Safeguarding Adult Review and Mental Health Homicide Review

Overview Report: Adult L

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lancashire safeguarding adults board

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1. Introduction

1.1 Adult L was a 90 year old female resident in Care Home 1, which provides residential care for up to 35 residents. During the early hours of 14th February 2019 she was physically assaulted by a 75 year old male resident (the second adult) who had entered her bedroom. Adult L was treated in hospital but died from her injuries just over two months later.

1.2 Lancashire Safeguarding Adults Board (LSAB) decided to arrange a Safeguarding Adult Review (SAR) on the grounds that Adult L died as a result of suspected abuse and there is concern that partner agencies could have worked together more effectively to protect her. The overall purpose of a SAR is to promote learning with which to improve professional practice.

1.3 NHS England (NHS E) is responsible for commissioning a Mental Health Homicide Reviews (MHHR) when homicides are committed by patients being treated for mental illness. The purpose of an independent investigation is to review thoroughly the care and treatment received by the patient so that the NHS can be clear about what – if anything – went wrong with the care of the patient, minimise the possibility of a reoccurrence of similar events and make recommendations for the delivery of health services in the future. NHS England decided that the death of Adult L following a physical assault by the second adult, whose care was being co-ordinated by a Community Mental Health Team (CMHT) at the time, met the criterial for a MHHR, but felt that the best outcome would be achieved by working as part of the SAR.

1.4 Lancashire Safeguarding Adults Board and NHS England decided to jointly commission this independent review to meet the requirements of both a SAR and a MHHR. LSAB appointed Heather Buckland as the Chair of a Panel established to oversee this review. She is Named Nurse for Adult Safeguarding at the Southport & Ormskirk NHS Trust and has extensive experience in the NHS and Armed Services in fields such as acute and forensic mental health and orthopaedic trauma. David Mellor was appointed as lead reviewer for the SAR element of the review. He is a retired chief officer of police with several years' experience of conducting statutory reviews. Nick Moor was appointed as the lead investigator for the MHHR element of the review. He is a partner (investigations and reviews) with Niche Health and Social Care Consulting. A former mental health and general nurse, Nick has led and directed many investigations into adverse events in healthcare including a recent independent mental health investigation into the care and treatment of an elderly woman who died after being pushed by a fellow male patient. Membership of the Panel established to oversee this review is shown at Appendix A.

1.5 An inquest into the death of Adult L will be held in due course.

1.6 Lancashire Safeguarding Adults Board and NHS England wish to express their sincere condolences to the family and friends of Adult L. They also wish to express their sympathy to the second adult - who was not held criminally responsible for the assault on Adult L because he lacked the mental capacity to form the intent to harm her - and his family and friends.

2. Terms of Reference

2.1 The primary focus of this review is on the period from when Adult L and the second adult were placed in Care Home 1 in 2018 up to, and including, the incident on 14th February 2019 in which Adult L sustained injuries from which she later died. The review will also consider the support

provided to the second adult and the other residents of Care Home 1 following the 14th February 2019 incident.

Generic questions:

- Determine whether decisions and actions in the case comply with the safeguarding policy and procedures of named services/ agencies and the LSAB;
- Examine inter-agency working and service provision for the adult and family;
- Determine the extent to which care was person centred and compliance with Making Safeguarding Personal;
- Examine the effectiveness of information sharing and working relationships between agencies and within agencies;
- Compliance with valid consent and Mental Capacity Act and application of the Mental Health Act;
- Consider and review the risk assessment and risk management processes in place to safeguard Adult L and prevent the second adult from harming themselves and or other people;
- Establish any learning from the case about the way in which local professionals and agencies work together to safeguard adults;
- Identify any actions required by the LSAB to promote learning to support and improve systems and practice.

Case specific questions (Adult L):

- The decision to place her in the care home and subsequently move from a short term to long term placement.
- When she sustained injuries from falling (believed to have been in December 2018) what action was taken by the provider to prevent the risk of further falls? Was a safeguarding alert made or considered at that time?
- How effectively was the whistle blower allegation that she had been assaulted by the second adult in December 2018 investigated? Was the allegation shared with her family?
- Were the risks the second adult presented to her, and other residents of the care home, assessed and managed/mitigated by the provider?
- Prior to 14th February 2019, did any of the incidents in which AM mistook female residents for his wife, threatened or physically abused residents or entered other resident's bedrooms, involve the deceased? If so, what action was taken by the provider to safeguard her.
- When she was hospitalised following the assault by the second adult, how effective was the care and treatment she received and how appropriate were the arrangements for discharging her from hospital?
- Were the family of Adult L communicated with adequately and appropriately during her stay in the care home?

Case specific questions (Second Adult):

- How appropriate was his placement in the care home? Was the care home capable of meeting his presenting needs at the time he was placed there initially for respite and subsequently as a long term placement?
- How effectively did the provider respond when he began to present with challenging behaviours? Was the behaviour management plan drawn up by the care home appropriate? Was the plan reviewed and updated when his challenging behaviour escalated? Was there appropriate involvement from the community mental health team in helping draw up the behaviour management plan?
- Were concerns about his challenging behaviour appropriately escalated by the provider to the commissioners of his placement and the community mental health team?
- Did the provider make safeguarding referrals when appropriate? Did the local authority address any safeguarding referrals effectively?
- Were physical assaults on other residents and his wife when visiting reported to the police?
- Was the impact of his presenting behaviour on other residents in the care home given appropriate consideration when decisions were made by the provider and other agencies, particularly when the 28 day notice to find an alternative placement was cancelled?
- When he was reassessed as requiring an Elderly Mentally Ill placement, why was he not transferred to a placement which was able to meet his assessed needs? Why was the recommendation for a Section 2 MHA rescinded?
- How effective was the support he received from community mental health services?
- How effectively were the concerns raised by the staff whistle blower addressed? Was it appropriate for the manager of the care home to enquire into these concerns, given that the concerns included serious criticisms of the management of the care home? Was it appropriate for the regulator (Care Quality Commission) and the commissioner Lancashire County Council to rely on the manager's investigation of the whistle blower concerns in these circumstances?
- When the care home submitted a DoLS application to the local authority were restrictions the care home staff may need to take to manage his challenging behaviour shared with the local authority at the time or subsequently?
- How effectively were concerns about the care provided by the care home monitored?
- The advice and support provided to the family of the second adult.

3. Glossary

Best Interests - if a person has been assessed as lacking mental capacity for a specific decision then any action taken, or any decision made for, or on behalf of that person, must be made in his or her best interests.

Deprivation of Liberty Safeguards (DoLS) were introduced in 2009 and protect the rights of people aged 18 or above who lack the ability to make certain decisions for themselves and make sure that their freedom is not inappropriately restricted. No one can be deprived of their liberty unless it is done in accordance with a legal procedure. The DoLS is the legal procedure to be followed when

it is necessary for a resident or patient who lacks capacity to consent to their care and treatment to be deprived of their liberty in order to keep them safe from harm. The DoLS can only be used if the person will be deprived of their liberty in a care home or hospital. In other settings, and for children aged 16 and above the Court of Protection may authorise a deprivation of liberty.

Independent Mental Capacity Advocate (IMCA) - The purpose of the Independent Mental Capacity Advocacy Service is to help particularly vulnerable people who lack the capacity to make important decisions about serious medical treatment and changes of accommodation, and who have no family or friends that it would be appropriate to consult about those decisions. The role of the Independent Mental Capacity Advocate (IMCA) is to work with and support people who lack capacity, and represent their views to those who are working out their best interests.

Making Safeguarding Personal - is a sector-led programme of change which seeks to put the person being safeguarded at the centre of decision making. It involves having conversations with people about how agencies might respond in safeguarding situations in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety. It is about seeing people as experts in their own lives and working alongside them. It envisages a shift from a process supported by conversations to a series of conversations supported by a process.

Mental Capacity Act (MCA): The Mental Capacity Act 2005 came into force in 2007. It is designed to protect and empower those vulnerable people who may lack capacity to make certain decisions, due to the way their mind is affected by illness or disability, or the effects of drugs or alcohol. The MCA also supports those who have capacity and choose to plan for their future. The MCA applies to everyone working in social care, health and other sectors who is involved in the support and treatment of people aged 16 and over who live in England and Wales, and who are unable to make all or some decisions for themselves.

NHS continuing healthcare (CHC) is a package of care provided outside of hospital that is arranged and funded solely by the NHS for individuals aged 18 years and older who have significant ongoing healthcare needs. When someone is assessed as eligible for CHC, the NHS is responsible for funding the full package of health and social care.

Section 2 Mental Health Act (1983)

Section 2 MHA permits the detention of a person with a mental health disorder for 28 days for assessment and treatment.

Section 42 Care Act 2014 Enquiry by local authority

This section applies where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there):

- has needs for care and support (whether or not the authority is meeting any of those needs),
- is experiencing, or is at risk of, abuse or neglect, and
- as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.

The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case and, if so, what and by whom.

4. Synopsis

4.1 Adult L lived in Scotland for most her life but during the Spring of 2017 two of her daughters helped her to move to Lancashire to live near them. They arranged for her to live in a rented bungalow for six months prior to a move into sheltered housing, during which time they supported her. During September 2017 Adult L was referred to the then Lancashire Care Foundation Trust (LCFT)* memory assessment service, the outcome of which appears to have been a diagnosis of Alzheimer's. She was referred to dementia advisor services and later prescribed Donepezil 5mg daily (increased to 10mg daily from late February 2018). LCFT wrote to Adult L's GP to request that she was added to the GP practice dementia register which would trigger a primary care dementia review.

* Now Lancashire and South Cumbria NHS Foundation Trust.

4.2 After around six months living in sheltered accommodation Adult L became ill with a urinary tract infection and pneumonia for which she was hospitalised for a period. Following this Adult L was placed in Care Home 1 to help her 'get back on her feet', in the words of her daughters who have contributed to this review. This, initially temporary, placement appears to have begun around the end of January 2018. The care home was located in between her daughter's homes and so they were able to continue to provide her with substantial support.

4.3 On 5th April 2018 LCFT wrote to Adult L's GP to advise that they were discharging her from the service and to request that the GP assume responsibility for prescribing and review of her medication thereafter. One of Adult L's daughters was documented to have reported a slight cognitive improvement in her mother.

4.4 By 4th June 2018 Adult L's placement in Care Home 1 appears to have become permanent. Her daughters said that their mother settled in the Care Home and liked it there.

4.5 The second adult's placement in Care Home 1 began a month later, in July 2018. The events which led to this placement are set out in the following Paragraphs 4.6 – 4.24.

4.6 On 2nd January 2018 the second adult's GP referred him to the then LCFT memory assessment service due to a deterioration in his symptoms, particularly that he was not sleeping, his confusion and disorientation had increased and he was starting to display aggression. The LCFT single point of access (SPA) clinician who assessed the GP referral documented the aggression to be 'verbal' towards his wife with whom he was living at home. The second adult was accepted into mental health services at this point.

4.7 On 22nd January 2018 the second adult received an initial assessment from the SPA clinician following which he was referred to the rapid intervention and treatment team (RITT) due to 'potential risk' and for support to be provided to his wife who was said to be struggling with her carer role. The risks documented at this time were 'threats or verbal intimidation/aggression' and 'carer breakdown'. The second adult was to be formally diagnosed and supported by secondary mental health services. The RITT is a specialist Older Adult Mental Health multidisciplinary community based service with the following key functions:

- SPA for all LCFT Older Adult Mental Health Services
- gatekeeping where an admission is being considered
- assessing the potential for diversion from admission

- treatment and management at place of residence
- intensive home treatment focus on older adults who present in crisis or with a challenging behaviour in order to prevent hospitalisation or a breakdown in their current residence.

4.8 On 26th January 2018 the second adult's GP received a letter from the LCFT SPA advising of his referral to the RITT. The letter also stated that the second adult's wife had reported that he was verbally aggressive and shouted at her on a daily basis and had 'jab/punched' her to the chest. Additionally, the second adult had been observed to direct irritability towards his wife during the assessment. (The GP records for the second adult contained no prior history of domestic abuse towards his wife).

4.9 On 23rd February 2018 the RITT conducted an initial review of the second adult, the outcome of which was a diagnosis of probable mixed type dementia. Due to the unpredictability of the second adult's behaviours in dementia it was agreed that Memantine 20 mg – which is a drug used to delay the onset of Alzheimer's type Dementia - would be trialled. The initial treatment plan was to look for the most suitable medication and support the second adult and his family. The RITT was to support titration of medication, assess his response to the medication and potential side effects, support the second adult with his behaviour and the psychological impact of the diagnosis and provide emotional support for the second adult and his wife.

4.10 On 23rd April 2018 a transfer Care Programme Approach (CPA) meeting took place at which it was decided to transfer the second adult's case to the community mental health team (CMHT) and allocate a care co-ordinator for long term support and monitoring. This represented a step down from the intensive support the second adult and his wife had been receiving as risks were said to be being managed well. He was said to have responded well to Memantine and presented as 'pleasant' with staff. His wife was said to be 'struggling to manage' but wanted her husband to remain at home. It was felt that this plan would enable the second adult to remain at home with appropriate support for as long as possible and was considered to be the least restrictive option.

4.11 On 23rd April 2018 a RITT clinician updated the second adult's risk assessment following the transfer of his care. His diagnosis was stated to be moderate/severe mixed dementia. An increased risk of aggression towards his wife due to the second adult becoming frustrated and angry in response to his functional difficulties was documented. He was reported to be controlling and argumentative towards his wife on a daily basis which was increasing her carer burden. His wife was said to have described his premorbid personality as quite controlling. The second adult was said to have experienced a marked deterioration in his short term memory since a previous assessment in September 2016 and this was now impacting more significantly on his functioning. His long term memory, though impaired, was better than his short term memory. He was said to have limited insight but willing to accept support from mental health services although resistive to care. No formal capacity assessment was carried out at this time. Protective factors included support from his family and a good network of friends and he had sufficient functioning to gain enjoyment from hobbies, including his pigeons. His wife was described as very proactive in accessing support and had accepted a referral for a dementia advisor after initially declining it. However, it was also stated that the second adult's wife needed support in understanding dementia and how to respond to her husband's presentation as she tended to become upset. She had been provided with out of hours and crisis telephone numbers and would contact services in the event of any urgent concerns or indicators of increased risk. She had also been provided with the details of n-compass, which provides services to carers, to self-refer for a Carer's Assessment, having declined a referral to 'social services' for a Carer's Assessment. She had self-referred for funding of 'downstairs facilities'.

4.12 On 21st May 2018 the second adult attended an ophthalmology outpatient appointment accompanied by his wife when he reported that his vision was 'not good'. The second adult's capacity was assessed and he was found to be unable to retain, use and weigh information regarding surgery. It appears that a decision to proceed with surgery was made in his Best Interests.

4.13 On 30th May 2018 A Carer's Assessment was completed in respect of the second adult's wife but it was not possible to record it on the LAS system as her record was assigned to the LCC Occupational Therapy (OT) team. The second adult's record was not reassigned to the LCC Service Access team until 10th July 2018 which then allowed the Carer's Assessment to be inputted onto the LAS system. The second adult's wife was re-contacted on that date, at which point she declined support. The case was later closed as she was no longer considered to be a carer once the second adult was placed permanently in Care Home 1.

4.14 On 15th June 2018 a CMHT medic carried out a review of the second adult as he was now being supported by that team. His diagnosis was documented to be late onset moderate Alzheimer's Dementia. His current medication was documented as Memantine 20mg and Citalopram 20mg although the latter had recently been stopped and Trazadone 50mg prescribed to help with the behavioural and psychological symptoms of dementia. The second adult was compliant with medication. Worsening cognition was noted. The second adult's wife had agreed to consider day care as the next step in order to support both her wellbeing and support the second adult to remain at home.

4.15 On 27th June 2018 the second adult's CMHT care co-ordinator received a telephone call from his daughter to express concerns about her mother's reluctance to accept support and be open with professionals. She said that her mother was 'terrified' of her husband who had repeatedly 'lashed out' at her and had hit her in the face causing bruising two days earlier. The care co-ordinator brought up the extensive bruising she had observed on the second adult's wife's neck on her last visit which the wife attributed to falling out of a chair whilst asleep. However, the daughter felt that her mother's explanation for this injury was true. The daughter said that her mother was aware that it was unhelpful to criticise her husband's behaviours but wasn't always able to refrain from doing so. The daughter went on to say that during a visit to her house, her father had really enjoyed sorting and moving wood with her husband and she felt that he needed to be occupied and feel useful.

4.16 The following day (28th June 2018) the care co-ordinator spoke with the second adult's wife by phone. She was aware that her daughter had contacted the care co-ordinator. Her husband was in the garden which gave his wife the opportunity to disclose that the second adult had 'grabbed' her on several occasions but had not left any mark on her when he hit her. She was also upset that her husband was taking items from their house and giving them away. She was adamant that she wanted to continue to support her husband to live at home but said that she would be more accepting of support including a support worker taking the second adult out into the community and further considering day care. The care co-ordinator reiterated advice previously given to her about keeping herself safe.

4.17 On the same date the care co-ordinator made a safeguarding referral in respect of the second adult's physical abuse of his wife. This was screened by the Lancashire Multi-Agency Safeguarding Hub (MASH) and an initial Section 42 safeguarding enquiry was carried out and a safeguarding plan developed which included the allocation of a social worker to conduct a mental capacity assessment, the arrangement of 'respite' and a joint visit by the care co-ordinator and a senior social worker which was arranged for 2nd July 2018. (The CMHT had requested a mental health

social worker due to the complexity of the case). Additionally an urgent Carer's Assessment for the second adult's wife was requested. At this point the safeguarding enquiry was closed. (The MASH is the single point of access in Lancashire for all safeguarding concerns across all service areas for adults with care and support needs. Social workers within the MASH service undertake an initial statutory Section 42 safeguarding enquiry on each safeguarding alert. This includes information gathering, risk assessing and analysis, decision making including strategy discussions and the development of a Safeguarding Plan in conjunction with the person and/or their representative/advocate and partners within MASH).

4.18 On 1st July 2018 the care co-ordinator updated the second adult's risk assessment to reflect advice given to his wife in respect of her personal safety – to leave the house if her husband became physically aggressive or she felt at risk – and to review the recently commenced Trazodone to see whether this may be contributing to agitation.

4.19 The planned joint visit to the second adult appears to have taken place on 5th July 2018. His wife and daughter were also present. The purpose of the joint visit was to commence a formal assessment of needs in order to inform the support offered. The second adult was stated to be resistive of interventions such as assistance to go to the toilet and with personal hygiene. His wife was noted to have Lasting Power of attorney (LPA) for property and finances but not for health and wellbeing. (LPA allows for the appointment of one or more people to help someone make decisions or to make decisions on their behalf. There are two types of LPA – 'health and welfare' and 'property and financial affairs'). The social worker carried out a FACE (Functional Analysis of Care Environments) assessment, but no Mental Capacity assessment took place despite the FACE assessment documenting that the second adult lacked capacity. A discussion of the support which could be provided took place including respite, day care, a home care package and a personal budget. The second adult's wife accepted the offer of a Carer's Assessment and a referral to Peace of Mind was also discussed. (Peace of Mind 4 Carers is an emergency support service funded by Lancashire County Council which, in an emergency, can provide up to 72 hours of free support to the person cared for). A CMHT community support worker was to provide more frequent visits to the second adult and his wife.

