# Executive Summary
# of the Serious Case Review
# in respect of Mr and Mrs X



Cumbria Local Safeguarding Adults Board Chair:
Mr M. Evans

Review Panel Chair:
Mr P. Duhig

Author:
Mr D Coverdale

December 2012

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# 1. Introduction

### The decision to conduct a Serious Case Review (SCR)

1.1 Following Mr and Mrs X's death there was a meeting of the Serious Case Review Group (SCRG) on 8th March 2011 which concluded that the circumstances surrounding Mr and Mrs X's death satisfied the criteria for a SCR. The Chair of Cumbria Safeguarding Adults Board (CSAB) then wrote to relevant agencies on 1st April 2011 and asked them to begin the review process.

### Glossary

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| CSAB | Cumbria Safeguarding Adults Board |
| SCRG | Serious Case Review Sub-Group |
| CPA | Care Programme Approach |
| IMR | Independent Management Review |
| ALS | Adult & Local Services (Cumbria County Council) |
| NCUHT | North Cumbria University Hospitals Trust |
| LCFT | Lancashire Care Foundation Trust |
| UHMB | University Hospitals of Morecambe Bay NHS Foundation Trust |
| CPFT | Cumbria Partnership NHS Foundation Trust |
| LSAB | Local Safeguarding Adults Board |
| MDT | Multi-Disciplinary Team Meeting |
| SCIE | Social Care Institute for Excellence |
| NICE | National Institute for health and Clinical Excellence |
| PPU | Public Protection Unit |

# 2. Terms of Reference

2.1 Following the decision by the Chair of the LSAB to conduct a SCR, the SCRG agreed the following draft Terms of Reference:

2.2 Establish chronological and factual information regarding your agency's input to Mr and Mrs X from 13th December 2010 to 18th February 2011.

2.3 Each agency individual management review will need to address the following:

1. Review the agreed systems, procedures and care pathways that applied in this case including how agency and professional responsibilities were discharged with reference to:
   - CPA
   - Care Management
   - Safeguarding
   - Risk Assessment/Management Plans
   - Admission and Discharge Protocols
   - Mental Health Act Assessments
   - Mental Capacity Act Assessments

2. Identify and review key points/opportunities for assessment, decision making and action against standards of expected professional practice.

3. Review the effectiveness of information sharing, record keeping and communication between professionals and agencies.

4. Review and consider any diagnosis, existing clinical conditions and treatments that may have been contributory factors in this case.

5. Review the level and quality of staff supervision and management oversight.

6. Consider if there were any capacity, resources, or boundary issues that impacted on agency or professional ability to deliver appropriate services.

7. With the benefit of hindsight, could the tragic outcome of this case have been predicted or prevented.

# 3. Procedural Information

3.1 The membership of the SCR panel was as follows;

Paul Duhig, Detective Chief Inspector, Cumbria Police (Chair)
Safeguarding Adults Manager, ALS
District Lead, Furness (formerly South Lakes Adults Teams), ALS
Deputy Director of Nursing, NCUH
County Manager, Cumbria Care
Lead Nurse Safeguarding Children's and Adults. LCFT
Lead Nurse Complex Discharge, UHMBFT
Detective Chief Inspector, Cumbria Police PPU
Named Nurse Safeguarding & Protection, CPFT NHS
Head of Clinical Governance and Standards, NHS Cumbria PCT
Named Nurse Safeguarding, Cumbria Foundation Partnership
Professional Lead Social Work, ALS
Adult and Local Services Management Support Administrator

3.2 Mr D.Coverdale, the Overview Report Author also attended the SCR Panel meetings in the role of participant/observer.

3.3 The Review Panel received Individual Management Reviews (IMR's) from the following agencies:

- Lancashire Care NHS Foundation Trust
- NHS Cumbria PCT
- Cumbria Partnership NHS Partnership Trust
- University Hospital of Morecambe Bay NHS Foundation Trust
- Cumbria County Council Adult & Local Services

3.4 Although Cumbria Constabulary was not required to complete an individual IMR, applicable information to clarify the sequence of events leading to deaths of Mr and Mrs X was provided to the panel and is utilised within this report.

