Surrey Safeguarding Adults Board

‘Mr J & Mr Y’

Serious Case Review

–

Executive Summary

January 2016

In order to preserve anonymity for the families and ensure the Serious Case Review’s purpose is maintained as one of learning lessons, the author has used fabricated initials to represent individuals and not used details about local services except where necessary or unavoidable.

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About this Review

This Serious Case Review (SCR) concerns an incident in a nursing home (referred to as XX) when a man with dementia (referred to as Mr J), assaulted another resident (referred to as Mr Y). Mr Y was taken to hospital where he died 3 days later.

The Review was commissioned by Surrey Safeguarding Adults Board (SSAB) under the terms of the SSAB SCR Protocol[1]. At the time of this Review, there was no mandatory requirement to undertake Reviews and this Protocol is a locally agreed process.
There are three purposes set out in the Protocol that an SCR should fulfil, namely:

- To establish whether there are lessons to be learned from the circumstances of the case about the way in which local professionals and agencies work together to safeguard adults at risk.

- To establish what those lessons are, how they will be acted upon and what is expected to change as a result.

- To improve inter-agency working and better safeguarding of adults at risk including the review of procedures where there may have been failures.

There is further information about the SSAB SCR Protocol and process at Appendix B.
This Review concerns events that took place before the Care Act 2014 came into effect therefore, where appropriate, this Review references the Department of Health publication 'No Secrets'.[2]

Family members of both Mr J and Mr Y have contributed to the Review and understandably seek assurances that lessons will be learned. They are thanked for their contribution and support of this Review.

[1] Surrey Safeguarding Adults Board Procedure for undertaking Serious Case Reviews on adult safeguarding cases (July 2013)

[2] 'No Secrets: guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse'

Background and Chronology

Mr Y was a man in his 90s who had been diagnosed with Alzheimers Disease in 2009. In April 2012 his condition had become more advanced and he moved to XX Care Home. XX is a care home with nursing that specifically looks after people who have a mental illness, including dementia (or Alzheimers) many of their residents are older people who have dementia.

By June 2013 Mr Y had become increasingly frail and he was being 'nursed in bed' ie. personal care was being given to him whilst he was in his bed. This was not unusual in this care home where some of the residents would be in the later stages of dementia.

On 24 November 2013 Mr Y was assaulted whilst he was in his bed at the care home. He was taken that day to hospital where he died on 27 November 2013. The person suspected of the assault is another resident at the care home - Mr J.

Mr J was a man in his 70s. In March 2013 (before he moved to XX) it had been reported he was experiencing memory problems. He attended the Memory Assessment Service where he was described as a 'cheerful, light hearted gentleman and cooperative if lacking insight'.

In May of that year, Mr J saw the consultant psychiatrist at the Memory Assessment Service. Mr J was diagnosed with early onset dementia. The psychiatrist said of Mr J: 'There was no evidence of any mood disorder, no psychotic features. His insight into his cognitive and functional abilities appears to be limited'.

At the beginning of July, his medical notes indicate he was showing signs of confusion but no sign of aggression and he was prescribed Memantine to slow the progress of his Alzheimers disease. His partner, who was also his carer, reported that she had been finding his behaviour at home to be challenging and demanding. In particular, she said he had become increasingly sexually demanding. Medical professionals attributed Mr J's increased libido to medication he had been taking. His partner stated that at times he had been intimidating but that he had not physically assaulted her.

Mr J's partner reported one incident of physical aggression. She said that on the weekend 11th to 12th July 2013 Mr J had got very angry because he believed she was having an affair with another man. During this angry episode, he had hit the bed with his walking stick and said that he was killing the man. His partner said Mr

J did not hit her but she did feel intimidated by him. She reported this to a member of staff at Sussex Partnership NHS Foundation Trust during a routine call from them a few days later. Mr J continued to live at home.

