SAFEGUARDING ADULTS REVIEW IN RESPECT OF Mrs B WHO DIED ON 27TH APRIL 2014

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On behalf of the Portsmouth Safeguarding Adults Board

CONTENTS

1. INTRODUCTION

1.1 This report covers the findings and recommendations of the Serious Case Review (now called a Safeguarding Adults Review) by the Portsmouth Safeguarding Adults Board (instigated in October 2014) and relating to Mrs B who died on 27th April 2014.

1.2 A Safeguarding Adults Review (SAR) is not intended to attribute blame but to endeavour to learn lessons and make recommendations for change that will help to improve the safeguarding and wellbeing of adults at risk in Portsmouth in the future.

1.3 This SAR complies with Section 44 of the Care Act 2014 and the accompanying Statutory Guidance.

1.4 The Care Act 2014 Section 44 Safeguarding Adults Reviews

> (1) A Safeguarding Adults Board (SAB) must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—
>
> (a) There is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and
>
> (b) Condition 1 or 2 is met.
>
> (2) Condition 1 is met if—
>
> (a) The adult has died, and
>
> (b) The SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

1.5 The decision to undertake a SAR in this case was taken by the Portsmouth Safeguarding Adult Board, due to the death of an adult (Mrs B) whilst she resided in a residential care home in Portsmouth (Alton Manor).

1.6 Mrs B had been allegedly assaulted by another service user (Mr C) in the home on 25th April 2014. Mrs B was subsequently taken to hospital, where she died 2 days later.

1.7 Contributions to this review were made by all agencies that were working with Mrs B, or Mr C at the time of the incident, as set out below;

Hampshire Constabulary
SevaCare
Portsmouth Adult Social Care
Portsmouth Clinical Commissioning Group
Alton Manor Care Home
Portsmouth Hospitals NHS Trust
South Central Ambulance Service NHS Foundation Trust
Solent NHS Trust
NHS England

1.8 Individual Management Reviews were requested from all agencies as part of this Safeguarding Adult Review Process.

1.9 In addition Mrs B's husband (Mr B) was interviewed for his views. Mr C was not interviewed for this report, as he was deemed to lack capacity to participate in the SAR.

2. THE CIRCUMSTANCES THAT LED TO THE SAFEGUARDING ADULTS REVIEW

2.1 Mrs B was of White UK origin; she married in 1993 and lived with her husband in Portsmouth. She was described as having a Learning Disability and had been treated for depression. She also had several strokes, causing her to have a severe contraction in one hand. Mrs B struggled to maintain a healthy weight and concerns about her health had prompted Portsmouth Adult Social Care to first become involved with her in 2008.

2.2 Mrs B declined community support packages in September 2013, in favour of her husband's care, which placed him under considerable strain. She also displayed some verbal and physical aggression toward her husband and there was sometimes tension between them. A care package was arranged for Mrs B on the 26th September, although Mrs B was aggressive toward the carers. Mrs B was taken to A&E on the 28th September, following a fall in connection with a physical assault on a home carer. She was discharged from hospital on the same day to Alton Manor residential care home.

2.3 Mrs B's situation appeared to stabilise during her stay at Alton Manor; her appetite improved and she appeared calmer. This changed in late October and on the 25th October Mrs B exhibited some verbal and physical aggression toward care staff and other residents. Medication was prescribed in attempt to manage Mrs B's behaviour. Referrals were made to adult mental health services in November in response to further physical aggression.

2.4 Whilst the placement was originally short term it became a long-term placement in January 2014. This was partly due to her husband's anxiety about Mrs B returning home, (given previous physical aggression toward him). This placement was discussed with Mrs B at the time and she stated that she liked the home and staff.

2.5 A review meeting was held with professionals and Mrs B's husband to discuss Mrs B's placement at Alton Manor. The placement was judged to be in her best interests and all agreed that it should continue. Shortly after this point in February 2014, Mrs B was diagnosed as having dementia.

2.6 Mr C is a 79-year-old man, also of white UK origin. He had been known to since 2002, when he first had a pacemaker fitted and had short term intervention in the form of a home from hospital service. He attended some day care in 2003, although there was no further contact with him until 2011.

2.7 In 2013 Mr C was admitted to Queen Alexandra hospital having had a severe stroke, which caused a visual impairment. He was registered blind and just had some shadow vision. He was discharged from hospital to Jubilee House in 2013. At this time he was known to have suffered from depression and had made a previous suicide attempt. Details of this were not available to the SAR. He moved into supported living in November 2013, but struggled to cope and was re-admitted to hospital with dehydration and signs of neglect in December 2013.

2.8 Later in December 2013 he was discharged from hospital and admitted to Alton Manor Care Home, where he remained until shortly after the incident in which he was involved with Mrs B.

2.9 During this incident on the 25th April 2014 Mr C is alleged to have assaulted Mrs B, causing her to fall and hit her head. Police and Ambulance were called to attend. Mrs B was taken to Queen Alexandra hospital by ambulance accompanied by Alton Manor staff. Mental Health services arranged an admission for Mr C. He was taken to a mental health inpatient service by the police and admitted as an informal patient.

2.10 On the 25th April Mrs B was assessed at casualty in Queen Alexandra Hospital. Mrs B had sustained a head injury, although the severity of this injury was not initially diagnosed and she was sent back to the care home. Her condition rapidly deteriorated and she was returned to hospital later the same evening. Mrs B was then admitted to hospital, but did not regain consciousness and died on 27th April 2014.

2.11 The Portsmouth Safeguarding Adults Serious Case Review Group undertook a scoping exercise to determine whether the death of Mrs B should be reviewed under the Safeguarding Adults Review Process. All agencies involved with both Mrs B and Mr C were requested to produce a brief chronology.

2.12 Upon receipt of the chronologies the independent chair of the group made a recommendation to complete a Safeguarding Adults Review on the circumstances leading up to the death of Mrs B. This was notified to the Independent Chair of the Portsmouth Safeguarding Adults Board. Terms of Reference for the SAR were agreed, the SAR Panel established and an independent author appointed.

2.13 Individual Management Reviews (IMR) were requested from the following agencies;

Portsmouth Adult Social Care
Hampshire Constabulary
Ambulance Service (SCAS)
Portsmouth Hospitals NHS Trust (Queen Alexandra Hospital)
Alton Manor Residential Care Home
Housing 21 (supported Housing)
SevaCare (Domiciliary Care Provider)
Solent NHS Trust (Mental Health Trust)
NHS England

3 TERMS OF REFERENCE OF THE SAFEGUARDING ADULTS REVIEW

3.1. The SAR Panel agreed the draft Terms of Reference for the SAR in January 2015 (as set out below). The circumstances surrounding Mrs B 's death are unusual and therefore it is difficult to carry out the review without considering the care and treatment of Mr C.

3.2. The focus of this review is to consider the level of intervention, care and support provided to Mrs B from 29th September 2013 until her death on 27th April 2014.

Identify which agencies were involved and the decisions made with Mrs B and Mr C with regard pre-admission assessments and securing placements

What was the quality and extent of assessments, risk assessments and care services that Mrs B and Mr C received and were they appropriate to meet their needs?

Could agencies have communicated and shared information about Mr C's historic and current behaviour, including risk to others, more effectively and did this present any missed opportunities for escalating concerns between agencies?

To seek to understand if these events could have been avoided and what lessons have been learnt as a result of the Serious Incident Requiring Investigation process and Safeguarding investigation.

To consider the overall effectiveness of inter-agency working at that time, and if agencies were working within the framework of safeguarding procedures and guidelines.

4. THE CONTENT OF THE SAFEGUARDING ADULTS REVIEW

4.1. FULL-INTEGRATED CHRONOLOGY

The Independent Author collated a detailed multi agency chronology of the circumstances leading up to, surrounding and after Mrs B's death. A full chronology was compiled separately for Mrs B and Mr C. Due to the volume of material for Mrs B and Mr C the subsequent contents of the report have been divided into the following five sections.

4.2. KEY SECTIONS OF CHRONOLOGY

As the full-integrated chronology is by its nature a very long and complex document, a series of brief summaries are included below to help understand the key moments of agencies' interventions at relevant periods of Mrs B's and Mr Cs lives. These should be read with further details sought from the full chronologies in the Appendices, as required.

The five sections of the report cover the following periods

5.) Mrs B (01/09/13-31/12/13),
6.) Mr C (01/09/13-31/12/13)
7.) Mrs B (01/01/14-24/04/14),
8.) Mr C (01/01/14-24/04/14),
9.) Detailed combined Mrs B and Mr C (24/04/14-28/04/14)

4.3. STRUCTURE OF THE REPORT

In each of the subsequent periods, there is a brief analysis of the involvement recorded by each agency and the key themes are then identified. Recommendations are then made to learn from the key themes for each period. These are then collated along with a draft action plan to address the recommendations in final section of the report.

4.4. Mr B'S ACCOUNT

Mr B now lives on his own, with his cat for company. The report author interviewed him in the presence of his Social Worker and his Advocate. He had known Mrs B for some time prior to their marriage in 1993. They lived together before getting married and moved into their flat in 1998. Mr B worked until 2003 when he was made redundant and has not worked since. Mr B had known Mr C through working together at the same firm before Mr B was made redundant. Mr B did not have further contact with Mr C until they met again at Alton Manor Care Home.

Mr B described his marriage with Mrs B as good and they had no problems. Mrs B had a fall in 2010 and then in 2013 suffered 3 strokes, which he found frightening. Mrs B then started to lose weight. Mr B thought this might have

been as a result of the strokes. Mrs B was also then unable to cook so Mr B had to do this, but they had help from a carer arranged by Adult Services.

In 2013 Mrs B grabbed Mr B, which hurt him and he didn't know why she did this. She subsequently went into hospital for tests and was admitted in September 2013. On the way home from hospital Mrs B apparently tried to get out of the car when it was still on the motorway. After she got home she scratched a carer and Mr B took her back to hospital, as he couldn't cope with her. She was then placed in Alton Manor Care Home and he visited her regularly every couple of days.

Mr B was happy with the placement and felt Alton Manor staff looked after her well. He had no complaints about the home. Although she was younger than most other residents and more able, he felt she was in the right place. She did not have any particular friends there, but got on OK, apart from one incident when she “nearly took a carer’s eye out”. Mr B did not witness this, but that was what he was told by the staff.

She did used to get angry when he visited because she wanted to come home. Mr B felt he would be under too much pressure if she came back and was pleased when her placement was confirmed as permanent in February 2014. When Mr B visited Mrs B he saw Mr C and recognised him from when they used to work together, they used to speak as Mr C also remembered him from this time.

Mr B was at Alton Manor on the 25th April when Mrs B was having her right hand bandaged by the District Nurse. After this was finished Mr B was with Mrs B in the dining room. He stood up and told Mrs B he was leaving and he walked towards the other dining room, with Mrs B walking behind him to say goodbye. At this point Mr C also got up and said he wanted to come with Mr B to leave Alton Manor and come home with him.

Mr B was looking the other way but he claimed that he knew Mr C pushed Mrs B and she fell, hitting her head on the floor. Mr B said it happened so quickly the staff could not have done anything about it. Mr B was upset and the staff took him outside. He knew Mrs B had gone to hospital, so he went home and was informed that Mrs B had come back home by Alton Manor later in the evening. He didn't know she had become unwell again and was re-admitted later on that evening, although staff tried to call that night they didn't get through.

The next day he went back to Alton Manor and it was then he was told she had been admitted to hospital. Mr B went to visit Mrs B on the Saturday but she was in a coma from which she did not wake up. He went back to the hospital on the Sunday, taking a picture of their cat to show Mrs B and it was not until he arrived at the ward he found out Mrs B had passed away earlier that morning.

He wished that someone had told him and had taken him to see Mrs B before she died. The police came to see Mr B later on Sunday and asked him some

questions. The Police Family Liaison Officer, who he said was very good and helped him a lot, then contacted him.

Mr B said he was gutted by what happened and angry that Mr C did not get punished for what he did, he didn't care whether Mr C has got dementia because he shouldn't have done it. He was offered counselling by his GP but didn't want it. He says he is still depressed and thinks about “doing himself in”, but wouldn't act on these feelings because he has to look after his cat. Mr B is not angry with anyone else, but thinks Mr C should have been made accountable for his actions.

5. FIRST PERIOD OF SAFEGUARDING ADULTS REVIEW

5.1 Summary of First Chronology Period (Mrs B 01/09/13-21/12/13)

The first summary covers the significant recorded events for Mrs B up to three months before she died and is sourced from information supplied by the records, Hospital Records, Alton Manor Care Home Records and the GP records.

5.1.1. September 2013

In September 2013 Mrs B was living at home with her husband (Mr B) and there was involvement from a number of Professionals, including a Social Worker and an Occupational Therapist (O.T.). Mrs B was described as very frail and having a major learning disability by the OT, although she was not known to the Learning Disability team. The GP records did not contain a formal diagnosis of learning disability.

She had 3 mini strokes in the past year, which led to her right hand being contracted. She had lost a lot of weight and the O.T. recorded this to have been half her body weight in the past 2.5 years. Her mobility had also deteriorated. Mrs B underwent investigations for her weight loss in hospital for a week, although no medical cause could be found. She was offered community support, but she was reluctant to accept this, as she wanted Mr B to provide her care. Mr B stated he was struggling to cope with the care needs of Mrs B, who was at times angry with him.

Whilst in hospital Mrs B was thought to lack capacity to consent to her treatment and she was noted to have suffered from depression for the past 12 years, since the death of her mother. She had previously been treated with ECT for her depression. She was considered for an admission to St James hospital for an assessment of her mental health. She did not need further inpatient treatment in the general hospital for her low weight.

She was then allocated to a Hospital Team Social Worker, who felt Mrs B did have capacity and Mrs B agreed to have support in the community. Her needs were assessed and Home Care was set up for daily visits prior to her discharge from hospital on 27th September. At this stage Mrs B struggled to walk and was provided with a walking frame. Her home carer reported that Mrs B was physically aggressive to her on two occasions and safeguarding referrals were made.

