

***Working Together***

*to safeguard adults*

in Solihull

# **Serious Case Review in respect of Mrs D N**

## **Executive Summary Report**

### **Acknowledgements**

The Solihull Adults Safeguarding Board would like to thank all those who contributed to this Review and particularly to Dorothy's son whose measured and helpful comments added significantly to our understanding of Dorothy and of the events towards the end of her life.

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## **1. Introduction**

This document provides an overview of the circumstances and findings of a Serious Case Review (SCR)<sup>1</sup> Panel set up in June 2009 by the Solihull Adult Safeguarding Board (SASB)<sup>2</sup> following the death in February 2009 of 96 year old Mrs Dorothy N<sup>3</sup>.

It also sets out in full the recommendations that are intended to enable the lessons learnt during this Review to be used to improve the safeguarding and wellbeing of vulnerable adults in the future.

The holding of a SCR is considered as a good practice response to the death or serious harm of a vulnerable adult when there are some questions to be considered about the circumstances of that death and/or where there are concerns about the adequacy of the response of responsible agencies in working together to safeguard vulnerable adults.

An SCR is not intended to attribute blame but to reveal and collate the lessons to be learnt from the review of the circumstances and to make recommendations for change, which will improve future practice in safeguarding and hopefully prevent future deaths or significant harm of vulnerable adults.

## **2. The circumstances that led to this Serious Case Review being undertaken**

In 2004, Dorothy moved into a Solihull care home from another part of England to be nearer to her son and family. She had a range of serious health problems including osteoporosis, severe deafness, very impaired sight, rectal prolapse and hypertension. She was also described by her son as someone who did like being dependent on others and she could be 'difficult'. Her physical and her mental health deteriorated over the years and she died in February 2009 aged 96. Her death certificate stated that she died from vascular disease.

In January 2009, just three weeks before her death, during an assessment to see if she was eligible for NHS Continuing Care funding, concerns came to light about her care at the home, specifically about the severity of a pressure sore on her heel. Solihull Care Trust (SCT) staff carried out an adult safeguarding investigation<sup>4</sup> and assessed that she needed care in a

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<sup>1</sup> See Appendix 1 for explanation.

<sup>2</sup> See Appendix 1 for explanation.

<sup>3</sup> Dorothy is not the lady's real name but will be used in this report rather than initials to emphasise that she was a person and not just a case. We asked her son whether there were any names that would not identify her but that she might have liked us to use and Dorothy was the name he suggested.

<sup>4</sup> See Appendix 1 for explanation.

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nursing home to meet her increasing health needs rather than a home registered for residential care. She moved in distressing circumstances to a nursing home two days before she died.

There is no suggestion that her death was directly associated with any actions by any person and it was recorded as a death from natural causes. She had, however, developed and was being treated for, a significant (Grade 4) pressure sore<sup>5</sup> in the weeks before her death; her anti-depressant and anti-psychotic medication had been increased though some professionals doubted that this was in her best interests; and she was moved to a nursing home in spite of opinion from some professionals and her son that she was dying.

There were other concerns about the standards of care at the home, which were highlighted in a Commission for Social Care Inspectorate report, (CSCI and since April 2009, Care Quality Commission, CQC) following an inspection in June 2008. The care home received a 0 star - poor quality outcomes rating from CSCI in June 2008 and again in March 2009 shortly after Dorothy's death<sup>6</sup>.

Managers in SCT reported their concerns about Dorothy's care and the care of other residents at the care home to the Solihull Adult Safeguarding Board (SASB)<sup>7</sup>. The Board made a decision in June 2009 to carry out a Serious Case Review (SCR). The Board believed that there were significant lessons to be learnt about how agencies worked together to safeguard residents at the care home and how they could improve their practice in the future.

### **3. Methodology and process of the Serious Case Review (SCR)**

This was the first SCR of an adult carried out by the Solihull Safeguarding Board under its Adult Safeguarding Procedures.

The SASB established a SCR Panel to take the review forward using draft guidance it had developed for conducting SCRs.

The members of the SCR Panel were chosen to provide representation at a senior level from all the statutory agencies on the Safeguarding Adults Board, and from the independent care provider sector and a Solihull voluntary organisation working with older people.

It had been decided by the SASB to appoint an independent person, experienced in adult safeguarding and contracted as the independent

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<sup>5</sup> See appendix A for more information.

<sup>6</sup> Quote from CSCI report June 2008, "The quality rating for this service is **0 star**. This means that people who use this service experience poor quality outcomes". More information can be found about the CQC at [www.cqc.org.uk](http://www.cqc.org.uk)

<sup>7</sup> See appendix A for more information.

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chairperson of an adult safeguarding board in a North West authority, to chair the Panel, and write the detailed Overview Report, of which this report is an Executive Summary.

The Panel agreed detailed Terms of Reference (TOR) for the Review. This can be found in Appendix C.

At the first meeting of the SCR Panel, discussion took place about whether the SCR should focus on concerns relating to potentially broader institutional neglect/poor practice at the care home or concentrate on the specific circumstances relating to Dorothy.

However, a decision was made to concentrate primarily on Dorothy but the timescale for the Review was extended beyond her death to May 2009 so that all the lessons of agencies working together could be fully explored.

The Panel agreed that relevant organisations would be asked to carry out an Individual Management Review (IMR) and submit a report and a chronology of their involvement with Dorothy during the period of time when she was a resident at the care home with particular reference to the period between 1<sup>st</sup> June 2008 and her death in February 2009.

The following agencies were invited to contribute to the SCR by submitting their Individual Management Reports (IMRs):

- The care home
- Solihull Care Trust - Community Services and Commissioning Directorate
- Care Quality Commission (CQC and formerly CSCI)
- West Midlands Police
- Dorothy's GP

It was unclear to the Panel until after their first full meeting how far relatives were involved with Dorothy prior to her death, and whether contact with them would enhance agencies' learning from this process and be beneficial, or at least not detrimental, to the relatives. Following information from the IMRs and Panel discussion a decision was made to contact Dorothy's son, and a meeting with him took place in November 2009.