On 14 August 2013 Mr J attended the day centre that he had been going to regularly for some time. When his partner came to collect him, he became angry, he is reported as being verbally abusive to his partner and that he threatened to hit the day centre staff with his walking stick. The police and ambulance were called. It was noted he had a raised temperature and may be unwell. He was taken to hospital where he was diagnosed with a respiratory tract infection. During his stay in hospital it was noted he was 'confused but pleasantly so'.

On 15 August Mr J's hospital notes indicate there had been an occasion when he was verbally aggressive towards staff. This had been managed by nursing staff providing him with reassurance and he then settled. He was still at the hospital when on 16 August Mr J's partner told a member of staff she felt unable to manage Mr J at home and she wished for him to be discharged from the hospital to a care home.

Mr J stayed at the hospital whilst a suitable Care Home was identified by his family. The medical notes indicate there are some occasions when he was verbally abuse to staff, however, when given reassurance, he becomes calm.

On 26 September a Mental Capacity assessment was undertaken in relation to financial affairs and the consultant assessed Mr J as having capacity in relation financial matters.

Mr J's family identified XX Care Home as being suitable and contact with the Care Home was made by West Sussex ASC.

On 27 October the manager from XX Care Home visited the ward to assess Mr J in relation to his suitability to live at the care home. The manager was given access to all the medical notes and nursing documentation. Mr J was accepted as suitable for XX Care Home.

On 30 October Mr J was taken by hospital transport to XX. The following documentation/items were sent with him: Discharge Summary, Transfer of Care form, medications. It is noted that on admission to XX, Mr J displayed 'some minimal verbal abuse towards staff'.

There is a record that whilst at XX, on one occasion Mr J grabbed the wrist of a member of staff who was attempting to give him personal care. As a result of this, the care home manager reassessed the way personal care was given to Mr J and increased the number of care workers so there would always be 2 people giving him personal care. There is no record of him exhibiting verbal or physical aggression towards the other residents. There is no record of any interaction or animosity occurring between Mr J and Mr Y.

On 24 November both Mr Y and Mr J were in their respective rooms at the 6.55 am 'room check'. Mr J apparently left his room a few minutes later. He walked down the corridor passed the lounge where there was a member of staff on duty. He was not observed by the member of staff. As Mr J walked down the corridor, Mr Y's bedroom door would be the first open door he came to. He entered the room, closing the door behind him. It is believed he then assaulted Mr Y who was lying in his bed. From the injuries sustained by Mr Y, it is clear that he had been repeatedly hit in the face.

Within a few minutes, a member of staff walked into Mr Y's room and saw Mr J sitting by Mr Y's bedside. Mr J had blood on his hands and the injuries to Mr Y were obvious. Whilst help was given to Mr Y, Mr J walked with the member of staff back to his own room. Ambulance services and the police were called. The call to the ambulance service was received at 7.19 am therefore less than 25 minutes since Mr Y and Mr J had been seen in their respective rooms.

Mr Y was taken to hospital where he died on 27 November.

A full mental health assessment was conducted on Mr J that day. This resulted in him being detained under Section 2 of the Mental Health Act. He was taken by ambulance to hospital. Further mental health assessments have since taken place. Mr J remains detained under the Mental Health Act in a secure setting therefore no criminal proceedings have taken place.

Risk assessment and management

At the heart of this Review is the issue of risk assessment, in particular, was the assault on Mr Y foreseeable and / or preventable. The purpose of risk assessment is to identify factors that could lead to harm to the individual or to others. Practitioners accept that adults have the right to make choices about their lifestyle and wellbeing that involves taking risks but in mental health services there are also situations in which a person presents a significant risk to themselves, other patients and/or members of the public that should never be minimised or left to chance. A formalised system of risk assessments exists to ensure that system-

wide precautions are always in place. A person with mental health problems has a right to care and treatment in the least restrictive environment that is compatible with avoiding these very serious events.

There were particular occasions when a change in circumstances relating to Mr J provided an opportunity for professionals to consider what risks he may pose to himself or to others. These are set out below.