4.20 On Friday 6th July 2018 the second adult's daughter contacted the CMHT care co-ordinator to report that her father had assaulted her mother several times that day. The care co-ordinator linked with the CMHT medic who advised that the current medication regime should be continued until possible physical causes of the second adult's agitation had been ruled out. This prompted the care co-ordinator to contact the second adult's GP to request the necessary checks and was advised that the second adult would need to go to the surgery before 6.30pm that day. (There is no indication that the second adult was taken to see his GP that day). The CMHT care co-ordinator contacted Adult Social Care to request urgent respite care for the second adult over the weekend (7th/8th July 2018) but this was not available. It was arranged that the LCC Emergency Duty Team (EDT) would contact the second adult's daughter – who planned to stay at her parent's address over the weekend - that evening. The CMHT care co-ordinator also referred the second adult to the RITT to provide more intensive support. The RITT visited over the weekend and the second adult's behaviour stabilised.

4.21 A scheduled home visit by the social worker on 12th July 2018 did not take place. No reason was recorded for the lack of a visit. The following day the RITT referred the second adult back to the CMHT as he was presenting as more settled although his behaviour was said to remain unpredictable.

4.22 On 17th July 2018 Care Home 1 was identified as a suitable respite placement for the second adult, his family having viewed the home three days earlier. The justification for this respite placement was that risks were escalating at home, the second adult's wife was struggling to cope with his aggression and there was a risk of further assaults. It was documented that the second adult required closer supervision and his wife needed a break from her caring responsibilities.

4.23 On 18th July 2018 the second adult 'attacked' his wife after becoming agitated whilst waiting for return transport after an appointment at hospital 2. No further details of the 'attack' are available.

4.24 On 19th July 2018 the second adult's three month respite placement in Care Home 1 began. The RITT psychiatrist wrote to the second adult's GP to advise that he was to continue on Memantine Hydrochloride 20mg and Trazodone Hydrochloride 50mg, an anti-depressant. On receipt of the letter on 25th July 2018, the GP commenced the second adult on Zopiclone 7.5mg – a drug used to promote sleep. In the letter to the GP the RITT psychiatrist also stated that the second adult's CMHT care co-ordinator would continue to 'supervise his wellbeing' and the psychiatrist would review him as needed.

4.25 The following day (20th July 2018) Care Home 1 completed an initial assessment of the second adult which stated that his wife was no longer able to manage at home and he was becoming increasingly aggressive towards her. The care plan advised staff to be aware that the second adult could become aggressive during personal care and that visits from his wife were also triggers for agitation. The Care Home has advised this review that they received no written assessment or care plan from the 'social worker' at that that time and that the information they relied upon for the initial assessment was relayed over the phone and obtained from the second adult's family. At one of the practitioner learning events arranged to inform this review CMHT practitioners disputed this account and stated that the care home was provided with a copy of their most recent assessment. This review has seen no evidence that an appropriate risk assessment which clearly articulated the risk of violence and aggression which the second adult presented was shared by the CMHT with Care Home 1. Care Home 1 appear to have assessed the second adult as a medium dependency resident and medium risk.

4.26 On 25th July 2018 Care Home staff documented several incidents of challenging behaviour by the second adult. At around 3.30am he damaged property in the lounge, became verbally abusive, lay down on the floor and refused to move when carers attempted to take him back to his room. Around an hour later he urinated over a chair in the lounge area and shortly after 5am he lay on the floor of another resident's room, refused to get up and was verbally abusive. Carers were able to reassure the second adult and return him to his room. At 11am the second adult would not allow carers to enter his room whilst being verbally abusive and shortly after noon he was found undressed in the lounge. He was encouraged to put his clothes on and his daughter was contacted.

4.27 On the same date the CMHT care co-ordinator telephoned the Care Home and was advised that the second adult was settling in but still having episodes of verbal – but not physical - aggression. He was said to have misidentified a fellow resident as his wife.

4.28 On 29th July 2018 the LCFT care co-ordinator visited Care Home 1 to review the second adult's care and behaviour. His care was said to be proceeding well although staff noted a deterioration in his illness and he had been mistaking other female residents for his wife. The second adult had entered a resident's room on 'Monday evening' (presumably 23rd July 2018) and misidentified the occupant as his wife and shouted at her. Care Home 1 has no record of this incident and has stated

that misidentification incidents only occurred in January 2019. This is incorrect – see Paragraphs 4.77 and 4.78. His future management plan was to be updated after a meeting with the second adult's daughter. The care co-ordinator noted that the second adult was being prescribed 3.75mg Zopiclone. A medical review was arranged.

4.29 On 1st August 2018 a Best Interests meeting took place at Care Home 1 which was attended by the 'social worker' (unclear if this was the LCC social worker or LCFT care co-ordinator), care home staff, the second adult's wife and his daughter. The second adult was assessed as lacking capacity to make decisions in respect of his placement and it was agreed that it was in his Best Interests for the placement to become permanent as he required 24 hour care to support his needs and manage his unpredictable behaviour and frustration.

4.30 On 2nd August 2018 the RITT psychiatrist visited the second adult who was asleep so it was not possible to assess his mental state. The psychiatrist documented sensorineural hearing loss, a cataract for which he was awaiting surgery, peripheral vascular disease, hiatus hernia, duodenal ulcer and osteoporosis. She also noted the second adult's diagnoses of Alzheimer's and moderate depression. The psychiatrist felt that the second adult was well contained with the support of the Care Home staff following a brief period of being unsettled. It was found that Memantine had been stopped by his GP and advice was given to re titrate. It appeared that the second adult's wife had informed the Care Home that Memantine had been stopped when this was not the case. Therefore the second adult did not have Memantine between 19th July and 2nd August 2018. It was noted that the GP had also prescribed Zopiclone and was advised to increase the dosage to 7.5mg to try and help the second adult to establish a good sleep pattern and assess whether this had an impact on his behaviour during the day.

4.31 On 7th August 2018 the Care Home submitted a request for a Deprivation of Liberty Safeguards authority in respect of the second adult to the LCC DoLS team. The application was screened the following day and as no priority factors were indicated by the application, it was considered to be lower priority and went unallocated as the DoLS team has not had the resources to allocate low priority referrals for some considerable time. The DoLS team received no further communication from any parties to indicate that the priority level assigned to the application in respect of the second adult should be reviewed.

4.32 Shortly before midnight on 11th August 2018, the second adult was found in another resident's room and was initially aggressive towards carers who were able to calm him and accompany him back to his room.

4.33 On 16th August 2018 the LCC social worker telephoned the second adult's daughter who was concerned that her father's symptoms were exacerbating. It appears to have been agreed that the daughter would contact the second adult's GP to check if any medication had been stopped or altered since admission.

4.34 On 18th August 2018 the CMHT care co-ordinator updated the second adult's risk assessment to reflect 'change in treatment'. The risk assessment stated that since moving into the Care Home he had been much more settled and whilst he required support with activities of daily living, his mood and agitation were reported to have improved. The second adult was reported to be 'pleasant' to his wife, who was said to be able to visit and enjoy time with her husband. The second adult was said to 'misidentify both his wife and other people as his wife'. The Care Home was said to feel that they could meet his needs at that time. The second adult's medication had been reviewed by the RITT psychiatrist who advised that Trazodone should continue, Memantine was to

be reinstated and that Zopiclone should continue as it appeared to help the second adult sleep. It was noted that prescribing had been handed over to the second adult's GP practice in April 2018 and his wife had been administering the medication when the second adult lived at home but 'appeared to have got lost on handover'. (It is assumed that this refers to the period during which the second adult was not prescribed Memantine). The plan was for the LCC social worker to review the second adult's placement and for CMHT to review and discuss discharging the second adult from their service with the Care Home now that he appeared settled and risks were said to have reduced.

4.35 During the late evening of 22nd August 2018 the second adult became agitated and began swearing at both residents and carers and punching doors. Shortly after midnight (now 23rd August 2018) the second adult kicked another resident in the leg. A carer moved the other resident from the room in which the incident took place. The Care Home manager subsequently notified the CQC of the incident in which the second adult had kicked out at the other resident who reported that the second adult had kicked the chair on which she was sitting but not made physical contact with her. CQC Inspector 1 later spoke with the manager (on 30th August 2018) and documented that this was the 'first incident', that 'a behaviour management plan had been put into the second adult's care file', his medication had been reviewed by his GP and his family had been informed. The CQC was later (6th September 2018) notified of the outcome of a Section 42 safeguarding enquiry by LCC which noted that the second adult was settling into the home at the time of the safeguarding concern which was recorded as partially substantiated. (This safeguarding enquiry is not in the MASH chronology prepared for this SAR. It is presumed that this is because safeguarding referrals are not searchable against the name of the service user whose behaviour may have led to harm to the 'victim' or injured party).

4.36 The second adult's LCC social worker had also become involved following the 23rd August 2018 incident and was advised by the Care Home manager that the second adult had also been wandering into other resident's rooms, had entered the hair salon thinking it was a toilet and was suffering from loose bowels. The second adult's medication was said to have been changed to 'titration by Memantine'. It was agreed that general supervision and toilet monitoring of the second adult would be increased. The second adult's CMHT care co-ordinator was informed and she documented that Care Home staff had also advised that the second adult became more agitated when his wife visited and it was agreed that the care home would speak with family to look at ways of supporting visits 'without causing too much disruption'.

4.37 Shortly after 4am on 27th August 2018 the second adult became agitated and tried to get into another residents bed. The resident, whose identity is unknown, was said to be away from their room at the time. The second adult was initially verbally aggressive to carers who were able to reassure him and take him back to his room.

4.38 During a telephone call between the second adult's LCC social worker and the Care Home manager on 28th August 2018 it was said that the second adult's mood had stabilised although the manager was concerned that during a recent family visit they had taken the second adult outside and offered him chocolate and a cigarette against advice and he had become agitated and eaten the cigarette. The manager felt that the family's expectations of the second adult may be too high and 'not conducive to his present state and general wellbeing'. The social worker suggested a sensitive discussion between the Care Home and the family. The CMHT care coordinator was informed of this discussion and documented that the Care Home staff were 'identifying triggers of increased aggression' when visited by his family.

4.39 On 3rd September 2018 the CMHT care co-ordinator visited the second adult and found him to be more settled, noting that his Memantine had been titrated 'back up' to 20mg. The CMHT planned to discharge the second adult from their service in a month if he was settled in the Care Home.

4.40 On 5th September 2018 the Care Home put a behaviour management plan in place because the second adult could become aggressive towards others (residents and staff).

4.41 During the evening of 10th September 2018 the second adult was found on the floor of another resident's room who was not in their room at the time. He was taken to the lounge by carers.

4.42 At 12.45am on 12th September 2018 the second adult was found sitting on the floor and began to shout and swear at staff who were able to reassure him.

4.43 Shortly before 2.00am on 13th September 2018 the second adult left his bed and entered another resident's room. Details of the resident have not been provided but they pressed their nurse call button. When staff arrived, the second adult refused to leave the room and became verbally abusive. Carers reassured him and accompanied him to his room.

4.44 At around 4.25 am on 17th September 2018 the second adult was found to have entered the bedroom of a male resident. Carers had been alerted by the male resident shouting at the second adult to get out of his room. Carers found the male resident sitting on the floor beside his bed having sustained a 'large bump' above his right eye and a bloodied nose. The male resident disclosed that the second adult, who was at the opposite side of the room, had hit him. The Care Home made a statutory notification to the CQC and CQC Inspector 2 contacted the manager the following day who advised the inspector that the second adult's room was two doors down from the injured resident, that there was a sensor mat outside the second adult's door (the manager later advised the LCC social worker that the second adult had disconnected the sensor mat by pulling out the wire although the CQC was not informed of this), that neither the second adult nor the injured resident had capacity, that this was the second incident in which the second adult had used or offered violence to another resident and a pattern of violence towards other residents after being visited by his wife was noted. A behaviour plan was said to be in place and a DoLS application had been submitted.

4.45 A safeguarding concern was submitted (no details of this in the MASH chronology). It is unclear which agencies submitted safeguarding concerns in respect of this incident. In the chronologies there are only details of NWAS submitting a safeguarding concern after carers initially contacted NHS 111 after finding the injured male resident. NWAS submitted a safeguarding concern to highlight risks to other residents of the Care Home. The CQC were subsequently (11th December 2018) advised of the outcome of the Section 42 safeguarding enquiry which was that the second adult was referred for review by his CMHT, he was on 1:1 for 28 days following the incident whilst his medication was reviewed, a DoLS application was made* and a pressure mat put in place outside the second adult's room and risk assessments and care plans for both residents were updated. The safeguarding concern had been substantiated although it was documented that the Care Home had been unable to establish whether a fall or an assault had taken place. The MASH described the incident as 'isolated'.

*No fresh DoLS application had been made following the earlier DoLS application (Paragraph 4.31).

4.46 Later on 17th September 2018 the second adult's daughter contacted the LCC social worker to express concern about the care home's ability to care for her father given that he had punched her

mother several times 'last week' during a visit (incident not included in the care home chronology) and, as described above, had struck the male resident in the early hours of the same day.

4.47 On 20th September 2019 the second adult's LCC social worker visited the care home and spoke to the manager who told her that the second adult had 'pulled a sensor wire in his room' which meant that staff were initially unaware that he had left his room. The second adult had been moved to another room. The social worker documented that the manager advised her that adequate preventative measures were in place, that despite family concerns about the level of care provided to the second adult, the manager felt that staff were able to meet his needs and that the second adult 'was not a management problem'. The social worker noted that if the placement continued to meet the second adult's care needs, she would consider closing his case in one month, which would mean that his care and support needs would be reviewed annually.

4.48 During the late evening of 27th September 2018 the second adult went into another (un-named) female resident's room. The resident began shouting for help. the second adult stood behind the resident's door, blocking carers from gaining entry. Carers were eventually able to gain entry to find the resident on the floor who the second adult was kicking. The second adult was also standing over the resident with a pillow in his hand. The second adult was eventually returned to his room where he threw items at staff, held up his fists and was verbally abusive. This incident took place over a 90 minute period and a 'high level intervention' was required. The care home manager was telephoned for advice. Lancashire MASH has no record of any safeguarding referral. Nor was the CQC notified of this incident. Care Home 1 has been unable to identify the female resident. In the Care Home 1 records the gender of the resident is not referred to but in records made by the RITT psychiatrist, in the subsequent registered nursing needs assessment (RNNA) and in the Complex Package of Care application (see Paragraph 4.59), the resident is referred to as a female.

4.49 On 28th September 2018 Care Home 1 contacted the RITT for support and advice as the second adult was refusing to leave his room. The RITT provided contact details for 24 hour support 'to ensure risks were managed and staff felt supported'. Contact was also made with the second adult's GP who prescribed Lorazepam – 0.5 to 1mg eight hourly if needed. The GP was advised that the second adult was being aggressive to other residents.

4.50 Shortly after 4am on 29th September 2018 the second adult was accompanied back to his own room after wandering the corridor punching doors. He then began to swear and throw objects. Carers calmed him over the following half an hour.

4.51 Later in the day the RITT contacted the Care Home and were advised that after presenting as agitated during the morning, the second adult's behaviour had become more settled and the care home declined a visit from the RITT.

4.52 Shortly after 4.30pm on 1st October 2018 the second adult declined personal care and went to the dining room where he had a verbal exchange with another resident during which the second adult clenched his fists and threatened the other resident with a fork. The second adult was taken to a quiet area of the lounge where he later fell asleep. Later that day the second adult became agitated and elbowed a carer in the chest. In the late evening the second adult became agitated and stressed and took 90 minutes to calm.

4.53 On the same date the care home manager telephoned the second adult's GP practice to arrange a GP review on the advice of the RITT. The manager told the GP nurse practitioner that the second adult was very confused and aggressive and that there had been nine incidents of challenging verbal and physical behaviour. She added that Lorazepam, which was for the treatment

of anxiety, Zopiclone and Trazodone had been administered to the second adult but had not had a sedating effect. The manager added that the care home were going to insist that the second adult left that day and was transferred to a placement which was able to manage violent and aggressive behaviour. The manager said that two safeguarding concerns had been submitted – a witnessed incident against a resident (the fork incident on 1st October 2018) and what was described as an 'unwitnessed incident' against the female resident on 27th September 2019 (Paragraph 4.48) and a member of staff had been punched in the stomach. The GP practice appeared to confirm that recent blood tests had not disclosed any physical cause of the second adult's agitated behaviour. A GP visit to the second adult was offered, subject to him remaining at Care Home 1

4.54 The care home manager advised the 'social worker' by telephone that the home was no longer able to cope with the second adult's behaviour which was said to have escalated. In response the 'social worker' was to arrange for a registered nursing needs assessment (RNNA) to be completed as soon as possible as the second adult may require an Elderly Mentally Ill (EMI) placement. Meantime the manager advised that she was putting in place 1:1 male carer support for the second adult between the hours of 8pm and 8am. The social worker was to explore funding of the 1:1 care. The RITT psychiatrist was to visit the second adult the next day as an emergency.

4.55 On 2nd October 2018 Care Home 1 gave the second adult's family 28 day's notice to find an alternative placement for him. On the same date the RITT psychiatrist visited the second adult. She documented the deterioration in the second adult's presentation including irritability and agitation, physical aggression towards staff and potential risks to residents. No consistent triggers were said to have been identified. The psychiatrist referenced the incidents described in Paragraphs 4.44, 4.48 and 4.52. The second adult had been seen reacting to unseen perceptual stimuli, but was not unduly distressed by them. Sleep was said to be poor with intermittent sleep during the day. As a 'host' of anti-depressants had been used to address the second adult's presentation with no consistent therapeutic efficacy, the antipsychotic drug Risperidone 0.5mg – which is licensed for short term use to help manage aggression in elderly people with Dementia - was prescribed and antipsychotic monitoring initiated*. Lorazepam and Zopiclone were discontinued and Trazodone was to be discontinued once the second adult was settled. RITT were to continue to support the second adult and the RITT psychiatrist was to review the second adult as needed. Identified risks were documented as verbal and physical aggression directed at staff with the potential for physical aggression directed at residents. During that day the second adult had been pacing up and down the corridor trying to enter other resident's bedrooms at lunchtime and in the early hours of the morning. * Risperidone is only licensed for 'short-term treatment (up to 6 weeks) of persistent aggression in patients with moderate to severe Alzheimer's Dementia unresponsive to non-pharmacological interventions and when there is a risk of harm to self or others'. The review has seen no indication that Risperidone was stopped after six weeks.

4.56 On 4th October 2018 a CMHT clinician completed a RNNA in respect of the second adult in order to identify nursing needs due to his increased episodes of agitation and aggression to ensure he was in a placement which could manage his needs well. The outcome was that the second adult required an EMI placement (homes that specialise in looking after patients with diagnoses of dementia and require qualified input due to challenging behaviour) due to his 'challenging behaviour and risk to others'. He was said to be 'unmanageable in his current setting due to his unpredictable nature'. He required an EMI placement with 'more specialist staffing provision to deal with aggression when it occurs'.

4.57 On the same date the CMHT care co-ordinator visited the second adult who was said to still be presenting as unpredictable and appeared to be suffering from visual hallucinations. The care home staff reported that 1:1 support was working well as the second adult was said to require constant reassurance to prevent his behaviour from escalating. The CMHT care co-ordinator documented that 1:1 was currently in place at night and that this was reported to have been successful in preventing further incidents of aggression.

4.58 On 5th October 2018 the second adult became agitated and went over to another resident and waved his fists at her. A carer attempted to distract him and usher him away and the second adult attempted to hit her (the carer). He continued shouting obscenities at other residents. Later the same evening the second adult approached another resident and attempted to hit her. When a carer intervened, he again attempted to hit her. The carers were unable to remove the second adult from the lounge and other residents became very upset about his aggression and shouting.

4.59 During the early hours of 7th October 2018 the second adult was trying to get out of care home 1. Later that morning he was trying to get in other resident's rooms.

