SAFEGUARDING ADULT REVIEW

An Executive Summary

PERSON 1

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1 Overview of the review process

1.1. Why the Review Took Place

This is an executive summary of the Safeguarding Adult Review (SAR) that considered the circumstances surrounding an incident on 11th June 2016 when a 92-year-old woman with 'end stage' dementia was reported to police as being subject to a violent physical assault in her room at a residential care home, whilst in bed and unable to mobilise. For the purposes of protecting her anonymity (and in agreement with her family) the SAR refers to her as P1. Police reports documented that P1 was assaulted by a male resident aged 94, who had dementia and a recorded history of violence and aggression towards residents and staff, at the care home. He will be referred to as P2.

The residential care home is regulated by the Care Quality Commission (CQC) to provide care and accommodation for a large number of residents, some of whom have dementia. There are two units: one for residential purposes (Res) and the other is for residents with Dementia (DU), who require a higher level of support. At the time of the incident, the published CQC Inspection (October 2013) found that overall, CQC standards were met.[1] On the 11th June 2016, the care home recorded there were 27 residents in the Dementia Unit.

P1's family understand that there was a planned party on the afternoon of the 11th June, in the communal area of the DU. At approximately15:20hrs, the care home's IMR advised that a member of staff noticed P2 in the communal area, near P1's room. When asked if he was lost, he replied "I killed her. I put her out of her misery. I will get the rest now". Staff checked on P1 and saw she had sustained injuries and was bleeding, and after alerting a senior member of staff, P2 was escorted to his room with supervision. First Aid was administered to P1 who had many cuts/lacerations, bleeding, bruising and swelling to chest, arms, legs and hands, was very pale, distressed, shaking and visibly in pain.

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

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

It is important to reflect on these injuries, given that they were sustained by nearly 93-year-old, frail woman, in receipt of palliative care, who was unable to provide an account of the incident or tell others how she felt. The family stated after the assault, that their Mother was **'quietly moaning in pain and her face was troubled and anguished'.**

[1] https://www.cqc.org.uk/what-we-do/how-we-do-our-job/fundamental-standards

There can be little doubt about the trauma that both P1 and her family experienced, given they feared, that their Mother may die as a result of these injuries.

At the hospital, P1 treated, and injuries were found not to be as serious as first thought by emergency services and was discharged in the early hours next morning. P2 was admitted for mental health assessment.

ASC had been alerted and the safeguarding process was initiated, and a Section 42 Enquiry was carried (Care Act 2014). The outcome was shared with P1's family, which was subsequently identified as containing inaccuracies and a second Section 42 (s42) enquiry was instructed, but to be completed, by the care home. This started on 1st December 2016 and completed on 11th June 2017. ASC Safeguarding Leads met with P1's family in May 2017, where the family advised that the second report did not, in their opinion: a) meet the statutory requirements of the Care Act 2014, b) fully reflect their views and c) answer their questions and concerns about the incident or surrounding circumstances. ASC agreed to undertake a third S42 Enquiry, which concluded on 6th July 2017.

A referral was made to the Surrey Safeguarding Adults Board (SSAB) for a SAR to be considered, as condition 2 (s44 Care Act 2014) had been met, which was agreed by the SSAB on 11th December, noting similarities between this and a previous Review re: Mr J and Mr Y.[2]

P1 sadly passed away in November 2016 and the cause of death was not recorded as being connected to the incident.

1.2. Terms of Reference

This set the scope of the SAR, to focus on the circumstances surrounding the assault to P1; to consider professional engagement and intervention, and to consider her family's views.

An independent SAR Chair, Deborah Stuart-Angus, was appointed to oversee progress, derive a methodology and drive outcomes for the family and SSAB. Specific issues considered were:

Risk Management

- risk management and quality assurance (including resourcing, supervision and training) in relation to potential violence and aggression in the care home and impact on residents receiving end of life health care in isolated circumstances
- the impact of the outcomes of the above on P1 and P2 and in relation to multi-agency partners, family and visitors
- if knowledge of P1 and P2 assisted organisational and partnership responsibilities to contribute to assessing risk when providing health and social care, and in the delivery of statutory safeguarding responsibilities, and if safeguarding was made personal

Post Incident

- How did post incident response contribute to the effectiveness of risk management for P1, P2 and other residents?
- How were P1's former wishes represented, and her views advocated, particularly given that she had been subject to an approved Deprivation of Liberty Safeguards (DoLS) application?