3.5 It should be noted that as from the 1st April 2011 community services provided by Cumbria PCT were transferred to Cumbria Partnership NHS Foundation Trust. NHS Cumbria now commissions community services and delivery of the "Closer to Home" strategy from the provider Cumbria Partnership NHS Foundation Trust. Therefore, responsibility for follow-up actions in response to the recommendations identified within this review and any associated Action Plans should recognise these changes.

3.6 Reference Documents;

- ‘The National Confidential Inquiry into Suicide and Homicide by people with Mental Illness’ - Suicide and Homicide in Northern Ireland
  The University of Manchester. June 2011

- ‘At a glance’ - Learning together to safeguard children; a ‘systems’ model for case reviews
  Social Care Institute for Excellence. September 2009

- Cumbria County Council Safeguarding Adults Board Multi Agency Policy and Procedures 2012.

- NHS Discharge and Home of Choice Policy

# 4. The Facts & Family composition

4.1 Mr and Mrs X were married in 1997 after a four year relationship and resided at an address in Cumbria. Mrs X had been married twice before, had no children of her own, but had a stepdaughter. Mr X had been married once before and had three sons, one surviving, with two now deceased.

4.2 Mr X had been having problems with his eyesight and had an operation to re-attach a retina on 11 January 2011, in Hospital 1.

4.3 Following a request from his GP, Mr X was admitted to Hospital 2 on 25 January 2011, with suspected acute confusion and paranoid delusions.

4.4 Mr X was discharged from Hospital 2 on 17 February 2011, returning to his home address.

4.5 On Friday 18 February, Mr X's son visited the house 3 times but got no reply. He contacted Hospital 2 at 7.40 pm to see if he had been re-admitted. He eventually entered the house with his wife and a neighbour using a spare set of keys. Mr and Mrs X were found deceased upstairs. Police investigations and Post mortem examinations have concluded that Mr X killed his wife, then himself.

4.6 Family Composition

Subject

Name: **Mr X**
Age; **92**
Address: **Cumbria,**
Ethnicity: **White British**

Wife**: Mrs X**
Age; **89**
Address: **Cumbria.**
Ethnicity: **White British**

Son: **Mr X's son**
Address: **Cumbria,**
Ethnicity: **White British**

# 5. Overview of Information known to Agencies

5.1 Mr X lost his sight in his right eye before Christmas 2010 and attended Hospital 1 for an operation shortly after Christmas.

5.2 After being discharged from Hospital 1 Mr X's character changed and he became verbally aggressive towards Mrs X. He also developed paranoid beliefs that his family wanted to kill him and take his money. He wrote notes to this effect and pushed them through neighbours' letter boxes and one in the post that was delivered to his GP. Mrs X had informed Mr X's son that Mr X would not eat or drink anything she prepared for him and he had been telling neighbours that Mrs X, Mr X's son and daughter in law were out to kill him. Mr X had told his daughter in law that he was not sleeping well and was having a problem with his balance, he told her there was something 'not right' and pointed to his head, she advised him to go to the doctors.

5.3 During this period, Mr and Mrs X had contact at home with District Nurses, Podiatrists and Carers. On 25 January 2011, following information received regarding Mr X's mental state, Mr X's GP visited the family home. The GP felt that Mr X was in an acute confusional state and as a consequence he was admitted to Hospital 2 for an assessment in relation to his mental state. It should be noted that there was an expectancy that Mr X would have initially been taken to Hospital 3, however a bed was not available.

5.4 Mr X was admitted to Hospital 2 on 25 January 2011. It was noted that Mr X had been treated for a suspected urinary tract infection prior to admission. He had been prescribed antibiotics by his GP and completed a five day course. His urine test results indicated no urinary tract infection. He underwent various investigations during his admission to exclude organic causes of his altered thoughts. Mr X believed his wife, son and daughter in law were poisoning his food and drinks in order to kill him since they were trying to make him change his will.