4.60 On 8th October 2018 the LCC social worker sent an 'action plan referral' to LCC Care navigation - which searches for services that match service user needs – requesting advice about EMI homes in the Preston and Fylde area. No review or FACE assessment was completed at this stage to reflect the anticipated change of placement type. The social worker requested the care home manager provide a list of incidents involving the second adult. Care Home 1 has recently shared a list of 21 incidents of agitated behaviour by the second adult which took place between 1st and 8th October 2018 with this review. It is unclear whether this was the list of incidents shared with the social worker. Subsequently a list of homes with vacancies was sent to the second adult's daughter. Neither she nor the second adult's wife had LPA for health and welfare at that time although this may have been obtained by 23rd November 2018 but has not been confirmed. On the same date the second adult hit and kicked the 1:1 carer.

4.61 On 9th October 2018 the social worker and the CMHT care co-ordinator applied for Complex Packages of Care (CPOC) funding to the Midland and Lancashire Commissioning Support Unit (MLCSU) for 1:1 support for the second adult by a male carer from 8pm to 8am when risks were elevated. This support was to continue until his family could identify an EMI nursing home or until he settled on newly prescribed psychotropic medication. Funding was approved the following day for the period 10th October until 9th November 2018.

4.62 On 10th October 2018 the care home manager revoked the 28 day notice. The Care Home 1 chronology states that the 'social worker' informed the manager that she could not issue such a notice as she had a duty of care to the second adult. The Care Home 1 chronology sometimes refers to the care co-ordinator as a 'social worker' so it is unclear from whom the 'duty of care' advice was received. From the letters sent by Care Home 1 to the second adult's wife and the CQC to advise that the 28 day notice had been rescinded, it appears that the decision to rescind was the outcome of a review conducted by Care Home 1. (The CQC investigation report states that 28 day notice was withdrawn on 16th October 2018 and the LCFT Safety and Learning Review states that the notice had been withdrawn by 25th October 2018).

4.63 Also on 10th October 2018 the LCC social worker was unable to visit the second adult as there had been an outbreak of vomiting and diarrhoea in Care Home 1. However, the social worker was able to speak to the care home manager who advised her that the 28 day notice had been revoked but that the second adult's family continued to look for an EMI home as a contingency. Two days

later the CMHT care co-ordinator reviewed the second adult who the care home manager said was presenting as more settled in his behaviour although 1:1 was still required at night.

4.64 On 16th October 2018 the second adult was seen by a CMHT medic who documented that he was presenting as more settled whilst still having episodes of agitation and so the dosage of Risperidone was increased to 0.5mg twice daily to assess whether increasing this drug would continue to have a positive impact on his behaviour. Two days later a CMHT support worker visited the second adult for antipsychotic monitoring and documented that care home staff had noted an improvement in the second adult's behaviour.

4.65 During the night of 20th October 2018 the second adult displayed challenging behaviour and hit the 1:1 agency worker and was verbally aggressive to other members of staff.

4.66 On 25th October 2018 the care co-ordinator visited the second adult and documented that care home staff reported that the second adult was very settled with no evidence of agitation or aggression. He was said to be accepting care and interventions and interacting with other residents. It was documented that the manager had withdrawn the 28 day notice as she felt that the second adult could be supported at Care Home 1. It was also documented that 'mental health staff wanted to support this and prevent further moves if possible which could have an impact on the second adult and cause further disorientation'.

4.67 On the morning of 30th October 2018 the second adult threw a metal spoon at a carer and was verbally and physically abusive to staff.

4.68 Between 31st October and 2nd November 2018 the CQC conducted a comprehensive inspection of Care Home 1 and the overall assessment was that the Care Home required improvement. Prior to the inspection visit, CQC Inspector 3 reviewed information the CQC held on the home and it was noted that the second adult had been displaying behaviours that may challenge. CQC Inspector 3 decided to review the risk assessments and care plans relevant to this aspect of the second adult's care during the inspection and talk to staff and check that audits identified incidents so that the service was identifying trends as required. The Inspector reviewed the second adult's risk assessment and behaviour management plan, saw documentation which evidenced there had been involvement by a mental health practitioner and discussed the second adult's current health with the care home manager. The CQC Inspector was informed that the second adult no longer displayed challenging behaviours and did not require 1:1 support from staff. This was corroborated by speaking with a member of staff who worked at the home, who was also able to explain the risk assessment and management plan for the second adult. The Inspector saw an accident audit and safeguarding audit which recorded the previous incidents and was informed by the manager that there had been no further incidents since. There is no record of the CQC Inspector being made aware of the rescinding of the 28 notice at the time of the CQC inspection, although, as stated in Paragraph 4.60 Care Home 1 had advised the CQC of their decision by letter.

4.69 Shortly before 5.00 am on 4th November 2018 the second adult was agitated, verbally aggressive towards staff and attempting to enter other resident's rooms. He entered another resident's room (identity of the resident not known) and got into the bed. The resident wasn't there at the time. Staff provided support to the second adult and reduced his agitation. Just over an hour later the second adult began hitting carers and trying to enter other resident's rooms. (The review has been advised that male carer 1:1 support was funded until 9th November 2018. It is unclear whether it was still in place at the time of the incidents described in this paragraph).

4.70 During the morning of 15th November 2018 the second adult hit two members of staff. Reassurance was given to de-escalate the situation.

4.71 On 16th November 2018 the second adult's GP increased his dosage of Risperidone to 0.5mg twice daily at the request of the memory assessment service. During the late evening of the same day the second adult began swearing and throwing unspecified items at carers.

4.72 Shortly after midnight on 19th November 2018 the second adult began trying to hit carers.

4.73 On 23rd November 2018 the care home manager contacted the second adult's GP to request a further increase in the dosage of Risperidone prescribed as his behaviour was said to be worsening again. He was said to have had a carer 'by the neck' and his mood had been worsening in the morning. The GP increased the dosage to 1mg twice daily. The RITT team was also involved in this decision (As stated in Paragraph 4.55 Risperidone is only licensed for short term (i.e. six weeks) use. By this time the second adult had been prescribed Risperidone for over seven weeks).

4.74 On 25th November 2018 the second adult hit a carer on the hand.

4.75 On 27th November 2018 the CMHT care co-ordinator visited the second adult to review his continued support. He was documented to still be presenting with some episodes of agitation, but the care home staff were said to be managing this well. The CMHT care co-ordinator documented that she was told that there had been no incidents of agitation within the last two weeks, which was incorrect. It was said to have been agreed to step down the second adult's care to the antipsychotic monitoring team in a month if he remained settled.

4.76 During the late evening of 1st December 2018 the second adult was verbally and physically aggressive towards carers who left his room and later re-entered to calm the situation.

4.77 During the evening of 4th December 2018 the second adult became agitated and began throwing objects at staff. Assistance from another member of staff was required to de-escalate the situation.

4.78 The following day a CMHT community support worker visited and documented that no issues were highlighted and care home staff reported that the second adult was settled in presentation. Again this was incorrect.

4.79 During the late evening of 10th December 2018 the second adult misidentified a resident as his wife whilst in an agitated state. He became very aggressive and was removed from the lounge to 'cool down'.

4.80 At 4.00am on 13th December 2018 the second adult began trying to kick and hit out at staff. During the early evening of the same day the second adult misidentified an un-named resident as his wife and was verbally aggressive and described as unhappy.

4.81 During the evening of 15th December 2018 the second adult attempted to hit a carer.

4.82 Shortly before 5.00am on 16th December 2018 carers were alerted by his pressure mat that the second adult was out of bed. He was agitated and his socks were wet with urine. He became verbally aggressive when staff attempted to assist him back to bed after removing his socks. He continued to shout for around 10 minutes, waking other residents.

4.83 Shortly before 7am on 18th December 2018 the second adult began hitting and punching staff for around 15 minutes whilst they were trying to guide him to the toilet. The carer noted 'the second adult won't have personal care without him lashing out!'

4.84 Shortly after 2.30am on 20th December 2018 the second adult's pressure mat alerted staff that he was out of bed. He was urinating in his sink and when carers attempted to assist him back into bed, he punched and kicked a carer and ran towards them attempting to hit them again. The duration of this incident was recorded to be 30 minutes.

4.85 Just before 8.00am on 23rd December 2018 the second adult was found in another resident's room and when carers asked him to leave, he hit them. Shortly before midnight on the same day, carers went to the second adult's room after they were alerted by his pressure mat that he was out of bed. He was urinating on the floor and when the carers attempted to assist him he became very aggressive, punching, kicking and spitting at staff.

4.86 The response to the second adult's presentation by Care Home 1 and other agencies inevitably dominates the chronologies shared with this review. Adult L's life in the care home had proceeded fairly uneventfully, although, in their contribution to this review, her daughters said that they were becoming concerned about staffing levels in the home. They felt that the manager had been successful in increasing the number of residents but this had placed greater pressure on the carers. Adult L's daughters also described the impact that the second adult's presentation had on their mother. The daughters said that the second adult was 'always walking about'. They said he was 'in and out' of other resident's bedrooms. They described him as a big man who could intimidate other residents and staff. The daughters said that Adult L began locking her door to stop the second adult going into her bedroom, which they say he habitually did, adding that she really didn't like him going in as she was scared of him (Paragraph 5.10).

4.87 Shortly after midnight on Thursday 27th December 2018 Adult L pressed the alarm in her room to attract the attention of a carer. The carer recorded that 'Adult L buzzed, very upset saying her head hurts (scalp), Adult L has a bruise on her scalp and a small cut, will hand this over to the day staff in the morning, hurts a whole lot, was unhappy. Medical'. There is no further mention of this incident in Adult L's care notes.

4.88 One of Adult L's daughters noticed bruising on both sides of her mother's face - next to her eyes - when she visited her between Christmas and New Year. The daughter advised this review that care home staff told her that Adult L had had a fall. Whilst the daughter was with her, the staff asked Adult L what had caused the bruises and she replied that she couldn't remember, but when it was suggested to her that the injuries were the result of a fall, she agreed with this. Her daughters have advised this review that the care home did not notify them of the fall until they only found out about it when they noticed the bruising and questioned staff about it.

4.89 Shortly after 5.00am on 27th December 2018 the second adult threw a shoe at a carer and tried to hit her whilst shouting his wife's first name. During the evening of the same day the second adult became agitated and threatened a carer with his clenched fist and was eventually assisted to his bed with the help of another carer.

4.90 Shortly after 4.00am on 30th December 2018 the second adult attempted to throw a drawer at a carer.

4.91 At 4.30am on 1st January 2019 the second adult hit a carer in the face.

4.92 On 2nd January 2019 the second adult's LCC social worker telephoned his daughter to inform her that due to her father's settled state, his case would be closed as no further involvement was needed. His case would be reviewed by the LCC social care team in twelve months.

4.93 Shortly after 6am on 4th January 2019 the second adult tried to get into another resident's room.

4.94 Shortly before 4am on 5th January 2019 the second adult's sensor mat alerted carers that he was out of bed. He attempted to throw items at carers.

4.95 On 5th January 2019 'Lancashire Safeguarding' visited the Care Home and met with the manager and deputy manager to discuss how best to support the second adult, his family and the care home. This meeting appears only in the Care Home 1 chronology. Lancashire Safeguarding have no record of the meeting on 5th January 2019 (which was a Saturday) or any date near that time. LCC Contracts Management was working with Care Home 1 during January 2019 (see Paragraph 6.95) but the issues they were monitoring did not include the support provided to the second adult. The Care Home has been unable to provide any further details of the 5th January 2019 meeting but have not said that it did not happen.

4.96 Around 8am on 6th January 2019 the second adult entered another resident's room.

4.97 Shortly after 5am on 8th January 2019 the second adult was out of bed 'lashing out at staff'. On the same date the CMHT care co-ordinator visited the second adult and documented that he was presenting as agitated in the evenings and mornings which care home staff were managing. It was reported that at those times he would shout and throw things around and hit out at residents and staff. It is unclear whether the care co-ordinator was informed of the nature and frequency of incidents which had been taking place. No new risks were identified.

4.98 Around 6.30am on 10th January 2019 the second adult attempted to enter another resident's room.

4.99 On 13th January 2019 the second adult pushed a carer during the afternoon and attempted to hit carers during the late evening. Shortly after 4pm he attempted to enter another resident's room.

4.100 The following day the second adult hit a member of staff with a belt.

4.101 During the early evening of 15th January 2019 the second adult entered another resident's room.

4.102 On 16th January 2019 the second adult was verbally aggressive to carers. At around 8pm on the same date the second adult tried to enter another resident's room.

4.103 On 17th January 2019 anonymous information was shared with the CQC via their 'share your experience' form on the CQC website. The information shared was as follows: 'A dementia resident with violent tendencies. The staff have no idea how to deal with him. When he becomes violent. A lot of the staff are scared of him but being made by management to deal with him. There is not enough staff to deal with all the residents.' The second adult was not named.

4.104 The resultant enquiry was assigned to CQC Inspector 3 – who had led the recent CQC inspection of Care Home 1 – and she attempted to contact the manager on the same date. The manager was unavailable but the inspector spoke to a carer who said that she felt there were enough staff on duty. She discussed the second adult who she said sometimes displayed behaviours which were challenging including pushing and picking things up to throw. However, the carer said that he was easy to distract and responded to a chat when agitated. She said that she was confident when supporting him. CQC Inspector 3 requested the manager contact her the following day.

4.105 On 18th January 2019 the CQC contact centre received an anonymous telephone call, the contents of which are summarised as follows:

- A violent resident, named as the second adult, sometimes goes into other resident's rooms during the night and punches them or pulls them out of bed. The caller has reported concerns about this to the manager but nothing has been done.
- He was said to have physically assaulted every member of staff (either punched, elbowed, or thrown crockery at them) last week he was found with a knife.
- Another resident was said to refuse to enter the dining room if the second adult was there, although all residents were said to 'fear him'. The other resident had begun to request his meals in his room out of fear he might see the second adult in the dining room.
- Approximately 3-4 weeks ago, the second adult went into Adult L's room and pulled her out of bed and gave her a black eye. The staff member who witnessed this recorded it on the system and it was reported to the manager who deleted the record from the system and told staff if any of Adult L's family ask how she was injured they must say she fell out of bed. This is despite Adult L never having fallen before and not being a fall-risk.
- Other records have gone missing from the system as well when they concern the second adult's violence. This behaviour is a daily occurrence because the home is too understaffed to provide the second adult the necessary 121 care to handle his dementia and violent activities. Once the second adult was given 28 days' notice to leave but nothing came of this and when the caller asked why he hadn't left the manager said, 'we're keeping him'.
- Residents are made to wait for their breakfast because staff are too busy calming the second adult in the mornings. There is a new staff member currently in her shadowing period but the manager is counting her as a full member of staff and making her work night shift with only one other carer.

4.106 This enquiry was also assigned to CQC Inspector 3 who telephoned the manager and requested information in respect of the allegations. The manager was documented to have told the CQC Inspector that the second adult did sometimes display challenging behaviour but that there were no reports of the incidents described by the whistle blower, except one incident when a staff member was elbowed because the member of staff did not follow the documented 'behaviour care plan' and risk assessments, the CMHT had reviewed his care the previous week and a review of medication also took place recently. 'Episodes' appeared to be linked to his bowel movements and care plan was in place'. The manager went on to say that staff had received 'training in challenging behaviour', but that further face to face training had been arranged for 'staff who needed more support'. Turning to the allegation that the second adult had assaulted Adult L, the manager said that she had suffered an unwitnessed fall and an investigation found that Adult L, who was said to have fluctuating capacity, had said that non-one had entered her room and pulled her out of bed or hurt her. The manager also commented on the other allegations made by the whistle-blower.

4.107 CQC Inspector 3 requested an investigation report including outcomes. On the same date (18th January 2019) CQC Inspector 3 raised the whistle-blower disclosures as a safeguarding concern with LCC and the CQC also informed LCC Contracts Management by email. The CQC Inspector also spoke to the regional manager of the provider of care home 1 (on 21st January 2019) who said that she would ensure that the concerns raised by the whistle-blower were investigated.

4.108 Shortly after 5pm on 19th January 2019 the second adult entered other resident's rooms.

4.109 On 20th January 2019 the care home manager contacted the CMHT to request further intervention and assessment for EMI care in respect of the second adult. During the morning of the same day the second adult went into another resident's room and later threw unspecified objects which hit a carer.

4.110 Shortly before 5.00am on the following morning (21st January 2019) the second adult hit a carer with a shoe.

4.111 Also on 21st January 2019 the deputy manager of Care Home 1 telephoned the CMHT care co-ordinator who documented that carers had told the deputy manager that they were scared of looking after the second adult and had taken their concerns to the CQC. However, there was said to have been no change in the second adult's presentation in that he appeared more settled than previously following the introduction of Risperidone, although he was very aggressive at night and in the mornings when he would hit out at carers. It was documented that as there had been no change in the second adult's presentation and the care home was not requesting additional support including 1:1 support, a step up to the RITT was not warranted at that time. It was also documented that there was agreement that 'this was a placement issue' and that the second adult may require an EMI placement which the CMHT care co-ordinator was to discuss with the RITT psychiatrist on 24th January 2019.

4.112 On 23rd January 2019 a staff meeting took place at Care Home 1 at which the manager told staff that she was very disappointed that someone had gone straight to the CQC without first following the procedure of approaching her first and then going to regional management. Training on behaviour which challenges had been sourced. Two masterclasses were to be delivered on 28th February and 19th June 2019. There appeared to be no reference to training to try and prevent the physical assaults on care staff.

4.113 On 25th January 2019 the second adult was prescribed Lorazepam on the instructions of the RITT psychiatrist who was said to have 'tried all types of medication to improve the second adult's behaviour' and felt that prescribing Lorazepam 'was the last resort' to support the care home until a more suitable placement could be identified. The care home manager expressed some doubt about the decision to prescribe Lorazepam on the grounds that it appeared to have made him more agitated when prescribed previously. A CMHT medic documented that care home staff were managing the second adult's behaviour well and the CMHT care coordinator did not feel that they required further 'education' as they had a 'good approach' which they had adapted to address the second adult's increased agitation in the early morning and evenings. However, during a conversation between the manager of Care Home 1 and the CMHT care co-ordinator it was agreed that the home was unable to manage the second adult as he was presenting currently and it was to be established if the previous RNNA needed to be updated or re-done prior to seeking an EMI placement.

4.114 On 25th January 2019 the second adult tried to enter another resident's room and later on the same date was said to be going in and out of resident's rooms.

4.115 On 28th January 2019 the CMHT care co-ordinator requested the completion of an 'up to date' RNNA to support the identification of a new placement.

4.116 On 30th January 2019 the CMHT care co-ordinator documented that the care home manager had reinforced the second adult's behavioural care plan with staff who were expected to manage

his behaviour by giving him space to prevent agitated behaviour and positioning a sensor mat by his door so that staff became aware of when he left his room. The second adult was said to be more settled and 'able to be managed better' by care home staff.

4.117 On 30th January 2019 the CQC received the Care Home 1 investigation report which had been authorised by the Regional Manager and led by the care home manager. The findings relevant to this review (there were 15 specific allegations) were as follows:

- the second adult was 'under review' from the CMHT and became aggressive when personal care was taking place or his wife was visiting. Risk assessments and a behaviour care plan were in place. 1:1 support had been put into place for 28 days, his behaviour monitored, which seemed to settle down. The second adult was said to go into other rooms 'on the odd occasion however he is looking for his wife'. The manager made reference to his entering a resident's room when an 'unwitnessed incident' occurred (Paragraphs 4.44 and 4.45) which had been raised as a safeguarding concern and closed by the MASH. Only care staff who 'persistently' did not follow the risk assessment and behaviour plan when delivering personal care had been assaulted by the second adult. There was no knowledge of the second adult being in possession of a knife.
- Turning to the allegation that Adult L had been assaulted by the second adult, the report stated that Adult L had had an unwitnessed fall and had been spoken about this in the presence of her daughter. The report stated that at no time had Adult L said that she had been pulled out of bed by the second adult.