Following receipt of the IMRs and the interviews of their authors<sup>8</sup>, it became clear that there had also been significant involvement from mental health services staff, and detailed information (though not a full IMR) was submitted by a psychiatrist from the Birmingham and Solihull Mental Health Foundation Trust (BSMHFT). He and some of the other clinical staff had seen Dorothy on several occasions from 2006 to December 2008.

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<sup>8</sup> This did not include the GP who submitted a letter rather than an IMR report.

**4. A summary of the key information relating to Dorothy and her care until her death in February 2009**

Dorothy had lived a long and mostly independent life prior to her admission in 2004 to a residential care home provided by an independent charitable organisation in the Solihull area. She had been a widow for fifteen years prior to her move and had one son, a daughter in law and grandchildren. Her son described her as an intelligent and capable woman who loved gardening and reading.

Although suffering from a range of health problems, Dorothy had not received any personal care services before becoming a resident in the care home in Solihull, though she had some private domestic help.

One of the key pieces of information to emerge in this Review was that Dorothy was a 'self funder' and paid all her own charges for her living and care expenses at the care home. This meant that she was not obliged to have a social services<sup>9</sup> care needs assessment prior to going into the care home as she did not seek financial support from the local authority.

There are, therefore, no formal community care assessment details about Dorothy's circumstances prior to her son applying for NHS Continuing Care funding<sup>10</sup>, which resulted in an assessment visit by a continuing care nurse and a social worker at the end of January 2009.

Information provided by the care home, her GP, and the psychiatrist, as well as her son, are the main sources of evidence about Dorothy and the events that occurred from 2004 to her death in 2009.

Difficulties in caring for Dorothy became more significant over the years. By 2005 she was experiencing some double incontinence but refused to have treatment for a rectal prolapse.

Her mental health difficulties and behavioural challenges to staff at the home also became more evident and in March 2006 when symptoms of aggression and marked anxiety began to be a regular feature of her presentation and behaviour, her GP made a referral to the Birmingham and Solihull Mental Health Foundation Trust (BSMHFT).

She had contracted a series of urinary tract infections and these were seen to account for some of her 'confusion'.

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<sup>9</sup> SCT social care staff carry out these assessments in Solihull as it is an integrated health and social care service but in most areas it is social care staff employed by the local authority.

<sup>10</sup> See Appendix 1

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Dorothy was visited in March 2006 by a psychiatrist, who in his notes to the SCR Panel, said she was upset and anxious about her incontinence and he prescribed 30mg Mirtazapine (an anti-depressant) to be given at night.

Over the next two years there were a number of contacts with the BSMHFT mental health team. A community psychiatric nurse and a clinical psychologist visited Dorothy to assess her and to advise the care team at the home on strategies to assist her in a way that reduced/managed her challenging behaviours.

No formal diagnosis of dementia or recorded test of Dorothy's mental capacity appears to have been made during this time, though the psychiatrist did consider her to have capacity to make a new will in November 2007.

Although staff were struggling at this point with Dorothy's refusal to accept their care they are reported as coming to the conclusion that, "whilst Dorothy was challenging she would not be better cared for in any other environment".

Dorothy's physical and mental health began to deteriorate significantly by November 2008. This is described in a detailed exchange of correspondence between the care home, the GP and Dorothy's son.

The essence of this correspondence was that the home was struggling with Dorothy's increasingly challenging behaviours, which they described as "now continuous with very little respite... we can no longer continue to care for her *safely*<sup>11</sup> long term".

Her son was against a move as it was not her wish and he was concerned that a move would kill her. He cited a very distressed response to the move of room within the care home (August 2008) and suggest that medication might help alleviate her anxiety.

The GP expressed sympathy for the views of Dorothy's son but wrote that there was no alternative to moving her and quoted from a letter he had received from the CPN in September 2008 expressing concern about the possible side effects of increased medication.

The manager of the care home wrote to Dorothy's son shortly before Christmas 2008 explaining that the psychiatrist had visited and the medication had been increased so that the Mirtazapine (anti-depressant) was to the maximum dose and the Quetiapine (anti-psychotic) was doubled. The manager wrote, "With all this on board Dorothy is *less mobile and therefore safer* – i.e. she isn't falling or launching herself onto the floor or kicking out at staff. I agree with the GP that the home is not the ideal place

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<sup>11</sup> Report author's italics



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for Dorothy and *it goes against the grain to succumb to chemical intervention to keep her safe*<sup>12</sup>. However, if you are satisfied that this is an acceptable strategy I am happy to continue to provide care for Dorothy for the moment". The rest of the letter is about the increased care charges given Dorothy's higher level of need.

A further letter from Dorothy's son to the care home's manager in mid January thanked her for continuing to care for his mother and informing her that he was applying for funding for NHS nursing care.

What is surprising is that none of this correspondence describes any concerns about the deterioration in Dorothy's physical health even though by 24<sup>th</sup> December 2008, just a few days after the care home's manager's letter to Dorothy's son, the care home was reporting a serious pressure sore on Dorothy's heel to the district nurses.

It seems a nurse visited Dorothy on 24<sup>th</sup> December but there appears to be no record of what that nurse did or advised. Further visits (9 recorded on the IMR between 27<sup>th</sup> December 2008 and 23<sup>rd</sup> January 2009) followed after Christmas and into January 2009. Treatment was administered and specialist pressure relieving equipment ordered and provided.

It was, however, Dorothy's son's request for an assessment for NHS funded nursing care that prompted an assessment visit at the end of January from the CHC nurse and a social worker. Their concerns about the severity of the pressure sore and the appropriateness of the residential home, given the level of nursing care needed by Dorothy, resulted in the safeguarding investigation taking place.

A planning meeting arranged by SCT in early February considered whether there had been, a failure by the home to request medical treatment, potential loss of nursing records, and whether Dorothy had the capacity to refuse treatment. This resulted in the meeting considering whether there had been 'wilful neglect', a criminal offence under section 44 of the Mental Capacity Act.<sup>13</sup> (Subsequent investigation by the police did not find any evidence of wilful neglect).

NHS CHC funding was agreed and the manager of the care home was communicating to the SCT staff that the home could no longer care for Dorothy as she had deteriorated further.