Mr B stated that he was unable to cope with her aggression at home, and brought Mrs B back to hospital. As an urgent response to this situation she was then placed into Alton Manor Care Home, on the 29th September, initially for short-term respite care. However, Mr B refused to have her back home, as he could not cope with her. This placement was undertaken, as a Best Interest Decision as Mrs B was thought to lack capacity into her care needs. Mrs B improved initially at Alton Manor Care Home, although still wanted to

go home. She weighed only 5 stone and 6 pounds on admission. The initial plan was for her to stay for a month.

5.1.2. October 2013

Mrs B was noted to be at risk of sacrum area pressure ulcers by the care home staff and was being transferred at Alton Manor by wheelchair, rather than being encouraged to use her walking frame. Her big toe nail was also noted to be falling off. She was at times verbally and physically aggressive toward both her husband (Mr B) and Alton Manor Staff. She was provided with dressings and a pressure relieving mattress, her medication was also changed by her GP, to treat her agitation and poor sleep patterns as she was not sleeping at night. She did improve and settled into Alton Manor during October, although the Home Manager continued to raise concerns with her GP about Mrs B shouting and lashing out at staff and other residents. Her GP again changed her medication, but she continued to show aggression, hitting out at another resident and at Mr B when he visited her.

5.1.3. November 2013

In response to the above aggression the Alton Manor Manager referred Mrs B to Adult Mental Health and the Crisis Team, for an urgent review, but did not get a response. Her GP once again prescribed additional sedatives to be used by the home staff as required. She was visited by a District Nurse to dress her sacrum area pressure sores and the District Nurse also raised concerns about Mrs B's behaviour with the GP, who prescribed yet more additional sedatives, to be given on an as needed basis. Mrs B's aggression to Mr B continued although she did apologise to him. She was recorded as showing some improvement. She was eating and sleeping at night. She was seen at an outpatient hand clinic for possible straightening of her contracture.

Her GP then sought a consultation from the Consultant in the Learning Disability Team and also referred her to the Mental Health Team, due to the above concerns about aggression from Mrs B, despite the medication changes. At this stage the plan was still for Mrs B to return home, once her behaviour and physical health had improved. Portsmouth Adult Social Care continued funding her placement on a temporary basis.

5.1.4. December 2013

Violence from Mrs B continued, despite the use of regular sedative medication. She claimed that other residents had hit her first, although this did not appear to have been the case. The District Nurse reviewed Mrs B and her sacrum ulcers continued to be treated; she was also assessed for continence pads. GP records do not record the progress of the treatment for her pressure ulcers. A Consultant Psychiatrist and mental health practitioner from the adult community mental health team (CMHT) visited her. She refused to be assessed by them. The CMHT discharged her back to her GP, without a mental health assessment being completed.

5.2 Analysis of First Period of the Chronology

5.2.1. Involvement with Mrs B

During this period of the chronology staff worked to support both Mrs B and her husband Mr B. Her needs for community support were assessed, due to her increasing difficulties coping with personal care at home. She was provided with a home care package, but this rapidly broke down. Her husband, who was her main carer found it difficult to cope with her needs and brought Mrs B to hospital refusing to have her back home, due to the aggression she showed to him and home carers. She was brought to A&E after a fall apparently in connection with an assault on a carer. A safeguarding alert was raised at this time, although not pursued.

She was appropriately placed for respite in residential care, initially for a month. At this stage it was still the plan for her to return home, if her physical and mental health improved to the point that Mr B could cope with her needs. There is evidence of good practice from her Social Worker and OT, however it was noted that Mrs B did not have a full assessment of needs prior to (or after) her placement at Alton Manor, nor did she have a Mental Capacity Assessment and Best Interest Decision formally recorded.

5.2.2. Alton Manor Care Home Involvement with Mrs B

Mrs B was admitted into the care home on a respite basis. She moved into a single en-suite bedroom and adjusted to her new surroundings fairly quickly. Initially she needed assistance and prompting from staff members with her meals and drinks but over time she regained her independence. She was able to eat by herself. Her appetite also improved and as a result she also started to gain weight.

She displayed verbal aggression towards her husband and staff. However, after a couple of months or so she settled into the routine of a care home and this calmed her. She required assistance of one carer with all her personal care, which she accepted at the care home, but had refused in the community. The care provided to Mrs B at the home appeared to meet her needs and she did start to gain weight.

5.2.3. Primary Health Care Involvement with Mrs B

Mrs B had a working diagnosis of mild learning disability. She had a history of hypertension and suffered a Transient Ischemic Attack (TIA), a mini stroke, in December 2012 after which she was prescribed Clopidogrel. She had a past

history of significant depression, for which she had been treated with Electro Convulsive Therapy (ECT).

In June 2013 Mrs B's food intake reduced massively and she refused to engage in dialogue as to the reasons (possible symptoms) and started to lose a considerable amount of weight. She did agree to an admission to hospital at this time, her BMI was 14. Extensive investigations were undertaken and no cause found. She was discharged with a diagnosis of decreased intake, self-neglect and possible eating disorder.

The GP was asked to review her at Alton Manor on a number of occasions because of concerns regarding her increasing agitation and aggression; initially Mirtazapine was prescribed then Trazadone. Records do not show evidence of organic causal inquiry e.g. urinary tract infection (UTI), physiological dysfunction, and infection. A referral to adult community mental health services (CMHT) was sent by her GP, citing agitation and aggressive behaviour. After the CMHT attempted to assess Mrs B, the GP immediately referred to the Older Persons Mental Health Team (OPMHT) due to his "considerable concerns". Referrals to secondary mental health services by primary care were therefore appropriate.

A letter from the community matron recommended analgesia for pressure sores to coccyx but there was no documentation of this at future visits. GP records do not therefore reveal progression of these pressure sores.

5.2.4.Portsmouth Hospitals NHS Trust Involvement with Mrs B

Mrs B was seen in the Medical Assessment Unit after being referred by her GP, due to her weight loss. She had an abdominal ultrasound and a chest x-ray that were both normal. She was seen as an outpatient by the Endocrine Team who found no reason for her weight loss. Blood tests were taken but Mrs B did not want to remain in hospital, although she was admitted and stayed on the ward for one week.

She stated that her husband did the cooking at home, but did not give her much food, although she has Forticips nutritional supplement drinks. The nursing records indicate that a safeguarding referral was required, due to concerns about possible neglect of Mrs B, although this does not appear to have been done.

There was a view recorded that Mrs B lacked capacity and despite not wanting to remain in hospital it was felt that this could be justified in her Best Interests. No formal Mental Capacity Assessment was documented as evidence for this view. However, within five days she was discharged home, after her Social Worker had set up the Home Care Package for her.

5.3 Learning from first part of chronology and review of key issues.

5.3.1. Mrs B's complex physical health needs

This was identified as a concern by all agencies during this period of the review. Adult Services were clearly concerned about Mrs B's deteriorating physical health, especially her dramatic and rapid weight loss, the cause of which was not clear. This was investigated by her GP who subsequently referred Mrs B for further inpatient tests and no cause could be determined. A nurse in the hospital did question whether Mrs B was being neglected in the community although this concern was not further explored or investigated.

Her loss of mobility whilst in hospital increased her needs for support upon discharge, which may have put more of a strain on her husband. The provision of community care services to meet her needs was problematic, in that she did not accept the level of care offered from the Home Care service.

5.3.2. Mrs B's complex mental health needs

Adult Social Care, her GP and the inpatient services all identified Mrs B as having a Learning Disability. However, there does not seem to have been a formal diagnosis. There had been no referrals or contact with Learning Disability Services. The impact of her intellectual impairment on her physical health and functional ability at home was not explored in any of the IMRs submitted.

This was complicated by her long-standing depression, although she was not formally diagnosed with depression during this period of the review. The impact of her mood on her relationships and physical health is not formally considered. Her mental health presentation during this review was mainly dealt with by her GP, by prescribing medication to deal with her aggressive behaviour at Alton Manor Care Home. There were attempts to get specialist input from mental health services for Mrs B during both her hospital stay and after her admission to Alton Manor, but these were not successful. She was discharged from mental health services without being seen, as she refused an assessment when visited at Alton Manor.

The final key aspect of her mental health was that of her mental capacity. This was at times thought to be lacking in relation to both her treatment in hospital and her placement in Alton Manor. Despite a number of references to Mrs B's mental capacity, there were not formal assessments made.

5.3.3. Admission to Alton Manor Care Home

Due to the urgent circumstances of this placement, Mrs B was not seen or assessed by Alton Manor prior to her placement. Also Adult Social Care did

not provide a written assessment of her needs, but only a verbal handover was given.

The challenges presented by Mrs B was that she needed some personal care support and prompting and encouragement to eat, although she did accept staff support with these care needs. She was recorded as settling into the care home she did also frequently exhibit both verbal and sometimes physical aggression. This was initially exacerbated by the regular visits to the home by her husband Mr B. At times she was described as being angry with him and at other times as angry that she could not return home with him.

5.4. Recommendations from First Chronology

Mrs B had complex needs due to both her mental and physical health. It was clearly difficult to meet her needs in the community and her husband was unable to cope. Adult Social Care appropriately supported her during this time in the community. As there was a crisis at home she needed an urgent placement. The emergency nature of Mrs B's placement at Alton Manor led to her being admitted without a full assessment of her needs. This was never completed and a question is raised about the suitability of her placement being accepted, without a proper needs assessment, especially because she had complex needs.

A further issue arising from this chronology is whether Mrs B had decision-making capacity about how to meet her care needs. This was unclear from the reports submitted. The management of Mrs B's mental health and aggressive behaviour was done by the home and GP, without input from mental health services, which left the home staff and residents at potential risk.

Recommendation 1
PSAB will seek assurance from Portsmouth City Council Adults Service that they have robust processes in place to ensure that Emergency Placements from Hospital to Residential Care are reviewed by Services, to provide an updated written assessment of needs within two weeks of the admission. This is to include any complex mental or physical health needs and a mental capacity assessment.

Recommendation 2
PSAB will seek assurance from Director of Nursing for Solent NHS Trust that violent/physically aggressive behaviour in Residential Care Homes (where this is linked to a complex mental health problem) is a priority for assessment by specialist Mental Health Services.

6. SECOND PERIOD OF SAFEGUARDING ADULTS REVIEW

6.1. Summary of Second Chronology Period (Mr C 10/08/13-31/12/13)

The second summary covers the significant recorded events for Mr C up to the time just after he was first admitted to Alton Manor Care Home. The information is sourced from the records, Solent NHS Trust Mental Health records, Portsmouth Hospital NHS Trust Records, Alton Manor Care Home Records and the GP records.

6.1.1 August 2013

Although this is outside the scope of the SAR, significant events occurred in August. Mr C was brought to Queen Alexandra Hospital, after a fall and a stroke leaving his vision very impaired with a right homonymous hemianopia (a visual field loss on the same side of both eyes). He was transferred from Queen Alexandra Hospital to Jubilee House, on the 28th August. Jubilee House have “step-down” beds from the acute hospital for those who may still need medical care or a Continuing Health Care Assessment.

6.1.2. September 2013

A nurse from the Adult Community Mental Health Team saw Mr C at Jubilee House. He was assessed for consideration of his aftercare needs. He knew that he couldn't return home due to his loss of sight and admitted frustration that he needed help from staff with eating and mobility. The initial plan was for him to go to a nursing home, although he was then thought to have greater potential for rehabilitation.

He was referred to Adult Social Care by Jubilee house, who deemed him medically fit for discharge. He needed help with activities of daily living, due to his visual impairment and also had a catheter, for which he needed support. Whilst remaining in Jubilee House he was assessed as being low in mood, quite tearful and frustrated that things weren’t moving on for him. He was thought by the mental health team to need residential care, due to his presenting needs for care.

However, at a meeting with a Social Worker, a Nurse, Mr C, a friend and his friend’s daughter it was concluded that Mr C should move to the Victory Unit. This was for further rehabilitation and it was recommended that he should be placed in extra-care sheltered accommodation. This was thought to be more appropriate for his needs than residential care at this time. His worker from the Community Mental Health Team did not share this view, (based on her assessment that Mr C required residential care) but was not involved in this meeting, or this placement decision.

6.1.3. October 2013

Mr C moved into the Victory Unit from Jubilee House. The Victory Unit is part of a Local Authority Residential Home, providing rehabilitation for up to a six-week stay. He was assessed for long cane training, to help with his mobility issues and visual impairment. A further planning meeting was held. The plan for him to move to extra care housing was discussed and it was thought he could manage with that level of support. He reported being able to see outlines and close objects. He was able to move about well and keep himself safe. He was assessed as needing help with his personal care, his catheter and his food. An application was made for him to move into extra care sheltered housing (Brent Court). Services and his friend's daughter were involved with helping Mr C with the financial implications of this tenancy, as he owned a flat.

6.1.4. November 2013

Brent Court accepted Mr C's application for extra care sheltered housing, although he had expressed to an OT on the Victory Unit that he wanted to move into a nursing home. Despite this, Mr C moved into Brent Court Extra Care Sheltered Housing Scheme on the 20th November.

The Portsmouth Rehabilitation and Re-ablement Team (PRRT) supported him during this move. The PRRT is an integrated health and social care team, which aims to provide responsive support for people whose needs have intensified, often as the result of an acute illness. The PRRT visited Mr C twice a day, during his stay at Brent Court.

Adult Social Care commissioned Sevacare to provide Mr C with extra domiciliary support, but they also commissioned another service by mistake (Crescent Care). On the 22nd November Crescent Care were unable to gain access to Mr C, so they obtained a key to his flat from his next of kin and discovered he had already received care from Sevacare. A safeguarding alert was raised as they retained his key. His key was returned, with no further action taken by the safeguarding team.