[2] https://www.surreysab.org.uk/safeguarding-adults-reviews/

- How were P1's family enabled to contribute to their Mother's risk and social needs assessment, and enabled to understand the ramifications of the Mental Capacity Act and the DoLS Amendment?
- Did any monitoring and review requirements from the regulator (CQC) and service commissioners, Continuing Health Care (CHC) and from ASC contribute to effective safeguarding?
- How did the S42 Safeguarding Enquiry enable understanding of key issues?

Information Sharing

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

Previous Safeguarding Adult Reviews

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

1.3. Other investigations, parallel process and linked safeguarding adult reviews

In January 2016, SSAB published a Review re: 'Mr J and Mr Y' where a person in a care home was assaulted by another resident, and recommendations were made. This raised questions on how well local care homes, and those commissioning or regulating services, had applied lessons learned, and how well SSAB was assured that lessons had embedded change. ASC held several s42 Enquiries, which were repeated and took a long time to conclude. The SAR reflected on why this was the case and noted that ASC had already put remedial actions into place. Police held an initial criminal investigation regarding the incident, and this and other contributing factors, were reviewed. No further police criminal action was taken. During the SAR process, CQC also decided to undertake an investigation resulting in the initiating of criminal proceedings against the care home (Regulation 12)[3]. The care home subsequently pleaded guilty to two charges; firstly, failing to provide safe care and treatment, resulting in avoidable harm to P1 while she was resident at the care home. The care home also pleaded guilty to failing to provide safe care and treatment exposing other people living in the service, to significant risk of avoidable harm.

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

1.4. Individual Management Reviews

The SAR Panel received IMR reports from the following agencies:

Agency	Nature of involvement
Adult Social Care (ASC)	Safeguarding responses to incidents involving P1 and P2 and oversaw S42 enquiry processes
The Care Home	Residential Care for P1 and P2
CCG 1 and CCG 2	Commissioners for P1.CCG 1 was host for safeguarding and CHC services
Continuing Health Care (CHC)	Latterly provided P1 with CHC funding

[3] Health and Social Care Act 2008

Agency	Nature of involvement
Hospital 1	Accident and emergency response to P1 and P2
Community Health Services (CHS)	Community nursing and therapy services for P1
The Mental Health Trust	Provided health services for P1 and P2
Ambulance Service	Emergency response for incidents involving P1 and P2
Hospice 1	Palliative care to P1, when required
Police	Criminal justice response to incidents involving P1 and P2
GP Practice	Primary care to P1 and P2 at care home

Individual follow up interviews were conducted by Panel members with particular organisations, where it was felt necessary to discuss outstanding matters or stimulate debate regarding learning. After submitting their IMR, the care home decided they were unable to participate further owing to criminal proceedings. A full IMR was not submitted by CQC, however they engaged with the SAR Panel Chair and Author in a face to face meeting, telephone calls and responded to detailed questions. P1's family made a submission to the SAR, reflecting information they had gathered, with a later addendum.

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

P1's family participation

It is important to reflect on the significant contribution that P1's family has made to S42 and SAR processes. From four family members contacted, two family members became representatives, who fully contributed, to enable learning to prevent reoccurrence of similar circumstances. The information and concerns that they shared, have helped inform the themed analysis, conclusions and recommendations and their views are reflected throughout this and the Overview Report. Their pro-active approach to participation enabled their Mother's voice to be heard. The Independent Chair and SAR Panel wish to extend their gratitude and sincere thanks for the family's ongoing commitment and dedication, given the traumatic impact that this incident has had on them all.

2 Person 1 and Person 2

2.1. Person 1

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

P1 moved to the care home in March 2007, experiencing memory loss and initially lived in the Residential Unit. Her GP diagnosed advanced dementia and P1 was unable to consent care,

treatment and or her accommodation needs. She became increasingly frail with significant sensory deterioration and in 2013 was moved to the higher needs unit, unable to weight bear self-position, or mobilise, and needing full care and health support for all aspects of daily living. Unable to verbally communicate, those who were familiar with her could understand facial and non-verbal communication, however she struggled to orientate or make decisions.

Such was her condition; Person 1 was nursed whilst she was lying down in bed. Of note, she was unable to summons help, or use the call bell to request assistance. Her frailty and medical condition influenced the decision to provide end of life care (for several years), so on occasion P1 received palliative care from community nurses. In April 2016, CHC were approached, and agreed to fund P1's nursing care needs, prior to this, she had funded her own care. It is believed that a DoLS assessment took place on 19th April, but this remains unconfirmed.