In early February Dorothy's son said he was advised by his mother's GP that she would not "last the weekend". He said CHC (Continuing Health Care) staff still wanted his mum to move and after refusing a move to two nursing homes outside of Solihull, he reluctantly agreed to a home within

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<sup>12</sup> Ditto

<sup>13</sup> See Appendix A

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the Solihull boundary (though it is said this home expressed doubts about the wisdom of moving her as they judged her to be dying). He wanted the move to take place when he could accompany her. There then followed two failed attempts to move her; on one occasion the ambulance only had a wheelchair and she needed a stretcher; and two days later the planned move failed because no one arrived to do the transfer. On the third occasion when she was moved her son said he did not accompany her as the ambulance arrived earlier than was expected.

As described previously in this report there is a concerning context to the care home where Dorothy lived for five years, particularly in the months leading up to her death. It is difficult to judge to what extent some practices during that period affected Dorothy directly. Her son gave no indication that he was dissatisfied with the care the home provided at any time, and only became angry when they wanted to transfer her.

The care home was generally judged to be a good service provider. CSCI and its predecessor regulatory body, the National Care Standards Council, regarded it a 'compliant with standards' provider. Inspections prior to June 2008 had not identified any major problems and, although 'ratings' of overall quality were not used in the previous inspection in July 2006, individual standards were scored from 1-4 and most of the areas looked at during the that inspection scored 3 out of 4 (Standard met - no shortfalls), with some scores of 2 (Standard almost met - minor shortfalls).

The June 2008 inspection, however, suggested some deterioration in meeting a number of standards and raised particular concerns about:

- inadequate care plans and record keeping including updating as residents' needs changed;
- problems with medication management;
- lack of training on the Mental Capacity Act
- lack of robust staff recruitment processes; and
- non compliant handling of complaints and concerns including, not informing CSCI about them.

CSCI carried out their inspection in June 2008 but SCT Contract's team said they did not become aware of the zero rating until 17<sup>th</sup> September 2008. They responded to this information by advising social workers to contact them before making a placement at the care home but did not immediately suspend admissions to the care home. In fact that did not take place until March 2009 following a complaint about the care home and then staff becoming aware of Dorothy's situation at the end of January 2009.

A series of discussions took place within the Safeguarding Adults Procedures Group (a subgroup of the SASB) and concerns were raised about the general standard of the care at the home. This resulted in a 'stop'

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on admissions to the care home and plans were put in place to offer assessment to all residents in the home as part of a wider review.

It is evident that this poor quality rating from the regulator came as something of a shock to the home, which was well regarded in the local community.

CSCI were not aware of Dorothy as an individual when they conducted their inspection in June 2008. There were no issues of residents being inappropriately placed in that inspection report, though there was concern about the quality of care plans, poor recording and staff needing training on the Mental Capacity Act; all features that were part of the concerns raised about Dorothy's care.

The CQC representatives who presented the IMR informed the Panel that the draft phase of a report can take fifty six days before a final version is published as a home has opportunity to challenge the judgement. They said there was no obligation to share the initial judgement with commissioners and contractors though they did agree that better communication was necessary.

Although they had not been aware that Dorothy was a self funder when they received information about the safeguarding incident they said their expectation of a home experiencing difficulty over a resident was that the care home should have contacted them. They said, which surprised the SCR Panel, that they could only enforce a breach of standards about a resident's suitability for the care home's registration category on the point of admission, and not if their health deteriorated later.

They were not made aware of the pressure sore until informed by an SCT social worker at the end of January 2009, though they should have been informed earlier by the care home as pressure sores/ulcers are reportable under Regulation 37 of the Care Standards Act 2000.

They did conduct a further inspection on 3<sup>rd</sup> March 2009 and gave a second 0 rating. Although they believed there were some improvements made after the June 2008 inspections, some of the same issues particularly around the management of medication were revealed in the March 2009 inspection.

The SCT Contracts team began to plan the arrangements to carry out the large scale review of the care home before the safeguarding meeting on 4<sup>th</sup> February. They made a number of visits to the care home and were discovering concerns similar to those of CSCI around record keeping and medication.

Advice and information was given to the care home, who were also working with advisors from another voluntary sector organisation who were providing management support to improve documentation and practice.

Monitoring visits continued and the stop on placements was lifted on 4<sup>th</sup> June 2009.

An inspection of the home in July 2009 found significant improvements and the home was rated as good and given a 2 star rating.

## **5. Findings and Learning**

There is one key question that has emerged from this Review that was not predicted at the beginning of the Panel discussions. What was the safeguarding issue in relation to Dorothy and was there more than one? What actions were potentially abusive even if no one had any intention of harming her?

The trigger to the formal safeguarding investigation in January 2009 was the discovery of the pressure sore on Dorothy's heel. Was the extent of the sore as a result of neglect by staff at the care home and/or by poor professional oversight and treatment of this pressure sore by district nurses? The more general concern was whether the care home was registered to meet the needs that Dorothy had developed and had sufficient expertise to meet those needs safely.

However, information came forward in this Review that suggested there were at least two other potentially harmful practices that could be regarded as safeguarding issues:

- Dorothy was prescribed increased anti-psychotic medication in December 2008 that may not have been in her best interests and was in fact questioned by several professionals; and
- She was transferred from her home (the care home) of 5 years to a nursing home, where she died two days later. Was this move of a dying woman of 96 in her best interests? All the evidence suggests that it would have been against her wishes when she had been well enough to express her choice.

### **5.1 Potential disadvantages for 'Self Funders'**

Dorothy did not receive local authority funding to pay for her residential care; she was a self funder.

When the NHS Community Care Act 1990 was being debated in late 1980s, one of the concerns was that older people who did not have high care needs were placing themselves/being placed in private residential care homes (old people's homes as they were usually referred to at that time) without any proper assessment of their needs. Those who could pay their own fees had the choice to go into a private care home as did those who

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were eligible for income support (DHSS funding in 1993 when NHS and Community Care Act was implemented) without any involvement from the local authority. The Griffiths report<sup>14</sup> of 1998 described this as the 'perverse incentive' of the 'board and lodging subsidies to the private residential sector'.