A finance officer from Portsmouth Adult Service Care visited him on the 25th November. While the finance officer was at Brent Court the carers' stated Mr C had no food and that help with shopping was urgently needed. The finance office was not able to undertake a financial assessment with Mr C, as he did not open his door. It was not recorded whether action was taken about his lack of food, or money.

Mr C had also not opened the door for an attempted GP visit. The carers had previously informed the GP that Mr C was socially isolated and low in his mood. Brent Court contacted Adult Social Care on the 25th November as Mr

C had stated that he had made a mistake moving in. He refused to get out of bed and had said he wanted to kill himself.

On the 25th November Mr C was then also visited by a CPN from the Older Person's Mental Health Team (OPMHT). Mr C reported feeling suicidal and said he wanted to move into residential care, as he wanted company.

On the 27th November, his Social Worker from the PRRT was updated on his assessment by the CPN, including Mr C's request for a transfer to residential care.

On the 28th November the manager of Brent Court relayed to the PRRT worker and the CPN that she felt unable to cope with Mr C, due to his shouting, banging on the walls, threatening staff and making more suicide threats. He did not want carers to leave him alone but also threatened to harm them.

On the 29th November, both the PRRT and OPMT staff then visited him. The Scheme manager reported that he had been refusing food and had thrown a chair across the room. He was angry when he was seen and threatened to both harm himself and other people. He stated that he wanted to be moved immediately and if he wasn't he would cause "enough of a stink" to make sure he was moved. The CPN told Mr C if he was violent this would be dealt with by contacting the police and that he would be re-housed as soon as possible.

He was visited again by his CPN the following day and Mr C reported regretting moving into Brent Court and that he needed more help and more company than was provided there. He wanted to sell the lease on his flat to fund a placement in residential care home.

6.1.5. December 2013

Mr C reportedly struck a Sevacare carer in the face at Brent Court. The carer had put her arm round Mr C to comfort him but he lashed out and caught her in the face. He was visited by his CPN and Mr C had no recollection of this incident, but apologised for it. At this visit his carers stated that he had no food, no money and did not get meals on wheels. He was then seen the next day by staff from the services Intensive Care Team (ICT) and was given help to eat his lunch.

Sevacare planned to withdraw their service, due to the above incident. When the carer was interviewed, she described Mr C throwing up his arms in an agitated state. Whist doing this he knocked the side of her face accidently. Despite this being reported as an accident the Sevacare manager decided to stop providing a care service, as she felt Mr C was a risk to the staff.

Mr C continued to shout and bang his stick in distress, still saying he wanted to die. Staff had found him trying to suffocate himself with a pillow over his face on two occasions. He continued to be verbally abusive to staff and

refused all offers of care for four days. A safeguarding alert was raised due to the Sevacare plan to stop providing him with care.

Staff then visited him from both the Services ICT service and the PRRT. Due to the above challenges of caring for Mr C, ICT staff provided Mr C with help with his meals, his catheter bag and gave him ongoing emotional support. They visited him daily and the Brent Court manager raised concerns about his aggressive behaviour to them.

PRRT staff visited him twice a day. He continued to shout, pull the emergency cord and demand help to be moved from Brent Court. The Manager at Brent Court also contacted Adult Social Care requesting for Mr C to be moved.

He was seen again by OPMHT for an assessment. Although his behaviour remained a cause for concern, this was not deemed to be due to his mental health, but rather that he was being deliberately provocative, so that he would be moved quickly.

Care staff continued to express concern at his shouting and aggressive behaviour. He was reported to have been up all night, faecally incontinent and standing naked at his window shouting.

The PRRT had stopped visiting him, as they felt there was no medical need for visits and thought that a care agency (Crescent Care) was still visiting him. However, Crescent Care had not been visiting him since the 21st November. When he was then seen by the CPN he had been incontinent of faeces. Faeces were seen on both Mr. C and on the furniture of his flat. His catheter bag was full, as it had not been changed. His CPN cleaned Mr C up and gave him some food and water.

A safeguarding alert was again raised about the poor condition that Mr C was in. It was alleged that Brent Court support staff had withdrawn care to Mr C due to his aggressive behaviour. This had necessitated ICT visiting twice daily. The alert also stated that Mr C was observed by a visiting nurse to be sat in a chair with his trousers around his ankles, full catheter bag, and evidence of faecal incontinence.

Mr C was alleged to have said that he had not had anything to eat since the previous afternoon. It was decided within the safeguarding team that a Level 2 safeguarding investigation would be undertaken by the allocated Social Worker. The outcome of the safeguarding referrals received at Adult Social Care was that an urgent MDT meeting was recommended to address his behaviour and care needs, however this was not done. The safeguarding team took no further action.

The PRRT started to visit Mr C again and this was reported to go well, with no hostility shown from Mr C. A residential placement was then sought for Mr C, with his Social Worker making contact with Alton Manor Care Home.

Mr C was visited by his Social Worker the following day, to explain the process of moving into residential care and he discussed the difficulties with personal care, in relation to his catheter and faecal incontinence. He was embarrassed about this and frustrated that he had to ask for help.

He was then referred to the OPMHT and seen by his CPN and a Consultant Psychiatrist for a medication review, although no changes were made to his treatment. This was due to the assessment that his behaviour was explained by his frustration with his current care arrangements.

Alton Manor had a vacancy and the manager was able to meet with Mr C the next day to begin an assessment. The manager confirmed that staff were trained to manage hostile behaviour and so were able to manage Mr C's mental health needs. Also, the manager of Alton Manor felt they could meet his needs regarding visual impairment, catheter care and preferences for social interaction.

The Manager of Alton Manor Care Home went to assess Mr C. However, he was too unwell to assess as he had continual diarrhoea and his catheter was not working properly. His urine was dark in colour and he appeared dehydrated. There was evidence of faecal matter on his carpet and the Manager reported that she was disgusted by the way Mr C had been left.

Mr C was then taken to Queen Alexandra Hospital by ambulance and admitted to the Medical Assessment Unit. He was treated with intravenous antibiotics for a UTI infection. He was also treated for dehydration. He remained in hospital for five days and was then thought to be medically well enough for discharge. The Hospital Social Work Team assessed his needs for a suitable discharge placement.

The CPN from OPMHT suggested two residential placements, which were not pursued by the Hospital Social Work Team. Instead, the Manager of Alton Manor Care Home was asked to assess Mr C again. He was accepted by the manager and discharged from hospital to the Alton Manor on the same day. He was visited at the home by his Social Worker two days later and reported to be feeling much better. He stated that he had settled into the home quite quickly. Arrangements were made to end his tenancy at Brent Court.

6.2. Analysis of Second Period of Chronology

6.2.1.Solent NHS Trust involvement with Mr C

Solent NHS Trust was involved with Mr C throughout this period of the chronology, in the following capacities;

6.2.1.1 Jubilee House (28/08/13-08/10/13)

This was first when he was transferred from Queen Alexandra Hospital to the Inpatient Unit Jubilee House on 28th August 2013.

He was seen by his allocated CPN during this admission and was initially thought to require aftercare in a nursing home. He became clearly depressed, tearful and suicidal during this admission. Due to his visual impairment he still needed someone with him to prompt him with his personal care, help him with eating and support him when moving around the unit.

The CPN and Social Worker clearly had different views about Mr C's needs and how these should be met. It does not appear that his CPN communicated with the Social Worker about this. The lack of communication or challenge to the decision about aftercare is a learning point for both organisations. Mr C remained an inpatient on this Unit until he was transferred to the Victory Unit on 8th October 2013.

6.2.1.2 Victory Unit 8/10/13-20/11/13

Mr C was transferred to the Victory Unit, from Jubilee House and the PRRT become involved with his care. A Social Worker from PRRT held a review and planning meeting ten days after Mr C's admission. At this meeting the plan for extra care housing was confirmed although Mr C had not made any further progress with rehabilitation. Although the CPN from OPMHT remained in touch by phone, she was not involved in placement decisions. Also the OT on the Victory Unit reported Mr C did not want supported living but wanted a care home.

There appeared a missed opportunity to bring the inpatient, OPMHT, the PPRT and Queen Alexandra Social Worker together to discuss this issue before a decision was made. There was no evidence this was done and no clear care coordination at this stage.

6.2.1.3 Brent Court 20/11/13-06/12/13

Mr C was under the care of the OPMHT during this time and continued to be seen by his CPN from the team. He was also seen at Brent Court by a number of professionals from the Portsmouth Rehabilitation and Re-ablement Team (PRRT).

Mr C's physical and mental health rapidly deteriorated whilst at Brent Court. He displayed challenging behaviour and aggression to care staff. This was related to his frustration at the placement and his unmet care needs. There was an unwarranted and considerable delay in decision making about this placement from the PRRT and the OPMHT staff.

Mr C clearly stated after a few days at Brent Court that he had made a mistake and was lonely. He continued to deteriorate for the rest of the placement, which was clearly breaking down long before he was finally re-admitted to Queen Alexandra Hospital, suffering dehydration, UTI and more significant depression. A more rapid and holistic assessment of Mr C's needs and placement was required.

6.2.1.4. Queen Alexandra Hospital (06/12/13-21/12/13)

During his hospital admission he was assessed by OPMHT Liaison services. The view was that he did not need to go back to Jubilee House when he was medically fit for discharge. Mr C was also thought to be likely to have vascular dementia, although he did not need a specialist dementia care home. His CPN and OPMHT doctor recommended a number of mental health residential homes for Mr C.

The Solent NHS Trust staff and Social Work staff worked in parallel with Mr C, but there seemed no opportunity for joint responsibility or shared decision making to assess and meet Mr Cs needs. For example a discussion of Mr C at the "Virtual Ward" (a multi-disciplinary meeting) could have been used as a forum to discuss his, needs, risks and services.

6.2.2. Involvement with Mr C

6.2.2.1. Jubilee House (28/08/13-08/10/13)

Adult Service Care staff did not know of the involvement of OPMHT Services at the time of his placement or discharge from Jubilee House. Therefore, the focus on Mr C's potential rehabilitation and care needs did not take account of Mr C's mental health problems, or the views of OPMHT staff on how best to meet his needs. There was a pre discharge meeting at Jubilee House on 23rd September, which did involve Mr C and his friends. It did not have any input from Mental Health, which was clearly a significant gap in hindsight.

6.2.2.2 Victory Unit (8/10/13-20/11/13)

Mr C was then seen by a different Social Worker whilst he was at the Victory Unit, from the PRRT. A further planning meeting was held with Mr C and his friends on 18th October. Again there was no input of mental health services at this time; despite PRRT being a joint health and social care service, which is managed by Solent NHS Trust. A discussion of his needs occurred at this meeting and Mr C confirmed that he could manage a tenancy with support. The Social Worker then made the application for his tenancy and also for additional domiciliary support services to be in place. Despite an offer for Mr C to visit Brent Court prior to the placement commencing there is no evidence that this took place.

6.2.2.3 Brent Court 20/11/13-06/12/13

During Mr Cs placement at Brent Court he continued to be seen by a Social Worker from the PRRT. The manager reported to the Social Worker that Mr C said he'd made a mistake after five days of commencing this placement. Mr C refused to get out of bed and stated that he wanted to kill himself. This was the first report on Adult Services records of Mr C's mental health problems.

The Brent Court Manager reported subsequent concerns about Mr C's threats and banging on walls to the Social Worker, who passed them on to OPMHT. Mr C hit a member of staff three days later and the Social Worker visited Mr C the same day. The Social Worker then ascertained that Mr C hit the carer by accident. Despite this Sevacare withdraw their staff and the Social Worker contacted the ICT to take over the care (help with catheter and meals).

At this stage the Social Worker's focus was on Mr C still going through a period of adjustment before settling into his placement at Brent Court. Although this placement only lasted for 17 days before breaking down there were clearly indications that it was not working before Mr C was admitted to hospital. The response to the distress expressed by Mr C and his subsequent aggressive behaviour was to try and keep him in the placement rather than for him to return to the Victory Unit and review his needs from a place of safety.

During this placement there were four alerts raised to the Adult Services Safeguarding Team;

1. 22nd November, an alert was raised due to a mix up in commissioning, as both Crescent Care and Sevacare attempted to provide domiciliary care to Mr C. A key to Brent Court was obtained by Crescent Care but not returned to Mr C. No action was taken about this as the key was subsequently returned to Mr C. It is not clear why two agencies were both simultaneously commissioned.

2. 3rd December, an alert was raised by a CPN from the OPMHT about the decision to withdraw care to Mr C by Sevacare, following the incident were he struck a carer. Mr C appeared to be in a state of neglect, with a full catheter, his trousers were down, he had been faecally incontinent and claimed he'd had nothing to eat for a day. This was supposed to be investigated by his Social Worker, although there was no evidence that an investigation was done.

3. 4th December, an alert was raised by the manager of Sevacare outlining her concerns about the above incident. The service could not safely meet Mr C's needs due to the risks he posed to staff and other residents. The safeguarding team decided an urgent Multi Disciplinary Team (MDT) meeting was required to review Mr C. No further investigation was done and this MDT meeting did not occur.

4. 4th December, another alert was raised by the Social Worker from PRRT about the above decision from Sevacare and that she had not been informed that an assessment was required. Also that her request to OPMHT

for an assessment by them had been refused. The safeguarding team decision was as above and no investigation was done.

In summary a series of concerns were raised about Mr C's placement at Brent Court and these were all recorded as safeguarding alerts. However, none of these were formally investigated and the proposal for an MDT meeting was never followed up. This should have been achieved and safeguarding procedures should have been followed. For example, by holding a multi agency strategy meeting. This is a gap in the response to these concerns, as clearly Mr C suffered neglect whist at Brent Court. However, there was no thorough investigation at the time.

6.2.2. (06/12/13-21/12/13)

When Mr C was returned to hospital he was seen on the ward by a different Social Worker from the Queen Alexandra Hospital Social Work Team. He was reported by the ward doctor to be medically fit for discharge at this point. Mr C is then allocated to another Social Worker from the Hospital Team and assessed four days later, in the light of detailed assessment of Mr Cs physical needs from the ward he was determined to require 24 hour care.