Following the incident on the 11th June 2016, the family have advised they decided to keep their mother at the care home as they believed she was safe and that this was in her best interests, however they were unaware of the full extent of the risk she faced regarding P2's mental ill health and distressed behaviour, within the environment where both residents lived.

2.2. Person 2

P2 aged 94, was a white male, recently widowed, and moved into the care home, paying for his care. His primary diagnosis was Depressive Disorder and Mixed Vascular Dementia. By 2015, he was regularly collapsing, although no one specific medical reason was identified. He had poor sight and he had needed an emergency response on several occasions, owing to deteriorating mental and physical health. He presented increasingly distressed, challenging and aggressive behaviour and from March 2016 onwards there was a marked escalation in both frequency and gravity of violence towards residents and staff.

The S42 enquiry revealed more information and the SAR has established, that P2 was involved in violent and or aggressive incidents from 27th March 2015. Following this, incidents recorded at the care home and by police, showed that additional violent incidents involving various people at the care home, occurred in 2015 on 11th November and the 23rd December 2015. They also occurred in March 2016 on 16th,18th and 23rd ; in April on the 3rd, 18th 19th and 29th; in May on the 3rd and 22nd and in June on the 4th, 5th 6th and 7th- and ultimately on the 11th June, when Person 2 assaulted Person 1. This totals 18 different incidents set within an escalating picture. Incidents of 23rd December; 18th March; 3rd May; 5th June and 7th June all involved P2 using his Zimmer frame to either assault or try to assault staff and residents.

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

However, it must be clear, that the circumstances surrounding P2 are subject to separate considerations under s44 Care Act 2014, and for the purposes of this SAR, circumstances appertaining to P2 were only considered, in relation to their impact on P1, and how she was safeguarded facing the high level of risk that was posed to her.

3 Conclusions

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

1. The care home's policy and practice relating to managing violent residents focused on post incident response, not on prevention or holistic risk assessment. The risk assessments and care plans in question, for individuals did not explicitly address risk from or to, other vulnerable residents, and did not effectively recognise changes in health, or in the living environment which could increase risk. The increased risk posed by P2, and the escalation of his aggression and violent behaviours were ineffectively monitored, and not accumulatively or holistically assessed, and a 'tracker system' left the GP uninformed of urgent concerns and risk levels. However, the latter may have been reduced if an effective mental health medication review for P2 had regularly taken place.

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

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

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

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

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

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

In addition, CQC may benefit from deciding how they can demonstrate that the learning from this and other SAR'S are considered in their regulatory inspections.

7. When families provide information to agencies regarding risk to loved ones, their views should be listened to, valued and recorded, and when there are grounds for their concerns, appropriate action taken. The SAR concludes that all agencies and providers involved in care and health provision, should ensure that where the law permits, accurate, proportionate and transparent information is shared with a family, regarding risk to their relative, when that person lacks capacity.[4] The family consider that not advising other families with incapacitated relatives at the care home, with regard to the risk posed, may also represent a breach of candour to others.