5.5 Whilst in Hospital 2 Mr X continued to exhibit confused and paranoiac thinking and initially prevented visits by his family, including Mrs X and his son. On 31 January 2011 he was seen and assessed by Older Adult Mental Health Liaison staff and Risperidone (500 micrograms, to be taken twice daily) was recommended in an attempt to alleviate his symptoms. He later saw the Consultant Psychiatrist and arrangements were made for follow up and review and transfer of care to Cumbria Mental Health Services upon discharge.

5.6 Medical and mental assessments and treatments continued throughout his stay and Mr X remained in Hospital 2 until Wednesday 16th February 2011 when the hospital contacted Mr X's son and

informed him he would be discharged the following day. They did not divulge further details at Mr X's request.

5.7 Mr X was discharged to his home address on Thursday 17th February. Mr X's son rang at 4pm and he spoke to Mrs X to see how his father was. Mrs X informed him that Mr X was in the garden banging and hammering something. Mr X's son had told Mrs X that she should get him back inside and stop him hammering as he needed rest and that he would visit the following day. Mr X then rang his son, very irate over being told to put the hammer down.

5.8 On Friday 18th February, Mr X's son went to his father's at 1230 but got no reply, he looked through the living room window and no-one was in, he went back around 2.30 and 4pm and again got no reply, he presumed they had gone into town so went home. When he returned home, he rang his father's house but the line was constantly engaged, the operator told him there was a fault with the line so he decided to travel back to his father's home. He rang Hospital 2 just to check his father had not been re-admitted. When he arrived back at his father's house at approximately 7.30pm there was no light on, which he found odd, he entered the house with his wife and upon checking upstairs his wife found Mr and Mrs X deceased.

5.9 A full and thorough Police investigation was carried out. Police Crime Scene Investigators attended the house and took photographs and videoed the scene.

5.10 There were no other indications of a third party involvement. The house was secure and there were no visible signs of a forced entry.

5.11 It was established that Mr X violently attacked and killed Mrs X before taking his own life. For the purposes of this report it would be inappropriate to describe the injuries both sustained.

5.12 The police had no involvement with either Mr or Mrs X prior this event.

# 6. Findings and Conclusion

6.1 On 18th February 2011 a 92 year old gentleman killed his wife and then himself at their home address. He had been in an acute hospital for four weeks prior where he had been treated for acute paranoia and delusions. He had no prior mental health problems and had previously lived independently with his wife at home.

6.2 Although a number of the agencies involved in the SCR process had limited contact with Mr X, the Panel felt that it was evident from the follow up investigations that he received a high standard of personal care in line with policy and practice during the period in question, however there are lessons to be learned regarding safeguarding and discharge processes.

6.3 The Panel raised questions about the decision that Mr X's circumstances indicated that this would be a non-complex discharge from hospital. This decision subsequently reflected in the way in which the discharge was conducted.

6.4 It is worth noting the differences between the laid down definitions for simple and complex discharge planning from the NHS Discharge and Home of Choice Policy;

Simple

The action needed in the discharge planning for these patients does not usually require the involvement of a full multi-disciplinary team or require the involvement of another agency.

Patients with simple discharge needs are defined as those;

- being discharged to their own home or usual place of residency having simple ongoing care needs that do not require complex planning or delivery

In addition they;

- are identified on assessment as having a predicted length of stay
- no longer require acute care
- can be discharged from Accident & Emergency, Primary Care Assessment Service, Step-up/Step-down Units, In-Patient wards or other assessment units.

Complex

Patients who are in hospital with complex needs will require referral for assessment by a range of members of the multi-disciplinary team, or the involvement of another agency or care provider.
Patients who have complex discharge needs are defined as;

Patients would be discharged home or to a carers home or to intermediate care or to a residential or nursing care home.

and

Who have complex ongoing health and social care needs which require detailed assessment, planning and delivery by the multi disciplinary team and multi-agency working.

and

Whose length of stay is more difficult to predict.