Hospital admission and discharge

The SCR Panel considered the hospital discharge process and agreed that it was carried forward appropriately. A proper discharge summary was produced by the ward staff and shared with the care home. The care home manager visited Mr J on the ward on the day after she received the referral and conducted her own assessment with full access to the medical notes. Mr J went to live at the care home on the following day.

The Care Home

Mr J's placement at the care home was chosen by Mr J's family and organised by West Sussex ASC. While he was on the ward there had been liaison between the Sussex Partnership Foundation Trust's (SPFT) Memory Assessment Service (MAS) and the ward staff and psychiatric liaison service at the hospital. As his needs became more complex, he was referred to the Dementia Crisis Service within SPFT who were standing by to assist but were not involved in the with the discharge arrangements.

Mr Y was a longer-term resident of the home and was being nursed in bed by this stage of his illness. His room was familiar to him and he liked to have his door open. This was not an unusual arrangement. Doors at the care home were normally left open and locks were not placed on resident's doors unless the resident specifically asked for one.

How foreseeable or preventable was the assault

There had been no previous interactions between Mr J and Mr Y that would indicate any animosity between the two men.

Mr J had not shown any aggression towards other residents at the care home.

There were no staff shortages on the morning of the incident and the staff were appropriately recruited and trained.

Whilst Mr J had on occasions engaged in challenging behaviour, typical of many dementia sufferers, this was largely limited to verbal aggression. The SCR Panel identified 3 occasions when he demonstrated physical aggression, namely, when he thought his partner was having an affair, when he threatened to hit staff at the day centre with his walking in stick and on a subsequent occasion grabbing the hand of a care worker at the care home. These occurred several weeks apart and it is important to put these in context to identify if they could have signalled to professionals that he was at risk of committing the assault that he did on Mr Y.

There is always a risk when completing SCRs that the Panel will apply 'hindsight bias'. The Munro Review of Child Protection[3] says this about hindsight bias: 'It is important to be aware how much hindsight distorts our judgment about the predictability of an adverse outcome. Once we know that the outcome was tragic, we look backwards from it and it seems clear which assessments or actions were critical in leading to that outcome. It is then easy to say in amazement 'how could they not have seen x?' or 'how could they not have realised that x would lead to y?' Even when we know the evidence on the hindsight bias, it is difficult to shift it; we still look back and over-estimate how visible the signs of danger were'.

The SCR Panel carefully considered the examples of physical aggression, balanced it against the hindsight bias that is an integral part of the Review process and came to the conclusion these could not have signalled he has going to commit the assault he did on Mr Y.

The SCR Panel concluded that this was not an event that could have been predicted or prevented.

There was a lot of information known about Mr J, however, this was spread across several different services. Whilst there was evidence of good practice, for example, sharing medical information with the care home manager, there were also some gaps, for example, in some of the information on the domestic circumstances of Mr J. Whilst it had no bearing on this case, the SCR Panel has made recommendations about ensuring that all information held by health and mental health agencies should be brought together in social care assessments, especially when placements are being made across geographical and administrative boundaries.

The Panel considered that XX was working well within the expectations that responsible bodies have about how residential or nursing homes should conduct themselves. They considered whether the introduction of electronic alarms or

[3] The Munro Review of Child Protection: Final Report A child-centred system Professor Eileen Munro, May 2011, Paragraph 1.14

physical barriers in resident's rooms should be installed to prevent entry by other residents. It was agreed whilst these are useful tools, but there are downsides to their introduction. Therefore, the panel's recommendation is for them to be considered in a personalized way to keep people safe and only introduced when in a person's best interests have been weighed up and when their use is considered the least restrictive way of assuring their safety.

XX was a home that operated with proper policies and guidelines. These are seen by all staff and signed to demonstrate that all staff are aware of proper standards within the service. Care planning was of an appropriate standard in the home and care plans were reviewed regularly. Risk management plans were also in place. An *Accident and Untoward Incident procedure* was in place and regularly reviewed. There was a *Safeguarding Vulnerable Adults Policy* in operation at the home. A policy on *Risk Assessment for Clients who are Nursed in Bed* was introduced after the incident. This will help to assess risks in the future.