This was stopped under the new legislation and anyone who sought state funding to meet their care needs had to have a community care assessment and to meet the social services' eligibility criteria to receive services.

There is, however, still unequal access to services in that people who have funds to pay fully for their own place in a care home, now as then, do not need to become involved with the local authority social services. They do, however, have the right to have their needs assessed by social services and not to receive a lesser assessment service because they are not eligible for financial support.

There is reluctance on the part of some individuals and families to get involved with social services<sup>15</sup> and some homes do not encourage potentially self funding residents to seek a community care assessment. It is believed that homes do not encourage it because social services may try to assist the resident to negotiate a lower fee rate (local authority contract rates are usually lower than those charged to private residents). There is evidence of cross subsidy of publicly funded residents by private payers.

Some research<sup>16</sup> has also indicated that in many authorities (generally informal) systems and procedures are in place to discourage potential self funders from seeking an assessment as a way of managing the heavy workload such increased assessments place on increasingly stretched social services staff.

The senior community services manager in SCT confirmed that the Trust's policy is that anyone with community care needs can have an assessment. However, evidence from some other SCR Panel members suggested these requests were not encouraged when individuals sought information about care homes if they revealed that they had income/capital above the eligible financial support limit.

For Dorothy an assessment at that stage *may* have at least identified her mental health/personality difficulties so the care home could have been better prepared. It is unclear whether an initial assessment would have

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<sup>14</sup> R. Griffiths, *Community Care: Agenda for Action*, HMSO, 1988

<sup>15</sup> In Solihull this social services responsibility is carried out by staff in the Care Trust.

<sup>16</sup> A fair contract with older people? A special study of peoples experiences when finding a care home CSCI 2007 October. [www.cqc.org.uk](http://www.cqc.org.uk)

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made any difference in the long run unless she 'got into' the system of regular social care reviews. This would have been unlikely particularly as she was moved from her own home in Northampton to a residential home in a different local authority area.

If Dorothy had been receiving financial support for her care placement there would have been an established relationship through at least yearly reviews, which would have looked at her changing needs. The care home would have been able to call on adult social care for re-assessment and advice, which they certainly would have done even if only because the cost of her care needs had begun to exceed what the Council/Trust would have agreed to pay for on her admission.

The only time an external (i.e. not by the care home) needs assessment took place was a few weeks after a marked deterioration in Dorothy's health around the 2008 Christmas period. When the care home reluctantly agreed that they would continue to care for Dorothy they told her son that they needed to raise the care fees.

A CHC nurse and a social worker went out to do an assessment to see if Dorothy was eligible for this funding at the end of January 2009 and this is how she became known to adult social care staff just three weeks before her death, though she had already been known to SCT district nursing staff.

Evidence does not suggest, however, that the nurses were bringing specific concerns about her to the attention of their managers prior to the safeguarding investigation, though they had concerns about the increasing demands the care home was placing on their service overall.

The SCR Panel believed that if Dorothy had not been self funding (or if she had been treated for assessment and review purposes as a contracted resident) the difficulties experienced by the care home in providing her with appropriate physical and mental health care would have come to the attention of social care staff much sooner. This *may* have offered the opportunity at an earlier stage to find a care home with nursing that met her health needs more appropriately, though, given the local shortage of nursing homes and her determination not to be moved even within the care home this would probably have still posed problems.

A report from the National Care Forum published in January 2010 said that the number of older and disabled people paying for their own care in care homes continues to rise with an increase of a third since 2002; 41% of residents now pay for their own care. These figures indicate a growing number of people who are outside the positive safeguarding framework that an assessment and regular review process may provide for them

## **5.2 Issues around mental capacity and the appropriate use of the legislation and code of practice.**

References are made from 2006 onwards by the care home's staff about Dorothy's increased confusion at times, particularly when she was suffering a urinary tract infection and/or had just come out of hospital; both are high risk indicators of the likelihood of temporary confusion for older people.

However, it does not appear that Dorothy's mental capacity to make decisions for herself, particularly about where she lived and how she was cared for, was ever formally assessed using the procedure set out in the Code of Practice to the Mental Capacity Act 2005 (MCA implemented in April 2007).

In 2007 the BSMHFT psychiatrist describes being asked by her solicitors to attend a meeting for her to sign a new will. He wrote to the SCR Panel that he believed she had the capacity to sign a new will.

In his letter following his visit to Dorothy in early December 2008, he describes her "high level of anxiety, obsessional behaviour and wish to die" but does not refer to any lack of capacity to make some decisions for herself.

In his correspondence to the SCR Panel he acknowledged some cognitive impairment and a fluctuating ability to give informed consent, especially if the issues at hand were complex but not a general lack of capacity.

Although Dorothy demonstrated by some of her behaviours that she was very unhappy about her illnesses and highly anxious, and could take out her frustrations on others, there is no evidence that she wanted to move from the care home. Her behaviour when moved within the care home in August 2008 provided evidence to others that she would see any move as very distressing and against her wishes.

Her son was clear in interview that her wishes were to die at the care home and that her high level of anxiety had a rational base; she had a number of illnesses with very distressing symptoms.

The care home stated that they believed Dorothy was capable of making informed decisions and had not had evidence from the mental health service to suggest other than that she had mental capacity.

In the multi- disciplinary meeting organised by SCT in early February 2009 questions were raised about her capacity but none of the actions from the meeting indicate that a formal capacity assessment was requested. Somewhat confusingly in the chronology completed by West Midlands Police it is recorded that that Dorothy was assessed for mental capacity at the end of January 2009 and found not to have capacity.

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The Mental Capacity Act 2005 (MCA) came into force in April 2007. The Code of Practice to the Act<sup>17</sup> sets out that “a person’s capacity (or lack of capacity) refers specifically to their capacity to make a particular decision at the time it needs to be made”. What is unclear from the SCT records is what decision Dorothy was not seen to have the capacity to make. One of the decisions that would have been discussed with her if she had capacity would have been to get her agreement to move from her residential care home to a nursing home.