4.118 The care home manager concluded the investigation report by stating that she had completed a full investigation and had identified the following actions:

- 'Extra external face to face training on behaviour that challenges has been arranged for staff'.
- 'All staff are to undertake their supervision where they can voice any concerns'.
- 'Staff meeting has taken place.'

4.119 The investigation report also stated that no immediate risks with the service delivery which residents were receiving, had been found.

4.120 During the afternoon of the same day (30th January 2019) the second adult tried to grab a walking frame off a resident.

4.121 Shortly after midnight on 3rd February 2019 the second adult was very agitated as carers tried to assist him out of another resident's bedroom.

4.122 On 5th February 2019 a CMHT support worker visited the second adult to take bloods for the purpose of antipsychotic monitoring and noted that he presented as unshaven, unkempt in appearance and was wearing no footwear. The second adult was documented to often resist personal care and so his appearance on that date was not regarded as unusual.

4.123 During the evening of 5th February 2019 the second adult hit another resident on the nose and later the same evening another resident entered the second adult's room and he (the second adult) threw objects including a chair which hit a carer.

Thursday 14th February 2019

4.124 During the preceding evening (13th February 2019), at around 9pm, the second adult grabbed a female resident's walking frame. During the incident the female resident fell to the ground. Whilst

one carer took the female resident to her room, the other carer on duty took the second adult to the dining room where he eventually fell asleep. He had awoken by around 1.30am on the morning of 14th February 2019 and a carer made him a cup of tea after which she and her colleague conducted trigger pad checks of resident's bedrooms. They heard Adult L screaming and rushed to her corridor where they found that the second adult had grabbed hold of Adult L, holding her neck with one arm and her legs with the other. He then 'catapulted' her into the corridor with force from her bedroom. He then tried to grab her again whilst saying 'come on (first name of the second adult's wife)'. The carers managed to drag Adult L into another resident's bedroom. The second adult banged on the door of this other resident's room for a time and one of the carers went into the corridor in an effort to calm him down and was punched in the face. The other carer rang the care home manager who advised her to ring the ambulance service which she did. The second adult then walked up and down the corridor kicking and pushing other resident's bedroom doors. His agitated behaviour continued until shortly before the police arrived.

4.125 At 2.22am NWAS received a 999 call reporting that Adult L had been 'chucked out of bed' by the second adult, sustaining a head injury although she was said to be completely alert. The care staff reported being 'locked in' Adult L's room whilst the second adult was outside the room banging on the door and was 'aggressive with other staff who were outside the room with him'. NWAS called the police at 2.25am who attended Care Home 1. An ambulance was despatched at 3.33am and on arrival Adult L was found on the floor and alert. She was complaining of arm/shoulder pain and pain in her hip which the crew noted to be shortened and rotated. She had a 1-2 inch laceration to the side of her right eye and was complaining of a headache. She was given pain relief and conveyed to hospital 1, accompanied by the care home manager, who had been called out, where she was diagnosed with a fracture to the right neck of her femur, a fracture to the right humerus and a lacerated forehead/eyebrow.

4.126 The police spoke to one of the care home staff who told them that the second adult had approached Adult L who was in bed and physically picked her up and thrown her out into the corridor. A criminal investigation was commenced.

4.127 Later that day, the care home deputy manager contacted the second adult's CMHT care co-ordinator to advise that the second adult had thrown Adult L to the floor fracturing her right hip and shoulder and that the police had been called.

4.128 Lancashire MASH received a safeguarding concern in respect of the incident at 9.25am which was screened and allocated out to a MASH social worker within the hour and an urgent joint visit with the police took place during which case records were removed and information gathering commenced. The social worker later recorded that the second adult pushed Adult L across the hallway causing a fractured hip and shoulder. The second adult was said to have become unpredictable in his behaviour, agitated at night and sometimes resistive to personal care intervention but that certain staff felt frightened of him. Care Home 1 was said to be no longer able to manage his care needs.

4.129 At 11.30am the CMHT care co-ordinator and medic visited Care Home 1 and made a medical recommendation for the second adult to be admitted under Section 2 of the Mental Health Act due to the potential risks of further incidents and the need for him to have a full inpatient assessment. The CMHT medic documented that the second adult had misidentified Adult L as his wife and pulled her from her bed causing injuries. (The RITT psychiatrist's letter of the same date stated that the second adult was calling out his wife's name whilst he was observed to be apologising to Adult L later). It was also documented that care home staff had been struggling with

the second adult's behaviour over the past week in that he had been observed moving furniture and had become irate at staff for not helping him. It was also documented that the only trigger appeared to be his wife's visits.

4.130 At 12.45pm a RITT Gatekeeping Assessment was completed and a bed requested for the second adult. The justification for admission was documented to be escalation of risks and the unpredictability of the second adult's behaviour which could place others at risk.

4.131 At 3.30pm a RITT MDT took place at which it was agreed to step the second adult down from a Mental Health Act admission and that the RITT would support the second adult in terms of optimising his medication, completing a RNNA, putting 24 hour 1:1 support in place and identifying an EMI placement. This was agreed to be the least restrictive option and 'would be best for the second adult'. An earlier referral to the Approved Mental Health Professional (AMHP) team for the second adult to be assessed under the Mental Health Act was withdrawn.

4.132 The CMHT care co-ordinator updated the risk assessment for the second adult which highlighted reduced impulse control which led to him becoming argumentative and shouting which was directed towards his wife or people he thinks are his wife. It was noted that the second adult was physically strong. It was noted that medication had been trialled but was only partially successful, tending to manage the second adult's aggression for a limited time only. The resultant plan was for 1:1 care to be arranged if the second adult was not able to be admitted that day. (The plan was prepared prior to the decision not to proceed with a Mental Health Act omission and does not appear to have been amended when it was decided not admit the second adult). The CMHT care co-ordinator contacted LCFT Safeguarding to request updates from previous safeguarding concerns raised in respect of the second adult.

4.133 Lancashire County Council Emergency Duty Team (EDT) agreed to fund 1:1 support overnight for the second adult who was said to have barricaded himself in his room. Care Home 1 has been unable to provide any further details of this incident.

4.134 Later that day Care Home 1 notified the CQC of the incident stating that care home staff were alerted when Adult L screamed after the second adult entered her bedroom, pulling her out of bed. Staff responded and entered and witnessed the second adult throw Adult L to the (laminate) floor of the corridor. CQC Inspector 3 was assigned to the incident and received an update from the Care Home manager the following day (15th February 2019).

4.135 On 15th February 2019 the RITT completed an urgent RNNA. They also applied to the CHC team (MLCSU) for funding of 1:1 support for the second adult from 10pm to 9am daily, adding that LCC Adult Social Care had agreed to fund 1:1 care from 4pm to 10pm daily. The RITT were advised by the CHC team to contact the complex care team as the second adult was not CHC funded. This led to a delay in funding being put in place but the care home manager went ahead and arranged 1:1 support for the full period without all funding being in place, due to the level of risk.

4.136 On the same date the RITT completed the RNNA and sent it to the MLCSU. The LCC social worker began looking for vacancies in appropriate placements which entailed completing a fresh action plan in consultation with the second adult's family and submitting it to Care Navigation who subsequently sent a list of nursing homes to the second adult's daughter. Over the next few days two EMI placements rejected the second adult owing to the risks he presented to other residents.

4.137 Between 16th and 20th February 2019 the RITT visited or telephoned the care home daily and were advised that 1:1 support remained in place for the second adult but his behaviour remained

unpredictable and aggressive. On 18th February 2019 the care home advised the RITT that they had given the second adult's family 48 hours' notice due to the risks involved in managing the second adult's needs. On 19th February 2019 the care home advised that a sensor mat had been placed in the second adult's room.

4.138 On 21st February 2019 the second adult's daughter discussed a further incident involving her father with the LCC social worker which she had not previously been aware of. She said that the second adult had hit the Care Home manager and a male staff member. (No further details.) On the same date a RITT MDT took place at which it was confirmed that the RITT would continue to provide support until an EMI placement had been identified.

4.139 On 21st February 2019 the second adult became agitated and began pacing the corridor and going into other resident's bedrooms. He entered the room of a bedbound female resident and became extremely aggressive towards staff and throwing objects. Care staff had to position themselves in front of the bedbound resident to prevent injury to her. The incident lasted for around 20 minutes. This incident was not included in the Care Home 1 chronology and was shared with the review at a very late stage during enquiries to establish details of the 'barricading' event on 14th February 2019 (see Paragraph 4.134) There is no indication that a safeguarding referral was made.

4.140 On 22nd February 2019 the care home manager completed an investigation report which found that staff required first aid training because Adult L had been moved after the assault, that there was no trigger for the assault which was described as 'random' and that the second adult needed to move into a 'specialised care unit'. On the same date a CMHT support worker was informed by staff that the second adult had become agitated that day and thrown a plate at a member of staff.

4.141 By 25th February 2019 the second adult had been offered a place at Care Home 2 and a RITT clinician visited the second adult to review the support he required prior to the forthcoming transfer. The CMHT care co-ordinator reviewed his risk assessment which was unchanged apart from the following elements; the psychiatrist had reviewed his medication and had decided to change Risperidone to Olanzapine once the second adult's placement began, covert administration of medication was said to have been agreed as compliance had become an issue, the CMHT would continue to support the second adult through the transition, the LCC social worker would review the new placement in respect of which a DoLS application was said to have been made.

4.142 On 25th February 2019 CQC Inspector 3 spoke with Care Home 1's regional manager about the care home's internal investigation and documented that 'the evidence suggests the second adult did not take Adult L from her bed'.

4.143 On 1st March 2019 the second adult was transferred to Care Home 2 by the RITT. (The second adult's daughter has provided a different account of how the transfer took place (Paragraph 5.39). 1:1 support was agreed for four weeks to support a period of transition to the new placement. 4.144 On 4th March 2019 the CMHT care co-ordinator received a telephone call from Care Home 2 reporting that the second adult was presenting as agitated and was wandersome. The care home was managing with 1:1 support but queried how long this would be in place for. They requested a medic review.

4.145 Following her admission to hospital 1 the previous day, on 15th February 2019 Adult L was operated upon and a dynamic hip screw inserted under general anaesthetic. Her fractured humerus was managed conservatively with a 'collar and cuff'. It appears that she was assessed as lacking capacity to consent to treatment which was said to have been undertaken in her best interests.

There is no indication that DoLS application submitted. The operation on her hip was described as uneventful and the plan was for fluids, pain relief, physiotherapy and discharge.

4.146 Adult L was observed to present as confused and sleepy with a poor dietary intake. She was unable to follow instructions when seen by the core therapy team. She continued to struggle to engage with efforts to assist her to mobilise due to pain.

4.147 Discharge planning commenced on 20th February 2019. She was described as severely frail and requiring assistance with personal care and hygiene. She received a blood transfusion on 22nd February 2019 to reduce the risk of a cardiac event and was considered to be medically fit for discharge. A care home reassessment highlighted a possible need for a nursing care placement, which was later confirmed.

4.148 On 5th March 2019 Adult L was reviewed by a speech and language therapist who noted mild swallowing problems which appeared to be related to overall fatigue rather than any obstruction or muscle loss.

4.149 On 7th March 2019 a deterioration in Adult L's condition was noted and there was a possibility that she had experienced a neurological event or decompensation (the failure of an organ (especially the liver or heart) to compensate for functional overload resulting from disease) secondary to other medical events. She was not considered to be suitable for feeding via a nasogastric tube.

4.150 On 11th March 2019 Adult L was discharged to Care Home 3. Two days later the care home arranged for a GP visit to Adult L who complained of a sore head and the light hurting her eyes. (The notification of Adult L's death to the CQC on 26th April 2019 by Care Home 3 referred to Adult L's suffering constant severe headaches following admission to Hospital 1 but there is no reference to this in the Hospital 1 chronology. Hospital 1 has advised this review that they had no knowledge of Adult L experiencing severe headaches during her admission).

4.151 Adult L was admitted to Hospital 2 with 'PR bleed' on 21st March 2019 (No details of the Hospital 2 admission, care & treatment have been requested by this review) and she was discharged to Care Home 3 on 2nd April 2019 for end of life care (No details of end of life care have been requested by this review).

4.152 Adult L died on 21st April 2019. A Home Office Post Mortem was undertaken which established that Adult L sustained a subdural bleed which appeared to have been overlooked by Hospital 1. Cause of death was given as bronchial pneumonia as a result of the injuries suffered during the assault on 14th February 2019.

5. Family Contribution

Views of the families of Adult L and the second adult

5.1 Two daughters of Adult L met with the Panel Chair and the SAR Independent Reviewer. The family had agreed that the two daughters would contribute to the review on behalf of their sisters and brothers.

5.2 The daughters said that Adult L came from a mining family in Fife in Scotland. She and her late husband had seven children. Her daughters described Adult L as a very sociable person who was an accomplished ballroom dancer.

5.3 Adult L lived in Scotland nearly all her life but the two daughters helped her move to Lancashire to live near them during 2017. They arranged for their mother, and her dog, to live in a rented bungalow for six months before helping her move into a sheltered housing scheme. The bungalow and the sheltered housing were situated near the sister's homes in Lancashire so they were able to fully support their mother. She later became ill with a urinary tract infection and pneumonia for which she was hospitalised for a period.

5.4 It was at this time that the daughters came to the conclusion that their mother would be unable to continue to live independently in her sheltered housing, and would probably need a residential placement. Around this time, they also arranged for Adult L to have a dementia assessment as she had started to become forgetful. This assessment disclosed that their mother had 'just a touch of dementia'. Looking back, the daughters said they regretted arranging for the dementia assessment as this diagnosis limited the care homes they could consider for their mother to those which specialised in providing care for people with dementia, which they understood the Care Home 1 to do. (The CQC describes Care Home 1 as a residential care home which specialises in caring for adults over 65 years, dementia and physical disabilities.)

5.5 The daughters said that their mother was initially placed in Care Home 1 to help her 'get back on her feet'. The care home was located in between the daughter's homes. They said that their mother occupied a ground floor room with en-suite bathroom and they moved in her furniture and photos. The daughters did all of their mother's washing and visited her very regularly, taking her dog with them. Together, the daughters and Adult L would walk the dog in the grounds of the care home. Their mother walked with a stick and needed some help bathing but was otherwise fairly independent. They said she could dress herself.

5.6 The daughters recalled the manager of Care Home 1 being promoted into that role and that she began working hard to increase the number of people placed in the care home. She was successful in increasing the number of residents but the daughters became concerned that the staff were under greater pressure as a result.

5.7 The daughters said that Adult L suffered with headaches and was prescribed paracetamol to be taken 4 times daily. She would complain to her daughters that she had not been given this medication by staff. The daughters thought she may have been given the paracetamol and forgotten that she had taken them. They said that they raised the issue with staff and were told that the night staff couldn't administer medication to the residents after 8pm in the evening. The daughters asked the manager about this and she replied that 'Of course the night staff can administer paracetamol'. The daughters were also concerned that the cream prescribed for their mother's back pain was not always administered by the staff, a concern which the MAR sheets they examined backed up. However, the daughters said that they applied the cream whenever possible on their visits to their mother.

5.8 The daughters said that Adult L settled into Care Home 1 and liked it there. The daughters were also happy with the home although they were concerned that because many of the other residents had greater needs than their mother, she didn't have many people with whom she was able to hold a conversation. They also felt that some of the other residents could be quite disruptive. The daughters felt that their mother would have had a better quality of life in Care Home 1 if the residents with the highest level of needs and those with lower levels of needs (such as their mother) had had separate lounges.

5.9 The daughters said that the second adult was 'always walking about', adding that he was 'in and out' of the resident's bedrooms, constantly performing actions which suggested he thought he was cleaning the windows. They went on to say that he was a big man who could intimidate other residents and staff. They recalled an incident when a female resident became distressed because the second adult was trying to tuck her into her bed. One of the daughters reported this to the staff. They also saw the second adult 'really slap' another resident. They said that staff were present at the time of this incident. The daughters recalled another incident in which the second adult held a member of staff in a head lock until another resident intervened and asked him to let the member of staff go, which he did. The daughter's assumed that this incident had been reported by staff. Overall, the daughters felt that the second adult was 'hard work' for the care home staff.

5.10 The daughters said that their mother began locking her door to stop the second adult going into her bedroom. They said that she really didn't like him going in as she was scared of him. They said that if he came into her room, she would say 'get him out, get him out'. The daughters said that they didn't like their mother locking her door and asked her not to do it, adding that they were worried that she might become ill whilst locked in and no-one might notice. They said that the staff did not carry a spare key to their mother's room with them and had to go to the office to obtain a duplicate key.

5.11 The daughters said that the second adult habitually went in their mother's room but he also went into other resident's rooms. They said they had been told that he was shouting his wife's name when he attacked their mother in February 2019, but they never heard him calling out his wife's name when he went into Adult L's room whilst they were present.

5.12 During December 2018, possibly sometime between Christmas and New Year, one of the daughters noticed blue coloured bruises on both sides of their mother's face, next to her eyes. The staff told her that Adult L had had a fall. When they asked their mother what had caused the bruises, she replied 'I cannae remember' but when it was suggested to her that the injuries were the result of a fall, she replied 'aye'. (Although their mother had become more forgetful, they didn't feel that there had been any cognitive decline during her time at Care Home 1, adding that 'she never forgot to be frightened of the second adult'). They added that the care home had not notified them of the fall at the time it happened and that they only found out about it when they noticed the bruising and questioned staff about it.

5.13 The daughters said that the care home never advised them of the disclosures made by the staff whistle-blower in January 2019. They said they had only been told about these by the police and a social worker quite some time after the 14th February 2019 incident.

5.14 Turning to the incident in which the second adult assaulted their mother, they said that one of the daughters received a telephone call from the care home around 4am to the effect that Adult L 'had been in an altercation with the second adult' and that their mother was on her way to hospital. The daughters were later told the second adult had been wandering around the home and that he was being monitored by the two members of staff who were on duty. The daughters said they had been told that he was agitated and that the staff took him to the lounge where he calmed down. The daughters said that they had been told that the staff had then been called away to deal with something else and had left the second adult alone in the lounge. The second adult then went to their mother's bedroom, which was 3 or 4 rooms away from the lounge, and attacked her.

5.15 The daughters were concerned that the staff had rung the registered manager before contacting the ambulance service given that their mother's head 'had been split open'. The

daughters said they were upset when a member of staff said that it was 'a shame' Adult L had not locked her door on the night that the second adult assaulted her. They felt that this was an insensitive and inappropriate comment to make.

5.16 The daughters also expressed concern about the time that the second adult spent at Care Home 1 after the attack on their mother. They recall seeing him in the home whilst they were clearing their mother's things out of her room after she had been hospitalised.

5.17 The daughters had understood the second adult's bedroom to be on the first floor (the floor above their mother) of the care home but after the attack on their mother, they were told that his bedroom was only 2 or 3 rooms away from their mother's room on the same floor (ground floor) which had surprised them. Care Home 1 has advised this review that both Adult L and the second adult had rooms on the ground floor but they were on separate corridors with two doors separating the rooms with key coded locks.

5.18 The daughters said that they had been told by the CQC that the second adult had assaulted another female resident on the day before the incident in which their mother was injured (the 'day before' was clarified with the daughters to be the morning of 13th February 2019). The CQC has no record of either this conversation with the daughters or being notified of the incident to which the conversation referred. The daughters are adamant this information was shared with them by the CQC during a meeting and, having now read this report, the sisters assume that the incident which took place the 'day before' their mother was assaulted is the incident described in Paragraph 4.124).