6.5 Mr X had been assessed whilst in the acute hospital by the Mental Health Liaison team who link into the acute hospital. The Mental Health Liaison Practitioner and Consultant Psychiatrist role was to provide consultation and advice on mental health issues. Comprehensive and thorough assessments were completed by both practitioners in line with their role. At no point did these practitioners believe Mr X needed acute psychiatric inpatient care from Mental Health services. At the point of discharge from the acute hospital Mental Health Liaison Practitioner reassessed Mr X. Mr X did not present with paranoia or delusions at the point of discharge and did not show any concern about returning home. He was welcoming of any further Mental Health involvement and showed planning for the future and a normal return to life in his conversation.

6.6 The Mental Health Liaison Practitioner made a referral to the Mental Health Trust where Mr X lived (another organisation) and asked for an ‘early follow up’. The Panel noted there was no apparent urgency to this, based on the assessment completed.

6.7 The Panel felt there was a lack of clarity regarding discharge planning functions and the co-ordination between agencies. There appears to be uncertainty in that process as to who and how discharge responsibilities lie. It is evident that historically, discharge can be hastily arranged and that in this case the mental health liaison practitioner was informed of the discharge the day before, this in turn had a knock on impact on the timing of the referral to Mr X’s local Mental Health services.

6.8 The Panel heard evidence that the professionals and agencies involved, because of the results from the assessments they had carried out, considered that Mr X was ready for discharge. Once any physical or organic cause for Mr X's mental health issues had been ruled out the appropriate course of action was to enlist the expertise of mental health colleagues. This was done and subsequent treatment was put into place. Mr X's mental state appeared to have improved and following discussion with mental health staff, social services, the patient and family, it was felt appropriate to discharge the patient home in the knowledge that Mr X's local mental health team would follow up.

6.9 It should be noted that the Panel learned Cumbria County Council, University Hospitals Morecambe Bay Acute Trust, Cumbria Primary Care Trust and Cumbria Partnership have an agreed joint discharge policy, however Lancashire Care are not signed up to the same document.

6.10 The Panel also recognised there was some uncertainty around who should take the lead in the discharge process.

6.11 The Panel agree that the process of discharge could have improved if a Multi-Disciplinary Team meeting had occurred. This would have formalised the arrangements within all agencies and offered the opportunity for formal involvement and face to face contact with members of the family.

6.12 The panel voiced its concern that the discharge planning meeting did not take place and arrangements did not appear to be centrally co-ordinated. It is unclear why this happened and may have been influenced by assumptions of roles.

6.13 The Panel accepts there was nothing within the records to indicate there were any concerns that Mr X posed a risk to others during his time in hospital. Ongoing assessment recognised that significant improvement in his presentation and thoughts had been noted and Mrs X talked about the future and happily invited contact from agencies. Mr and Mrs X were happy that he was going home and supported the discharge and follow up arrangements.

6.14 The Panel did agree however that if a formal discharge planning meeting had taken place this would have been inclusive of both Mrs X and Mr X's son, and may have provided additional opportunity to fully understand their views and thoughts regarding the discharge arrangements and their support needs.

The National Confidential Enquiry into Suicide and Homicide by people with mental illness completed by the University of Manchester in June 2011 recommends;

*"Services should ensure that comprehensive care planning takes place prior to hospital discharge as a key component of the management of risk."*

6.15 Although there is evidence that safeguarding issues were considered by a number of practitioners involved with Mr and Mrs X, the Panel felt strongly that there were missed opportunities to raise concerns regarding potential safeguarding issues following contact with both Mr and Mrs X. This was particularly relevant during Mr X's time in Hospital 2 where the potential for a safeguarding alert was considered but not acted upon in line with laid down procedures.

6.16 The Panel noted comments from a number of agencies regarding variations in the accuracy of written information, general documentation and lack of commentary in recording systems.