There are five statutory principles in the MCA:

1. A person must be assumed to have capacity unless it is established that they lack capacity.
2. A person is not to be treated as unable to make a decision unless all practicable steps to help him to do so have been taken without success.
3. A person is not to be treated as unable to make a decision merely because he makes an unwise decision.
4. An act done or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.
5. Before the act is done, or the decision is made, regard must be had to whether the purpose for which it is needed can be as effectively achieved in a way that is less restrictive of the person’s rights and freedom of action.

As it seems to have been judged that Dorothy did not have capacity then principles 4 and 5 should have influenced the process of decision making. What decision was in her best interests and what would have been the least restrictive of her rights and freedom of action?

The Code of Practice offers guidance on how best interest decisions can be reached and asks “What role does a person’s past and present wishes and feelings play. People who cannot express their current wishes and feelings in words may express themselves through their behaviour. Expressions of pleasure or distress and emotional responses will also be relevant in working out what is in their best interests. An advocate could help the person make choices and express their views. The person may have held strong views in the past which could have a bearing on the decision now to be made. All reasonable efforts must be made to find out whether the

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<sup>17</sup> MCA 2007 Code of Practice can be found at [www.dca.gov.uk](http://www.dca.gov.uk)



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person has expressed views in the past that will shape the decision to be made”.

The Code of Practice also recommends that “if it is practical and appropriate to do so, consult other people for their views about the person’s best interests and to see if they have any information about the person’s wishes and feelings, beliefs and values. In particular, try to consult:

- anyone engaged in caring for the person
- close relatives, friends or others who take an interest in the person’s welfare”.

It does not appear that SCT community services followed this guidance; their actions appear to have focused on meeting Dorothy’s immediate physical health needs by a move to a nursing home.

Dorothy’s son said he was never officially informed by SCT about the safeguarding investigation, though he was made aware of some issues under investigation in a letter from the care home. He said that his experience of CHC (his description of the staff who carried out the NHS CC assessment) was one of pressure to move his mother even though he said they had been made aware that she did not have long to live.

As this was an adult protection/safeguarding matter the MCA Code of Practice does allow for an Independent Mental Capacity Advocate (IMCA) to have been appointed to represent Dorothy’s interests even though she had a family member involved. This does not seem to have been considered by SCT staff.

The more formal use of the MCA and the involvement of Dorothy’s son in discussing the safeguarding issues possibly with the support of an IMCA might have led to a greater focus on Dorothy’s needs and best interests and possibly a more dignified death.

Whilst the information above suggests some less than good practice by SCT community care staff, it is very clear that they were under a great deal of pressure. Dorothy had a severe and deteriorating pressure sore and other needs that were assessed as requiring nursing care; the care home had been rated by CSCI as providing a poor quality service following the June 2008 inspection; there was a need to investigate concerns about other residents; and the care home and the GP were expressing serious concerns that they couldn’t continue to care for Dorothy. The SCT assessment and care management service was short of experienced frontline social workers, though an experienced agency worker was recruited to the safeguarding investigation team; and the managers of the service were relatively newly appointed and inexperienced in safeguarding investigation work. Crucially Dorothy and her son were unknown to social care staff and from their first visit to Dorothy until her death there were only fifteen working days.

### **5.3 The potential negative impact of medication on Dorothy**

Information about Dorothy's medication came to light during the SCR process. When she was first seen by the psychiatrist in March 2006 he prescribed the anti-depressant, Mirtazapine 30mg by night. This was reviewed in April and she was judged to be benefitting from the medication and was less anxious and more able to join in with activities in the home.

On re-referral the psychiatrist saw Dorothy in March 2007. She had been in hospital for brief periods and had been confused, expressing delusional beliefs and aggression on discharge. She was prescribed an atypical anti-psychotic, Quetiapine 25mg night and 25mg day, which appeared to have some effect in reducing her symptoms.

Following a further referral in March 08 where there had been a severe deterioration in Dorothy's health she was visited by the CPN and the anti-psychotic medication had been stopped but Dorothy continued to be prescribed the anti-depressant.

In December 2008 the psychiatrist saw Dorothy again and recommended an increase in her anti-depressant medication to 45mg nocte and Quetiapine 50mg bd.

In July 2009 as part of the Dementia Strategy the government asked Professor Sube Banerjee to undertake an independent clinical review of the use of anti-psychotic drugs in recognition of widespread concern about the over-prescription of anti-psychotic drugs for people with dementia.<sup>18</sup> Although the media made some sensational comments about the findings in this report and fuelled the fires of the 'chemical cosh' allegations the report did see the positives of using anti-psychotic medication to control symptoms of psychotic illness. Dorothy's psychiatrist was clear that she did exhibit psychotic symptoms on occasion and there is no evidence that this medication was not appropriate for her. In his correspondence with the Panel he gave information that she "...was making paranoid complaints ...was having a delusional recollection of her (hospital) stay and was adamant that she had been trapped and imprisoned in hospital. Because of the delusional belief and aggression I commenced her on Quetiapine 25mg nocte that I doubled to 25mg bd which appeared to have some effect in reducing the target symptoms".

He recognised the dilemma of increasing her medication, "Because of her advanced age I did not want to increase her sedation any further" but also

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<sup>18</sup> [www.dh.gov.uk](http://www.dh.gov.uk) "A report for the Minister of State for Care Services by Professor Sube Banerjee October 2009 –independent report for DH"

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noted the “risks of moving such an elderly patient”. However, pharmaceutical advice to the SCR Panel did suggest that it was not considered good practice to give medication of the type described for Dorothy without a *formal* diagnosis of dementia.

All medicines are likely to have some side effects and it is debateable whether it was a good decision for Dorothy’s medication to be increased as this further impaired her already poor mobility, and put her at greater risk of a pressure sore developing. Of course, it is not possible to say that this would not have happened if she had been moved to a care home with nursing registration.

A number of staff including the CPN and the care home’s manager shared these concerns with the care home’s manager writing, “I agree with the GP that the home is not the ideal place for Dorothy and *it goes against the grain to succumb to chemical intervention to keep her safe*<sup>19</sup>.”

It is concerning that a manager of a care home should make that statement and appear to take such a serious decision without documented reference to others. Given these recorded doubts there was at least a professional responsibility to carry out a formal risk assessment so the specific negative consequences could have been identified and might have been prevented or at least better managed.