He was referred to Alton Manor, who then assessed him on the ward and accepted him for a placement the next day. There was undoubtedly pressure on the Social Worker to find a suitable placement for Mr C, especially as this occurred just before Xmas. The process does appear to have been rushed and did not include consideration of how the placement would meet Mr C's complex physical and mental health needs.

6.2.3.Sevacare Involvement with Mr C

The manager of the Portsmouth Branch of Sevacare submitted a very limited case chronology to the SAR Panel. This only contained records of five phone calls between the agency and other professionals. Further clarification and questions were submitted to the agency by the SAR Panel, but were not responded to. There was no evidence that Adult Services held Sevacare to account for their decisions in this case. The failure to provide an Individual Management Report for this Safeguarding Adults Review has not been addressed by the SAR Panel.

Also, it did not appear appropriate for Sevacare to withdraw the care service, because Mr C had struck a carer by accident.

6.2.4. Primary Health Care Involvement with Mr C

Unfortunately the GP interviewed for the Primary Health Care IMR was not involved with Mr C until after he was discharged from Queen Alexandra Hospital, which is covered in the fourth chronology. Therefore no comment

can be made about what input the GP had whilst Mr C was placed at Brent Court.

6.2.5. Portsmouth Hospitals NHS Trust Involvement with Mr C

Mr C was admitted to the Medical Assessment Unit at Queen Alexandra Hospital on the 6th December. He was treated for a UTI and given fluids with potassium, he had an electrocardiogram (ECG), blood and urine tests. He then had a computerized tomography (CT) scan, which revealed some infarcts in the right parietal and left occipital lobes. These were different from those seen on his previous scan, which he had in August, but were not judged, to be acute. He was also then treated with different antibiotics for a possible chest infection. He was also prescribed antidepressants.

A medical review was requested from the OPMHT Hospital Liaison service. The Hospital records show that the opinion of the OPMHT was there was a likely diagnosis of vascular dementia and discussed his needs with his CPN.

6.2.6. Alton Manor Involvement with Mr C

Alton Manor provided additional reports, including assessments undertaken by the home for Mr C. On the basis of the information contained in his pre-admission assessment Mr C was accepted as a suitable resident for Alton Manor and he moved the same day that this was completed.

The assessment did contain all the relevant information about Mr C's needs as reported to the assessor at the time. However, there is no reference to any physical aggression, or risk of violence from Mr C when he gets frustrated. This appears not to have been known at the time of the decision to offer Mr C a placement. The potential risks to other residents were therefore not known at this stage.

The issue of his mental health was noted to be depression on the assessment, but further information was not sought from Mental Health Services prior to his admission. There was therefore a missed opportunity to both share relevant information about Mr C's aggression and to develop an appropriate risk assessment.

In hindsight this gap was significant as it may have informed a different decision about his discharge destination and whether Alton Manor was the correct placement to meet Mr C's mental health needs. Also, it may have informed a risk assessment about whether Mr C would be a risk to the other residents at Alton Manor.

6.3 Learning from second part of chronology and review of key issues

6.3.1. Mr C's complex physical health needs

The impact of Mr C's stroke on his functional ability clearly was a major aspect of concern during this period of the review. He lost almost all of his

vision after the stroke in August 2013, although there was not a detailed assessment available as to what vision he did have left after this event. There were references to some very limited sight of objects close up to him. Mr C stated that he understood that losing his vision was a life-changing event. He knew he would struggle with this and found it difficult to accept. The issue of how he dealt with the loss of his independence and its impact on his behaviour towards care services was significant in understanding his later actions.

His potential for further rehabilitation to regain more independence was also a theme in understanding what his care needs were and how best they should be met. There was only a single reference to input into his care by the Sensory Impairment Team, whereby an assessment for long cane training was commenced when he first moved to the Victory Unit. The progress and success of this training was therefore a significant omission, as it would clearly have had an impact on his functioning and possibly helped deal with the losses associated with his loss of sight.

The specific difficulties that his visual impairment posed for his confidence and mobility left him house bound and there were no reports that he ever went out of home after his stroke.

Also, his need for help with his Catheter, which was in place due to urinary incontinence, was a major source of discomfort, stress and embarrassment to Mr C, especially when assisted by female staff. This had a detrimental impact on him and was a major source of frustration to him. Finally, his faecal incontinence, whilst at Brent Court was similarly very upsetting to him as he was left in a soiled condition as at times refused help with this. His refusal to accept offers of help with his personal care could have been seen as part of his wider difficulties in accepting his loss of independence.

6.3.2. Mr C's complex mental health needs

Mr C was reported to have suffered from a significant depressive illness prior to suffering from the stroke in August 2013. He continued to present with symptoms of depression, such as staying in bed, being tearful and making statements about wanting to die.

His on-going mental health needs were met by continuing with the same medication and offering him reassurance about his situation. The more acute depressive symptoms, such as being found in Brent Court with a pillow over his face, trying to suffocate himself did not result in any changes to his mental health care or treatment. The other focus of mental health services at this stage were related to concerns at Brent Court being raised by staff about Mr C's verbal hostility and aggression. Both the OPMHT and PRRT were called about these incidents, although viewed them as resulting from frustration and not related to his mental health problems.

Communication between OPMH services, PRRT services and Adult Services was clearly poor and lead to professionals working in isolation rather than through effective sharing of information.

Mr C was admitted to hospital in December and had a CT scan. This scan revealed some infarcts in the right parietal and left occipital lobes. These were different from the previous scan in August, but were not thought to be acute. The OPMHT Liaison service subsequently thought it likely he had Vascular Dementia. Although this was recorded on the Alton Manor Pre-admission assessment it does not seem to have then been addressed further.

6.3.3. Mr C's admission and placement at Brent Court

The decision to place Mr C at Brent Court was taken by a Social Worker, in the absence of good information sharing with mental health services (as outlined above). The Social Work view was that he would be able to cope with Extra Care Housing, although he had high levels of support needs in relation his physical health. His mental health needs were not clearly known to the Social Worker at the time of deciding on the placement. This resulted in the Brent Court Service also being unaware of Mr C's mental health needs when he was admitted.

The response of Mr C to being placed in Brent Court was that he rapidly viewed it as a mistake and wanted to leave. His subsequent challenging and at times aggressive behaviour was in response to feeling that he wasn't being heard and his desperation to leave Brent Court. The efforts to support him to remain in this placement were understandable but ultimately misguided, resulting in him suffering from not having his care needs met.

This led to him suffering unnecessary physical health problems, including the pain and distress of a urinary tract infection (UTI), dehydration, faecal incontinence and exacerbating his depressive illness. It was not until an outside agency visited him that the circumstances were urgently addressed through his admission to hospital.

6.3.4. Mr C's Admission to Alton Manor Care Home

Mr C's admission to Alton Manor was an emergency placement, somewhat similar to that of Mrs B. The manager of Alton Manor clearly reported feeling under pressure from the Social Worker to accept Mr C and there was also pressure from the hospital as the placement occurred just before Christmas 2013. This placement request was not accompanied by any written Social Work assessment of needs, something the manager of Alton Manor reported as not unusual.

This is a clear gap for consideration for learning from this event, as Alton Manor may have not been the right choice of placement for Mr C. Alton Manor does not have a clear admissions policy. The manager made the decision whether a request for placement is accepted, on the basis of information received and her own assessment. An admissions policy would assist with formalising this process and could include the requirement for pre admission information sharing from relevant agencies, such as Mental Health Services. Although the Alton Manor assessment did record that Mr C had

depression it did not include any further information from OPMHT including any information about a potential risk to staff or residents from Mr C.

6.4. Recommendations from second part of the chronology

Mr C clearly struggled to cope both emotionally and practically with the loss of his sight. He received limited help to adjust to his loss of vision and loss of independence whilst in hospital. The extent to which he could regain some measure of independence was unclear before he was discharged to Brent Court and there were clear differences of opinion between Adult Services and Mental Health Services about how much care he needed.

Mr C's placement at Brent Court rapidly broke down and should have been terminated more quickly. Despite regular contact with PRRT Mr C did suffer significant neglect and suffered unnecessary harm. This was not properly investigated.

The emergency nature of Mr C's placement at Alton Manor led to him being admitted without a full assessment of his needs and the author questions the suitability of his placement given his complex needs and risks.

Recommendation 3

PSAB will seek assurance through audit that where safeguarding adult concerns are raised these are thoroughly investigated in line with the requirements of Section 42 of the Care Act 2014 and statutory guidance good practice principles. An outcome for the enquiry is always recorded and where a risk is identified an appropriate protection plan is put in place.

Recommendation 4

For adults with complex physical and mental health needs there is a commitment to share information between all relevant agencies before decisions are made about how to meet these needs. If changes to long-term placements are considered there is full involvement of the service expected to meet complex needs.

Recommendation 5

As part of any proposed new placements in supported living/residential services, there is a plan for the adult to prepare for the new environment. A contingency plan is also agreed, so if the adult decides it is not suitable for them within six weeks of beginning the placement, an alternative can be arranged.

7. THIRD PERIOD OF SAFEGUARDING ADULTS REVIEW

7.1. Summary of Third Chronology Period (Mrs B 01/01/14-24/04/14)

The third chronology summary covers the significant recorded events for Mrs B up to the time just before the incident occurred with Mr C. Mrs B continued to reside at Alton Manor throughout this period.

7.1.1. January 2014

The District Nurse reviewed Mrs B's sacrum area pressure ulcers and her dressing was changed nine times in January.

Her mood remained variable. Her GP prescribed Diazepam as she had become unsettled and displayed daily verbal and physical aggression. Mr B was upset by her behaviour and worried how he would cope if Mrs B returned home. Her GP referred her for a psychiatric review by the mental health team. She was reviewed by them, but was felt to be unsuitable for adult mental health services due to her level of confusion, poor memory and agitation. Her GP then referred her to the Older Persons Mental Health Team (OPMHT).

Her Social Worker and OT saw her in her room. Mrs B told them that she liked Alton Manor and the staff, but she did not like the other residents. It was observed that Mrs B's mental state had deteriorated since she had been at Alton Manor. Mrs B was inconsistent with her responses to questions. Mrs B agreed to stay in Alton Manor and did not ask to leave or have care provided in another place of residence. Staff at Alton Manor confirmed that Mrs B had never attempted to leave or asked to go out.

Her Social Worker then considered what would be in Mrs B's best interest: and considered that the least restrictive option, care at home would not meet all of Mrs B 's needs. Also, in the event of Mrs B becoming aggressive Mr B would not be able to appropriately respond and this would most likely to cause him anxiety and distress. No formal Mental Capacity Assessment was done at this time.

7.1.2. February 2014

The District Nurse continued to visit Mrs B during February; she reviewed Mrs B's sacrum area and assessed her right hand. On each visit dressings were applied to both areas**.** A chiropodist visited Mrs B, checked her feet and cut her toenails.

When seen by her GP, Mrs B was noted to be leaning to her left side. She was feeling unwell with a sore throat, for which she was prescribed pain relief. Her behaviour was assessed and her medication was changed. The left side of her face was noted to have some flatness and a viral infection with generalised lethargy was recorded. An OT noted that her right hand fist had tightened leading to skin breakdown and provided a thinner layer of sheepskin to protect her palm area.

Mrs B asked her husband if she could come home, but he told her he would not be able to look after her. A review meeting was held on the 19th February at Alton Manor. This included Mr B, Care Home Staff, her Social Worker and OT. Mrs B's weight had improved and she was more settled at the home. Mr B requested that Mrs B remain at Alton Manor. To remain in long term residential care was agreed to be in Mrs B's best interests by everyone at the review. No formal MCA assessment or Best Interest Decision was recorded.

A psychiatrist from OPMHT reviewed Mrs B. He diagnosed early onset dementia in addition to her learning disability and further stated that her capacity was variable. Her GP referred Mrs B to a hand specialist at Queen Alexandra hospital.

7.1.3. March 2014

The District Nurse again reviewed Mrs B's sacrum, which had healed well, but continued to change the dressings on her contracted right hand. Services assessed her placement including her financial contribution. Her Social Worker visited Mrs B. She did not recognise her Social Worker but was happy to talk to her. The home manager stated that the situation was generally settled. However, Mrs B had hit another resident on 2nd March. She tended to get agitated when her husband left, although Mrs B had not asked to leave the home.

She was reviewed at the hand clinic at Queen Alexandra Hospital and was recommended for surgery for straightening her hand.

Adult Social Care received an assessment from the OPMHT after they reviewed her again in March. She was found to have responded to a change in medication and had calmed down, with only occasional episodes of agitation.

7.1.4. April 2014

Mrs B's right hand remained a concern and the District Nurse dressed the area on six visits during April. Mrs B had also developed a possible infection in both her hand and her eye. She was prescribed antibiotics and eye drops by her GP. The District Nurse requested an urgent GP visit to review Mrs B 's hand as she had a grade four pressure ulcer. Her weight was noted to have increased to 6 stone and 9 lbs.

7.2. Analysis of Third Chronology (Second Period of the Mrs B Chronology up to 24th April 2014)

7.2.1. Involvement with Mrs B

Mrs B remained allocated to a Social Worker from a locality team in Adult Services until the case was made inactive on 19th March. The input from the Social Worker was primarily concerning her placement at Alton Manor, with a Best Interests decision being taken at her review in February. This was only

recorded in a case note. No assessment of Mrs B's Mental Capacity for the decision to stay at Alton Manor was recorded, which was a gap in practice.

The funding for this placement was initially short term, but was made permanent at her review in February 2014.

There was not a clear overall risk plan in place for Mrs B at this time although there were individual actions noted in response to risks. Support was also offered to Mrs B's husband during this time, mainly around his anxiety about her potential discharge home.