6.17 The Panel noted issues relating to cross boundary referrals between health services which have potential to impact on timeliness of assessments and care planning. Despite excellent links and contacts between mental health providers, historically, functioning of teams has not allowed attendance from out of county to discharge meetings and LCFT staff had been advised in the past to only refer across boundary at discharge.

6.18 Whilst considering the information received regarding this case it should be noted that the Panel felt there were areas of good practice demonstrated by agencies throughout the period considered;

- The Mental Health Liaison Team referral was categorised as urgent (24 hours response expected) however Mr X was seen within 4 hours.

- The Mental Health Liaison Team contacted Specialist Mental Health services in Cumbria to ascertain whether Service Users are known to them and to gather relevant history.

- The MMSE was carried out as per NICE Clinical Guidelines 42 November 2006 - Dementia and undertaken by the Ward Doctors as part of their screening process

- A Good Quality thorough assessment was completed by MH Liaison Practitioner including:

    - Ruling out infection
    - Advising ward staff to seek safeguarding advice
    - Advising ward staff to refer to Social Services re: Mr X's social situation for assessment and support

- Liaison with Consultant Psychiatrist for advice

- The Consultant Psychiatrist assessed Mr X within one day of referral by the Mental Health Liaison Practitioner, this was a good response time to the referral and within the response time described within the Mental Health Liaison Team Operational Policy

- Treatment and Prescribing was in line with Best Practice Guidelines (NICE guidance.)

- The Mental Health Liaison Practitioner followed up Adult & Local Services referral and asked that when the case was allocated could the Social Worker contact the team for further information prior to any contact with Mr X.

6.19 The Panel were encouraged in that a number of agencies have already commenced or completed follow up actions applicable to this case, namely;

- The internal review provided LCFT with an opportunity to review and reflect on safeguarding adult practice, some immediate steps have been taken and already implemented to strengthen and develop safeguarding adult practice within the organisation. LCFT safeguarding adult policy has been reviewed and updated to reflect some of the learning from the review.

- The positive learning achieved regarding the thorough assessment that took place and the good model of care provided by the Mental Health Liaison service into the acute hospital. Recommendations have been made to celebrate this model across the Mental Health Trust.

- Within the LCFT, the model of identifying safeguarding champions within clinical teams had already been adopted in respect of safeguarding children, this model has been expanded within the older adult network and this has resulted in the identification of safeguarding adult champions across the network. The role of safeguarding champions will support staff and raise awareness of staff responsibilities to safeguard both children and adults within the teams.

- Within ALS, all transfer of Care and Discharge Policy information has been shared again with identification of experienced staff to consult with. Management support continues to be given to learning processes and activity. Reorganisation of teams s now better support a single

allocated practitioner throughout a person's 'journey' in services, and this will better support communication and awareness to changes in a person's needs or to their carer's needs.

- Safeguarding Adults Training for the PCT at the time of this case was not a mandatory requirement for all disciplines but has been since April 2011 for all disciplines employed by CPFT and therefore this is an action which has been addressed.

6.20 During the latter stages of completing this overview report the Coroner's Inquest relating to the deaths of both Mr and Mrs X took place. The Panel were subsequently notified that information revealed during the inquest with reference to an apparent psychotic episode involving Mr X prior to his discharge from Hospital 2, had not previously been considered in detail within the SCR process. As a result, the appropriate information was sourced and considered by the Panel. The Panel concluded that although the information supported the issues previously highlighted regarding safeguarding and the discharge process, it did not believe this specific information had significant effect on the tragic outcome of this case.

6.21 This SCR and associated IMR production has highlighted a number of issues in respect of expectations, knowledge and understanding of the process. The Panel agreed there was a wide variation in experience, availability and training in respect of the individuals from the agencies involved and this had affected the overall process.

6.22 It is difficult to understand what exactly occurred in the home of Mr and Mrs X on Friday 18 February 2011. It can be assumed that the incident was particularly harrowing to both Mr and Mrs X, however, taking account of the information received during the SCR process the Panel concluded that the events that took place were not predictable or preventable.

