EXECUTIVE SUMMARY
OF A SERIOUS CASE REVIEW
IN RESPECT of Mrs W and Mr H
Incident date 23rd July 2008

1. Introduction

1.1 The case under review will be used to determine positive recommendations for improvements to Safeguarding Adults work. Any reports, leading to, or setting out any recommendations will contain no personally identifiable information of individuals.

1.2 This review has been carried out with the provisions of the following three documents in mind

- "No Secrets" – Guidance on implementing and developing multi-agency policies and procedures to protect vulnerable adults from abuse – Department of Health 2000

- "Safeguarding Adults" – A National Framework of Standards for good practice and outcomes in adult protection work – Association of Directors of Social Services 2005

- Cumbria Safeguarding Adults – Multi-Agency Policy and Procedures document

2. Summary of the circumstances that led to a Serious Case Review being undertaken in this case.

2.1 Shortly before 10.00am on the 23rd July 2008 staff at Nursing Home B, Carlisle found an 81 years old male resident (Mr H) in the bedroom of a 93 years old female resident (Mrs W). Mr H was escorted from the room by staff and it was found that Mrs W was lying on the floor, near to her bed and there appeared to be no signs of life.

2.2 Paramedics attended and pronounced Mrs W "life extinct"

2.3 A Police Investigation commenced and Mr H was regarded initially as a suspect in the suspicious death of Mrs W.

2.4 A post mortem by a Home Office Pathologist revealed that the cause of Mrs W's death was a single fracture of the spine.

2.5 There was no eyewitness account of how Mrs W came to be in the position she was found, but Mr H's presence in her room resulted in the Police requiring to interview him.

2.6 Mr H, at the request of the Police, was assessed by a Forensic Medical Examiner who declared that he was not fit to be detained or interviewed because he lacked mental capacity.

2.7 A Consultant Psychiatrist later attended and agreed with the Forensic Medical Examiner's assessment.

2.8 Post incident Mr H was returned to the NHS Unit and is still resident there.

2.9 The Police conducted further enquiries, but concluded on the 15th August 2008 that there was insufficient evidence for a criminal prosecution against any individual, group or agency

3. Terms of Reference

3.1 Establish the circumstances and events leading to the death of Mrs W, especially as regards management of the individuals by the relevant services.

3.2 Examine whether any change in operational methods, policy, practice, or management arrangements would help prevent a recurrence.

3.3 Review the effectiveness of procedures (both multi-agency and individual organisations).

3.4 To inform and improve local inter-agency practice.

3.5 To improve practice by acting on learning.

3.6 To make recommendations for future action.

3.7 Provide explanations and insight for the bereaved relatives.

3.8 Timescales – report by end March 2009.

3.9 In addition to the above overarching "Terms of Reference" agencies and stakeholders were asked to include specific areas relevant to their organisation in their respective reports:

4. Process of the Serious Case Review

4.1 The review was undertaken by a Serious Case Review Panel, chaired by an Independent Person, and commissioned by the Chair of the Safeguarding Adults Partnership. Contributions from the following agencies assisted in compiling the report;

- Cumbria Partnership NHS Foundation Trust
- Cumbria Primary Care Trust
- Cumbria Constabulary
- Nursing Home B
- Cumbria Adult and Cultural Services
- Commission for Social Care Inspection

- Health & Safety Executive

4.2 Individual management reports were provided by the above agencies and stakeholders.

4.3 Members of the Review Panel also spoke individually and in some cases collectively to Clinical Governance and Risk Managers representing the agencies and stakeholders and also with individuals connected with the case

5. Key Facts

The NHS Unit

5.1 The NHS Unit, Workington, is a 15 bedded organic assessment NHS unit, clinically led by a Nurse Consultant.

Normal staffing levels within the unit are

- Morning – 6 staff (including 2 RMN's)
- Afternoon/evening – 5 staff (including 2 RMN's)
- Night – 3 staff (including 1 RMN)

Individual patients cannot access other patient's bedrooms within the NHS Unit. Each room is locked from the outside and can only be accessed by a member of staff. The doors are not locked on the inside of bedrooms and can be opened without a key.

Nursing Home B

5.2 Nursing Home B, Carlisle is a Registered Nursing Home providing 82 care beds for a mixture of elderly/ frail and elderly mentally ill residents. The home is divided into two units

- Elderly/frail (EF) providing 39 beds
- Elderly Mentally Ill (EMI) providing 43 beds

Normal staffing levels within the EMI are

- Morning – 8/9 staff (including 2 qualified RMN/RGN)
- Afternoon/evening – 7/8 staff (including 2 qualified RMN/RGN)
- Night – 4 staff (including 1 qualified RMN/RGN)

Patient's bedrooms are not locked and individual patients can access other patient's bedrooms

5.3 There is clear evidence that all staff at the NHS Unit followed their Trust's policies and procedures in relation to Mr H's care plans, administering of medication and involvement of his family.