5.19 Turning to Adult L's care in hospital following the attack, the daughters said that their mother had been cared for very well in A&E but that the staff on the four bedded ward to which she was subsequently transferred had struggled to care for her adequately. The daughters said that they asked the ward staff to help their mother get out of bed, but they managed this only once. The daughters felt that their mother needed help to 'get her back on her feet' but that this was not forthcoming, adding that during her entire hospital stay, their mother never fed herself or went to the bathroom again. The daughters said that Adult L was catheterised and was unhappy about using a bedpan. They recalled one incident when their mother said she needed to go to the toilet and was told by a nurse 'to do it in her pants'. They said they complained about this incident and received an apology.

5.20 The daughters were unaware that their mother had sustained a 'bleed on the brain' at that time but noticed that whilst she was in hospital, she couldn't tolerate bright lights.

5.21 During the hospital admission, the daughters noticed a deterioration in their mother's cognitive ability, adding that she eventually stopped communicating. They said that their mother had no recollection of the 14th February 2019 attack although they recalled her screaming when one of the daughter's husbands, who like the second adult is very tall, went to kiss her goodbye at the end of a family hospital visit. The daughter's wondered whether their mother had mistaken her sonin-law for the second adult and that this had triggered a fleeting memory of the attack.

5.22 The daughters were very upset that their mother had experienced nine weeks of suffering as a result of the attack. Whilst in hospital, they recalled her asking them to 'take me home hen to ma wee hoose'. However, the daughters said that they accept that the second adult is not to blame for their mother's death.

5.23 The daughters requested answers to the following questions:

- Why was the second adult placed in Care Home 1?

- What did the care home put in place to support the second adult? They understood that no floor alarm mat had been placed in the second adult's room to alert staff when he got out of his bed during the night. As far as the daughters could see, the support provided to the second adult appeared to be no different from that provided to the other residents.
- Should they (the daughters) have been told about the risks the second adult posed to their mother and other residents?
- How competent and how well trained were the staff employed by Care Home 1 to work with vulnerable residents?
- Was the ratio of staff to residents sufficient as the numbers of residents increased, particularly as many of those residents were people with quite challenging behaviours? The daughters didn't notice staffing levels increase as the number of residents increased and there were times when it was difficult to find a member of staff in the care home during the evenings.
- The daughters want to be completely clear how the bruising they saw on their mother's face in late December 2018 was caused. Was it the result of a fall, or was it the result of an incident involving the second adult? If he caused these injuries and they had been told, they say they would have promptly moved her out of Care home 1 and she would still be alive. They also say that if they had been told about the disclosures made by the whistleblower, that may also have prompted them to move their mother out of the Care Home 1.
- The daughters felt that it would have been useful to have known who the keyworker was for their mother. They implied that they were told that Adult L had a key worker but they were never told which member of staff was fulfilling this role.

5.24 The daughter and son-in-law of the second adult met with the Panel Chair, the SAR Independent Reviewer. The CSU Head of Safeguarding was also present.

5.25 The daughter said that her father's placement at Care Home 1 was initially for two weeks to provide her mother with respite from the challenges of caring for the second adult. She said that by this time he had become very confused, was becoming more and more violent towards her mother and wasn't using the bathroom and so was becoming unkempt. The daughter said a difficult dynamic developed between her parents as her father became increasingly confused. She felt that her mother did not understand her father's illness and simply thought he was being 'difficult' and so she criticised his behaviour and made demands of him which he was too unwell to comply with. The criticisms from his wife 'wound the second adult up' and so he behaved aggressively towards her and a vicious cycle developed.

5.26 The daughter said that her father settled well in Care Home 1 initially. He was away from the relationship with his wife which the daughter felt had become quite 'toxic'. Several of the female residents 'made a fuss of him' and he initially enjoyed the attention. However, over time, the daughter said that she became aware that staff and residents were scared of her father and that some residents expressed the opinion that he shouldn't be in Care Home 1.

5.27 The daughter felt that her father was difficult for the staff to manage, but this was partly because he was quite a private person and there were no male staff to help him use the bathroom, which led to tension between himself and the female staff. However, she went on to say that she felt that her father became something of a scapegoat and that some of the complaints about his behaviour may have been exaggerated. On one occasion a member of staff said that the second adult had thumped her but there wasn't even the slightest sign of any injury. The daughter said

that things got so bad that they would avoid the Care Home 1 manager in case she raised another complaint about her father's behaviour.

5.28 The daughter recalled that on one occasion a member of staff told them that her father had 'bust a door' at Care Home 1 and her husband was asked to fix it. The daughter went on to say that when they spoke about the issue to the manager she did not appear to know anything about it, which caused the daughter to wonder whether the staff were keeping information from the manager.

5.29 The daughter recalled that her father kept trying to 'escape' from Care Home 1. He was found climbing the perimeter fence on one occasion she recalled. This was a source of great anxiety to the second adult's wife as the home that they had shared was 'just around the corner' from Care Home 1 and she (his wife) was frightened that he would 'escape' and kill her. Specifically, she was worried that he would return home and see that she had disposed of his carrier pigeons, which she feared would make him angry.

5.30 The daughter felt that because of the risk of 'escape' from Care Home 1, a member of staff should have monitored him when he went outside, as he often did, to smoke. She added that there were many times when the family visited the second adult in Care Home 1 and the staff were unable to locate him. Invariably he would be found in the garden. She felt that Care Home 1 was 'massively under-staffed' and that the staff were 'tearing around' all the time because they were so busy.

5.31 The daughter confirmed that there was an alarmed mat next to Adult L's bed but she said that the mat never seemed to be connected, or to work properly or perhaps to be 'listened to'.

5.32 The daughter also said that the management of her father's medication 'was never right'. Often the medication wasn't there, she said. On one occasion she recalled being asked to go to the pharmacy and collect her father's medication. She wondered if there were insufficient staff to collect prescriptions from the pharmacy.

5.33 The daughter said that when she and her mother visited the second at Care Home 1, she 'never felt safe'. She described how they were put in a side room with her father and the door was closed. She said that she eventually forbade her mother from visiting because she was worried that the second adult would be violent towards her.

5.34 The second adult's daughter said that the first 28 day notice from Care Home 1 came 'out of the blue' (October 2018). The family then tried to find an alternative placement, but potential providers asked them why they needed to find a placement for her father so quickly. The daughter implied that disclosing that they had been served with a 28 day notice could result in potential providers being reluctant to offer her father a placement.

5.35 At that time Care Home 2 was considered as a potential destination for her father, but Care Home 1's manager advised the daughter that her father might find that home to be quite noisy. The daughter said her father was unable to tolerate a noisy environment. The daughter remembered that her father's medication was changed at this time and, as a result, he 'went really quiet' and it was agreed with the manager that he could remain at Care Home 1.

5.36 The daughter also recalled that her father was provided with 1:1 support at this time. She said that there was an argument over how this would be funded and that 'they' billed her mother for it who was unable to meet the costs from her pension. She said that the matter was only resolved when the CHC funding 'came through'.

5.37 The daughter said that the manager told her about the whistle-blower allegations in January 2019. The registered manager didn't give her any details of the allegations but described the manager as 'furious' that the staff member had blown the whistle rather than raising the matter with her directly.

5.38 When the February 14th incident took place, the daughter said that she was told that her father had been wandering in the night and pushed Adult L over and broken some bones, adding that by the time the police were called, her father was sleeping in the lounge. The daughter also recalled being told that her father had been in another female resident's room and pulled her out of bed whilst shouting his wife's name and telling her to 'get up'. She couldn't remember when this incident took place other than it may have been in her father's 'early days' at Care Home 1.

5.39 Following the 14th February 2019 incident, the daughter said that a second 28 day notice was sent to her mother's address whilst she (her mother) was being treated in hospital. She felt that Care Home 1 were desperate to 'get her father out', with the manager even suggesting they could take him to A&E in order to achieve this. The daughter went on to say that Care Home 1 was so desperate to 'get her father out' that they simply put him in the back of a car, accompanied by a carer and one of the Care Home 1 administrative staff and drove him to Care Home 2, despite the fact that the daughter and her husband had been asked to arrange the transfer to Care Home 2 themselves. The daughter and her husband had planned to transport her father to Care Home 2 in their car with the assistance of the member of staff who was providing 1:1 support to him. This member of staff did not commence their shift until 4pm, following which it was planned that they would help the family convey the second adult to Care Home 2. However, before this plan could be put in place, the daughter said that the manager arranged her father's transfer as described above.

5.40 Overall the daughter reflected that she was faced with a very challenging set of circumstances and didn't really know what to do for the best. Initially her focus had been on protecting her mother from her father's deteriorating mental health and the accompanying violence and providing her mother with some respite. Her father had seemed to settle in Care Home 1 well to begin with but when problems began to arise with the placement, she said she would have welcomed more advice and support, particularly when Care Home 1 served the first 28 day notice in respect of her father, which had come as quite a shock. The daughter felt she had been quite naïve in subsequently accepting the manager's assurances that her father could be cared for safely in Care Home 1.

5.41 The daughter also felt that when her father was initially placed in Care Home 1, she wasn't well informed about her father's needs, any assessment that was completed at that time and whether Care Home 1 was equipped to meet his needs. She felt that she had to rely heavily on information provided by her mother, who didn't really understand the second adult's illness, didn't share all relevant information with the daughter and was to an extent 'broken' because of the increasing difficulty in coping with the second adult's behaviour.

5.42 Adult L's daughters and the second adult's daughter were provided with the opportunity to read and comment on the final draft of this report.

5.43 Adult L's daughters said that they were shocked to read of the number of incidents involving the second adult's agitated behaviour which took place in Care Home 1 prior to the 14th February 2019 assault on their mother. The sisters said that they counted 56 separate incidents and felt that it was unacceptable that the second adult was not moved to a placement where he could be managed safely. Having read the report, they questioned the competency of the manager of Care

Home 1 and ask why no-one questioned her competency and some of her decisions at the time, particularly as she was an unregistered manager. They said that they were happy with the report and supported the findings and recommendations.

5.44 The second adult's daughter said that it was evident to her that Care Home 1 clearly couldn't manage her father when he was agitated. She went on to say that Adult L and her father were let down by a lack of basic communication and information sharing by the agencies involved in supporting her father. She said that she was happy with the report and supported the findings and recommendations and hoped that some good would come out of the review.

6. Analysis

Each of the terms of reference questions will be addressed in turn.

The decision to place Adult L in Care Home 1 and subsequently move from a short term to long term placement.

6.1 Adult L appeared to have an unremarkable placement in Care Home 1, but for the presence of the second adult and the risks he presented to her, other residents, Care Home 1 staff and himself when agitated.

6.2 She was assessed by Care Home 1 against the broad headings of 'cognition', 'psychological', 'physical', 'social' and 'end of life'. She was said to have diagnoses of 'early onset' dementia (it was incorrect to describe her dementia as 'early onset') and aortic stenosis. There appeared to be no doubts about her mental capacity at this stage although she was said to be affected by occasional forgetfulness. Her mood was noted to be 'low' as a result of the change in her circumstances. No history of falls was noted and there was no requirement for a pressure mat or bed rails. Her daughters were documented to visit her frequently.

6.3 The regional manager contributed to one of the practitioner learning events arranged to inform this review and commented that at the time both Adult L and the second adult were placed in Care Home 1, pre-admission assessment were not completed in sufficient detail and steps have been taken to make improvements including the introduction of an electronic system and improved training. Care Home 1 has advised this review that their systems were reviewed and a decision was made that they would no longer accept residents currently under the RITT and that they would not accept any admissions without a full assessment received from LCC Adult Social Care. The care home has also advised that pre-admission assessment would highlight impacts on the community already resident within the home.

When Adult L sustained a head injury in December 2018 what action was taken by the provider to prevent the risk of further injury? Was a safeguarding alert made or considered at that time?

6.4 There are differing accounts of the head injury sustained by Adult L in December 2018.

6.5 Care Home 1's care notes for Adult L record that at 12.15am on Thursday 27th December 2018 Adult L pressed the alarm in her room to attract the attention of a carer, who recorded that she was 'very upset saying her head hurts (scalp), Adult L has a bruise on her scalp and a small cut, will hand this over to the day staff in the morning, hurts a whole lot, was unhappy'. An hour earlier – 11.15pm on 26th December 2018 – her room had been visited by a carer when she was noted to appear to be asleep. There is no further mention of this incident in Adult L's care notes.

6.6 The Care Home 1 accident/incident report states that the incident took place at 6.35pm on 27th December 2018 and that she sustained a small graze to the head when she slipped out of bed and banged her head on a bedside cabinet. The report was completed on the same date and documented that it had not been necessary to seek medical help and that the action taken consisted of an initial wound assessment and observation record. No risk assessment or falls observation record were considered necessary nor was any alteration to her care plan. The accident/incident form also stated that Adult L's relatives were notified.

6.7 One of Adult L's daughters noticed bruising on both sides of her mother's face - next to her eyes - when she visited her between Christmas and New Year. The daughter advised this review that care home staff told her that Adult L had had a fall. Whilst the daughter was with her, the staff asked Adult L what had caused the bruises and her mother replied that she couldn't remember, but when it was suggested to her that the injuries were the result of a fall, she agreed with this. Her daughters have advised this review that the care home did not notify them of the fall until they noticed the bruising and questioned staff about it. The Panel overseeing this review questioned how appropriate it was to ask Adult L, a person with a diagnosis of dementia, a 'leading' question in an effort to establish how her head injury had been caused. The Panel also felt that the Home's internal investigation of this incident should have documented whether there were doubts about Adult L's mental capacity at that time.

6.8 The injuries described by Adult L's daughter – bruising on both sides of her mother's face next to her eyes – differ from the injuries noted by the carer who responded to Adult L's buzzer – bruise on her scalp and small cut – and the injury noted in the Care Home 1 accident/incident report – small graze to her head. There is also a large discrepancy over the time the incident took place – 12.15am according to the care notes and 6.35pm according to the accident/incident report. A plausible explanation is that 6.35pm was the time that the accident/incident report was completed. The report states that Adult L's relative had been informed so it seems possible that the report was only completed after her daughter asked about her mother's visible injuries during a visit.

6.9 A further account of the injury sustained by Adult L was provided by the staff whistle-blower who alleged to the CQC that she sustained a black eye after the second adult went into her room and pulled her out of bed. The whistle-blower further alleged that the manager had deleted the record of the incident from Care Home 1's information system and told the members of staff involved to tell Adult L's family that she had fallen out of bed. The whistle-blower added that Adult L had never fallen out of bed before and was not considered a fall risk. The CQC became aware of this incident when it was disclosed to them by the whistle-blower. It had not been reported to them by Care Home 1 at the time it happened.

6.10 The providers of Care Home 1 have advised this review that it is not possible to delete an entry from their information system so any allegation that the manager deleted the record of the incident appears to be completely untrue. However, it was true to say that Adult L was not documented to have fallen before and was not previously considered a falls risk. It is also abundantly clear that the second adult habitually went into other resident's rooms and that some residents sustained injuries during these visits. Care Home 1 has no record of the second adult entering Adult L's room although they are unable to say whose room he entered on the majority of occasions when he was documented to have entered another resident's room. If the whistle-blower provided an inaccurate explanation of how Adult sustained the injuries to her head on 27th December 2018, it is unclear what the whistle-blower's motives would be for providing a false

account when there were several incidents in which the second adult entered other resident's rooms and the resident sustained injuries.

6.11 Adult L's daughters understandably wish to find out whether their mother was assaulted by the second adult on 27th December 2018. They say that he did enter their mother's room at times and that she was afraid of him. However, it is difficult to reach a definitive conclusion about what happened on 27th December 2018. Adult L did not allege that the second adult was responsible for her injury although the care home manager documented that she had fluctuating capacity at that time so she may not have fully comprehended what was happening to her, particularly if she was woken suddenly. The second adult's care notes indicate that he was asleep at 12.15am on 27th December 2018.

How effectively was the whistle blower allegation that Adult L had been assaulted by the second adult in December 2018 investigated? Was the allegation shared with her family?

6.12 Please see the analysis of the later investigation of the allegations made by the whistle-blower, including the allegation that Adult L had been assaulted by the second adult.

Were the risks the second adult presented to Adult L, and other residents of Care Home 1, assessed and managed/mitigated by the provider?

6.13 It is clear that any resident of Care Home 1 could be at risk from the second adult when he was presenting with agitated behaviour. Female residents appeared to be at higher risk because of the frequency with which the second adult misidentified female residents as his wife, to whom he increasingly presented with violence and aggression in the period prior to his placement in Care Home 1 and during his wife's visits to him after he was placed there. However, the second adult also assaulted male residents and frequently assaulted the exclusively female care staff. A male carer provided 1:1 support during October and November 2018.

6.14 It is not known whether the second adult particularly targeted Adult L. The incidents in which the second adult is known to have entered other resident's rooms and apparently assaulted them involved residents other than Adult L. However, her daughters have confirmed that their mother was in fear of the second adult and began locking her bedroom door to prevent him entering, which exposed her to other risks. Care Home 1 has advised the review that Adult L began locking her bedroom door prior to the admission of the second adult and that the 'seniors' held a master key at all times. Adult L's daughters disagree with this. They say that their mother only began locking her door when she became scared of the second adult and believe her to have started locking her door in September or October 2018.

6.15 If the second adult did enter Adult L's room and assault her on 27th December 2018, this would give the theory he may have been targeting her greater credence. However, this review has been unable to confirm that this was the case.

Prior to 14th February 2019, did any of the incidents in which the second adult mistook female residents for his wife, threatened or physically abused residents or entered other resident's bedrooms, involve Adult L? If so, what action was taken by the provider to safeguard her?

6.16 The second adult began misidentifying fellow residents as his wife from the first week of his placement in Care Home 1 (Paragraph 4.27). Not all incidents of misidentification are recorded in the Care Home chronology. Misidentification was not referred to in risk assessments and was not seen as a trigger for agitation unlike visits by the second adult's wife, his resistance to personal care and his bowel movements, which were all seen as triggers for increased agitation at times.

6.17 Misidentification was noted as an issue when the CMHT care co-ordinator updated the second adult's risk assessment to reflect the fact that he had recently been placed in Care Home 1. Given his observed and reported aggression - including physical violence - towards his wife when he was being supported to live at home, one might have expected the issue of misidentification to have been given greater prominence as a risk to other residents. It seems possible that the second adult's eyesight problems could also have been a factor in his misidentification of fellow residents as his wife as at the time his placement began he was waiting for a cataract operation (Paragraph 4.35) and a professional who has worked with him since the 14th February 2019 incident said that she had been advised that he did not have good spatial awareness.

Were the family of Adult L communicated with adequately and appropriately during her stay in Care Home 1?

6.18 Adult L's daughters have advised this review that they were not told about the 27th December 2018 injury to their mother and one of her daughters needed to ask for an explanation from care staff when she noticed her mother's injuries.

6.19 Adult L's daughters are particularly upset that Care Home 1's management did not tell them about the whistle-blower allegations. They felt that as the allegations related, in part, to their mother, they had a right to know about them. They feel that had they been told about the whistle-blower's allegations they could have reviewed their mother's placement in Care Home 1 and considered moving her to a different home. Neither the CQC nor LCC MASH considered contacting Adult L's family or advising that this should be done. The CQC has advised this review that it was the responsibility of the provider of Care Home 1 and the LCC safeguarding lead to inform/liaise with the family. It is neither their remit, nor their normal practice where they have received information of concern from a whistle-blower relating to an individual who has been safeguarded. The CQC add that the provider and local authority have a duty of candour.

When Adult L was hospitalised following the assault by the second adult, how effective was the care and treatment she received and how appropriate were the arrangements for discharging her from hospital?