7.2.2. Alton Manor Care Home Involvement with Mrs B

Mrs B was initially placed at Alton Manor for respite care in September. She was very underweight on admission (5st 6 lbs.). A key role for this Residential Care placement was to monitor and increase her weight. A weight chart was kept and by the end of this period of the chronology her weight had increased to 6st 9lbs.

Although she initially settled well into Alton Manor Mrs B would get agitated after her husband's visits. She wanted to leave with Mr B, although she quickly calmed down after these visits. She said she liked Alton Manor and the staff, although she did not like other residents.

The legal basis to keep her at Alton Manor was unclear when she wanted to leave as Alton Manor staff recorded that Mrs B had Capacity.

Alton Manor referred Mrs B to her GP on several occasions due to her aggression. She was alleged to have hit another resident in March 2014. No details of this incident were available and it did not lead to a Safeguarding Alert being raised. There were no concerns about the level or quality of care Mrs B received at Alton Manor during her stay there; she did seem to benefit from her placement, which all agencies felt was an appropriate placement for her.

7.2.3. Primary Health Care Involvement with Mrs B

There was regular liaison between Alton Manor, and her GP during this period of the chronology. Her GP responded to the concerns raised at Alton Manor appropriately by reviewing her and referring Mrs B first to Adult Mental Health and subsequently to OPMHT in February 2014.

There is no evidence of GP notification by District Nurses, community matron or care home staff of the ulceration to Mrs B's hand prior to 17th April, when a ''grade 4 ulcer'' was documented. GP entries prior to this do not reference any dressing to her hand. Consideration of the impact an infected ulcer might make on Mrs B's mood was not documented.

Mrs B's medication included Clopidogrel 75 mg, an anticoagulant that was prescribed in 2012 to reduce the risk of blood clots following transient ischemic attacks. This is medication that could increase the risk of traumatic hemorrhage, however the treatment was in line with NICE guidance for

patients with a past medical history of transient ischemic attacks. The use of this medication may have been significant in that it could have affected Mrs B's reaction to her injury when she fell on 25th April.

7.3. Learning from third part of chronology and review of key issues.

7.3.1. Mrs B's complex physical health needs

Mrs B's physical health needs are related to her very low BMI and low weight upon admission to Alton Manor. Her weight was a focus for the placement and did improve during her stay. However, Mrs B did remain underweight. She had lost half her total body weight between June and November 2013. She regained one stone and three pounds during her five months at Alton Manor. Her sacrum pressure ulcer was treated by the District Nurse and healed during this period. Her right hand further constricted, leading to a skin breakdown and pressure ulcer on her hand. Her District Nurse also treated this and her GP referred her for an assessment for surgery.

Changes in Mrs B's behaviour may have been related to the infected ulcer on her hand, although this was not considered by her GP. She was prescribed antibiotics for her hand and eye drops for a possible eye infection on 17th April.

7.3.2. Mrs B's complex mental health needs

Mrs B became aggressive and was not sleeping well at Alton Manor. The GP reviewed her on a number of occasions and prescribed medication; initially Mirtazapine was tried then Trazadone. Her GP referred Mrs B initially to Adult Mental Health Services for an assessment, but when she was deemed unsuitable for their services her GP re-referred her to OPMHT. She was then assessed and diagnosed with early onset dementia and prescribed medication (Memantine) for this. She did not receive ongoing care from OPMHT and remained under the care of her GP.

Mrs B's capacity to remain at Alton Manor was unclear, as the staff felt she had capacity. Her mental health assessment by OPMHT described her capacity as variable. No clear capacity assessment was recorded on any of the records submitted for this review.

7.3.3. Placement at Alton Manor Care Home

Mrs B's placement was initially a temporary respite placement but was reviewed in February and then became a permanent placement. The key issues during this placement were her weight and the management of her aggressive behaviour. Mrs B was reported as being happy at Alton Manor and did not try to leave, or ask to go out.

7.3.4. Recommendations for third part of chronology

It was noted that there was a lack of a formal Mental Capacity Assessment and consequently there was not a clear legal basis for her on going placement, if she had wanted to leave. There was also a lack of any link between her physical health problems and agitated behaviour, which should have been explored. There was not a clear risk assessment in place for Mrs B's on going placement in relation to her challenging behaviour.

Recommendation 6

All adults in residential or nursing care homes, with a diagnosed mental disorder who are thought to lack decision-making capacity should have a formal mental capacity act assessment. If the outcome of the assessment is that they lack capacity then consideration for a Best Interest Assessment is recorded. Where they are under continuous supervision and not free to leave the home, an assessment under the Deprivation of Liberty Safeguards should be requested.

Recommendation 7.

All adults who are deemed to pose a risk to themselves or others should have a formal multi agency risk assessment and risk management plan in place, which is shared with the adult or their appropriate representative, if they lack capacity. This should be reviewed on a regular basis by the agencies involved with the adult or their appropriate representative.

8. FOURTH PERIOD OF SAFEGUARDING ADULTS REVIEW

8.1. Summary of Fourth Chronology (Mr C 01/01/14-24/04/14)

Second Part of Mr C Chronology

The fourth chronology summary covers the significant recorded events for Mr C up to the time just before the incident occurred with Mrs B.

8.1.1. January 2014

Mr C had been discharged from Queen Alexandra Hospital to Alton Manor in December 2013. He was reported to be well and settled in his room. He was able to make friends with other residents and reported that he felt a lot better. He signed a notice to formally quit Brent Court. His friend was authorised to deal with the repairs needed to the flat and to remove his property.

A District Nurse fitted Mr C with a new catheter and tried to take his blood for tests, but was unable to do so. His GP prescribed on-going antibiotics for a UTI and reviewed his hernia. His GP described Mr C as confused and not eating or drinking well. His PPRT Social Worker closed his case and transferred Mr C to Adult Social Care North Locality Team. His Social Worker recommended that Mr C should have a review in February 2014. He was also referred to the Stroke Association for a support worker. Solent NHS Trust held a separate CPA review, where his mental health care was transferred to a CPN in the OPMHT. The CPN recorded a plan to visit Mr C in January but this was not done.

8.1.2. February 2014

Mr C continued to suffer pain from his catheter and the District Nurse washed this out and collected blood for tests. He was seen by his GP for mood swings, which were to be monitored and he was encouraged to participate within the home. No problems with his placement were recorded during this time. Adult Services did not hold a placement review and his CPN did not visit.

8.1.3. March 2014

A North Locality Team Social Worker reviewed Mr C's placement on the 25th March. The review stated that Mr C had settled in well but had emotional episodes, which were due to his frustration and lack of insight into his care needs. Staff were said to be able to manage this well. Mr C did socialise but liked to spend most time in his room on his own. Mr C stated he would like to be in a place with less people with dementia. He also stated that he still suffered from depression.

There was contact between the Social Worker and a CPN in OPMHT at the end of March, which was recorded in the social work notes. This included a possible diagnosis of vascular dementia for Mr C, which required monitoring.

An incident of Mr C throwing a chair at care home staff was also recorded and the CPN agreed to visit Mr C to re-assess him.

8.1.4. April 2014

On the 7th April Alton Manor Home Manager contacted Adult Services to inform them that Mr C had been served with one month's notice to quit Alton Manor. This was due to his behaviour as he was frightening and upsetting other residents. The staff could no longer manage him.

This was the first notification that the home was struggling to deal with Mr C and had decided that they could not manage him; because of the risk he posed to their residents and staff. This was quite different to the impression given from the above review in March, when he was described as having emotional outbursts that the staff did seem to be able to manage.

On the 9th April, this was passed onto his CPN and OPMHT were requested to do an urgent home visit. The Home Manager also contacted his GP due to Mr C's agitation and outbursts. The GP also phoned OPMHT to report these concerns.

His Social Worker spoke to Mr C's friend who was dealing with the sale of his house and had recently visited Mr C at Alton Manor. Mr C told her that he had got into a fight, which she thought was down to Mr C waiting for water. Mr C said he was waving his arms about and shouting and showed her bruises to his wrist. He told her that a carer had threatened to punch him between his legs. The Social Worker recorded that a safeguarding alert will be made. The safeguarding team subsequently requested a level 1 investigation be undertaken by the Social Worker in response to this allegation. It is not clear from the recording what action was taken, nor what the outcome of the investigation was.

The CPN visited the next day and recorded that Mr C had hit staff and was lifting up furniture in a manner threatening to staff and other residents. There was a predictable pattern to this, according to the staff. The staff stated that Mr C became agitated from teatime onwards and that noise provoked him.

He had become quiet and withdrawn since being served with the notice to quit. There were also incidents of Mr C refusing care and being verbally abusive, threatening both staff and residents. Mr C stated that he was frustrated with the environment and the other patients.

There were no further records of any subsequent professional intervention until a phone call is recorded eleven days later between his Social Worker and CPN, who had been to see Mr C again. At this visit he was described as passive and in a good mood, with no evidence of confusion. He was thought to be hard of hearing and acted out of frustration when things were not explained to him clearly.

There was then a conversation between the Social Worker and the Alton Manor Home Manager about Mr C. The manager reported Mr C's aggression at trivial things (the content of the home menu, waiting for staff attention), that he was unpredictable and both staff and residents were scared of him. Furthermore the manager stated that she did not know of his aggression whilst a tenant of Brent Court, and if she had known she would not have accepted him at Alton Manor. The notice of eviction was discussed and remained in place as Mr C's aggression was disproportionate and beyond the capabilities of the home to deal with. The Social Work plan in response to this telephone call was to discuss behaviour management with the CPN from OPMHT.

Mr C was visited the following day, by another Social Worker from the locality team, at which he was described as calm and relaxed. Mr C did give an account of his threatening behaviour (said he "threatened to punch their lights out" to staff). He also said he had no regrets about his behaviour and would do it again if he thought it necessary to get their attention. He also acknowledged staff and residents are scared of him and avoid him.

His Social Worker then called his friend and advocate. She stated Mr C was aggressive because of frustration and the staff were not good at preventing situations from happening. She also stated she doesn't want to look for an alternative placement for Mr C.

The Home Manager stated to the Social Worker that due to his explosive and unpredictable nature it was hard to put a plan in place to manage him. No options to manage him were explored at this time. His notice to quit was due to expire on the 7th of May.

On the 24th April, the manager stated that during the CPN visit on 10th of April, the CPN said that there was to be an MDT meeting to discuss Mr C and for the home to manage his symptoms through PRN medication. The Manager had not heard from the CPN again since this visit.

On the 24th April, there were also further phone calls from the Social Worker to both the home manager and to Mr C, about the incident, which had been raised as a safeguarding alert. Mr C stated that it was history and he didn't want action taken. He acknowledged to the Social Worker that he flew off the handle, was over the top and that he would try to control his anger in future.

The Home Manager also acknowledged the incident. She said that Mr C would 'explode' at the slightest thing and was unpredictable. He refused to wait for hardly a moment and his responses were disproportionate. She confirmed that the home was not a suitable placement for Mr C and confirmed the eviction notice, which was due to expire on the 7th May.

The Social Worker then recorded his opinion that Mr C had capacity about the provision of care at the home and the risks he presented when aggressive. Mr C did not want any action taken about the incident with staff, but did want to move to another home. The Alton Manor Home Manager was due to

undertake an internal investigation into the incident where a carer had held Mr C and threatened him. The outcome of this investigation was not clear.

The Social Worker contacted two alternative residential homes that both had vacancies and both agreed to go and assess Mr C. He also contacted the CPN who agreed to discuss Mr C with a Consultant Psychiatrist. The outcome of these discussions were planned to be followed up by the Social Worker on his return from leave on the 6th May, but were not done due to the subsequent incident with Mrs B. There were no recorded arrangements for cover whist the Social Worker was on leave.

8.2. Analysis of Fourth Chronology (Second Period of the Mr C Chronology up to 24th April 2014)

8.2.1. Solent NHS Trust involvement with Mr C

Solent NHS Trust was not involved with Mr C during most of this period of the chronology. His case was allocated to a CPN in the OPMHT, according to a formal Care Programme Approach (CPA) Meeting, held on the 8th January. His care was transferred from PRRT to the OPMHT. The Plan at that time was for OPMHT to visit Mr C at Alton Manor. However this was not done and there was no contact with Mr C for over three months.

The next contact was a conversation between the CPN in OPMHT and Mr C's Social Worker on the 28th March. The CPN reported she had just taken over Mr C's case. This is in conflict with the CPA in January which recorded the CPN took over the case at this point.

The CPN visited Mr C at Alton Manor on the 10th April. It was not clear from the CPN recording what subsequent action was being proposed by OPMHT in response to Mr C's aggression, which was identified at this visit.

There were no more records made by the CPN until the 24th April. This was a record by the CPN of another discussion with the Social Worker about Mr C's behaviour and the incidents leading to notice of eviction. There was no plan as to what the CPN was proposing to do in response to this discussion.

In summary, there appeared to be limited involvement from OPMHT, with minimal recording and only one visit to Alton Manor. The case was formally transferred in January to OPMHT, but there was no attempt to visit or contact Alton Manor to inform them of this transfer until 10th April. No medication reviews took place and there was no direct input from a Responsible Clinician from OPMHT.

This must be viewed as a gap in practice, due to the escalating concerns over Mr C's behaviour. The Manager from Alton Manor was informed that a CPA was going to be held to discuss the concerns, but this was not done. No records were made to assess the potential risks Mr C posed to other residents and the staff at Alton Manor. There was also no risk management plan identified by OPMHT.

8.2.2. Involvement with Mr C

Mr C's case was formally transferred by the Social Worker at PRRT to the Adult Services Locality Team on 21st January. There was no input from the Locality Team until Mr C's placement was reviewed on 25th March.

This placement review did include some discussion of Mr C's aggression, which was described as "emotional episodes" which the staff could cope with well. This was in contrast to the subsequent contact on the 8th April, when notice had been served on Mr C. The Alton Manor manager then stated that they couldn't cope with Mr C, due to his aggression.