5.4 Mr H remained at the NHS Unit for a number of months. His presentation became more settled and behaviour more appropriate and his clinical team determined that he required to be discharged to an appropriate, long stay Elderly Mental Illness (EMI) facility.

5.5 The NHS Funded Care Panel met on the 30th January 2008 and agreed that Mr H met the criteria for funding. Mr H's family were actively involved in February 2008 looking at different nursing homes and decided that their preference was Nursing Home B in Carlisle.

5.6 There was a delay in completing the move, which cannot be fully explained. There was poor collaboration between staff at the NHS Unit and Nursing Home B.

5.7 Based on very brief information, no care plan, no risk assessment and no formal discharge meeting Nursing Home B agreed to accept Mr H for admission to their home.

5.8 After representation from Nursing Home B and consultation with the NHS Unit, the PCT agreed to fund an additional 4 hours nursing care and 3 hours carer support, above the core staffing levels at Nursing Home B.

5.9 The request by Nursing Home B for extra staffing levels were not specifically related to any risks that Mr H presented with, but because of the different staff ratios between the NHS Unit and Nursing Home B.

5.10 Mr H was discharged to Nursing Home B on the 17th July 2008, arriving in the early evening with his wife and daughter and two nurses from the NHS Unit. An envelope containing documents relating to Mr H was handed over to the Nursing Home B staff but there was no formal nurse to nurse transfer between NHS Unit staff and Nursing home B staff during the transfer

Events leading up to the Incident

5.11 On arrival Mr H was angry with his wife and daughter, banging on doors and wanting to leave. He was given medication and eventually settled. On being shown the room by nursing staff Mr H's wife asked the staff to remove the television in the room because he would try and move it. Staff complied with this request.

5.12 On the 18th July it is recorded in Mr H's notes that he had been seen going into a female patient's room on two occasions and sitting on her bed. Staff removed him on both occasions and decided to monitor Mr H more closely.

There does not appear to have been any formal special observations put in place.

5.13 On the 19th July Mr H was found in another female patient's room. The patient was in bed and Mr H was lying on the floor attempting to pull the bedclothes off the bed. Staff again intervened and escorted him from the room. The incident was recorded in Mr H's notes and verbally relayed to staff coming on duty later that night. The same day the key nurse from the NHS Unit telephoned staff at Nursing Home B, discussed Mr H's wandering and offered advice on management.

5.14 On the 21st July Mr H was found wandering in a quiet room at the home and staff decided to keep discreet observations

Date of Incident - 23rd July 2008

5.15 Mr H got up in the early hours and wandered inappropriately. He went back to bed at 1.30am. He got up again and began angrily pushing fire doors and moving furniture. He was given space by staff and fell asleep in the quiet room at 3.00am.

5.16 Mr H got up early and had his breakfast and was dressed by 7.30am. Meal times are particularly busy periods in the nursing home because the majority of residents require staff support/supervision to eat.

5.17 The Manager of the home commenced duty at 7.45am that morning, but because of staff sickness began work on the EF Unit as a unit nurse. Apart from this, staffing levels were complete that day.

5.18 At 8.00am that morning Mrs W was washed and changed by staff and she was repositioned in her bed. At 9.00am staff gave Mrs W her breakfast. She was responsive to care staff who attended her. When staff left the room Mrs was in her height adjustable bed which was very low to the floor. She was left at that time on her own in the room.

5.19 Shortly before 10.00am on the 23rd July 2008 staff at the nursing home found Mr H in Mrs W's bedroom. Mr H was escorted from the room by staff and it was found that Mrs W was lying on the floor, near to her bed and to the side of a crash mat. Although she was breathing when first found, her breathing was very shallow and infrequent. As other staff members arrived Mrs W's breathing stopped and there appeared to be no signs of life.

5.20 The nursing staff who had attended Mrs W earlier noted that items in the room had been moved. They found her blankets in a pile on the bed. An air mattress and air pump, normally kept on a hook on the bottom of the bed, were on top of the bed. Mrs W could not have moved these items and could not get herself out of bed because of her physical frailty.

5.21 The Manager, who had been summoned from the EF Unit, called for the emergency services and secured the room.

5.22 Paramedics attended and attempted resuscitation but there was nothing they could do for Mrs W and she was pronounced "life extinct" at 10.20am the same day

Police Inquiry

5.23 The Police attended and quickly established that the incident was a suspicious death. They secured and preserved evidence and initially commenced enquiries to ascertain whether any individual, group or agency was criminally culpable.