6.20 It is not possible to fully address this terms of reference question as chronologies were not sought from Care Home 3, to which Adult L was discharged from hospital 1 or hospital 2, to which Adult L was admitted from Care Home 3.

6.21 However, this review has received the Rapid Review conducted by hospital 1 after they were informed that the post mortem examination of Adult L disclosed an undiagnosed serious head injury. The Rapid Review acknowledged that no CT scan had been completed following Adult L's admission despite her Glasgow Coma Scale (GCS) score of 14. National Institute for Health and Care Excellence (NICE) guidelines – *Head injury: assessment and early management* – recommends that patients with a GCS of less than 15 at two hours after injury should have a CT scan (1). However, the guidelines also recommend that account should be taken of the patient's pre-injury baseline, which may have been less than 15 where the patient has dementia or learning disabilities for example. The Rapid Review states that in this case Adult L's baseline GCS was 14 due to her dementia and therefore a CT head scan was not clinically indicated. Clearly this was a clinical judgement taken on the basis of information available at the time. However, the SAR questions whether it was appropriate to rely on a pre-injury baseline based on conversations between the ambulance service and care staff in the immediate aftermath of the incident i.e. post injury. It is accepted that Adult L

had a diagnosis of dementia. When they read the final draft of this SAR/MHHR, Adult L's daughters said that they were unhappy that a CT scan was not completed.

6.22 The Rapid Review considered the subdural bleed found at post mortem and whether the Coroner deemed it chronic or acute. It was agreed by participants in the Rapid Review that an acute bleed would have occurred subsequent to the 14th February 2019 incident, whilst it would be difficult to tell how long a chronic subdural bleed had been present.

6.23 The Rapid Review concluded that had Adult L received a CT scan and a subdural bleed identified, due to the patient's medical conditions, the hospital would not have operated and the outcome for the patient would have been the same. However, it is unclear from the Rapid Review whether her care and treatment would have been different had the subdural bleed been identified.

How appropriate was the second adult's placement in Care Home 1? Was the care home capable of meeting his presenting needs at the time he was placed there, initially for respite, and subsequently as a long term placement?

6.24 Care Home 1 is registered to provide 'Accommodation for persons who require nursing or personal care, Dementia, Physical disabilities, caring for adults over 65 years'. As a Care Home the staff will not be required to have nursing qualifications, nor specialist knowledge of dementia, although some staff may have. Care homes in general are known to have a very high proportion of residents with dementia. An Alzheimer's UK report entitled *'Home from home: A report highlighting opportunities for improving standards of dementia care in care homes'* stated that two thirds of residents were known to have dementia (2). The same report highlighted the difficulties faced by care homes in caring for people with dementia and the need for enhanced skills so that staff can better manage the behavioural and psychological symptoms of dementia (BPSD).

6.25 The second adult had been increasingly aggressive at home, with several quite violent assaults on his wife. He was accepted by the Single Point of Access (SPA) for mental health services on 5th January 2018 after referral by his GP, due to concerns with regard to deterioration in memory, disorientation, and verbal aggression to his wife. Although he was assessed by a clinician from the SPA on 22nd January (Paragraph 4.7) we have not seen evidence that an assessment of the risks posed by the second adult was completed then. The SPA sent a letter to the GP which noted verbal aggression and shouting on a daily basis, and mentioned a recent 'jab/punch' to the second adult's wife's stomach (Paragraph 4.8). A risk assessment was completed on 23rd April 2018 which noted the risk of aggression to his wife, to whom he was said to be controlling and aggressive, with a marked deterioration in short term memory (Paragraph 4.11). No formal assessment of mental capacity was undertaken or sought at this stage.

6.26 By the 15th of June 2018, the second adult was under the care of the CMHT and receiving medication to help reduce the behavioural and psychological symptoms of dementia (Paragraph 4.14). He was reported to be irritable and verbally aggressive to his wife but not physically aggressive at this time.

6.27 On the 27th June the CMHT received a 'phone call from the second adult's daughter reporting his verbal aggression to her mother, that he was 'vile towards her', that she was 'terrified of him' and he had repeatedly lashed out at her and had hit her in the face causing bruising two days earlier (Paragraph 4.15). Following this call, the care coordinator telephoned the second adult's wife who reported that he had grabbed her on several occasions but not left a mark when he had hit her, but also that she wanted to support him at home as much as possible (Paragraph 4.16). It appears that the second adult's wife felt able to make these disclosures during the telephone call

as her husband was in the garden. Had he not been in the garden, she may not have felt safe in making the disclosures. It would have been preferable for a home visit to have been made. Additionally the second adult's wife could have been offered specialist domestic abuse support. The physical aggression was reported to Lancashire County Council (LCC) Safeguarding and received by the MASH on 28th June 2018 (Paragraph 4.17).

6.28 The care co-ordinator completed a risk assessment on 1st July 2018 which noted a 'risk of aggression due to becoming frustrated and angry in response to functional difficulties' (Paragraph 4.18). On 5th of July the care coordinator noted that the second adult was resistive to personal care interventions (Paragraph 4.19).

6.29 On 6th July 2018 urgent respite support was sought due to an escalation of aggression to the second adult's wife. His daughter reported that he had hit her mother several times (Paragraph 4.20). He was referred to the RITT in an attempt to step up the support given at home to the couple. By the following day (7th July) the second adult's wife reported that he had settled following the call to the Emergency Duty Team and a visit by the RITT.

6.30 On 17th July 2018 Care Home 1 was identified by the CMHT care coordinator and the social worker as suitable for respite care for the second adult as risks were escalating at home, and his wife was struggling to cope with his aggression and was at risk of further assaults.

6.31 The care plan written by the CMHT co-ordinator on 30th July 2018 - which was shared with Care Home 1 - notes that the second adult had moderate to severe dementia and that his 'difficulties are causing significant frustration for him, which is triggering anger and aggression directed towards his (wife). Often he does not recognise (her) as his wife but continues to target her'. It goes on to note that personal care was difficult as he could become agitated and verbally aggressive when his wife attempted to assist him, and that his wife was struggling with her role as a carer due to the increased aggression.

6.32 The care plan advises Care Home 1 that 'the CMHT will continue to monitor and support with behaviour in short term care', and if there were any concerns about the second adult's mental health to contact the care coordinator in office hours, and that the RITT was available from 8am to 8pm. However, the care plan does not identify how Care Home 1 staff should provide personal care to the second adult, and how to respond to any aggressive outbursts if they occurred.

6.33 An LCC FACE Mental Capacity Assessment for the second adult - which appears to be dated 1st August 2018 - appeared to consider the benefits of staying in Care Home 1. This assessment documented that the second adult's wife could no longer sustain her caring role, and had difficulties coming to terms with her husband's illness and behaviours. It was documented that the second adult had grabbed and pushed her, not recognising what he had done, that he was neglecting his personal hygiene, and refusing to change clothes. His wife expressed her wishes for her husband to remain at Care Home 1, which was 'deemed appropriate to meet his current needs'.

6.34 On admission, Care Home 1 completed an initial assessment of the second adult which stated that his wife was no longer able to manage at home and he was becoming increasingly aggressive towards her (Paragraph 4.25). The care plan advised staff to be aware that the second adult could become aggressive during personal care and that visits from his wife were also triggers for agitation.

6.35 Care Home 1 has advised this review that they received no written assessment or care plan from the 'social worker' at that time and that the information they relied upon for the initial

assessment was relayed over the phone and obtained from the second adult's family. At one of the practitioner learning event arranged to inform this review CMHT practitioners disputed this account and stated that the care home was provided with a copy of their most recent assessment.

6.36 It is clear that CMHT shared a care plan with Care Home 1, although the wording did not adequately describe the risks he presented, despite a well-known and documented history of aggression and violence to the second adult's wife. It is also clear in both the CMHT care plan and the LCC FACE assessment that the risks identified are all towards the second adult's wife and at that point no risks were identified to other people.

6.37 At the practitioner learning event many attendees expressed the view that, in hindsight, despite being a care home for dementia, Care Home 1 was not a suitable place to provide care for someone with the complexity of the second adult, as the staff would not have been adequately trained and skilled to deal with this degree of challenging behaviour.

How effectively did the provider respond when the second adult began to present with challenging behaviours? Was the behaviour management plan drawn up by Care Home 1 appropriate? Was the plan reviewed and updated when his challenging behaviour escalated? Was there appropriate involvement from the community mental health team in helping draw up the behaviour management plan?

6.38 (Paragraph 4.25) Care Home 1 appears to have assessed the second adult as a medium dependency resident and medium risk. There is no indication that this risk assessment level changed until the 14th February 2019 incident.

6.39 There are noted differences in what was actually happening with the second adult on a day to day basis, and the information shared with the CMHT and other health and social care professionals. Whilst it is possible that health and social care professionals downplayed the degree of risk, it is also possible the same could be said for the care home. It is also possible that there is a difference between care home management views and care home staff on the floor.

6.40 For example, on 20th September (Paragraph 4.47) there was a discussion between the social worker and the care home manager, who informed the social worker that the second adult was not a management problem and that adequate measures were in place. It is assumed that this discussion informed the social worker's plans to discharge the second adult. However, between the 12th of September and the 17th September there had been two incidents of the second adult entering the wrong room, three aggressive episodes and one violent episode (resulting in a safeguarding referral). It was also reported that the second adult had punched his wife on several occasions in the previous week.

6.41 Similarly, on 30th October he was aggressive and threw a metal spoon. However, the following day the CQC visited and they were informed that the second adult was no longer displaying challenging behaviour (Paragraph 4.68).

6.42 Between November 4th and 27th there were three aggressive incidents and four violent incidents, yet when the care coordinator visited on 27th November 2018, whilst it was documented that the second adult was displaying some episodes of agitation, the care home staff were said to be managing him well (Paragraph 4.75)

6.43 By late November 2018 the CMHT care co-ordinator was said to be planning to step down support to the antipsychotic monitoring team (Paragraph 4.75) despite the fact that his male carer 1:1 support had only ended earlier that month which had been followed by instances of increased

agitation although at the practitioner learning event the care co-ordinator said that she had been unaware of all the incidents documented in this report.

6.44 On 5th December 2018 the second adult was visited by the CMHT support worker. It is recorded that 'no issues were highlighted on this visit' (Paragraph 4.78) but there had been two episodes of violent and aggressive behaviour reported on 1st and 4th December (Paragraphs 4.76 and 4.77).

6.45 Between 13th December 2018 and 2nd January 2019 there were eight aggressive and eight violent incidents, including instances of the second adult throwing a drawer and a shoe, lashing out at carers whilst being taken to the toilet and hitting a carer in the face. On 2nd of January 2019 the social worker informed the second adults daughter that due to his settled state they would discharge him from their caseload (Paragraph 4.92).

6.46 It is apparent that despite the frequent aggressive and violent incidents between August and January, often when the CMHT staff enquired how the second adult was doing they were informed he was settled and the staff were managing him, despite the fact there had been recent incidents.

6.47 It would have been helpful for the CMHT and Care Home 1 to have commenced an incident log early in the placement, so as to report and record the frequency and number of incidents more accurately. It appears that without more accurate information regarding the frequency and nature of the incidents, and the lack of reporting by Care Home 1 staff, the CMHT were often (falsely) reassured that the second adult was settled when in fact this was not the case and more robust intervention was required to help manage the aggressive and violent incidents.

6.48 Mental health services sometimes downplayed the risks the second adult presented. For example the RITT psychiatrist visited him shortly after his placement began referred to a 'brief period of being unsettled' as though the behaviours he presented with at the start of his placement (Paragraphs 4.26-4.28) were in the past, when it was far too soon to tell, and these behaviours continued.

6.49 When the CMHT care co-ordinator updated the second adult's risk assessment following his placement in Care Home 1 (on 18th August 2018), she also struck an unduly optimistic tone. It was documented that he 'had been much more settled' since moving to Care Home 1, and his 'mood and agitation were reported to have improved' (Paragraph 4.34). In comparison with the crisis which had developed in the last few weeks during which the second adult had been supported to live at home, the situation had undoubtedly improved, but it seems to have been premature to begin contemplating discharging him (also Paragraph 4.34).

6.50 The 'rule of optimism' may be apparent here i.e. a tendency by social workers and healthcare workers towards rationalisation and under-responsiveness in certain situations. In these conditions, workers focus on strengths, rationalise evidence to the contrary and interpret data in the light of this optimistic view (3). The SAR independent reviewer has begun to notice a connection between the 'rule of optimism' and workload pressures in this and other reviews in that one factor in taking an optimistic view appears to be the potential removal of a client from the case load of very busy professionals.

6.51 Visits by the second adult's wife were perceived to be a trigger for his agitation. It is unclear what the outcome of the care home's plan to speak with the family to look at ways of supporting visits (Paragraph 4.36 and 4.38). The chronology supplied to this review by Care Home 1 provides no evidence of any connection between family visits to the second adult and subsequent agitated

behaviour, nor is it is known if this was actively monitored. However, there is an indication of a link in Paragraph 4.46 when the second adult's daughter reported that he had punched her mother several times the week before the 17th September 2018 incident in which the male resident was injured. The second adult's daughter has advised this review that she eventually forbade her mother from visiting her husband in Care Home 1 because she was worried he would be violent towards her (Paragraph 5.33). It is not known when the second adult's wife stopped visiting him, or whether she completely stopped visiting him. There appears to have been an over emphasis on the visits of his wife as a trigger for the second adult's violence as opposed to his tendency to misidentify female residents of Care Home 1 as his wife and re-enact the violence and aggression towards them which had become a feature of his relationship with his wife after he became increasingly unwell.

6.52 The care home manager twice advised the LCC social worker that the second adult had disconnected a sensor mat outside and inside his bedroom door by pulling out the wire (Paragraphs 4.44 and 4.47). If this is correct and if it was suspected that the second adult disconnected his sensor mat to avoid his movements being detected, then this represented an increase in risk.

Were concerns about the second adult's challenging behaviour appropriately escalated by the provider to the regulators, the commissioners of his placement and the community mental health team?

6.53 When Care Home 1 notified the CQC of the incident in which the second adult kicked out at a female resident on 22nd August 2018, the CQC was informed that this was the 'first incident' (Paragraph 4.35). It is not known how the CQC gained the impression that this was the 'first incident' other than it was the first incident Care Home 1 had notified them of in respect of the second adult. This may have been the beginning of a tendency for the care home manager to minimise the impact of the second adult's behaviour and claim that Care Home 1 could manage this. The two exceptions to this tendency to minimise were at the time of the first 28 day notice and following the 14th February 2019 incident. If it is accepted that the manager repeatedly minimised the risks presented by the second adult, it is not known why she might have done this. (The manager had left Care Home 1 by the time of the practitioner learning events arranged to inform this review). It has therefore not been possible whether, for example, she might been under pressure not to 'give up' on residents for financial reasons.

6.54 The safeguarding referral submitted by Care Home 1 in respect of the above incident was partially substantiated but LCC noted that the second adult was 'settling into the home' at the time of the incident in which the second adult kicked out at a female resident (Paragraph 4.35). He had been placed in Care Home 1 for over a month at the time of this incident which was actually the latest in a sequence several incidents in which the second adult had presented with aggression to either staff or residents.

6.55 Minimisation may also have been present in the outcome to the Section 42 Enquiry following the 17th September 2018 incident (Paragraphs 4.44 and 4.45) in which it was documented that the care home had been unable to establish whether a fall or an assault had taken place. The circumstances as shared with this review strongly indicate an assault.

6.56 The CQC appropriately obtained assurance that the risks presented by the second adult were being managed effectively by Care Home 1 when they inspected that establishment between 31st October and 2nd November 2018 (Paragraph 4.68). However, the second adult's male carer 1:1 support was not withdrawn until after the CQC inspection visits took place (on 9th November 2018).

6.57 Overall Care Home 1 should have considered raising safeguarding concerns more frequently in respect of incidents involving the second adult when agitated. The lack of escalation of safeguarding concerns to the local authority has probably had the effect of placing greater emphasis on the role of the CQC in this case who point out that where they are the first receiver of information of concern, they triage/risk assess the information and raise a safeguarding alert with the local authority where necessary. The local authority are the lead and investigate the concerns. As stated elsewhere in the report, the Section 42 Enquiry conducted following the whistle-blower allegations did not challenge the internal investigation conducted by the Care Home. There is no indication that there was any linkage between the section 42 Enquiry and LCC Contracts Management who were working with the Care Home at the same time.

Did the provider make safeguarding referrals when appropriate? Did the local authority address any safeguarding referrals effectively?

6.58 LCC MASH has not advised this review of a number of safeguarding referrals made by Care Home 1 in which the second adult has harmed or threatened harm to other residents. This appears to be because the MASH does not have authority to record or search safeguarding referrals other than against the name of the person harmed or threatened with harm. The result of this is that the ability to track the risk presented by a care home resident to other care home residents via the monitoring of safeguarding referrals is unavailable. This is an issue which has been commented upon by the SAR independent reviewer in a previous LSAB SAR and is an issue which must be addressed on public protection grounds.

6.59 It is therefore unclear whether the MASH connected the first safeguarding referral they received in respect of the resident who the second adult kicked out at on 22nd August 2018 (Paragraph 4.35) with the safeguarding referral they received in respect of the 17th September 2018 incident (Paragraph 4.44 and 4.45). Each safeguarding referral would have been searchable against the names of the residents harmed or threatened with harm, but not against the second adult. (Although it was possible to search for safeguarding referrals by location i.e. Care Home 1). It is of note that the later 17th September 2018 incident was described by the MASH as 'isolated' which suggests that it had not been linked in any way to the earlier safeguarding referral.

Were the second adult's physical assaults on other residents, and his wife when visiting, reported to the police?

6.60 There is no indication that any of the assaults sustained by the second adult's wife before or after his placement at Care Home 1 began, or assaults sustained by residents or staff at Care Home 1, as a result of the second adult's agitated behaviour were reported to the police prior to the 14th February 2019 incident. This may suggest that there is a much greater tolerance of violence within care homes than in society generally despite the fact that the residents of care homes are amongst the most vulnerable people in society and the overwhelming majority of care home staff are women. LSAB guidance on 'physical abuse and reporting incidents to the police' states that 'criminal acts must be reported to the police' (4).

6.61 The Panel overseeing this review questioned whether there needs to be some reflection on the impact of the second adult's behaviour on the community in which he lived and asked whether there was learning about the cultural acceptance of behaviour which challenges in care homes. The Panel asked if agencies responses would have been different if the second adult's behaviour was known to have been occurring in a private dwelling? The panel also questioned the extent to which the second adult's behaviour was minimised because of his dementia and age. The Panel also

challenged how acceptable it was for care home staff have to deal with this level of behaviour which challenges and asked whether care staff are sufficiently skilled to address it.

Was the impact of the second adult's presenting behaviour on other residents in Care Home 1 given appropriate consideration when decisions were made by the provider and other agencies, particularly when the 28 day notice to find an alternative placement was cancelled?

6.62 Consideration of the impact of the second adult's behaviour on the other residents of Care Home 1 appears to have been given insufficient weight by the CMHT or the LCC social worker throughout. In contrast NWAS made a safeguarding referral following the 17th September 2018 incident which explicitly highlighted the risks to other residents from the second adult (Paragraph 4.45).

6.63 The CMHT supported the manager of Care Home 1 in reversing the decision to transfer the second adult to an EMI home in October 2018. One of the reasons documented for this was CMHT concern that the second adult could experience disorientation as a result of the move (Paragraph 4.66).

6.64 The decision not to proceed with detaining the second adult under the Mental Health Act was justified on the grounds that the alternative to detention was the least restrictive option and 'would be best for the second adult' (Paragraph 4.130). Again the needs of other residents of Care Home 1, where the second adult remained for a further two weeks after the 14th February 2019 incident, do not appear to have been prominent in decision making. It was suggested that the Mental Health Act route should be reconsidered when difficulties were initially encountered in placing the second adult in an EMI home following the 14th February 2019 incident, although this option was not progressed.

