impairment of ADL function. Unable to fulfil self-care and social and family roles. Major impairment of role functioning.

Broadly speaking, these clusters map across to other severity ratings of dementia (for example, the Clinical Dementia Rating Scale and the Alzheimer's Society's early, middle and late stages):

Cluster 18 = mild dementia; Cluster 19 = moderate dementia; Cluster 20 and Cluster 21 = severe dementia