It was not clear what had happened in the subsequent two weeks to make such a drastic change in the risks and viability of the placement. There were no details of incidents to explain this and no clear multi agency response to this change in risk.

On 10th April Mr C's friend reported an alleged incident where Mr C stated that he was restrained and threatened by staff. The Social Worker recorded this as a safeguarding alert. On the 24th April the Social Worker recorded that Mr C confirmed the allegations but said he didn't want anything done. The Social Worker thought Mr C had capacity for this decision, but there was no record of an assessment to evidence this view.

Even though Mr C withheld consent for an investigation, the potential risks to staff and other residents should have led to a further investigation in the overall Public Interests. The home manager acknowledged the incident and stated that she would do an internal investigation into the allegation. There were no more records of this investigation or its outcome. It was not known whether the staff member was identified nor whether any action was taken about this serious allegation.

8.2.3. Primary Health Care Involvement with Mr C

The GP undertook an extensive one-hour review at the first contact with Mr C, which included examination, medication review and checking bloods. This had not raised any concerns. There were two visits in January, where he was prescribed antibiotics for a possible UTI and his hernia was examined.

There were three visits in February, one for a physical review which revealed no concerns and a second for a mental health review as Mr C was relaying suicidal thoughts and refusing to eat and drink. The second review advised on-going monitoring of Mr C's mood but no changes to his treatment regime. The third visit was due to Mr C's pain with the catheter, again antibiotics prescribed for a further UTI.

A final contact with his GP was by phone in April, due to concerns about his agitation and outbursts from the home. The GP felt unable to prescribe medication as his behaviour was in response to his circumstances. The GP felt that he needed to be managed by non-pharmacological interventions (Behavioural route) but did agree to contact mental health services.

8.2.4. Alton Manor Involvement with Mr C

The home manager had assessed Mr C prior to his admission to Alton Manor. This process began whilst he was at Brent Court and was concluded while he was an inpatient in Queen Alexandra hospital. This assessment did include a possible diagnosis of vascular dementia and his history of depression.

It also included reports of his verbal aggression, outbursts and frustration when he feels he is not being listened to. A plan was made in response to this to make sure he had someone to explain things to him and to give him time and listen to him. Mr C stated that he enjoyed company and he had not had this at Brent Court, which he identified as the source of his frustration.

It was significant that no history of physical aggression or risk to others was identified at this assessment. Also, there was no record of mental health services involvement with Mr C. Alton Manor were not made aware of Mr C's violence and subsequent eviction from Brent Court at the time of his referral to Alton Manor in December. It appeared that the reason for his referral to Alton Manor was that his personal care needs were not being met at Brent Court.

The initial information supplied to Alton Manor did not contain the key information about his violence and aggression to those attempting to provide him with care at Brent Court.

Mr C stated he didn't like too much noise and chose to spend afternoons in his room for some quiet time. The plan was for staff to provide support and monitoring of his mobility, to offer arm or shoulder for Mr C when he was walking.

The care plan noted his history of depression and his thoughts about not wanting to live anymore. When this happened, it noted that Mr C might refuse to eat or drink. At these times Mr C needed a lot of patience, support and understanding from staff to help him get through it. He needed staff to sit with him and give reassurance, and that he could get angry and shout. The plan was for one carer to sit with him and monitor him even when he wanted to be on his own.

During January and February Alton Manor staff were addressing the impact of Mr C's depression appropriately, which did include some contact with his GP, as outlined in above section.

There was one monthly review in March that noted he had a couple of episodes in March but had managed these well and there were no changes to this plan. In early March 2014, Mr C started to display a more aggressive nature.

At first it was verbal aggression but gradually over the next few days and weeks, it developed into physical aggression too. All of his outbursts were directed at staff but he would also invade the other clients' space, sometimes

by raising his voice at them. There was no particular trigger to these outbursts.

There were no further details as to what the escalating nature of these incidents and risks were from Mr C. He was deemed unsafe to remain in the home, but the evidence for this judgement was not clear. The decision to evict Mr C was taken by the Director of Alton Manor.

Alton Manor did not refer Mr C to mental health services, via his GP, prior to serving him with notice to quit. The report of Mr C's eviction was reported to Adult Services and it was at this stage OPMHT were contacted by the Social Worker. They were requested to do an urgent visit and the CPN went out to see Mr C the next day.

As Alton Manor didn't know about OPMHT prior to this point they had not attempted to access support for Mr C, or the placement before this. There was clearly a missed opportunity that this did not happen before he was served with a notice to quit.

A further missed opportunity to intervene after the CPN visit was that there was a recognised need by the CPN for a Multi Disciplinary Meeting to discuss and review Mr C's needs/risks. Also, that he might benefit from some additional medication on a PRN basis. The CPN did not follow up on the recommendations. No direct communication occurred between the OPMHT and the Home Manager and this is a gap in practice.

There was better communication from Adult Services with Alton Manor although there was still a two-week gap between the CPN visit and the Social Work visit. During this time Alton Manor were coping with Mr C without any direct or outside input to assist them. In the Social Worker's recording the advice given was that the police should be called if Mr C was violent, but in Alton Manor's account it stated that the mental health team should be called.

8.3. Learning from fourth part of chronology and review of key issues.

8.3.1. Mr C's complex physical health needs

There were no major concerns recorded about Mr C's physical health during this period, apart from recurrent UTI infections, possibly due to issues with his catheter, which were addressed by the GP prescribing antibiotics and care from the District Nurse.

The issue of Mr C's visual impairment does not receive much attention, apart from his need to be guided around the home by staff, which was identified in the care plan. The potential impact of his impairment on him both emotionally and functionally does not appear to have been addressed in any detail during his time at Alton Manor.

For example, he could have benefited from more input in the use of his stick from visual impairment services, which would have helped his mobility and

independence around the home. He had to wait for staff to accompany him if he wanted to go to his room, as he could not go unaided. This could have contributed to his frustration, as the behavioural management plan was for Mr C to go to his room to calm down if he got agitated, but he could not do this until staff were available to take him. Given his frustration when waiting for staff attention, this was significant.

8.3.2. Mr C's complex mental health needs

The key concerns from this period of the chronology were around the management and treatment of Mr C's mental health. He was known to have a long history of depression prior to admission, but was not known to have also had a long history of input from mental health services. He expressed suicidal ideas and at times withdrew to his room in the first two months of his placement, but no mental health services input was requested by the home. This was because they did not know of OPMHT role, despite the fact his mental health care had been transferred to them at a CPA in January. The failure to share information about Mr C's mental health was a gap in practice by OPMHT. Also, the diagnosis of possible vascular dementia just prior to his admission did not result in any further mental health assessment or treatment.

Mental Health input was received in response to Mr C's aggression. However, it was not clear what (if any) relationship there was between his violence and his mental state. Most accounts describe this as because of his frustration rather than because of his mental ill health. However, the relationship between his depression, or his dementia and his aggression was never formally assessed.

The final aspect of Mr C's mental health was his mental capacity to consent to his placement and care whilst at Alton Manor. The views of Alton Manor, his GP, his Social Worker and his CPN are consistent in that he was thought to have capacity to make decisions. There was no record of a formal capacity assessment by any agency working with Mr C at this time. There were a number of decisions regarding treatment and intervention where a Mental Capacity Assessment should be documented as both time and decision specific. Although, the principle of the presumption of capacity may have applied, it would still be good practice to record that Mr C has capacity, even if a full assessment was thought to not be required. This was not done and is a gap in practice.

8.3.3. Mr C's Placement and eviction from Alton Manor Care Home

Mr C's placement initially appeared to be appropriate and the first two months of this appeared to progress well. He received no input from either Adult Services or OPMHT during this time. His placement was reviewed on 23rd March, at which time it was confirmed as a permanent placement. There were no concerns about violence or risks to others identified at the review.

However, only two weeks later he was seen to be so inappropriately placed to be at the point where he was issued with an eviction notice. The placement changed dramatically in this time but the details of events leading to this

change were not clearly documented. There were references to Mr C scaring people and to have picked up a chair to throw through a window although further details of this sudden escalation were not clear.

There was a gap in proportionate interventions to deal with his behaviour prior to issuing a notice to evict him. Neither multi agency work, mental health input, nor medication reviews were pursued until after he was served with the notice. This does then precipitate intervention from the GP, the OPMHT and Adult Services. This should have done before the placement deteriorates to the point it is judged to be unsustainable. At no point did all agencies get together to discuss risks and plans for Mr C. The risks to others were not deemed to be so acute that he needed to be moved urgently. He remained in Alton Manor for a further 3 weeks of his 4-week notice period and he was not assessed or offered a move. Unfortunately, the incident with Mrs B then occurred prior to this process being completed.

8.3.4. Recommendations for fourth part of chronology

There was a failure to share information about Mr C's mental health by OPMHT and there was no input to Mr C for four months. However, there was also a failure to share information on Mr C's deterioration and aggressive behaviour with OPMHT, or Adult Services by Alton Manor staff prior to serving him with an eviction notice.

There was no discussion about Mr C's risks at his placement review and no formal risk assessment of his presenting a risk to staff or other residents at Alton Manor. This led to no formal risk management plan, other then to either call the police, or mental health services if he is violent again.

If the severity of the risks were known and assessed this may have led to a more rapid intervention to move Mr C, either to a hospital, or to an alternative placement. There was an opportunity and a recommendation for a multi-agency meeting and for increasing Mr C's medication after the CPN visit but this was never followed up and did not take place.

Recommendation 8.

There is a commitment to inform any community/residential placement about the involvement of Mental Health Services with a service user, either with the adults consent, or if there is a need for this to be known in the adult's Best Interests, or for the Public Interests of other service users at the placement.

Recommendation 9. Where placements are at risk of breaking down as the service user's needs or risks appear too high for the placement, an urgent multi agency review is called to agree a plan, which is appropriate and proportionate to the assessed risks.

9. FIFTH PERIOD OF SAFEGUARDING ADULTS REVIEW

9.1. Summary of Final Chronology (Mrs B & Mr C, 25/04/14-28/04/15)

The final chronology summary covers the significant recorded events for Mr C and Mrs B on the day the incident occurred with Mrs B. The next three days are also included in this section of the chronology, which deals with the subsequent outcomes for both Mr C and Mrs B.

9.1.1. 25th April 2014

The incident between Mrs B and Mr C was recorded by a number of agencies. The details of the incident vary in the different agencies accounts and so they are all summarised below:

Home Manager's Account

The manager was in her office at the time of the incident and initially heard Mr C shouting at about 3.50 pm. She went to investigate and staff said Mr C's catheter was full and was leaking, but he would not let staff change it. Mr C had been sitting in the lounge, but had got up and demanded to be let out of the home.

The manager then returned to her office to call Mr C's CPN from the OPMHT, but the call went to voicemail. As Mr C was still heard to be shouting the home manager then phoned the police on 999. The manager explained the situation and the police agreed to attend, but insisted that she remained on the phone until they arrived.

At the time Mr C, Mrs B and her husband Mr B were all in the lounge. Mr C knew Mr B and they used to speak on previous occasions when Mr B visited Alton Manor. On this occasion Mr C was thought to have seen Mr B and headed towards him. Mr B got up to get out of the way and this led to Mrs B also getting up to follow Mr B away from Mr C. Mr C then pushed Mrs B out of the way in order to get to Mr B and because he wanted to get out of Alton Manor. Mrs B fell after she was pushed and hit her head on a radiator.

Whist waiting for the police to arrive a member of staff then came to the office and told the manager that an ambulance was now needed as Mr C had pushed Mrs B, who had fallen to the floor. The member of staff called an ambulance from her mobile. The manager updated the police that an ambulance had also been called.

The district nurse was at the home and administered first aid to Mrs B. The ambulance arrived first and then the police. Mr C was in the treatment room and both police officers went to speak to him.

Telephone contact was then made with the CPN, who was also updated by the home manager. The CPN spoke to the police officer and then agreed to

liaise with a consultant to try and locate an inpatient bed for Mr C at the psychiatric hospital.

By this time Mrs B had been assessed by the ambulance staff and was in the ambulance. The home manager arranged for a member of staff to accompany Mrs B to hospital. Mr B had also been at the home during this incident and was supported by staff. He did not want to go to hospital with Mrs B.

District Nurse's Account

The District Nurse was in the small treatment room, off the dining room and had finished dressing Mrs B's hand, with her Mr B present. They had both left the room and the District Nurse was writing her notes up. The District Nurse heard raised voices and some screaming but she did not see the incident.

Mr C came towards her and entered the treatment room. Mr C sat down and the District Nurse was able to leave the room. She then administered first aid to Mrs B, who was bleeding profusely and appeared to have fallen on her left side. Mrs B was conscious the whole time and the District Nurse applied a pressure bandage. By the time Ambulance arrived the bleeding had stopped. Mrs B's husband was very upset and distressed.

The Police Officers' account

The Police account identified that they were called at approx. 4pm as Mr C was lashing out at residents and shouting. He had pushed Mrs B to the floor and she had received a head wound.

Police attended and ascertained that both Mr C and Mrs B had significant mental health vulnerabilities and their capacity was in question. Mr C had become angry due to his catheter care needs not being met by staff and had decided to leave, making his way to the front door. He had pushed a staff member out of the way but inadvertently caught Mrs B who had fallen to the floor and hit her head on a radiator.

This admission to a mental health unit as a voluntary patient had been arranged by the CPN and police agreed to provide transport to Mr C. This incident was recorded as a mental health occurrence rather than an assault and it was tasked to the next shift to see if there was any complaint forthcoming from Mrs B. Adult at Risk reports were completed by the police for both Mr C and Mrs B and forwarded to Adult Services.

Ambulance crew's account

The Ambulance account stated that they attended for a patient who had been pushed over and had fallen to the floor with a cut above her left eye. Mrs B was transported to Queen Alexandra hospital, arriving at 17.16 pm.

A member of staff from Alton Manor accompanied Mrs B to hospital and was able to provide information to the medical team that saw her in A&E.