When the second adult was reassessed as requiring an Elderly Mentally Ill placement, why was he not transferred to a placement which was able to meet his assessed needs?

6.65 A number of the serious incidents involving the second adult during September 2018 strongly indicated that his agitation and risk to himself and others was escalating and by 1st October 2018 the manager of Care Home 1 had concluded that the care home could no longer safely manage him. On the basis of the information shared with this review, this appears to have been an entirely appropriate decision. It is unclear who the manager communicated this decision to because of the care home's practice of referring to a generic 'social worker' in their records who could have been the LCC social worker or the CMHT care co-ordinator. Given the 'social worker' the manager notified of her decision to serve notice on the second adult then arranged for a RNNA to be carried out, it would this suggest that the 'social worker' was the CMHT care co-ordinator. The RNNA was promptly carried out and the outcome was that the second adult required an EMI placement. The second adult's family were given 28 days' notice to find an alternative placement for him. Meantime appropriate steps were taken to manage the risks he presented to himself and others. The RITT psychiatrist prescribed Risperidone which appears to have been effective and the care home manager quickly put male carer 1:1 support in place for the second adult, for which funding was subsequently agreed. The second adult's family experienced some difficulty in identifying a placement but Care Home 2 emerged as a viable option.

6.66 However, the manager then reversed her decision and the second adult was allowed to remain at Care Home 1. The full rationale for this decision has not been shared with this review. The Care Home 1 chronology states that the 'social worker' informed the Care Home manager that she could not issue the 28 day notice as she had a duty of care to the second adult. If given, this was

clearly incorrect advice which the care home should not have acted upon. Any duty of care the care home owed the second adult did not extend to keeping him in a placement which did not meet his needs and where the risks he presented to himself and others could not be managed. At the practitioner learning event the CMHT care co-ordinator said that she would not have given such advice to the manager. The LCC social worker, who may also have been involved in the decision making, has since retired. Neither agency's records shed any light on this matter. The letter from Care Home 1 to the second adult's wife rescinding the 28 day notice implied that the care home had conducted some form of 'review'. Whilst Care Home 1 was in a stronger position to manage the agitated behaviour of the second adult as a result of the combination of medication and male carer 1:1 support, his agitated behaviour continued. Care Home 1 has recently provided details of 21 separate incidents documented between 1st and 8th October 2018 alone. The severity of incidents which occurred during September 2018, including a serious incident involving a female resident which Care Home 1 states they have no record of, and the continuing incidents even after 1:1 support was put in place should surely have been given more weight in any review of the 28 day notice. The CMHT also appear to have come round to the view that the second adult should remain in Care Home 1 in order to prevent him experiencing disorientation arising from the move. It also appears that the second adult's family may have been dissuaded against his transfer to Care Home 2 over concerns that he may be unable to tolerate the level of noise at that location (Paragraph 5.35).

6.67 Within a short time of the male carer 1:1 support ending, the challenges staff faced in managing the second adult's behaviour began to increase. Additionally, at the care home manager's request, the second adult's GP twice increased his dosage of Risperidone.

Why was the recommendation for a Section 2 Mental Health Act assessment of the second adult rescinded?

6.68 Section 2 of the MHA (1983) is intended to provide the lawful means so that mental health services can detain, assess and treat a person who is:

> *"suffering from mental disorder of a nature or degree which warrants the detention of the patient in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period; and*
>
> *(b) he ought to be so detained in the interests of his own health or safety or with a view to the protection of other persons.*

6.69 It is a principle in the Mental Health Act Code of Practice 2015 that mental health care should always be of the least restrictive option. The 'least restrictive principle" states that *"Where it is possible to treat a patient safely and lawfully without detaining them under the Act, the patient should not be detained. Wherever possible a patient's independence should be encouraged and supported with a focus on promoting recovery wherever possible."*

6.70 In 2015, the Mental Health Act Code of Practice called on mental health services to reduce restrictive interventions. These practices include the use of restraint, seclusion and rapid tranquilisation. They also include wider practices: for example, preventing a patient from accessing outdoor space (5).

6.71 The MHA also affords certain rights to individuals, including access to advocacy, rights of appeal, providing the nearest relative with rights of discharge, and perhaps most important, oversight of detained patients by the CQC.

6.72 It is understand that the recommendation for a Section 2 MHA (to be followed by admission to be detained in hospital) was withdrawn and replaced with 1:1 support over 24 hours from a belief that this was the 'least restrictive option'. However, providing continuous 1:1 supervision for any person must be seen as preventing a person's independent ability to determine where they want to go, and is therefore restrictive practice, even if deemed necessary and in a person's best interests. It now appears that after the recommendation for detention under Section 2 MHA was rescinded, the second adult was still subject to a restriction of his liberty.

6.73 The Mental Capacity Act (2005) is intended to provide safeguards for people who lack capacity and are unable to communicate their wishes, but who are not behaving in a way that would indicate they wanted to leave. Although a FACE assessment on the 5th July 2018 identified that the second adult lacked mental capacity, he never received a mental capacity assessment. A 'Best Interests' meeting took place on 1st August where it was decided that the second adult lacked capacity to make decisions regarding his placement, and it was agreed to make the placement permanent. An application was then made for detention under the Deprivation of Liberty Safeguards on 7th August 2018.

6.74 It is difficult to see how the decision to rescind the recommendation for Section 2 MHA was the least restrictive option, since he was then placed under continuous 1:1 supervision, and arguably this was not in the second adult's best interests since he was denied the oversight and safeguards provided by the Mental Health Act. Nor did he receive the protections intended by the Mental Capacity Act as despite the restrictions on his liberty imposed by 1:1 supervision, no fresh DoLS application was made.

6.75 Section 2 MHA would also have provided a lawful means to give the second adult medication without their consent, albeit in a suitable hospital or nursing home registered for that purpose. (Care Home 1 was not such a place and so it would have been necessary to admit the second adult to a new facility (either hospital or EMI registered nursing home). The second adult had been assessed as lacking capacity to consent to his placement in Care Home 1. There is no indication that his capacity to consent to medication was assessed in his placement in Care Home 1 during which he was given psychotropic medication.

6.76 It is of note that even with 1:1 support from 4pm to 9am etc. Care Home 1 were unable to manage the second adult effectively and gave his family 48 hours' notice to his family to find an alternative placement four days after the decision not to proceed with MHA (Paragraph 4.136).

6.77 Also of note is the barricading incident later on 14th February 2019 (Paragraph 4.132), assuming this is a separate incident to the incident in which Adult L was injured. At a very late stage in this review Care Home 1 shared details of a further very serious incident in which the second adult entered the room of a bedbound female resident which required staff to position themselves in front of the resident to protect her from injury whilst the second adult was aggressive and throwing objects (Paragraph 4.138).

How effective was the support the second adult received from community mental health services?

6.78 From the initial assessment and referral to the RITT in January 2018, and then transfer to the CMHT in April 2018, the second adult and his wife were provided with a degree of support whilst he remained in his own home, and the second adult commenced treatment for his newly diagnosed dementia with Memantine. However, this support could not respond to his increasing aggression throughout the day, and it became apparent that urgent respite care was needed for his wife.

6.79 On transfer to Care Home 1 the expectation would be for a robust care plan that identified all of the second adult's needs and suggested interventions based on a thorough formulation. This care plan should have included identification of triggers for aggression, factors that made aggressive outbursts worse, and suggested interventions to minimise the consequences of any aggression, to prevent it escalating to a violent incident. This might for instance include suggested behaviours of staff, and ways of approaching the second adult when he became aggressive.

6.80 Following reports of increasing aggressive and violent episodes, the expectation would be for Care Home 1 and the CMHT to have developed a joint care plan which included escalation if behaviour became increasingly worse. Also expected would have been a discussion of how the CMHT and psychiatrist could best help the care home manage the second adult's behaviour, with consideration of the possible need for a short admission to help titrate his medication.

6.81 However, it is known that care home often did not report the second adult's escalating behaviour or report exactly the frequency and number of incidents. In fact, on several occasions the care coordinator and the psychiatrist were informed that the second adult had settled when the opposite was the case, and there had been recent aggressive episodes.

6.82 It is clearly difficult to assess the appropriateness of care planning if the information necessary to inform the care planning is inadequate and knowledge of key events and incidents is not shared with those who could plan more appropriate care. The care plan dated 30th July 2018 outlined the second adult's problems and that the CMHT would continue to 'monitor and support with behaviour' but did not provide any guidance on how to minimise any aggression when providing personal care, or how to respond if the second adult became aggressive.

How effectively were the concerns raised by the staff whistle blower addressed? Was it appropriate for the manager of Care Home 1 to enquire into these concerns, given that the concerns included serious criticisms of the management of the care home? Was it appropriate for the regulator, the Care Quality Commission and the commissioner, Lancashire County Council to rely on the manager's investigation of the whistle blower concerns in these circumstances?

6.83 Many organisations have come to regard whistleblowing disclosures as a valuable 'early warning system' to alert them to malpractice that senior management may be unaware of. The providers of Care Home 1 did not appear to see whistleblowing in this light (Paragraphs 4.112 and 6.90).

6.84 In this case the allegations made by the staff whistle-blower represented an opportunity for agencies to intervene to prevent the second adult harming himself or others in a placement which had, for some time, been unable to address his needs and manage the risks arising from his agitation.

6.85 There is much learning to be had from the manner in which the whistle-blower allegations were handled. The core allegation, that 'a violent resident, named as the second adult, sometimes goes into other resident's rooms during the night and punches them or pulls them out of bed', was accurate. Other specific allegations may or may not have been accurate, but the core allegation was true.

6.86 The CQC Inspector to whom the whistle-blower allegations were allocated had knowledge of the second adult, having examined the manner in which the risks he presented were managed during the most recent CQC inspection. She had been satisfied with what she found and may

therefore not have been as open as she could have been to evidence which contradicted her previous findings.

6.87 Although the subsequent investigation of the whistle-blower allegations was overseen by the Care Home 1 provider's regional manager, it is clear that the investigation was led by the manager of the care home. The CQC would normally engage with the registered manager of the establishment. There was no registered manager at that time. It is clear from the Care Home 1 manager's initial response to the CQC (Paragraph 4.106) and from the contents of her investigation report (Paragraphs 4.116 and 4.117) that she minimised the risks that the second adult presented, concluding that he went into other resident's rooms 'on the odd occasion' but that he was 'looking for his wife'. The manager would have known that this was a gross understatement of the position. If one examines only the period from 1st January 2019 until the date on which the full whistle-blower allegations were made to the CQC eighteen days later, the second adult entered or attempted to enter other resident's rooms six times and physically assaulted carers five times. In addition to minimising the second adult's behaviour, the manager blamed her staff, saying that only staff who 'persistently' did not follow the risk assessment and behaviour plan had been assaulted by the second adult.

6.88 The investigation report appears to have been accepted without question or challenge by the providers of Care Home 1, the CQC, the LCC MASH and LCC Contracts Management and there appeared to be no concern that the investigation report had largely been completed by the manager about whose oversight of the care home the whistle-blower had been critical and no attempts were made to verify any of the findings in the investigation report.

6.89 Curiously, in parallel with completing an investigation report which minimised the challenges presented by the second adult and attributed the majority of the problems to staff not complying with behaviour management plans, the management of Care Home 1 were simultaneously communicating to the CMHT care co-ordinator that the second adult needed to move to an EMI placement (Paragraphs 4.111) and a further RNNI was to be commissioned (Paragraph 4.114). The further RNNI had not been completed prior to the 14th February 2019 incident. The LSCFT Safety and Learning Review found that there are no timescales set or guidance given on how quickly an RNNA should be completed. The Care Home 1 investigation report made no mention of the need for the second adult to be placed elsewhere, recommending only improved staff training and more opportunity for staff to voice concerns in supervision and stating that no immediate risks had been found.

6.90 The provider's apparent disregard for staff safety is another concerning aspect of the investigation report. Whilst there are indications that some staff were more confident in managing the second adult's agitated behaviours (Paragraph 4.104), it is clear that other staff were in fear of the second adult (Paragraph 4.111). However, the scale, frequency and duration of the physical abuse endured by the staff of Care Home 1 is completely unacceptable and this was completely minimised by the investigation report.

6.91 As previously stated, Adult L's daughters have advised this review that neither Care Home 1, nor any other agency advised them of the allegations made by the whistle-blower in January 2019. They said they had only been told about these by the police and a social worker quite some time after the 14th February 2019 incident.

6.92 As previously stated, the second adult's daughter has advised this review that the care home manager told her about the whistle-blower allegations in January 2019. The manager didn't give

her any details of the allegations but the daughter said that the manager was 'furious' that the staff member had blown the whistle rather than raising the matter with her directly.

6.93 A very curious feature of this case is that the minimisation of the risks presented by the second adult when agitated appeared to continue even after the 14th February 2018 incident. At one of the practitioner learning events arranged to inform this review, CMHT staff appeared to doubt whether Adult L's injuries had arisen from physical contact from the second adult. The evidence submitted to this review leaves no room for doubt that Adult L sustained injuries after the second adult entered her room and forcibly removed her from her bed and further assaulted her. However, although the Care Home 1 provider's internal investigation concluded that Adult L was assaulted, when the CQC conducted their investigation, the provider of Care Home 1 appeared to cast doubt on whether an assault actually took place (Paragraph 4.140). The CQC investigation also documented investigation meetings between the manager and deputy manager of Care Home 1 and the carers on duty on the night of the 14th February 2019 incident, in which it appears to have been suggested to one of the carers that Adult L had been looking for carers and had fallen rather than been assaulted. The carer appeared to have agreed with this suggestion.

When the care home submitted a DoLS application to the local authority were restrictions the care home staff may need to take to manage the second adult's challenging behaviour shared with the local authority at the time or subsequently?

6.94 At the time that Care Home 1 submitted a DoLS application in respect of the second adult, it was assessed as low priority by the LCC DoLS team as no priority factors were indicated in the application (Paragraph 4.31). The Care Home do not appear to have advised LCC DoLS of subsequent restrictions such as 8pm-8am 1:1 support from early October 2018 until 10th November 2018 and 24 hour 1:1 support following the 14th February 2019 incident.

6.95 When the 17th September 2018 incident occurred in which the second adult may have injured a male resident (Paragraphs 4.44 and 4.45) there is an implication that a fresh or updated DoLS application was to be submitted by Care Home 1, but this was not the case. None of the agencies supporting the second adult in his Care Home 1 placement appear to have noticed the restrictions on his liberty increasingly applied.

How effectively were concerns about the care provided by Care Home 1 monitored?

6.96 As stated in Paragraph 4.66 the CQC conducted a comprehensive inspection of Care Home 1 between 31st October and 2nd November 2018 and the overall assessment was that the care home required improvement. At the previous inspection in August 2017 the CQC had found that people could not be assured that medicines were managed safely as staff trained in medicines were not always available and infection control practices did not protect people from the risk and spread of infection; that staff were not consistently available to meet people's needs and staff were not always well rested; that care records were not always completed with up to date information about people's individual needs; and that the care home's audit systems had not identified the concerns the CQC had found on inspection and if people raised concerns, these were not always continuously followed through and reviewed. During the October/November 2018 inspection the CQC found that improvements had been made to manage the risk and spread of infection and the home was visibly clean and checks were carried out to ensure the environment remained hygienic. However, the CQC found that medicines were not always managed safely; that the home had transferred paper care records to a computer based system and that it was sometimes difficult to find details of the care and support people needed to meet their needs; that documentation viewed did not

consistently record people's consent or involvement; that records relating to the food people had eaten and the times they had bathed or showered were not consistently accurate; and that one recruitment record did not contain a full employment history of a staff member.

6.97 Shortly before the 14th February 2019 incident (on 22nd January 2019) LCC Contracts Management undertook a contract monitoring exercise in respect of Care Home 1 which identified the need for improvement in training, safeguarding policy including staff awareness of how to raise a safeguarding alert, the lack of a registered manager (the then manager having applied for registration which had been denied – a decision she was appealing) and sufficiency of staffing.

Advice and support provided to the family of the second adult.

6.98 Overall the second adult's daughter reflected that she was faced with a very challenging set of circumstances. She reflected on the difficulties involved in trying to get her father the support he needed whilst protecting her mother from harm when efforts to support the second adult at home became untenable; her fears for her mother's safety when she visited the second adult in Care Home 1; dealing with two 28 day notices in October 2018 and February 2019 and the challenges in finding an alternative placement for her father at very short notice on those two occasions; and the distress arising from the 14th February 2019 incident. She said that she often didn't really know what to do for the best before going on to say that she said she would have welcomed more advice and support. (Paragraph 5.40)

The questions asked by Adult L's daughters:

6.99 As previously stated two of Adult L's daughters contributed to this review and identified the following questions they hoped the SAR would answer.

Why was the second adult placed in Care Home 1?

6.100 The appropriateness placing Adult L in Care Home 1 is commented upon in Paragraphs 6.24 to 6.37.

What did the care home put in place to support the second adult? They understood that no floor alarm mat had been placed in the second adult's room to alert staff when he got out of his bed during the night. As far as the daughters could see, the support provided to the second adult appeared to be no different from that provided to the other residents.

6.101 The support provided to the second adult during his placement in Care Home 1 is commented upon in Paragraphs 6.38 to 6.52 and 6.76 to 6.80.

6.102 Turing to the pressure mat. It appears that a pressure mat was placed inside the second adult's room to alert care staff to him getting out of bed. It was only on 30th January 2019 that a pressure mat was placed near his door to alert staff that he had left his room (Paragraph 4.115). There are indications that the second adult disconnected his pressure mat (Paragraph 4.44) and that it may not have been in good working order at other times (Paragraph 5.31).

Should they (the daughters) have been told about the risks the second adult posed to their mother and other residents?

6.103 Adult L's daughters should have been advised about the whistle-blower allegations in January 2018. Providers are expected to be open and honest with service users and other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology. Providers have a duty of candour.

How competent and how well trained were the staff employed by Care Home 1 to work with vulnerable residents?

6.104 This issue is commented upon in Paragraphs 6.24 and 6.37.

Was the ratio of staff to residents sufficient as the numbers of residents increased, particularly as many of those residents were people with quite challenging behaviours? The daughters didn't notice staffing levels increase as the number of residents increased and there were times when it was difficult to find a member of staff in the care home during the evenings.

6.105 The providers have shared the approach they adopted to setting safe staffing levels with this review. Given the focus of this review is on the care and support provided to two residents – Adult L and the second adult – it is difficult to comment on overall staffing levels without knowledge of the needs of the other residents. However, it is evident that when the second adult was presenting with aggressive behaviours whilst agitated, this would have caused staff resources to be diverted to the care of the second adult until his agitation had settled. Additionally the LCC Contracts Management contract monitoring exercise completed shortly before the 14th February 2019 incident (Paragraph 6.95) observed that no staff were present in the lounge area for some time during an afternoon despite the fact that the manager had advised them that a member of staff should be present there at all times.

The daughters want to be completely clear how the bruising they saw on their mother's face in late December 2018 was caused. Was it the result of a fall, or was it the result of an incident involving the second adult? If he caused these injuries and they had been told, they say they would have promptly moved her out of Care home 1 and she would still be alive. They also say that if they had been told about the disclosures made by the whistle-blower, that may also have prompted them to move their mother out of the Care Home 1.

6.106 This question is addressed in Paragraphs 6.4 to 6.11. Unfortunately it is not possible to provide a definitive answer to the daughters' question.

The daughters felt that it would have been useful to have known who the keyworker was for their mother. They implied that they were told that Adult L had a key worker but they were never told which member of staff was fulfilling this role.