If the care home believed they could not care for Dorothy safely, and were not entirely happy about the medication but were being put under pressure to carry on caring, the professional expectation would be that they sought external help from CSCI and/or SCT community commissioning staff even though Dorothy was a self funder.

The findings of the CSCI inspection in June 2008 and follow up in March 2009 relate to the management of the process and recording of medication and not the prescribing. However, the risks of the poor management practice potentially put Dorothy in double jeopardy; high risk medication being poorly managed. Recently published research<sup>20</sup> indicates high levels of error in the prescribing, dispensing, and handling of medication of residents in care homes so this risk of double jeopardy is not minimal.

#### **5.4 Values and philosophy at the home and its standing in the local community.**

In a regulator inspection report dated 15<sup>th</sup> October 2003 the care home was achieving mostly 3’s (good) for the standards inspected, with some 4’s (excellent) and only a small number of 2’s on the 1-4 scale.

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<sup>19</sup> Report author’s italics

<sup>20</sup> [www.dh.gov.uk](http://www.dh.gov.uk) ‘Use of medication in care homes’ 2009

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Under Standard 11, which seeks evidence for “Care and comfort are given to service users who are dying, their death is handled with dignity and propriety, and their spiritual needs, rites and functions observed” the care home scored 4/4 and the policies and procedures described as excellent.

The description above of how the care home sets out to practice its values would seem to be admirable whether one is religious or not. The care home’s IMR described a place where staff tried to follow a social model of care rather than becoming a mini hospital and it is evident that staff were sensitive to both Dorothy and her son.

The care home and grounds are described as a beautiful place and people who may be regarded as having high status are involved with the home.

This combination of a high local profile and a well expressed value base was judged not to be matched by high professional standards of care in the last few months of Dorothy’s life. In order to maintain that misguided interpretation of the ‘social model of care’<sup>21</sup> decisions were being made that may have contributed to the lack of dignity experienced by Dorothy towards the end of her life.

**5.5 Role of CQC in safeguarding: when is a zero rating assessment a safeguarding issue in itself?**

It is quite difficult to understand how a judgement of “The quality rating for this service is 0 star. This means that people who use this service experience poor quality outcomes” (quote from June 2008 CSCS Inspection report), would not trigger an immediate sharing (if not an actual safeguarding alert) of that information from the regulator to the service commissioner and/or contractor, if not to a wider audience. The residents of care homes are usually extremely vulnerable people who don’t have the ability to withstand additional poor quality outcomes and at least need immediate and organised assessment to see what impact the poor care is having on their wellbeing even if there is no deliberate neglect.

**5.6 Role of contracts/monitoring in safeguarding and ‘large scale review’ process**

It is also not entirely clear why more immediate and assertive action was not planned by SCT when the 0 rating of a previously well regarded home did come to their attention in September 2008. The Contracts team did have staff capacity problems but action at this stage may have identified the risks being posed by Dorothy to herself and to staff and allowed a more dignified pace for considering her future care arrangements.

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<sup>21</sup> The debate about social and medical models of care is not an either/or but a combination and equal value for social and medical needs

What is clear is that all staff found the setting up of a different process to look at the larger scale safeguarding issues confusing and distracting.

It does not seem unreasonable that such a process should have been considered given the growing concerns that were coming to light but it needed planning, senior management leadership, and resources if it was not going to cut across action that was already in place.

## **6. Conclusion**

The key questions are: was Dorothy's death predictable; was it preventable; and if not preventable did the agencies responsible for her care provide support that enabled her to die in a dignified manner?

There is nothing that has emerged from this Review that contradicts the findings that Dorothy died from natural causes. She was a very old lady with a range of increasingly debilitating health problems that had unpleasant and distressing consequences for her.

Given the range of her illnesses her death was predictable and given her not unreasonable resistance to interventions it was also not preventable.

What is clear, and very sad, is that from what those who knew her have said she did not die where she would have wanted to die, and she, her family and staff at the care home experienced some distressing and preventable events as her life came to an end.

It is understandable that once SCT staff became aware of Dorothy's high health needs and the acknowledged difficulties the care home had in meeting those needs, and information that the care home itself was considered 'inadequate' by the regulator, that staff were anxious that she should receive care in an environment with professionally qualified nursing staff on site.

It does, however, feel that most of the professionals involved with Dorothy stopped seeing her as a person who was in the last weeks/days of her life and this was certainly her son's judgement. He said the GP told him she was dying and the staff member from the nursing home is said to have assessed that she was dying and did not want to accept her transfer. There does not seem to have been any consideration of increasing the community nursing resource into the care home to ensure that the End of Life Care Pathway for a dying patient could be followed with a better chance that Dorothy would have had a dignified death.

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If anything the care home tried for too long to maintain her in the residential environment and professional decision making was overshadowed by being too kind and obliging.

There are many lessons to be learned from this SCR and the recommendations that have been made will hopefully provide the impetus for that learning to be embedded in practice. Most of the organisations that contributed to this Review appropriately identified some of the ways they were (and in some instances had already begun) planning to improve.

One of the overall lessons from this Review is that caring for potentially vulnerable people in a way that enables them to maintain control over as many aspects of their life as possible, whilst at the same time keeping them, and the staff who are involved with them safe, is an extremely complex task. It may not be 'rocket science' but it is just, if not more difficult and needs a high level of thinking and skilled evidence based practice.

## **7. Recommendations**

### **Local Policy and Practice**

1. The Solihull Adult Safeguarding Board (SASB) should advise Solihull Care Trust to clarify and make available to the public the policy and the practice relating to availability of community care assessments for individuals who are not eligible for community care funding for a care home placement.
2. The SASB should recommend that SCT enter into discussions with a voluntary sector partner(s) to provide advice, information and ongoing review and support to self funders who go into a care placement.<sup>22</sup>
3. The SASB should recommend to SCT that it works with CQC to provide clear information to care home residents and potential residents, care homes and community care assessment and contracting staff about the different eligibility criteria for residential and nursing care and clarifies under what circumstances a resident can be required to move so that their needs can be appropriately met. As part of this, homes need to be reminded that caring for vulnerable people without the appropriate skills and resources is a contractual and a potential safeguarding issue.
4. The SASB should recommend to SCT that it considers how it can provide professional social work advice to a home where the care home is concerned about a self funding resident.