In addition to this serious case review individual agencies have conducted their own internal reviews of the issues raised by this case. A serious incident (SI) Level 2 review was conducted by Sussex Partnership NHS Foundation Trust who had a duty of care to Mr J. All agencies are committed to learning from the case and to strengthening practice around assessment and discharge planning arrangements.

The Panel also made recommendations about strengthening the guidance on certain aspects of Surrey's Safeguarding Adults Multi Agency Procedures in relation to safeguarding cases in relation to the following three issues:

- ⇒ How to manage the issues that arise if a perpetrator does not have capacity and/or seems likely to be deemed by the CPS as *not* having criminal responsibility
- ⇒ The role of family members and service providers in safeguarding meetings and case conferences
- ⇒ The relationship between the on-going investigation and a serious case review into the circumstances of a level 4 case.

The guidance should also be expanded to provide more information about what to do when,-

- ⇒ two separate strategy meetings are required to address the needs of both a victim and perpetrator who are adults-at-risk
- ⇒ a safeguarding intervention is being carried out in which they have a duty of care to a perpetrator who lacks capacity when the responsibility for decision making has not been assumed by mental health or criminal justice agencies
- ⇒ they seek to Involve family members without compromising the confidentiality of individuals or agencies,- for example there are good reasons why in a case like this the victim's family should be appraised of the

decisions regarding a possible prosecution but other personal information,- the perpetrator's history, their current placement and so forth that might have a bearing on whether their anonymity can be maintained might need to be withheld.

⇒ they need to put limits around the role of service providers in safeguarding meeting when the service provider's practice comes under scrutiny as part of the safeguarding enquiry.

Analysing factors that contributed to this event

A root cause analysis was carried out to identify factors which may have contributed indirectly to this incident -

Factors that may have made Mr Y more vulnerable

⇒ Mr Y's safety from other residents was not assessed at the point where he began to be nursed in bed and it represented one opportunity to put additional safeguards in place.

⇒ There was no barrier, - physical, virtual or by staff sightline, between the main corridor and Mr Y's room
Factors that may have predicted the assault by Mr J

⇒ Information from Mr J's carer relating to his behaviour at home had not been fully incorporated into the risk assessments that informed his placement

⇒ The risk assessment that was completed when Mr J moved into XX focused on risks to him, not risks that he might pose to others

⇒ The incident when Mr J grabbed the wrist of the person giving him care triggered changes to the way personal care was delivered to him at the care home but this heightened concern about staff safety did not raise concerns about the risks that Mr J's behaviour might present to other residents.

Findings

The SCR Panel did not feel that the care home, or other agencies, had acted outside the boundaries of agreed practice in the way they assessed and responded to the needs of Mr J or in the way that they managed his care. The Panel have concluded that although a more accurate picture of risk could have been collated from the services that knew Mr J, the incident that led to the death of Mr Y could not reasonably have been foreseen and was therefore not preventable.

➢ Notwithstanding this, the Panel would like services to review the way they protect people being nursed in bed from those who are more ambulant and/or potentially challenging.

These are the headline issues relating to this case. A full list of recommendations is listed below, and these will be translated into an action plan by each of the partner agencies involved in safeguarding adults in Surrey. SSAB will take an overview of the implementation of our recommendations and we ask them to note the concerns voiced through this report both for the safety of adults-at-risk and for the protection of those who are at risk of committing violent offences as a result of psychiatric illness and/or dementia.

Recommendations

The SCR Panel had before them a great deal of information about the way agencies and individuals worked together before and following the assault. Whilst the core purpose of this Review was to consider the circumstances leading up to the assault, whether it was preventable and to identify how agencies could work better together in the future, there was information about what happened after the assault that the Panel felt should not be excluded from their recommendations. Individual agencies also had the opportunity to identify recommendations from their own Internal Management Reviews. Therefore, this list of recommendations contains some that are core to the purpose of the Review and some that are subsidiary to the main purpose. The recommendations have been annotated accordingly.