6.23 In terms of preventability, the Panel agreed it could be open to debate that if Mr X had not returned to his home address then the tragic outcome may not have occurred. However, despite the issues previously raised regarding the discharge process, Mr X had never indicated or displayed any violent intent towards his wife or others during his time in hospital and therefore it was felt appropriate that he be discharged home. All indications were that both he and his wife were happy with that arrangement.

# 7. Recommendations

## Single agency

7.1 Each agency has produced an Action Plan as part of the IMR process aligned with the identified recommendations and including appropriate timescales for completion.

**Lancashire Care NHS Foundation Trust**

7.2 Raise awareness with LCFT staff that Safeguarding Adults alerts to be completed and sent to the authority that the Patient resides and LCFT staff to complete these alerts if concerns arise. LCFT are responsible to check out that a referral to Social Services for help/assistance has been made if necessary.

7.3 LCFT Safeguarding Team and Locality Team Managers to arrange and facilitate briefing sessions for staff to increase awareness regarding the role of LCFT Safeguarding Team and staff responsibilities in the alerting process.

7.4 Utilise LCFTs BlueLight system to alert all staff to Safeguarding Adult responsibilities.

7.5 LCFT to work with the Hospitals Trust to strengthen the discharge planning arrangement.

**University Hospital of Morecambe Bay NHS Foundation Trust**

7.6 Raise awareness of UHMBFT staff of adult safeguarding and procedures within the organisation and the wider health economy; Staff clearly need to understand the procedures associated with safeguarding adults. Awareness needs to be raised at all levels in order to help prevent issues raised in this case. Staff should also have a better understanding of the processes and practises in relation to alerts and referrals as well as the outcomes.
Staff should not make assumptions that someone else is dealing with the issues. This will be achieved by implementing a robust training strategy with different levels of training for all staff as well as identified key individuals.

7.7 Review safeguarding structure within UHMBFT; Increased levels of safeguarding expertise in order to advise and deal with safeguarding

issues. We need to have assurance that an improved safeguarding structure is embedded within our entire practise.
There will be a ward to board approach monitored via the safeguarding adult and children's group, reporting to the Trust governance committee

7.8 Review safeguarding policy; The policy will be reviewed and will reflect any changes required to improve our procedures and practise in order that all staff from ward to board will be clear in relation to their responsibilities for safeguarding.

7.9 Review discharge policy and procedures; In light of the concerns raised re the discharge process of this case the policy will be reviewed and changes made. Clear responsibilities will be outlined to staff from ward to board.

**NHS Cumbria (PCT)**

7.10 Using this case in an anonimised form, community staff should receive training and development, highlighting the dangers of making assumptions and how such assumptions may hinder the provision of good quality care.

7.11 All community staff to be reminded of their responsibilities to provide holistic patient centred care.

7.12 Safeguarding Adults Training is not a mandatory requirement within all agencies and this needs to be addressed.

**Cumbria Partnership NHS Foundation Trust**

7.13 All referrals of older people to the Old Age Community Mental Health teams containing evidence of recent psychosis; should receive an urgent assessment appointment. This assessment appointment should be informed by historic information provided by the referrer.

7.14 Communication with Hospital 2 Mental Health Liaison team should be clarified. Formal pathways describing involvement of Cumbrian teams with the planned discharge of local residents must be jointly agreed, with particular reference to information sharing expectations.

7.15 Ensure clear understanding of difference between allocation of person to worker and assigning a person to worker.

7.16 Ensure accuracy of recording as to which individual when partners each open cases to ALS

7.17 Where new services are being piloted, established agreements are maintained

7.18 Ensure Hospital discharge Protocols (internal) maintained. Transfer of Care and Discharge Policy adhered to

7.19 Review of IAS (Integrated Assessment System);

- To identify and prompt separate recording for individual service users, where co-located/spouse/partner also service user;
- To add prompt for safeguarding consideration in Reablement cases (none statutory involvement by ALS);
- To add prompt to identify Reablement Co-ordinator and 'other professional involvement'.
- To add prompt for notification (Section 2 and 5 ) where Hospital Discharge referral back to community.