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

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

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

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

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

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

4 Recommendations

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

Mental Health Services and The Trust	
1.	**That the Trust audit a sample of not less than 50 mental health reviews from January 2019 to December 2020 (to include a focus on those receiving care in bed and/or displaying distressed/aggressive behaviour). To conduct a deep dive to establish that risk was effectively assessed and acted on; that correct policy and procedure was adhered to, that and that the Mental Capacity Act was, where necessary correctly applied correctly applied according to the decision specific issue and that the views of patient and family are evident and outcomes contribute to improvement planning.**
2.	**That the Mental Health Trust conduct a scoping exercise to identify patients in the community who may represent a risk to others and check if these patients have received a review within correct timescales, and if not to provide a review. This exercise should shape development of an ongoing monitoring system to improve future risk management**
3.	**That the trust set up a monitoring system to ensure timely reviews take place.**
4.	**That Trust Policy regarding the management of potentially violent patients in the community be reviewed and that associated guidance be shared with the SSAB for circulation (to commissioned and or independent provider services) and it should include guidance on: the necessity for multiagency contributions; the need for contextual information; the value medication reviews; advice on the prevention of risks to others, particularly if they are receiving care in bed and the framework for monitoring arrangements.**
GP Practice	
1.	**That systems are reviewed to ensure all urgent referrals to mental health services are flagged clearly as urgent and that they are subject to a timely administrative follow up, in accordance to CCG expectations or KPIs.**
Ambulance Service	
1.	**That Ambulance staff are fully conversant with how to undertake a verbal mental capacity assessment and are trained accordingly.**
2.	**That if two people are to be conveyed to Hospital that consideration is made to if they could attend different hospitals, where there is a victim and a suspect.**
Police	
1.	**That a multi-agency audit of a sample of crime reports takes place, where an allegation of crime has been made, and where the mental capacity of the victim and /or suspect is a factor.**
2.	**That an internal training programme is set up for all officers to refresh learning on the practical and lawful deployment of The Mental Capacity Act and The Statutory Code of Practice; Multi-Agency Adult Safeguarding Procedures and Policy and relevant learning derived from within 'The Poor Relation: The police and Crown Prosecution Service's response to crimes against older people'[5].**
3.	**When seeking access to medical notes in this case, and after a voluntary request for documents had been declined by the care provider as part of an ongoing criminal investigation , Police (having sought legal advice) felt unable to legally utilise powers under Section 9 of Police and Criminal Evidence Act in order to seize relevant material; as the personal records involved could be considered 'excluded material'. The impact of receiving this legal advice has wider implications for Police when carrying out Safeguarding investigations.** **The SAR acknowledges that there are opportunities for information sharing between partner agencies. This includes the sharing of relevant and proportionate information with the Police e.g. it is the public interest to do so or where there is a legal mandate such as the Data Protection Act 2018 legislation or a relevant court order in place e.g. power of attorney. It is therefore recommended that**

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

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

[6] Care Standards Act 2000

	iv. to ascertain if the latter applies to resident on resident incidents, particularly in high risk cases and when people pay for their own care **v. a view if current inspection arrangements may represent a system failure regarding 'a safe service' standard, if a care home fails to make relevant notifications** **vi. how the learning from this SAR could impact on family involvement in the inspection process in future and help to raise public confidence in care home ratings and** **vii. that care home managers evidence their understanding of both The Care Standards Act 2000, during regulatory inspections, as well as the Health and Social Care Act 2008.** **c) ADASS[7] Local Government Association and the National Adult Safeguarding Board Chair's Network – to engage discussion about the need for national guidance on writing Individual Management Reviews and opportunities for developing standards for completing S42 Enquiries.** **d) Department of Health. To engage discussion on issues related to the duty of candour and how all agencies and providers involved in care and health provision, should ensure that where the law permits, accurate, proportionate and transparent information is shared with a family, regarding risk to their relative, when that person lacks capacity. Specifically, to consider how s81 of the Care Act 2014 updated s20 of the Health and Social Care Act 2008 in relation to the provision of information in a case where an incident of a specified description affecting a person's safety occurs in the course of the person being provided with a service.** **e)The National Police Chief's Council Safeguarding Lead - to request that the implications of this SAR are nationally considered to improve the quality in similar police investigations and to share the considerations posed with CQC, and the implications of the legal advice provided to police to when trying to secure access (without consent) to medical and care records from a care home, given the direct impact on the potential for a revised police investigation and the significant implications for investigation of all offences, where this evidence needs to be sought.**

5 Agency's own recommendations, partner improvements and actions already taken

In addition to the recommendations made by the SAR, other lessons learnt, action to be and already taken, were identified by agencies:

5.1. ASC

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

Changes already made

Revisions to the policy and procedures for adult safeguarding work in Surrey: policies and procedures for SSAB and for ASC have been separated, which has helped to clarify distinctions between the role of the ASC and the multi-agency elements of adult safeguarding work. The current policies and procedures set out clear expectations of good practice and include a method for adult safeguarding enquiries which will help reduce the likelihood of the problems experienced in this case. ASC have also produced good practice guidance for staff and revised training arrangements for adult safeguarding, and the content of new courses reflect new ways of working. ASC has improved arrangements for quality assurance, auditing safeguarding

[7] Association of Directors of Social Services

practice, to improve standards and meet policy and procedural expectations. ASC has produced Good Practice Guidance on adult safeguarding enquiries to help its staff apply in practice the approach set out in the revised policies and procedure. It is noted however, these are relatively recent changes and confidence that there has been the change in practice still needs to be fully achieved. Planning to carry this forward will involve:

- complete roll-out of the new policy and procedure with workshops in localities to inform staff of the changes being made and to support local leadership with implementation
- revision of the adult safeguarding workflow on our client recording database, to help support staff to work in line with good practice modelling
- ensuring that all adult safeguarding referrals go via the MASH, working with Police. Providers, Emergency Duty Team (EDT) and The Trust to improve ways of working so that: a) non-adult safeguarding referrals from the Police are dealt with efficiently and effectively and MASH has capacity to deal with adult safeguarding concerns and b) adult safeguarding referrals receive an effective response by MASH, with timely and good quality decisions regarding a S42 Care Act Enquiries, and initial decision making about what and whom that will involve.
- Identifying and implementing improvements in the application of Mental Capacity Act practice
- EDT to review its work to ensure there are no systems, policy or practice barriers to ensuring a proactive response to situations when they are aware of a person in need of a Mental Health Act Assessment
- Social Care Staff to be reminded to be clear with family members and or people's representatives, regarding the purpose of a S42 Enquiry and to keep people appraised and updated at key points in time and to have clear communications with co-ordinators and or key contact people, for the duration of the s42 enquiry.
- S42 enquiries to have clear Terms of Reference, to ensure they fully cover all aspects of the concern, particularly preventative and background circumstances.
- When a SAR is published this will be disseminated to ASC staff.

The effectiveness of these changes will be monitored and reviewed by the Head of Safeguarding on a regular basis.

5.2. CCG and CHC

CHC to develop operational guidance describing the process to be followed on receipt of a safeguarding concern and/or serious incident and to ensure that patients in receipt of NHS fast track funding receive a 3-month care review (in accordance with the National Framework NHS Continuing Healthcare and NHS-funded Nursing Care)

- Safeguarding and CHC team to continue to work together to strengthen clarity regarding specific roles and responsibilities and the interface between safeguarding and CHC.
- CHC to ensure information relating to the health and care of patients is recorded in the appropriate health record and information received is attached to the health record in line with local and national record keeping standards.
- Safeguarding team to ensure that safeguarding advice and ad hoc supervision is recorded in line with local and national record keeping standards.
- Adult Safeguarding: Roles and Competencies for health care staff Intercollegiate Document (2018) will advise the safeguarding leadership team to undertake an analysis of team member's appraisals to ensure that staff have achieved and are maintaining safeguarding competences appropriate to their role.

CCGs are required to demonstrate that they have appropriate systems in place for discharging their statutory duties in terms of safeguarding. The integrated safeguarding team undertook a review of the adult safeguarding governance and assurance processes on behalf of all the CCG's. The learning from this case outlined above is in line with what the CCG had already identified, and measures have already been taken to address these issues. In particular, work has commenced to strengthen clarity regarding specific roles and responsibilities and the interface between safeguarding and the CHC team. The CHC team did respond to the fast track referral from the district nursing team within the specified time frame outlined in national guidance. Furthermore, there is evidence the CHC team liaised with the clinical networks involved in P1's care to discuss various care options to ensure P1 remained in her preferred place of care, the home she had lived in since 2007.

Changes already made

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

5.3. Community Health Services and The Mental Health Trust

The investigation has highlighted the importance of raising awareness of professional curiosity. Responding to concerns requires the ability to recognise (or see the signs of) vulnerabilities and potential or actual risks of harm. Reported isolated issues or concerns within the DN team must prompt further discussion but provide intelligence to decide whether the concerns should have been raised to the Multi-Agency Safeguarding Hub. P1 was cared for in the residential home and her needs were met by community nurses and other professionals in a regular basis.

Upon reviewing P1's care, it raises question whether she would have been benefited from being cared for in a nursing home rather than a residential home due to her needs. The nursing home would have provided her with care and support she required without any delay due to availability of nurses and other professionals on site. Living in an environment with residents with similar needs could have potentially reduced the risk of harm from others. On the 26th November 2012 it is documented on RIO that a CNS was asked by the home to assess P1 for a Nursing Home (NS) placement. There was no further information supplied by the DN team of the outcome of the assessment. There was no documented evidence to show whether it was P1's choice to stay in the home.