25th April 2014 (continued)

Mrs B was then assessed in A&E, including her past medical history, current medications, vital signs, conscious level, vulnerabilities, clinical injuries and investigations to be undertaken (x-rays of her face and wrist). Her conscious rating on the Glasgow Coma Score (GCS) was noted to be 14/15, which was said to be normal for her by the staff from Alton Manor, due to her dementia.

She was examined and had a small wound to left forehead which was actively bleeding, there was also evidence of blood loss noted from both nostrils. She was noted to be on clopidogrel (an anti-coagulant). There was no nasal misalignment, but there was tenderness over the rim of Mrs B's left eye. Also, Mrs B left wrist seemed to be uncomfortable although her cranial nerves were difficult to fully assess, due to her dementia and some non-compliance

She was then recommended to have x-rays of her wrist and cranium. A fracture was noted to her left wrist. A below elbow back-slab and sling was applied. No fractures were noticed to Mrs B's face, although a radiologist had not formally reviewed the X ray of Mrs B's face at this time.

Mrs B was then discharged back to Alton Manor, with a follow up appointment booked for two weeks. She was prescribed painkillers and a Head Injury information card was given and explained to her carer.

She left the Casualty Department at 19:48

Mrs B was then taken back to Alton Manor by the carer who took her to hospital. Mrs B arrived back at Alton Manor at about 20.15 and was clearly not well. By 20.30 Mrs B was vomiting blood and an ambulance was again called to take her back to hospital.

This was logged by the Ambulance Service at 20.28 pm and when they arrived Mrs B was described as drowsy, unable to recall the date or time. She had a nosebleed and was short of breath, so was taken back to the Queen Alexandra hospital by the ambulance. Her GCS, when she was re-assessed in the Emergency Dept. at 22.11 that night was noted to be 13/15. The doctor's notes identified the need for Mrs B to have a CT scan, blood tests, neurological observations and stop clopidogrel (an anticoagulant); the clinical impression was of an acute subdural haemorrhage.

At 23:00 the Nursing notes record that Mrs B was very dirty and cold, with her clothing soiled with faeces and scratching and bruising to her body. She was washed, assisted with clean clothing and transferred from a trolley to a bed.

Meanwhile Mr C was taken by police officers to St James Hospital. The Senior House Officer (SHO) on call assessed Mr C at 20.38 and he was admitted informally onto Appleby Ward for further assessment. He was unable to tell the SHO what happened but said the staff had riled him after they asked him to change his catheter bag and he lashed out. He reported feeling unhappy at the home and that it was the wrong place for him, due to majority of other residents having dementia.

The SHO then records a conversation with Mr C's Consultant, who advised there had been previous incidents at the home where Mr C had become aggressive and further assessment of his mental health was needed before looking for suitable alternative accommodation. The consultant advised prescribing PRN Lorazepam in case Mr C should need it over the weekend. Also, if Mr C tried to leave inpatient staff, were advised by his consultant, to assess him under the Mental Health Act 2007.

9.1.2. 26th April 2014

At 00.10 Mrs B had a CT Scan, which revealed a large injury with bleeding to her brain (intra axial haemorrhage in the left fronto-temporal region with a mid line shift). The outcome of this scan was then discussed with Wessex Neurology, who advised that this was not suitable for neurosurgical intervention and advised that it should be treated as a stroke. Her GCS score was still 13/15 at this point

At 02.30 Mrs B was transferred to a Medical Assessment Unit, her GCS scores had rapidly deteriorated and was 07/15 at this stage.

At 03.36 she was reviewed by a Doctor, who noted her worsening condition and that she was now grunting respirations and had a possible seizure, for which Lorazepam was given. Unsuccessful attempts were made by the Doctor to contact Mrs B's husband.

At 04.10 there was further deterioration and her GCS was 03/15. The Lorazepam had resolved her breathing changes and seizure. Her left pupil was enlarged but both still reactive. There were further attempts to contact Mr B but these were not successful, although Alton Manor was alerted to Mrs B's situation. Mrs B was now noted to be dying and care to ensure her comfort was a priority.

After a medical review at 08.20 the decision was taken to not attempt resuscitation. The Do Not Attempt Cardio Pulmonary Resuscitation (DNA CPR) form was signed by a Senior Registrar and countersigned by a consultant at 10.00. No family were present at this time.

At 08.30 this was discussed with Mr B over the telephone and he agreed to come in to the hospital, he also requested Mrs B's sister be notified. At 10.00 Mrs B was reviewed again and recommended for Palliative support only.

Mr B attended the hospital and at 11.30 a Dr spoke with Mr B and two friends that had accompanied him for support. Explanations were given about the bleed inside Mrs B's head and she was unlikely to survive.

At 18.30 Mrs B's sister, brother in law and niece were seen by the Dr, who explained why Mrs B had not had a CT scan initially when she came to the hospital. He also explained that it was unlikely an operation would have been performed, even if a scan had been done earlier. They were informed that Mrs B was very unwell and not likely to survive.

During this time the police had made welfare enquiries with Alton Manor. The officer was informed she had been admitted to Queen Alexandra hospital. When officers were able to visit they were informed of the above situation; that Mrs B was not expected to survive the night. Police requested the hospital notes, which were supplied.

At 19.31 a Detective Sergeant assumed responsibility for the investigation and took advice from a senior. He decided not to arrest Mr C at this time, on the basis of his dementia, depression, blindness and felt custody was inappropriate.

During this time Mr C remained in hospital and was reviewed on the ward, he was assessed and recorded to be in a very pleasant mood. His Catheter was changed and he was guided around the ward, due to his eyesight. There was no evidence of aggression and he took part in a quiz on the ward. He was pleased to be on the ward and felt safe there.

9.1.3. 27th April 2014

At 02.30 Mrs B's family asked a doctor to review her, as her breathing had become shallower. Her death was certified at 02.58. At 03.10 the Police were informed by the Dr of Mrs B 's death and the police agreed to inform Mrs B 's husband.

At 12.30 Police visited the ward in St James Hospital to speak to Mr C, as Mrs B had died. Advice from Mr C's consultant was that Mr C was not to be informed of Mrs B's death and he was to be detained if he tried to leave the ward. Mr C was settled and pleasant to staff on the ward at this time.

9.1.4 28th April 2014

His Consultant Psychiatrist interviewed Mr C in his room. Mr C stated that he knew why he was admitted to hospital as he had assaulted staff. He did not like the staff and knew immediately after moving there that he did not want to stay at the home.

At 13.05 Mr C's consultant psychiatrist gave a professional witness statement to the police detective constable regarding Mr C's admission details. Both the police officer and his consultant then spoke to Mr C. He was informed of Mrs B's death and was shocked to hear of this.

A Detective Constable contacted the ward at 15.49 to come to the ward to interview Mr C. An Appropriate Adult was requested, but could not be provided by the ward. The interview was subsequently postponed, as Mr C could not be interviewed without an Appropriate Adult present. The police then formally sent a supply of information request form (DP2) to the ward, which requested information on Mr C and his admission.

9.1.5. May 2014

His Consultant Psychiatrist interviewed Mr C again on the ward. The Consultant then liaised with the Police, informing them that Mr C was fit to be interviewed about the incident, along with an appropriate adult and solicitor. This took place on the 15th May on the ward

An investigation continued over the next few months and the Crown Prosecution Service (CPS) reviewed the case. The CPS decided that no further action could be taken in respect of Mr C. This was on the basis that the cause of Mrs B's death could not be solely attributed, beyond reasonable doubt, to the injuries she suffered at Alton Manor in the above incident.

9.2. Analysis of Fifth Period of Chronology, (Mrs B and Mr C up to 28th April 2014)

9.2.1. Solent NHS Trust involvement with Mr C

On the day of the incident Mr C was admitted to St James Hospital, as an informal patient. This was arranged with the help of his CPN, who liaised with the Consultant Psychiatrist. Mr C was assessed and admitted to Applebury Ward, where he remained an informal patient. There were no incidents of aggression after his admission. He discussed the incident with nursing and medical staff on several occasions. He remained depressed and there was concern that he may be developing vascular dementia due to his poor memory of recent events. The treatment for Mr C's mental health remained the same, although at times he was put on increased supervision because of possible risks of self-harm.

9.2.2. Alton Manor Involvement with Mrs B and Mr C

Both Mr C and Mrs B were in the lounge at Alton Manor at the time of the incident, which was just before 16.00 on the 25th April 2014. Staff were also in the lounge and the home manager was on duty, although she was in the office and she did not witness the actual incident.

The Alton Manor care home staff could have done something differently to manage Mr C's verbal aggression, by either taking him back to his room or somewhere away from the other residents. However, given the difficulties for staff working with Mr C, this intervention was not thought to be safe for the staff to attempt.

It may have been an option to let Mr C walk out of Alton Manor when he wanted to and to have given him some supervision outside of the home, until he had calmed down. As Mr C was thought to be capacitated and wanted to go out of the home, the legal basis for preventing him from doing so was not clear, given that he was not detained in Alton Manor.

The reaction of the Home Manager after the event, were appropriate in contacting the appropriate statutory services and sending a member of staff with Mrs B to hospital. After Mrs B returned to the home it was rapidly

apparent that Mrs B was still unwell and in need of urgent medical attention. The home staff acted appropriately to call another ambulance in order to return Mrs B to hospital.

The Home Manager had liaised with Mr C's CPN, who negotiated an urgent admission for Mr C to St James hospital, which was assisted by the police on the scene taking Mr C in their vehicle. This did effectively manage the risk to the other residents and appeared to be an appropriate response to the crisis situation.

9.2.3. The Hampshire Constabulary Involvement with Mr C and Mrs B.

Police attended rapidly to the request for assistance by Alton Manor, arriving on the scene just after the ambulance, at 16.14. At this time two PCs responded to the call, one dealt with Mrs B and the other with Mr C. Staff updated the officers about the difficulties managing Mr C and gave an account of the incident.

Mr B was trying to get out the front door, staff were following him and he attempted to push staff but accidentally hit Mrs B instead, causing her to fall. This was different to the account supplied by Alton Manor Manager, who stated that the incident occurred in the lounge with Mr C trying to follow Mr B and pushing Mrs B out of the way. This discrepancy was not investigated at the time.

The injury to Mrs B was thought at the time to be a minor cut although the paramedics then conveyed her to hospital because of her frailty.

There was then a decision taken by the officers on the scene not to arrest Mr C for the offence of Actual Bodily Harm, despite this offence being noted by the officers. This was because of the poor mental health of Mr C and in liaison with the supervisor it was thought best to safeguard rather than arrest him.

On Saturday this was followed up by the next shift, where a visit to Alton Manor informed the officer that Mrs B had been taken to Queen Alexandra hospital for a separate matter.

The case was then reviewed on Saturday evening by the shift supervisor, in the light of the update from hospital that Mrs B was unlikely to survive. This was seen as a critical incident and advice was gained from the Hampshire Major Investigation Team Detective Inspector. A decision was made not to arrest Mr C, as it was not to be appropriate for him to be in custody, due to his need for physical and mental health support.

An investigative plan was then produced, including ascertaining Mr C's mental capacity and ascertaining the injury to Mrs B. A visit to Alton Manor was made that evening when it became clear Mrs B was in hospital because of the incident with Mr C, not for another matter as was first thought. The police were notified by Queen Alexandra hospital of Mrs B 's death on Sunday morning. The Detective Inspector of the Major Investigation Team decided the local police team could manage the incident and the investigative process for

major incidents was adopted. A Home Office Post Mortem was authorised, a Family Liaison Officer was assigned and a request for the matter to be investigated in partnership with the Care Quality Commission.

The officers who first attended the call out to Alton Manor indicated that they identified that an assault occasioning Actual Bodily Harm had occurred. Although Mr C may have not intended to assault Mrs B the doctrine of transferred malice applied, in that Mr C may have intended to assault staff but instead hit Mrs B and was therefore potentially still liable for her injury. Potential evidence was secured in that witnesses were identified and forensic issues were considered although not included in the Mandatory Action Plan (MAP) a document, which provides details of the investigation to date.

The decision not to arrest Mr C was considered to be correct, due to his mental and physical health, as he may not have been deemed fit to be detained or interviewed at the time. There appears an early decision by officers attending Alton Manor that there was no intent to injure Mrs B and because this had occurred in a care home and both parties had dementia there was unlikely to be a criminal prosecution.

Describing this as a non-crime incident led to follow up actions being seen in terms of welfare calls to the home, when these were done Mrs B's re-admittance to hospital was not connected with her previous injury following being pushed by Mr C. The poor handover process led to Mrs B 's condition not being assessed by the police for over 24 hours and any criminal investigation was delayed.

However, this did not materially affect the subsequent investigation. Once her condition was known, the case was escalated and identified by the CID supervisor as a critical incident with lines of enquiry set out. A full and thorough investigation was then carried out.

However, an analysis of the police involvement demonstrated the importance of correctly classifying crimes as such by the attending officers. It appeared that because this occurred between two older people in a care home the attending officers viewed it as a non-crime incident.

9.3.4. South Central Ambulance Service (SCAS) involvement with Mrs B.

The SCAS were called at 16.01 on 25th April by Alton Manor staff to attend as Mrs B had been assaulted by a male resident, had fallen over and suffered a head injury. Observations were done by the ambulance crew, who cleaned her head wound and took Mrs B to Queen Alexandra hospital, accompanied by a member of care home staff. The observations included her Glasgow Coma Score (GCS) of 15/15, her pulse, blood pressure, blood glucose, temperature and Oxygen Saturations, which were all normal.

A further call was then received at 20.28 again by Alton Manor staff to report that Mrs B had returned at 20.00 from hospital but was vomiting and bleeding from the nose. On arrival the ambulance crew noted Mrs B was drowsy and

short of breath, she was unable to recall the date or time. The ambulance crew once again transported her back to hospital.