These recommendations represent learning from the SCR Panel's work. They are intended to guide agencies to improved ways of working. They are not criticisms of the way particular agencies worked.

The SSAB is asked to monitor the implementation of these additional safeguards and to remain responsible until they are confident that the changes identified have been embedded into practice.

No	Recommendation	Agencies responsible
1	When conducting risk assessments in residential and nursing care, staff should identify concerns about risk to others as well as risk to the person him or herself.	Residential and nursing home staff Mental health teams
2	The SCR Panel make the following subsidiary recommendation: When police are called to manage a serious and/or violent incident within a residential or	Police Multi Agency Safeguarding Hub

	nursing home they should, at the earliest safe opportunity, clarify with residential and nursing home staff how they intend to manage the situation and allocate roles and responsibilities accordingly.	
3	When working with a person who is suspected of having committed an offence but who also has mental health problems, all operational staff should know how to access mental health assessments and should have clear routes for referral and escalation of requests for urgent psychiatric evaluation, including during out of hours. CCG and provider agencies should ensure that sufficient services are available to meet needs including out of hours.	Community Mental Health Teams (CMHT) Out of hours Emergency Duty Team (CMHT) All providers of health and social care Clinical Commissioning Group
4	When a person being nursed in bed is frail and/or immobile, consideration should be given to housing them in a different part of building to ambulant and more active residents and/or to using a barrier, such as a stair gate or pressure mat to ensure that their room remains a safe space: any restrictions should be instituted on a personalised basis and, where they constitute a deprivation of liberty, authorized through formal channels.	Residential and nursing home staff District Nurses/ Primary Care Teams Occupational Therapists Physiotherapists
5	Given that residential and nursing homes admit patients from hospital and draw up initial care plans on the basis of discharge summaries, a complete history, including any previous episodes of threatening behaviour or violence, (including domestic abuse), must be placed at the core of the discharge planning process: this requires the agency responsible for discharge to ensure that they have consulted all records and collated information held by all the agencies who have managed this person's mental health in recent years including those outside their usual geographical boundaries.	ASC Acute hospital discharge teams (TOCT) Ward staff in acute hospitals Psychiatric Liaison Service in acute wards CMHTS and CMHT OP's Health and ASC teams across Surrey and Sussex who work with people with dementia

6.	The SCR Panel make the following subsidiary recommendation: All residential and nursing homes, especially those that are owned and managed by the same person or by a group of family members, should have robust deputising arrangements in place.	All Residential and nursing homes CQC
7.	The SCR Panel make the following subsidiary recommendation: Ward staff should ensure that any information relayed to them from community teams or other providers that might be salient to discharge planning is properly recorded and appropriately shared in order to inform the risk planning and management carried out by those who take on, or resume, responsibility for the person's care.	Nursing staff on acute wards especially those for older people
8.	The SCR Panel make the following subsidiary recommendation: When investigating serious incidents that have taken place in residential or nursing home settings, police should consider whether criminal offences have been committed by agencies as well as by individuals, for example they should collect evidence to inform decisions about health and safety practices in the home and investigate whether there are any grounds for considering charges of corporate negligence or corporate manslaughter as defined in the Corporate Manslaughter and Corporate Homicide Act 2007 that came into effect in the UK on 6 April 2008. This is in addition to, and not instead of, considering whether neglect by individual staff as defined within the Mental Capacity Act 2005 section 44 has been a feature of the case.	Police All ASC staff who are involved in safeguarding enquiries