The following are changes in hand:

- To raise awareness of professional curiosity and effective documentation
- To review care of all patients in residential homes cared by community nursing services to establish if their views of their care, and needs, have been documented.
- That healthcare professionals should advise the adult social care team so that a Care Act assessment can be offered or completed to determine level and appropriateness of care input required regardless of funding arrangements for care and support needs for patients in the community, especially when a patient lacks capacity to make a decision regarding these needs
- To ensure safeguarding incidents from community settings are recorded in A&E
- To review why there was a delay in responding to referrals and to establish if this is more widespread, and if so, what needs to be done about this.
- CMHT to review why there was a delay in responding to these referrals and if this is more widespread and if so, what it needs to be done about this.
- Commissioners of the CMHT service to seek assurance of the timeliness of responses to referrals and consider reviewing the monitoring arrangements of the timeliness of response to referrals in line with the Service Level Agreement.
- Recording safeguarding alerts should be a high priority in A&E for patients presenting with injuries which have occurred as a result of assault in the community or hospital
- There is evidence of good practice in the partnership, working with both individuals, their families, friends and the other agencies involved. Additionally, there is evidence that both P1 and P2 were seen within or more frequently than the assessed timescales.
- Some records are unclear there are others that are clear, comprehensive and enable the reader to easily follow the path taken by the clinician in supporting the patient, in particular P2. This includes a holistic approach.
- Although there is evidence of good practice there are still lessons to be learnt in terms of communication, evidencing that safeguarding procedures are followed and reporting and recording for some staff.

5.4. Police

- Police Chief Officers should raise the profile and standard of safeguarding adult's investigations using methods similar to those that have been used on a force-wide basis to improve the police response and investigations in child protection, domestic abuse, modern slavery and hate crime. They should use appropriate internal communications and existing training programmes to address the culture that exists amongst officers and staff when responding to incidents occurring in care settings, to one of positive action, and wider consideration of offences relating to possible abuse and neglect.

  When investigating serious incidents that have taken place in residential or nursing home settings, police should consider whether criminal offences have been committed by agencies as well as by individuals, e.g. they should collect evidence to inform decisions about health & safety practices in the home and investigate whether there are grounds for considering charges of corporate negligence or corporate manslaughter (where appropriate). This is in addition to considering whether neglect by individual staff as defined within s44 of the Mental Capacity Act has been a feature of the case
- The Head of Public Protection should remind all front-line and secondary investigations of a) the requirement to initiate a strategy discussion and what this entails at the earliest opportunity with ASC, when attending incidents within care settings b) remind the requirement when responding to allegations of abuse in care settings, to carry out a rigorous investigation as they would when responding to any allegation of a crime having been committed outside of a care setting

  c) the investigative requirement to obtain formal evidence from an appropriate mental health professional, in cases where a suspect has been deemed to lack capacity d)the statutory requirement under the Code of Practice for Victims of Crime to afford close relatives (nominated family point of contact) of a victim who lacks capacity and the services that must be provided by police e) carrying out a review of the current Adults at Risk policy and procedure to ensure that it includes sufficient guidance around the investigative standards expected when staff investigate incidents in care settings where neglect and/or abuse are suspected and where mental capacity is an issue
- Individual learning has been identified and accepted by a supervising officer in this SAR.
- Organisational learning in respect of practice and procedure and culture have been identified in this IMR and are detailed as recommendations below.

This incident, report, learning and recommendations should be cascaded and adhered within all the relevant organisations

5.5. Care Home

- An urgent need was identified following the incident on 11th June 2016 for more of the team in the Dementia Unit to have lessons and input in their practice through a Dementia Pathway Training Course which includes: Dementia Awareness Training (Types of Dementia); Person Centred Care; Communication in Dementia; Cognitive Stimulation and Reasoning; Record Management in Dementia and in Care Services and Virtual Dementia Tour. This will equip staff with the skills to identify, manage and refer as appropriate, any needs that they cannot meet in a timely manner. Most of the staff in the Dementia Unit Neighbourhood should take a step further in their training and complete a Level Three Distressed Behaviour Training Course.
- Training Dementia Unit Team on correct documentation of ABC charts and ensuring that this is reflected on Behaviour tracker.
- Following this incident, the outcomes will be shared with other General Managers via Clinical Governance news brief.

- The organisation needs to focus more on training and compliance and regional tracking of the use of behaviour trackers through our auditing process and add the findings to the key performance indicators which will be monitored regularly.
- The organisation will benefit from carrying out a Post Incident Analysis to improve system performance and help equip staff with the skills for incident management procedures. For the organisation to have guidance on strategies to ensure people nursed in bed have regular checks in place and where appropriate specialist equipment is used to monitor and keep them safe and engaged as part of the Neighbourhood.

5.6. GP Medical Practice

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

5.7. Ambulance

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

6 Glossary of Abbreviations

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