Neither ambulance crew identified the incident between Mr C and Mrs B as a Safeguarding Adults Issue. Therefore SCAS staff did not raise a Safeguarding Alert with Services, which is a gap in practice.

9.3.5. Portsmouth Hospital involvement with Mrs B.

Mrs B was first seen in the Emergency Dept. at 17.16 and assessed using the Glasgow Coma Score and found to be 14/15, which the carer said was normal for her. This is different from the ambulance assessment prior to Mrs B being brought to hospital when her GCS was 15/15.

Her carer reported her history and her injury was examined, along with x-rays taken of her wrist and face. A fracture of her wrist (left distal radius) was found and a below elbow back slab and sling was applied. She had a wound to her forehead, which was bleeding and she had been bleeding from both nostrils. The fracture to her head (intra orbital fracture) was not seen when the doctor in A&E reviewed her X ray. These can be hard to detect and radiologists have specialist training to help interpret X-rays. Radiologists do not routinely review the X-rays in the Emergency Dept.; it was picked up when subsequently reviewed.

Despite her head injury Mrs B was not thought to meet the criteria for her to have a CT Scan at this time. If she had a CT scan when first brought to A&E her haemorrhage and fracture would have been detected earlier. Although this would still not have led to any different treatment, for example surgery being offered to her.

The next notes refer to her being reassessed in the hospital at 22.11 and it was at this stage she was sent for a CT scan. The result of the scan was known at 00.10 of the 26th April, when her haemorrhage was seen. This was at the same place as her external injury to her left forehead, which was initially treated earlier in A&E. This injury would appear to be highly likely to have been the cause for her brain haemorrhage, given it was at the same place and noted hours after Mrs B fell.

Mrs B's condition deteriorated rapidly in hospital over the morning of 26th April, with her GCS being 7/15 at 02.30 and her GCs being 03/15 by 04.10. The family attend the hospital at 11.30 and Mrs B's doctor updates them that she is unlikely to survive. Family agree to supportive management of her condition but question why Mrs B did not have CT scan earlier when first presented at hospital. The consultant advised she didn't meet the criteria at that time and even if her haemorrhage had been detected earlier it is unlikely that an operation would have been performed, due to her co-morbidities and the size and position of the bleed. Her initial presentation was not symptomatic of the large bleed that was subsequently seen on her CT scan.

A key issue for Mrs B's treatment at hospital was that she had a fracture of her left eye socket, which was missed when her X-ray was first seen in A&E.

It was subsequently seen when the radiologist reviewed this the following day. Mrs B's family were concerned that this led to a delay in her treatment for the fracture and brain haemorrhage.

Despite the serious injury caused to Mrs B, no one at the hospital identified the injury as sufficient grounds for raising an Alert under safeguarding adults' procedures.

9.4. Learning from fifth part of chronology and review of key issues

9.4.1. The incident between Mrs B and Mr C

Alton Manor and the Police recorded the details of the incident, with some discrepancies noted. It was agreed by everyone that Mr C pushed Mrs B and she fell to the floor, which caused injuries to her head and wrist.

One discrepancy was where the incident took place; according to Mr B it was in the dining room, the home manger stated it was in the lounge and according to the police it was in the hallway near the front door.

Another discrepancy is whether Mrs B hit her head on the floor, or on a radiator. Finally it is not clear whether Mr C pushed Mrs B over, to push her out the way to get to Mr B, or because he was attempting to push staff out of the way but mistakenly pushed Mrs B instead.

The exact details of what took place are therefore in doubt, but it was clear that Mr C did admit to pushing Mrs B, but did not intend to do this. The situation progressed rapidly and could not have been prevented by staff at the time. However, the risk of Mr C to both staff and residents had been raised some weeks beforehand when he was served notice by the home, due to these risks. If more rapid action had been taken to remove Mr C before this incident it could have been avoided.

9.4.2. The response to Mr C after the incident

Mr C was rapidly removed from Alton Manor after the incident, as a bed was arranged at St James Hospital, via his CPN for him on the same day. He was admitted as a voluntary patient having been taken from the home by the police who attended the scene. It was therefore possible that an earlier admission could have been facilitated in response to his risk of violence, which is the missed opportunity, as outlined above.

The view of the police attending the scene was that this incident was a mental health incident, which was not recorded as a crime of assault. This was a mistake, however it did not affect the quality of outcome of the overall police investigation. The police dealt with the immediate risks appropriately by removing Mr C to hospital.

He was subsequently interviewed two weeks later at the hospital by police officers. He was deemed to be fit to be interviewed including at a police station if necessary by his Consultant Psychiatrist at this time and was thought to have capacity.

He did appear to have assaulted Mrs B but did not face any criminal consequences of this assault. The view of the Crown Prosecution Service was that Mrs B's death could not be proven beyond a reasonable doubt to have been as a result of this alleged assault

9.4.3. The response to Mrs B after the incident

Mrs B was taken urgently to hospital and seen in the Emergency Department, where her wrist was found to be broken and her head injury received a dressing. She was then sent home, but rapidly became much more unwell and returned to hospital, where she has a CT scan revealing a large brain haemorrhage.

She lost consciousness and died 24 hours later. The fracture to her eye socket was not seen when her facial X-rays are first reviewed in the Emergency Dept. but subsequently was spotted when reviewed by a radiologist. Despite this the fracture would not have kept her in hospital. Also, even if a CT Scan had been done earlier she would still not have been thought appropriate for surgery, due to the size and nature of the bleed. It would appear that her head injury whist initially not appearing severe rapidly deteriorated to the point that it became impossible to resolve and her death from the injury was inevitable.

One issue that was identified was the conflicting information to what was the normal GCS for Mrs B. The ambulance crew rated this as 15/15 on the first call out. The Emergency Department doctor assessed her at 14/15 which was supported by the care staff accompanying Mrs B who stated that this was her normal GCS. Mrs B's presentation did not trigger National NICE guidance for undertaking a CT scan. If Mrs B's normal GCS was 15/15 then a CT scan would have been triggered later during her first ED attendance. However, this would not have changed the outcome for Mrs B as her injury was too severe to be operable. In respect of the skull fracture, had this been diagnosed during the first ED attendance, this would not have prevented discharge.

Recommendation 10.

Hampshire Constabulary should conduct an audit of attendances at residential care homes and mental health services. In cases where violence is alleged to have occurred between parties suspected of suffering from mental health problems, all apparent offences are recorded and investigated appropriately.

Recommendation 11.

All agencies, including all health services, will take individual responsibility for raising appropriate Safeguarding Adults Alerts with Services, even if this leads to multiple referrals for the same incident.

10. Overview and Summary Conclusions

10.1. Mrs B

Clearly Mrs B had complex needs relating to her physical health and unexplained weight loss. This was in addition to her mental health needs, as she had a learning difficulty, suffered from depression and was diagnosed with dementia. The combination of these needs with her social situation meant that she could not be cared for by her husband and required a high level of care. She had long-term complex conditions, which were not matched by the sophistication of services offered to her. There was a crisis situation, as her husband was unable to cope.

She was then appropriately placed initially temporarily in Alton Manor, but without a full assessment of her needs either at the time of the placement, or subsequently. Her GP tried to engage specialist mental health services, when her agitation and aggression increased at Alton Manor, but this was unsuccessful. Alton Manor staff coped well with her complex care needs and her placement led to some improvements in her physical health.

Her husband was well supported to have on-going contact with her. She remained at a low weight and was on blood thinning medication, both factors which made her especially vulnerable to serious injury if assaulted. There was not a risk assessment of her vulnerability and although her capacity was in doubt it was not formally assessed. Her placement was made permanent as a Best Interest decision, but lacked the documentation to evidence this in line with the MCA Code of Practice.

After Mrs B was pushed over emergency services were appropriately involved and she received medical attention. The seriousness of her injuries were not initially detected in the Emergency Department and she was sent home. The medical assessments may have been affected by her reported mental health problems, in particular her normal GCS. She rapidly deteriorated after being discharged and by the time of her subsequent admission and medical tests determined the nature of her injuries they were inoperable. She lost consciousness and died just over 24 hours later. Her husband remains traumatised by his loss and feels strongly that she did not get the justice she deserved.

10.2. Mr C

Mr C also had complex physical and mental health needs. These were not met through a coordinated approach but were dealt with by services working in isolation. He had a long history of depression. This was exacerbated by his sudden loss of independence following the loss of vision after his stroke.

His frustration and anger at his losses were never resolved, which made meeting his personal care needs extremely difficult. His potential to regain a measure of independence was not fully assessed prior to his discharge from

hospital to supported living. The long-term involvement of mental health services was not known to the placement, or to Services, who did not work together to assess the suitability of this placement. He quickly realised he had been placed in a service that did not meet his needs and asked to be moved. Services focussed on maintaining the placement after it was known not to be working. Despite regular input from services he became very unwell and there were risks both to his health and safety and to those trying to care for him.

He was admitted to hospital in a state of dehydration, with infection and serious signs of neglect. These were noted but not fully investigated at the time. He was discharged to Alton Manor after the manager assessed him, but this was done without the manager being informed of all his needs and potential risks. He was thought to be developing a vascular dementia whilst in hospital but this was not pursued further. His care and support needs were initially met in Alton Manor, but rapidly his behaviour deteriorated and he quickly became unmanageable at the home. He was aggressive and at times unpredictably violent, which-given the vulnerabilities of Mrs B and the other residents meant the potential risks were very high. Mental Health services were informed and he was assessed, but no changes in his treatment or care plan were made at the time.

As in his earlier failed placement in supported living, the focus was on keeping him in the service after the risks were known, rather than removing him from it, whilst alternatives were pursued. He was admitted to Queen Alexandra hospital after his first placement broke down and was admitted to St James hospital after the Alton Manor placement broke down. In both these situations it was not until after the crisis had happened that action was taken.

With the benefit of hindsight, both responses could have been taken earlier, which could have avoided Mr C suffering physical harm in the first instance and avoided Mrs B being assaulted in the second instance. Although, the death of Mrs B could not have been predicted, by implementing the following recommendations the Portsmouth SAB can demonstrate learning from this enquiry and hopefully prevent a similar situation occurring again.

10.3 Summary of Recommendations

Recommendation 1

PSAB will seek assurance from Portsmouth City Council Adults Service that they have robust processes in place to ensure that Emergency Placements from Hospital to Residential Care are reviewed by Services, to provide an updated written assessment of needs within two weeks of the admission. This is to include any complex mental or physical health needs and a mental capacity assessment.

Recommendation 2

PSAB will seek assurance from Director of Nursing for Solent NHS Trust that violent/physically aggressive behaviour in Residential Care Homes (where this is linked to a complex mental health problem) is a priority for assessment by specialist Mental Health Services.

Recommendation 3

PSAB will seek assurance through audit that where safeguarding adult concerns are raised these are thoroughly investigated in line with the requirements of Section 42 of the Care Act 2014 and statutory guidance good practice principles. An outcome for the enquiry is always recorded and where a risk is identified an appropriate protection plan is put in place.

Recommendation 4

For adults with complex physical and mental health needs there is a commitment to share information between all relevant agencies before decisions are made about how to meet these needs. If changes to long-term placements are considered there is full involvement of the service expected to meet complex needs.

Recommendation 5

As part of any proposed new placements in supported living/residential services, there is a plan for the adult to prepare for the new environment. A contingency plan is also agreed, so if the adult decides it is not suitable for them within six weeks of beginning the placement, an alternative can be arranged.

Recommendation 6

All adults in residential or nursing care homes, with a diagnosed mental disorder who are thought to lack decision-making capacity should have a formal mental capacity act assessment. If the outcome of the assessment is that they lack capacity then consideration for a Best Interest Assessment is recorded. Where they are under continuous supervision and not free to leave the home, an assessment under the Deprivation of Liberty Safeguards should be requested.

Recommendation 7.

All adults who are deemed to pose a risk to themselves or others should have a formal multi agency risk assessment and risk management plan in place, which is shared with the adult or their appropriate representative, if they lack capacity. This should be reviewed on a regular basis by the agencies involved with the adult or their appropriate representative.

Recommendation 8.
There is a commitment to inform any community/residential placement about the involvement of Mental Health Services with a service user, either with the adults consent, or if there is a need for this to be known in the adult's Best Interests, or for the Public Interests of other service users at the placement.

Recommendation 9.
Where placements are at risk of breaking down as the service users needs or risks appear too high for the placement, an urgent multi agency review is called to agree a plan, which is appropriate and proportionate to the assessed risks.

Recommendation 10.
Hampshire Constabulary should conduct an audit of attendances at residential care homes and mental health services. In cases where violence is alleged to have occurred between parties suspected of suffering from mental health problems, all apparent offences are recorded and investigated appropriately.

Recommendation 11.
All agencies, including all health services, will take individual responsibility for raising appropriate Safeguarding Adults Alerts with Services, even if this leads to multiple referrals for the same incident.

APPENDIX A

GLOSSARY

IMR	**Individual Management Review**
SAR	**Safeguarding Adults Review**
OT	**Occupational Therapist**
ECG	**Electrocardiogram**
ECT	**Electro-Convulsive Therapy**
CT scan	**Computerized Tomography scan**
PRRT	**Portsmouth Rehabilitation and Re-ablement Team**
CPN	**Community Psychiatric Nurse**
OPMHT	**Older Person's Mental Health Team**
MDT	**Multi - Disciplinary Team**
ICT	**Intensive Care Team**
MCA	**Mental Capacity Act 2005**
UTI	**Urinary Tract Infection**
CPA	**Care Programme Approach**
PRN	**Pro Re Nata (Medication to be taken as required)**
SHO	**Senior House Officer (junior doctor)**
GCS	**Glasgow Coma Scale**
DNACPR	**Do Not Attempt Cardio Pulmonary Resuscitation**
TIA	**Transient Ischemic Attack (mini stroke)**
MAP	**Mandatory Action Plan**
CRU	**Central Referrals Unit**
RMN	**Registered Mental Health Nurse**
CPA	**Care Programme Approach**