5.24 During the initial stages of the inquiry the Police had difficulties establishing who the Regulatory Authority was for vulnerable adults and there was some delay in information reaching the relevant partner agencies.

5.25 A post mortem conducted by a Home Office Pathologist found that although Mrs W was frail and thin she had been subject to good physical care, she was clean, appeared well looked after and had received appropriate nourishment. The pathologist determined that the cause of death was a single fracture to the spine and that this injury would be consistent with Mrs W being pulled from her bed or falling off the bed onto a hard surface.

5.26 From information they had obtained the Police wanted to interview Mr H in connection with the incident, but were aware that his mental illness was an issue and he needed to be assessed.

5.27 Once it was established that Mr H could not be detained or interviewed the focus of the Police inquiry concentrated on trying to establish whether any other individual, group or agency was criminally culpable or liable.

5.28 Mr H's behaviour deteriorated during the remainder of his stay that day at Nursing Home B. He damaged the garden, garden ornaments and was aggressive to staff. Later that day the Consultant Psychiatrist made a Capacity Act "Best Interest" decision in conjunction with Mr H's family to return Mr H to the NHS Unit.

5.29 On the 15th August 2008 the Police concluded their inquiry by stating "As enquiries progressed it became apparent that although there appeared to be organisational shortcomings these appeared to fall well below the threshold test required for a criminal prosecution against any individual, group or agency, from what was known at the time"

6. Summary of Recommendations

Nursing Home B's Parent Company

Recommendation 1 - Nursing Home B's Parent Company.

It is recommended that Nursing Home B should review their policy of keeping elderly mentally ill patients who have become physically frail and bed bound in the EMI unit. The mix of elderly physically frail bed bound patients and mobile mental health patients is a significant risk area and consideration should be given to the practical aspects of the living environment with a view to separating the two client groups

Recommendation 2 – Nursing Home B's Parent Company

It is recommended that Nursing Home B implement a policy that ensures the normal staffing levels within the home meets the required level at all times, without the need for the manager of the home to be used as a unit nurse during periods of sickness.

Recommendation 3 - Nursing Home B's Parent Company

It is recommended that Nursing Home B ensure that the home has an admission process that includes an improved initial nursing assessment document and that this document is completed within 2 hours of admission. The document must incorporate full and substantial aspects of daily living, mental status and capacity and full risk assessment

Recommendation 4 - Nursing Home B's Parent Company

It is recommended that Nursing Home B implement an incident reporting system that includes the reassessment of risk when incidents occur and a documented record of decisions made and actions agreed and taken. Staff should be encouraged to report incidents and be fully trained in this area

Cumbria Constabulary

Recommendation 5 - Cumbria Constabulary

It is recommended that the Constabulary instigate an audit of their Operational Staff to establish whether Safeguarding Adults training has been delivered. An ongoing audit of compliance with Adult Protection procedures should be implemented. Senior Investigating Officers should also be trained and be made aware of the process and pathway of informing partner agencies when a vulnerable adult is subject to a Police Inquiry. This recommendation links with recommendation 11

Cumbria Partnership NHS Foundation Trust

Recommendation 6 - Cumbria Partnership NHS Foundation Trust

It is recommended that the Trust should ensure that the NHS Unit Operational Policy and Care Process is updated to include regular reviews of FACE Risk Assessment Profile of patients. This should be integrated into existing MDT reviews with key workers having clear responsibility for completion

Recommendation 7 - Cumbria Partnership NHS Foundation Trust

It is recommended that the Trust should ensure that the NHS Unit Operational Policy and Care Process includes a clear Care Pathway, highlighting the need for regular reviews, MDT meetings and key processes from admission. This would include clear documentation of reviews, meetings and processes and show clear evidence of progress from admission through to discharge and highlight assessments and care plans required to be completed and allow an action plan to be developed during discharge planning

Recommendation 8 - Cumbria Partnership Trust NHS Foundation Trust

It is recommended that the Trust should ensure that the NHS Unit Operational Policy and Care Process includes a discharge checklist and that risk profiles must be updated prior to discharge planning meetings and should be clearly communicated to relevant parties on discharge. This would give clear guidance and process for coordinated discharge and follow up and this should be recorded as completed with the time and date of completion and the signature of the health professional completing the entry

Recommendation 9 - Cumbria Partnership NHS Foundation Trust

It is recommended that the Trust should ensure that all Consultant Psychiatrists are fully conversant with the Multi-Agency Cumbria Mentally Disordered Offenders County Protocol.