7.20 Review of transfer between Adult & Local Services team members to reflect Better for People model of one worker allocated to service user, to follow through Hospital admission to community discharge via assessment and review.

7.21 Review of Risk Assessment and Management documentation to provide shared and agreed templates across the organisation and wider Health and Social Care partners.

7.22 Raise awareness of appropriate discharge activity and agreed discharge Protocol documentation within operational teams.

7.23 Raise awareness of need for Capacity assessment of cared for and carer where concerns exist as to their ability to care appropriately and understand needs following a discharge process

7.24 Raise awareness of the different status of Acute Hospital and PCT step up/down beds in operational teams.

# Multi agency

7.25 In addition to the identified Single Agency recommendations, The Panel invites the Safeguarding Board to consider the following recommendations and where applicable, these should be included in any Action Plan created as a result of this case.

7.26 Evidence suggests that Safeguarding Adults Training is not a mandatory requirement within all agencies and this should be considered for all personnel who have direct contact with patients or clients. The Board should ensure that the CSAB Learning and Development Strategy is implemented by partner agencies ensuring that personnel receive the correct level of training and the process is monitored appropriately.

7.27 As part of the aforementioned training Staff must be reminded of the relative dangers of making assumptions, as such if an aspect of patient care does not present as expected then they should report and discuss this aspect to other appropriate professionals. It is important to note that an adult safeguarding alert is triggered when someone is believed or thought to be at possible risk of harm/abuse and not only at the point where there is demonstrable evidence of harm. All relevant Healthcare professionals should apply holistic patient care in their practice. It is everyone's responsibility and duty to raise an alert if there is a concern that an adult has, is, or is at risk of being harmed, abused or neglected. Individuals should guard against assumptions that 'someone else' is dealing with the issue and ensure the alert is either actioned by themselves or referred onwards to an appropriate individual who can assist the patient and through the Safeguarding Referral system as appropriate.

Cumbria County Council Safeguarding Adults; Multi-Agency Policy and Procedures 2012 states;

"*It is expected that all agencies, settings and residential establishments ensure that staff and/or volunteers are provided with training appropriate to the tasks they perform. This training should cover the recognition of abuse and neglect and the application of these guidelines*."

7.28 Taking account of the lessons learned in this case, The Board should seek assurances from partner agencies to ensure that arrangements are made to review the existing formal discharge processes. There needs to be a clear and timely system in place to ensure all relevant agencies are informed and included in the process which ultimately allows a person to receive a co-ordinated and appropriate care,

support and interventions. In addition, there should be a clear understanding by all parties involved as to who is the lead professional responsible for the formal discharge process.

This review should include all appropriate agencies and consider inter-departmental and cross boundary issues as part of its remit.

7.29 The Board should seek assurances that partner agencies ensure all staff understand the importance of completing robust, appropriate and legible written information, using applicable recording systems.

7.30 IMR Training; The Board should consider the development of specific training for applicable personnel to enable completion of robust and impartial documents. An understanding and appreciation of the expectations, time and commitment required for completion should be understood by the participating agencies. The Board should ensure that applicable agency Managers understand the SCR process along with the guidance and support requirements for IMR authors. It is suggested that this recommendation forms part of the Learning and Development Strategy for 2012/13.

7.31 The Board should consider how to improve links with the Coroner to ensure appropriate information, relevant to the SCR process, is made available.

7.32 The Board should consider options for an alternative methodology for the completion of SCR's.

Adoption of the SCIE model (or variant) may improve the timeliness, independence, quality and consistency of information received.

Signed; .....

D. COVERDALE
Independent Author

Date; .....

Signed; .....

P.DUHIG
SCR Panel Chair

Date; .....