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<sup>22</sup> 29 April 2009 01:36 Community Care [www.communitycare.co.uk](http://www.communitycare.co.uk) 'A fair deal for self funders' describes a scheme East Sussex Council, set up the Support to Access Care Service, specifically for self-funder.

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5. The SASB should advise SCT and its partner agencies to ensure that Solihull residents who need a nursing home placement can exercise their choice of staying in Solihull in a good quality home and at a cost that does not demand a third party top up payment.
6. The SASB should review the content and availability of its Mental Capacity Act training programme to ensure that the purpose and process of assessment is fully understood by all agencies and that the best interests of the assessed person and the views of their significant carers are fully considered.
7. The SASB should review the training for all professionals on person centred assessment and support planning, particularly for people at the end of their life.
8. The SASB should review the use of advocacy, both general advocates and Independent Mental capacity Act Advocates (IMCAs) in safeguarding and consider what data/information the Board needs to ensure these services are being used appropriately.
9. The SASB should align the process of individual safeguarding investigations and large scale reviews of provider services to ensure individual vulnerable people are not lost in the process. There needs to be clear guidance, a project management approach, the appropriate level of decision makers, agreed communication lines and lead officers established for both processes.
10. The SASB should ask community commissioners, contract monitoring staff and providers to develop a policy and set of procedures to manage end of life care and to consider what extra supports may need to be made available to homes to enable residents to die 'at home'.
11. The SASB needs to ask all agencies to consider their staff training in respect of medication and ensure that staff who carry out safeguarding investigations are made aware of key research about the impact certain medicines can have on vulnerable adults and are equipped to carry out risk assessments.
12. The SASB should review the research on service user and carer experience of the safeguarding process and if necessary conduct some local research so that the views of users and carers inform the safeguarding procedures and practice.<sup>23</sup>

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<sup>23</sup> There is a small piece of local research conducted by Liverpool John Moores University and Halton Council that could be requested from the DASS at Halton

**National policy**

- 13.** The SASB should request the Care Quality Commission to provide information for commissioners, providers and service users and their families to clarify the role of CQC in safeguarding processes. This information should set out the action expected of CQC and service commissioners when a home is rated as poor and develop protocols for providing this information to commissioners/contracting agencies even before a final judgement is made so that immediate risk management strategies can be put in place to safeguard residents.



## **Appendix A**

### **Glossary and brief explanation of relevant guidance and legislation relating to safeguarding vulnerable adults.**

**Pressure sore (ulcer)** A recent report from the NHS gives the following information about pressure sores (ulcers):

“Pressure ulcers often affect older, obese or malnourished people, or those with certain underlying conditions. Ulcers occur when there is damage to tissue as a result of long-term immobility, a patient’s body weight, friction or the shearing of skin or deeper tissues. The majority of pressure ulcers are entirely preventable through a risk assessment and the implementation of pressure-relieving measures, such as moving immobile patients. We have set out an ambition to eliminate all avoidable pressure ulcers in NHS-provided care”.<sup>24</sup>

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

**‘Safeguarding Adults’** – A national framework of standards for good practice and outcomes in adult protection work – Association of Directors of Social Services 2005

**A Vulnerable Adult** is defined as: -

A person aged 18 years and over:

‘who is or may be in need of community care services by reason of mental or other disability, age or illness;

and

who is or may be unable to take care of him or herself or unable to protect him or herself against significant harm or exploitation’  
(*No Secrets*).

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<sup>24</sup> [www.dh.gov](http://www.dh.gov) “NHS 2010–2015: from good to great. Preventative, people-centred, productive” CM 7775

## **Appendix B Research**

### **A fair deal for self funders**

Wednesday 29 April 2009 01:36 Community Care [www.communitycare.co.uk](http://www.communitycare.co.uk)

A growing “us and them” situation is developing between vulnerable adults who qualify for council services and those who own enough assets to be deemed capable of paying for their own care. As cash-strapped councils prioritise their limited resources to those who pass the means test, self-funders are often being left to fend for themselves.

This lack of support particularly affects older people as they move into residential care, many of whom enter into deferred payment schemes as they sell their homes to pay for fees. There are all too many stories of social workers just handing self-funders a list of local care homes and precious little else.

The trouble is that everyone is entitled to support, information and advice from their local authority, no matter how much money they have managed to save for their retirement years. Even millionaires should in theory be offered a care assessment and help investments counts as a self-funder, and according to Age Concern there are about 115,000 self-funders in care homes, accounting for 27% of all residents. In 2007 a report by the Commission for Social Care Inspection, *A fair contract for older people?*, found that many self-funders were not being given the chance to discuss their care options with social services. Half of those surveyed said they had not received a care assessment. Some had even been put in a care home when they didn't need to be. In all, a shocking four out of 10 councils acknowledged that people who fund their own care received less support than other older people.

It was also discovered that self-funders were often paying over the odds for the same care home places as publicly-funded clients because local authorities were able to drive down prices through purchasing block contracts. In effect, self-funders were found to be subsidising publicly-funded residents, something that Age Concern is still campaigning vigorously against.

From every angle, self-funders are not getting a fair deal at all, and although their numbers are expected to rise over the next decade not much has been done to address the situation since the CSCI report. Now at long last national director for social care transformation Jeff Jerome has brought the subject up again. He admitted at a recent personalisation conference that “we do not understand the self-funded market” and clearly realises where the shortcomings are.

“The problem that we've got, given that Putting People First is asking us to concentrate on the whole community, is that we have a lot more understanding of people coming through the council system than those who don't,” he says. “We

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know that in certain parts of the country the proportion of self-funders in care homes is very high, but we don't know how they got there, where they originate from, what sort of support they've had in thinking out their options or what their choices and preferences have been."

The first step, as Jerome sees it, is to pull together existing research and set up specific projects to find out more about the situation. But is it not down to councils to get their act together? "Some authorities have made some inroads, but they are a small minority," he says. "We're having a look at that at the moment and I am trying to commission some work around this. It's quite clear that unless something dramatically changes, the amount of private money that's going in to the care and support system will perhaps become the majority in the not-too-distant future."