6.107 Care Home 1 has advised the review that Adult L had a keyworker and the identity of this member of staff was documented on a wallet sized card. The daughters of Adult L disagree with this. They showed the independent reviewer a notice they retrieved from their mother's bedroom door in Care Home 1 which listed the names of key contacts within Care Home 1, including the manager. On this notice the name of the keyworker is blank.

Good Practice

6.108 The pathway for referral to assessment to diagnosis and treatment of the second adult's dementia was smooth and timely in that his family were consulted with and involved in decisions at each step of his care and his wife's needs and wishes were identified.

6.109 The manager of Care Home 1 proactively arranged for 1:1 support to be put in place for the second adult on 2nd October 2018 in advance of funding being agreed.

7. Findings and Recommendations

7.1 It quickly became apparent that Care Home 1 was not an appropriate placement for the second adult. When agitated he presented risks to himself, other residents and care staff which were not successfully managed for the duration of his placement. Even when he was provided with 1:1 support in October/November 2018 and following the 14th February 2019 incident, it was not possible for Care Home 1 to safeguard other residents and their staff from harm. It can only be concluded that the incident in which Adult L sustained injuries which subsequently led to her death - after the second adult had entered her bedroom during the night, misidentified her as his wife and caused her serious injuries – was an avoidable tragedy.

7.2 The focus of both a Safeguarding Adults Review and a Mental Health Homicide Review is broadly to identify learning with which to improve policy and practice in an effort to prevent a reoccurrence of similar events. The key areas of learning are summarised below accompanied by recommendations for improvement. Pre-admission assessments by care homes

7.3 The pre-admission assessments of the second adult was insufficiently informed by the risks he may present to others. In particular, this review has seen no evidence that an appropriate risk assessment which clearly articulated the risk which the second adult presented was shared by the CMHT with Care Home 1. The care plan shared by CMHT with Care Home 1 did not adequately describe the risks the second adult presented, despite a well-known and documented history of aggression and violence to his wife. It is also clear in both the CMHT care plan and the LCC FACE assessment that the risks identified were all towards the second adult's wife and at that point no risks were identified to other people.

7.4 Lancashire Safeguarding Adults Board may therefore wish to obtain assurance about the standard of pre-admission assessments by care homes and the sharing of relevant information by services providing care and support to the person at the time the pre-admission assessment is carried out. Clearly this would be a substantial task to undertake and the Board may wish to seek the commissioning of audits of a sample of pre-admission assessments.

Recommendation 1

That Lancashire Safeguarding Adults Board obtains assurance in respect of the standard of pre-admission assessments by care homes and the sharing of relevant information by services providing care and support to the person at the time the pre-admission assessment is carried out.

Response to Domestic Violence and Abuse

7.5 Prior to second adult's placement in Care Home 1 commencing, the CMHT, LCC Adult Social Care and the RITT provided considerable support in order to enable the second adult to live in the family home he shared with his wife for as long as possible. During this time, the second adult's wife suffered domestic violence and abuse from her husband when he was agitated. (It is not suggested that the second adult was a perpetrator of domestic abuse but that his wife experienced domestic abuse when his mental health began to deteriorate). The response to these incidents did not demonstrate expected practice in responding to domestic violence and abuse in that the second adult's wife was not offered specialised domestic abuse support and no DASH risk assessments were considered which could have informed safety planning.

7.6 The second adult's wife continued to be assaulted by her husband when visiting him in Care Home 1 and was fearful that he might be able to leave the home and return home and harm her. Whilst visits by the second adult's wife were considered to be a potential trigger for violence within

Care Home 1, the risks he presented to his wife whilst she was visiting him were not seen as domestic violence and abuse. From the review of this case, it appears that there is a tolerance of domestic violence and abuse from a partner who is elderly, has a diagnosis of dementia and presents aggressively when agitated. The tolerance of violence within Care Homes will also be explored in this section of the report and recommendations made.

Carer's Assessment

7.7 The second adult's wife waited an inordinate amount of time for her carer's assessment to be actioned (Paragraph 4.13) This appears to be a technical systems issue in that the carer's assessment could not be inputted to the LAS system until her record had been reassigned from LCC Occupational Therapy to LCC Service Access team. The Safeguarding Adults Board may wish to obtain assurance that this issue is resolved to prevent avoidable delays in progressing Carer's Assessments.

Recommendation 2

That Lancashire Safeguarding Adults Board obtains assurance that the technical systems issue which caused an unacceptable delay in the progressions of the Carer's assessment for the second adult's wife is resolved to prevent avoidable delays in progressing future Carer's Assessments.

Risk assessment, mitigation and management.

7.8 During the 14th February 2019 incident, the second adult misidentified Adult L as his wife. He appears to have begun misidentifying female residents as his wife as early as July 2018 although this is documented to have become more prominent from December 2018. The risk of violence to female residents whom the second adult misidentified as his wife was never articulated as a trigger for agitation and violence, or the threat of violence. As a result it was never fully assessed, mitigated or managed as a discrete risk. Had this been identified as a specific risk this *may* have led to fuller recording of incidents in which the second adult misidentified female residents as his wife and either threatened or used violence against them whilst agitated. Threatening or using violence after having also entered the bedroom of female residents was an aggravating factor to which insufficient attention was paid. Had this been identified as a specific risk and had recording of incidents been fuller, it might have been possible to identify whether the second adult was targeting particular residents.

7.9 The Safeguarding Adults Board may wish to seek assurance in respect of the quality of risk management by care home providers and agencies which support them to manage the risks presented by some care home residents. Again, this is a substantial task but it may be possible to make progress in this area through Radar and the Quality, Performance and Improvement Planning process.

Recommendation 3

That Lancashire Safeguarding Adults Board obtains assurance in respect of the quality of risk management by care home providers and agencies which support them to manage the risks presented by some care home residents.

Monitoring of the second adult's placement

7.10 The RITT, the CMHT, LCC and Care Home 1 all minimised to varying degrees the risks the second adult presented to other residents. There was too much optimism that the improved management of the second adult's agitation during a period when he was being supported on a 1:1 basis for a considerable period, could be sustained when that level of support ended. The 'rule

of optimism' was evident again when the LCC social worker closed the second adult's case in January 2019.

7.11 However, there is overwhelming evidence to indicate that the RITT, the CMHT and LCC were not informed about all relevant incidents involving the second adult. Indeed, Care Home 1 omitted many relevant incidents involving the second adult from the information they provided to this joint SAR/MHHR. At the time of writing it is not possible to have anything approaching full confidence that all relevant incidents have been shared with this review.

7.12 The breakdown of the second adult's placement at the end of September 2018 was an opportunity for a placement which better met the second adult's needs to be found. It was entirely appropriate for Care Home 1 to give the second adult's family 28 days' notice to find an alternative placement and for a RNNA to be promptly completed which identified that the second adult needed an EMI placement. It was entirely inappropriate to rescind the 28 day notice decision and the rationale for that decision has not been fully explained to this review. However, partner agencies appeared to accept the rescinding of the 28 day notice. It could have been appropriate to consider a multi-agency discussion at this point.

7.13 It is therefore recommended that the Safeguarding Adults Board may wish to obtain assurance over provider recording of incidents and the methods used by services which support people in care homes whose behaviour when agitated presents a risk to others to seek out accurate information about incidents involving those people. The Safeguarding Adults Board may also wish to obtain assurance about the criteria used to decide when to discharge people from mental health and adult social care services when they appear settled in their placement.

Recommendation 4

That Lancashire Safeguarding Adults Board obtains assurance over provider recording of incidents involving care home residents assessed as presenting risk to others.

Recommendation 5

That Lancashire Safeguarding Adults Board obtains assurance over the methods used by services which support people in care homes to seek out accurate information about incidents involving those people whose behaviour when agitated presents a risk to others.

Recommendation 6

That Lancashire Safeguarding Adults Board obtains assurance about the criteria used to decide when to discharge people placed in care homes from mental health and adult social care services when they appear settled in their placement.

The needs of other care home residents

7.14 A very strong theme emerging from this review is that when key decisions were being taken about the second adult, insufficient attention was paid to the impact of such decisions on the safety and wellbeing of other residents of Care Home 1. As further details of the incidents involving the second adult have gradually been uncovered, a highly disturbing picture of vulnerable residents being exposed to violence, the threats of violence, verbal abuse and frequent invasions of their privacy over a prolonged period has emerged. The second adult was a tall man and Adult L's daughters have shared their mother's fear of him with this review. In addition to the 14th February 2019 incident there were other incidents which also had the potential to have had an equally serious outcome, particularly the incidents involving the male resident (Paragraph 4.44), the female resident (Paragraph 4.48) and the bedbound female resident (Paragraph 4.139). The Panel which

oversaw this review pertinently asked whether such incidents would be tolerated had they taken place in a private dwelling and been reported? The Panel also asked whether the incidents may have been tolerated because the second adult was an elderly person with a diagnosis of dementia. Clearly the second adult cannot be held responsible for violent acts when agitated as a result of his declining mental health but the impact on the victim is no less serious.

Violence to care staff employed in Care Home 1

7.15 In addition, many care staff employed in Care Home 1 were assaulted on a regular basis by the second adult. The response to this by the provider of Care Home 1 was inadequate. Whilst it is clear that some care staff felt more confident in managing the second adult when agitated, it is clear that many struggled with his agitated behaviour and were exposed to regular violence. Although additional training and support was to be provided to staff this only appeared to be prompted by the whistle-blower disclosures to the CQC in January 2019. However, the dominant approach of the provider was to blame care staff for violence they experienced. The Panel raised the issue of the duty of care providers owed to their staff and also questioned whether clinical supervision should be available to care home staff supporting people with complex needs. The Panel also observed that oversight of incidents in which care home staff were injured did not really sit firmly within any body's remit.

7.16 Violence by the second adult towards his wife, residents of Care Home 1 and many of the staff in Care Home 1 was tolerated and sometimes minimised and sometimes not properly recorded over a period of eight months and continued even after the 14th February 2019 incident. It cannot be right for vulnerable people to be exposed to this level of violence and the fear and anxiety which this must have generated.

7.17 It is therefore recommended that the Safeguarding Adults Board reflect on the level of violence tolerated in this particular Care Home and consult with the regulator, commissioners, providers and residents and their families before deciding what action needs to be taken to address the issue. The Panel questioned whether the toleration of violence in care homes was a national issue.

Recommendation 7

That Lancashire Safeguarding Adults Board reflects on the level of violence tolerated in this particular Care Home and consult with the regulator, commissioners, providers, their staff, residents and their families before deciding what action needs to be taken to address the issue more widely.

7.18 However, as an initial step it is recommended that the Safeguarding Adults Board ensures that providers are reminded of the Board's guidance on the reporting of incidents.

Recommendation 8

That Lancashire Safeguarding Adults Board ensures that providers are reminded of the Board's guidance on the reporting of incidents.

The response to the whistle-blower disclosures

7.19 The response to the whistle-blower disclosures to the CQC was a missed opportunity and it is no exaggeration to take the view that had this been responded to more effectively by the provider, the CQC and LCC MASH, it could have been possible to prevent the incident in which Adult L sustained the injuries which led to her death.

7.20 The investigation conducted by the provider seriously minimised the risks that the second adult presented and largely attributed responsibility for his behaviour when agitated to the

unsatisfactory actions of care staff. This investigation report went unchallenged by the provider, the regulator, commissioners and the Section 42 Safeguarding Enquiry. An internal investigation led by a manager who had been explicitly and implicitly criticised by the whistle-blower was accepted without question. Regrettably, at the same time as producing an investigation report which rejected the whistle-blowers concerns about the risks presented by the second adult, Care Home was discussing the need for an alternative placement for the second adult with the CMHT. This raises concerns about how frank the investigation report actually was.

7.21 Adult L's family strongly feel that they should have been advised of the whistle-blower disclosure that an assault by the second adult was the cause of the injuries their mother sustained in December 2018. Although the evidence that the second adult was responsible for these injuries could not be substantiated, the fact that the allegation was made and was then investigated should surely have been communicated to Adult L's family under the duty of candour which applies to the provider and others. Adult L's family has advised this review that had they been told about the whistle-blower's disclosures, they would have had the opportunity to review their mother's placement in Care Home 1.

7.22 Whistle-blowing is now recognised as a valuable early warning system of problems which managers may not be aware of. In this case the provider did not appear to view whistle-blowing in this light and it was disturbingly easy for the manager of Care Home 1 to undermine the whistle-blower disclosures. The Safeguarding Adults Board may wish to promote the value of encouraging whistleblowing and listening to whistle-blowers as a key element of the whole system for safeguarding adults. Additionally the Safeguarding Adults Board may wish to satisfy themselves that there is always an element of independence in the investigation of whistle-blower disclosures by providers.

Recommendation 9

That Lancashire Safeguarding Adults Board promotes the value of encouraging whistle-blowing and listening to whistle-blowers to all relevant stakeholders as a key element of the whole system for safeguarding adults.

Recommendation 10

That Lancashire Safeguarding Adults Board seeks assurance that there is always an element of independence in the investigation of whistle-blower disclosures by providers and that the family of any resident affected by a whistle-blower disclosure is informed.

Safeguarding Referrals – the ability to monitor referrals which raise concerns about particular residents

7.23 LCC currently has no capability to search their information systems for accumulating concerns arising from safeguarding referrals in which specific care home residents posed a threat to other residents. They can search only by the name of the injured party or the particular care home. This is an issue which has been highlighted in a previous SAR. This issue is a public protection issue and needs attention if the residents of care homes are to be safeguarded from abuse by fellow residents.

7.24 It is therefore recommended that the Safeguarding Adults Board challenges Lancashire Adult Social care to find a solution to this issue, possibly by exploring good practice from elsewhere.

Recommendation 11

That Lancashire Safeguarding Adults Board challenges Lancashire Adult Social care to find a solution to their current inability to search their information systems for accumulating concerns arising from safeguarding referrals in which specific care home residents posed a threat to other residents.

Deprivation of Liberty Safeguards

7.25 When the second adult was subject to increasing restrictions in October and November 2018 and following the 14th February 2019 incident, DoLS applications were not made by Care Home 1 to reflect the changes since their original DoLS application was submitted and was appropriately assessed by Lancashire DoLS as low priority based on the information provided to them at the time.

7.26 It is therefore recommended that the Safeguarding Adults Board seek assurance that providers of care homes have clear advice on when to submit updated DoLS applications and comply with this advice.

Recommendation 12

That Lancashire Safeguarding Adults Board seek assurance that providers of care homes have clear advice on when to submit updated DoLS applications and comply with this advice.

Mental Health Act

7.27 The LSCFT Safety and Learning Review highlighted as good practice that the least restrictive options for the second adult's care and management had always been considered and followed. Arguably this was not the case when it was decided to rescind the plan to apply Section 2 of the Mental Health Act to the second adult following the 14th February 2019 incident. Instead the second adult was subject to deprivation of his liberty without the protections afforded by DoLS and the restrictions did not prevent him from exposing himself and another very vulnerable resident of Care Home 1 to the risk of serious harm (Paragraph 4.139).

7.28 When the learning from this review is disseminated, the Safeguarding Adults Board may wish to draw attention to the interface between the Mental Health Act and the Mental Capacity Act.

The care and treatment of Adult L following the 14th February 2019 incident.

7.29 Adult L's family have expressed concern that the head injury she may have sustained in the incident on 14th February 2019 was overlooked by hospital 1. The Rapid Review conducted by hospital 1 has been shared with this review. However, it is felt that further exploration of this issue should be a matter for the Coroner.

Single Agency Learning

7.30 There have been a number of separate reviews of aspects of this case by agencies. Lancashire Safeguarding Adults Board may wish to request reports from these agencies on the implementation of any recommendations arising from their reviews. Additionally, agencies involved in this Safeguarding Adults Review will be asked to complete a 'learning log' to identify single agency learning.

8. References

1) Retrieved from https://www.nice.org.uk/guidance/cg176
2) Retrieved from https://www.alzheimers.org.uk/sites/default/files/migrate/downloads/home_from_home_full_report.pdf
3) Learning Lessons from Serious Case Reviews 2009-2010 - Ofsted
4) Retrieved from https://www.lancashiresafeguarding.org.uk/media/1453/V2- Guidance-for-Safeguarding-Concerns-final.pdf
5) Retrieved from https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF

9. Appendix A – Panel Membership & Process

Process by which the joint safeguarding adults review (SAR) and mental health homicide review (MHHR) was conducted and membership of the Panel

A panel of senior managers from partner agencies was established to oversee the Review. The membership was as follows:

Role	Organisation
Chair	Heather Buckland, Named Nurse for Adult Safeguarding, Southport & Ormskirk NHS Trust
Panel Member	NHS England
Panel Member	LSCFT
Panel Member	LCC - MASH
Panel Member	Pearlcare
Panel Member	Lancashire Constabulary
Panel Member	Fylde & Wyre CCG
Panel Member	CQC
Panel Member	MLCSU
Panel Member	LCC Adult Social Care
Panel Member	LTHTR
Panel Member	NWAS
Business Co-ordinator	Lancashire Safeguarding Adults Board
Business Support Officer	Lancashire Safeguarding Adults Board
Independent Investigator (MMHR)	Nick Moor
Independent Reviewer (SAR)	David Mellor

It was decided to adopt a systems approach to conducting this SAR. The systems approach helps identify which factors in the work environment support good practice, and which create unsafe conditions in which unsatisfactory safeguarding practice is more likely. This approach supports an analysis that goes beyond identifying *what* happened to explain *why* it did so – recognising that actions or decisions will usually have seemed sensible at the time they were taken. It is a collaborative approach to case reviews in that those directly involved in the case are centrally and actively involved in the analysis and development of recommendations.

Specifically, it was decided to adopt the Welsh concise child practice review methodology which focusses on recent practice and places strong emphasis on engagement in the SAR of practitioners and managers involved in the case.

Chronologies which described and analysed relevant contacts with Adult L were completed by the following agencies:

- Blackpool Teaching Hospital
- Care Home 1
- Care Quality Commission
- Fylde & Wyre Clinical Commissioning Group
- Lancashire Constabulary
- Lancashire MASH
- Lancashire Adult Social Care
- Lancashire County Council (in respect of DoLS)
- Lancashire and South Cumbria NHS Foundation Trust
- Lancashire Teaching Hospital NHS Foundation Trust
- Midlands and Lancashire Commissioning Support Unit
- North West Ambulance Service

Midlands and Lancashire Commissioning Support Unit also shared the STEIS (Strategic Executive Information System) concise learning review they conducted into decisions made in respect of the second adult following the 14th February 2019 incident.

Lancashire and South Cumbria Care NHS Foundation Trust also shared the STEIS (Strategic Executive Information System) concise learning review they conducted into the 14th February 2019 incident.

Lancashire Teaching Hospital NHS Foundation Trust also shared the Rapid Review they conducted into Adult L's undiagnosed head injury.

The Care Quality Commission also shared the internal investigation they conducted into their response to the allegations made by the whistle-blower.

The Panel analysed the chronologies and identified issues to explore with practitioners at two practitioner learning events facilitated by the lead reviewer. Covid-19 restrictions prevented physical learning events taking place and so 'virtual' events using video conferencing technology took place which were very well attended.

Two of Adult L's daughters contributed to the review as did the daughter and son-in-law of the second adult. They were also provided with an opportunity to read and comment on the final draft of this report.

The SAR independent reviewer developed a draft report to which the NHS E independent investigator fully contributed to reflect the contents of agency chronology, other investigation reports, relevant policies and documents and the contributions of practitioners who attended the learning events.

With the assistance of the panel, the report was further developed into a final version and presented to Lancashire Safeguarding Adults Board and NHS England.