Cumbria Primary Care Trust

Recommendation 10 - Cumbria PCT

It is recommended that the PCT review their method of contracting services with providers and in particular audit and review the request, agreement and implementation of the additional funding of nursing and care staff. The PCT‘s Fraud Prevention Team should look into this particular case to determine whether they need to take any further action

Cumbria Safeguarding Adults Partnership

Recommendation 11 - Cumbria Safeguarding Adults Partnership

It is recommended that the partnership develop a clear process and pathway route for agencies and other organizations, when serious incidents occur, involving vulnerable adults. Cumbria Adult and Cultural Services are the lead agency in the County for the protection of vulnerable adults and the lead agency for facilitating Safeguarding Training. Delivery of Safeguarding Training is the responsibility of individual stakeholders.

Recommendation 12 - Cumbria Safeguarding Adults Partnership

It is recommended that the Partnership should require each partner agency involved in the recommendations to draw up an implementation plan within two months of receipt of the final report. The Partnership will scrutinise and monitor the plan until all recommended actions are fully completed

Multi Organisation

Recommendation 13 – Cumbria PCT & Cumbria Partnership NHS Foundation Trust

It is recommended that the PCT and Trust develop a policy and resource whereby a care co-coordinator or case manager is appointed on discharge to a nursing home. Responsibility for care co-ordination or case management would depend on an individual's needs and diagnosis and should come from the team relevant to the individuals needs e.g. Mental Health, Acquired Brain Injury, Learning Disabilities, and Physical Disabilities

Recommendation 14 - Cumbria PCT, Adult & Cultural Services & CSCI

It is recommended that the PCT & ACS (through their Contract Compliance and Performance procedures) and CSCI (through their regulatory & inspection framework) ensure that Nursing Home B Healthcare draw up an implementation plan immediately in relation to the recommendations for that organisation. The PCT, ACS & CSCI should scrutinise and monitor the plan until all recommended actions are completed. On completion of the actions the ACS will inform the Safeguarding Adults Partnership Board

7 Conclusions and Findings

7.1 There is evidence of good practice, which has been highlighted, in the body of the main report.

7.2 There are no eyewitness accounts of the events, which led to Mrs. W's death in her room on the 23rd July 2008. We do know that Mr. H was in Mrs. W's room shortly before she was found and that staff had reported that items had been moved in the room. Mr. H naturally became an important figure for the Police to focus on when they commenced their enquiries.

7.3 This review has not established whether Mr. H was directly, indirectly or not involved in the death of Mrs. W and does not have a remit to determine how the death occurred or if anyone was responsible.

7.4 During the course of this review the review panel has found that

- Staff in the NHS Unit did not comply with the processes, procedures and policies of the Cumbria Partnership NHS Foundation Trust in relation to effective risk assessment and discharge of Mr. H

- There was poor collaboration and communication between staff at the NHS Unit and Nursing Home B in relation to risk assessment, risk management, care plans and discharge procedures

- It had been established at the NHS Unit that there were specific areas in relation to agitation and aggression that required proactive management strategies, including periods of agitation around meal times, which led to a

high likelihood of an aggressive episode that required managing. This was not known to Nursing Home B staff

- The NHS Unit is a NHS facility and therefore should meet the highest standards to ensure that effective risk factors are known and that patients are discharged to a safe environment, appropriate for their presentation and needs. The failure to hold a multi disciplinary discharge meeting to ensure this was carried out was a major factor in increasing the likelihood of risk not being assessed or managed effectively

- Mr. H was discharged from a single gender (male) challenging behaviour mental health unit, with a high staff to patient ratio and protective patient measures in place (no access to bedrooms). He was admitted to a mixed gender nursing home responsible for the care of mentally ill and physically frail elderly residents. The staff to patient ratio was lower and residents could gain access to other residents bedrooms

- There was no management lead, no effective reassessment of risk, no incident recording and no priority or resources were applied either proactively or reactively when Mr. H began displaying signs of risky behaviour in Nursing Home B

- Although Safeguarding Training is of vital importance in the effective management of vulnerable adults there appeared to be a lack of practical application of the main principals of adult protection and a lack of knowledge of pathways and processes regarding the same across a number of agencies/organizations

- The above deficiencies allowed an environment, the opportunity and the likelihood that anyone with the risk of violent or aggressive behaviour would have the conditions where those risks could be exposed

- Cumbria PCT had agreed to fund an additional 4 hours nursing care and 3 hours carer support. This was not implemented.

7.5 During the course of the review the panel was fully aware that there was a possibility that Mr. H had been involved in some way with the death of Mrs. W. As stated elsewhere in this report, it is not within the remit of the review to determine how Mrs. W died and who was responsible for her death and the panel has not formed any opinion in relation to this.

7.6 Mr. H found himself the subject of a criminal inquiry, which would most probably have been avoided, if

- There had been more effective collaboration and communication in relation to the information exchange of known risks

- There had been a more proactive and reactive management approach when the risks began to emerge in the nursing home