9	West Sussex ASC should take steps to strengthen the links between their social work service and the local teams and services working with people with dementia.	West Sussex ASC Mental Health Teams in West Sussex
10.	The SCR Panel make the following subsidiary recommendation: Surrey Police, in association with ACPO and the Crown Prosecution Service should develop a protocol about how far Family Liaison Officers should disclose information to relatives in cases where the perpetrator of a crime that has affected them is someone who lacks mental capacity and/or who is likely to be assessed as unfit to stand trial	Surrey Police Multi Agency Safeguarding Hub
11	Where a serious safeguarding incident involves both a victim and a potential perpetrator who are both adults-at-risk, their issues should be addressed through separate strategy meetings and case conferences to reflect the best interests of both parties; this will also allow the meeting to manage issues of confidentiality and to share information appropriately on a need-to-know basis.	ASC especially those responsible for safeguarding enquiries
12.	Surrey's guidance on how to manage senior strategy meetings should be updated to include issues of mental capacity; data protection, involving family members without compromising confidentiality and managing the boundary between the safeguarding investigation and any subsequent reviews.	Surrey ASC SSAB

Appendix A - Glossary of terms and acronyms

ASC	Adult Social Care
CMHT	Community Mental Health Team
CPA	Care Programme Approach
CQC	Care Quality Commission
DoLS	Deprivation of Liberties Safeguards - arrangements that are formally approved under the 2005 MCA
EDT	Emergency Duty Team
IMR	Internal Management Review
MAS	Memory Assessment Service - Sussex Partnership Foundation Trust service
MCA	Mental Capacity Act 2005
MHA	Mental Health Act 1983(amended 2007)
SABP	Surrey and Borders Partnership Foundation NHS Trust
SAR	Safeguarding Adults Review (new term for SCR set out in Guidance to the Care Act 2014
SCIE	Social Care Institute for Excellence
SCR	Serious Case Review
SI	Serious incident, terminology used within the NHS to trigger a formal inquiry
SPFT	Sussex Partnership Foundation Trust
SSAB	Surrey Safeguarding Adults Board
WSCC	West Sussex County Council
WSSAB	West Sussex Safeguarding Adults Board

Appendix B - Serious Case Review Process

At the time this SCR was initiated, there was no mandatory requirement for Safeguarding Adults Boards to be in place or for Serious Case Reviews to be undertaken in respect of adults who have been harmed by abuse or neglect. However, in Surrey, agencies have voluntarily come together for a number of years to safeguard adults and undertake SCRs. A SCR protocol was agreed by agencies and this SCR was completed using the process set out in that protocol.

The purpose of a SCR is set out in the Protocol as:

- To establish whether there are lessons to be learned from the circumstances of the case about the way in which local professionals and agencies work together to safeguard adults at risk.
- To establish what those lessons are, how they will be acted upon and what is expected to change as a result.
- To improve inter-agency working and better safeguarding of adults at risk including the review of procedures where there may have been failures.

SSAB set up a panel of senior managers to undertake this SCR. It was a requirement that the managers had had no involvement in the case prior to being on the panel. The following agencies were on the panel either as Panel members or to provide support to the process:

Surrey Police
Surrey County Council (Adult Safeguarding lead)
Surrey County Council (Legal)
Surrey County Council (ASC Assistant Director)
Surrey Downs Clinical Commissioning Group
Care Quality Commission, Inspection Manager
Sussex Partnership Trust
Surrey and Borders Partnership NHS Foundation Trust
West Sussex County Council (ASC Operations Manager)
Care Home Proprietor (this panel member had no involvement with the Care Home XX and attended to provide other panel members with expertise on issues relating to the running of care homes)

The SCR Panel was chaired by the representative from Surrey Police

SSAB appointed an author to write the initial report. The author, Professor Hilary Brown, is an experienced author of Serious Case Reviews and has substantial experience of health and social care services.

The SCR Panel commissioned Internal Management Reviews (IMRs) from a number of agencies. The agencies were given detailed Terms of Reference for what their IMRs must cover. The authors of those IMRs were then required to attend a meeting with the SCR Panel to discuss and answer questions on their IMR. The SCR Panel used those same Terms of Reference for the SCR.

An initial report was prepared by Professor Hilary Brown and presented to SSAB. SSAB would like to thank Professor Brown for her detailed work which has been taken forward and developed into this Executive Summary.