Sarah Pickup, co-chair of the Association of Directors of Adult Social Service's resources network, has a similar prognosis. "When I talk to other directors, they are clear that this is an area for improvement," she says. "My expectation is that with Putting People First and the provision of the social care reform grant, authorities will be placing a greater emphasis on the need to offer support to self-funders."

So what does the situation look like from the independent sector side fence, and can the personalisation agenda really provide all the solutions? According to Alex Edmans, a care funding adviser for Saga Personal Finance, more than 4,000 people contacted her service in 2008 for information on how to pay for their care. Many of these inquiries were from people who were entitled to social services funding.

"Unfortunately, all too often, we still receive calls from those who have received little guidance, or indeed, incorrect information," she says. "This would suggest that the situation has not changed over the last few years."

Pauline Thompson, policy adviser for Age Concern, has been concerned about self-funders for a number of years, not just in care homes but also those who need domestic help for independent living. "A care package at home can be very complex, because you've got different people in at different times of day to do the various services that you need," she says. "If any one of those fails to turn up, then you really need some help. The care manager role is there to help sort it out and organise it.

Self-funders to a large extent are in a worse position because they haven't got that structure of help around them if their care package isn't working that day. "Also people who have direct payments often get access to advice and payroll organisations, whereas a self-funder – who is technically the same as somebody who receives a direct payment – is often left to their own devices. There is a huge issue around this and it does need to be resolved."

Not all councils have ignored self-funders, however. Keith Hinkley, director of adult social care at East Sussex Council, [set up the Support to Access Care Service](#)

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specifically for self-funders in the wake of the Fair contract report. Currently four practitioners work on the project, which has seen take-up increase from 374 clients when it first launched in 2007 to more than 550 and the numbers are expected to increase year-on-year. All clients are offered care assessments as well as information on care home fee levels in order to help tackle the problem of cross-subsidy between private and public residents.

There is still a long way to go in order to reach out to self-funders who have shied away from council services, Hinkley warns. “In common with every local authority in the country with Putting People First, we’re changing how we assess and deliver support to people,” he says. “One of the clear points about the service transformation is that we need to get better at developing choice in the market. Because we’re not having as much contact with self-funders we’re not necessarily getting the information from them about what sorts of services they need.”

This brings matters neatly back to Jerome’s original point – it’s an area we just don’t know enough about. What we do know is that all councils will eventually have to ensure that self-funders receive the same level of service as their own clients.

But councils may not end up that providing the service themselves, says Jerome. “Perhaps we also need to think about whether organisations other than local government, is the best way to deal with this,” he says. “Quite a lot of people don’t want to approach their council. We need to think about best access points and mediums to receive information, but it doesn’t have to be delivered by the local authority. We will be talking with organisations such as Age Concern, Counsel and Care and others about that sort of partnership approach.”

**A fair contract with older people? A special study of peoples experiences when finding a care home CSCI 2007 October**

Older people who are likely to fund their own care are at a disadvantage at the first step in considering going into a care home. Whilst people who approach their council about care services are entitled to an assessment of their care needs before their financial needs are considered, 50% of people who funded their own care responding to our survey did not have a care assessment

Four out of 10 councils in our study acknowledged that people who fund their own care receive less support than other older people. Assessments were not well publicised for people likely to fund their own care and little more was offered than a list of care homes following any ‘assessment’.

- 1.3** Older people who do get an assessment and whose care is funded by the council appear to find the process largely satisfactory. Two thirds of the older people we interviewed who had moved into a care home and were council funded were generally satisfied with the assessment of their needs and the outcome.

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- 1.4** Councils vary in the information they provide about entitlements and support to older people and carers during and after the assessment process. Fully coordinated multi-disciplinary assessments are not yet commonplace, even where health and social care staff share offices.

Two of the 10 councils in our study had introduced extra support services for people going into care homes, including staff appointed specifically to support people who pay for their own care.

In summary:

- People who are expected to pay for their own care are particularly disadvantaged by a lack of information, support and advice at every stage in making a decision about going into a care home.
- People have limited choice and it appears the statutory directions on choice are not being followed.

**More choice**

Councils have a key role in developing the local care market and commissioning for all the communities they serve – not just for those people whose care they expect to fund. If they do not consider the supply of services for their whole population, this could result in shortages and higher fees. They should be closely involving older people from all communities to develop a portfolio of services to offer genuine choice for people, both in innovative alternatives to residential care and in high quality local care homes.

“Councils have a legal duty to assess a person’s needs where their circumstances come to the attention of the council and they may be in need of community care services that the council has the power to arrange. This duty applies regardless of the person’s entitlement to services or financial circumstances. Overall, therefore, there are three components – the assessment of needs and circumstances, a decision about entitlement (i.e. what will be provided under the council’s eligibility criteria), and a financial assessment of what the person will be expected to contribute to the costs of support and care provided”.

**Banerjee Report [www.psychrights.org](http://www.psychrights.org)**

Antipsychotic drugs are used for the management of behavioural and psychological symptoms in dementia. The development of such symptoms is a core part of the syndrome of dementia. They can cause major problems for people with dementia and their carers and are a legitimate focus for intervention to decrease distress and harm, and increase quality of life.

Where medication is considered, the person to whom it is to be given should be as involved as possible in decision-making, although many will lack the capacity to consent. In all cases relatives, particularly the main family carer, and other carers or advocates should be involved in discussions about the use of the medication.

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They should be given information on the possible positive and negative effects of the medication and be invited to contribute fully to the discussion. Ultimately the decision on whether to prescribe the medication or not will be a 'best interests' decision.

It is clear from this review and others that there is overprescribing of antipsychotic medication for behavioural problems in dementia, and that this prescribing is associated with significant harm in terms of increased mortality and incidence of cerebrovascular events, including serious ones such as stroke. Balancing this in clinical governance terms is the potential good that these drugs may be doing for individuals with dementia in terms of the control of distressing symptoms, the supporting of carers, and the prevention of unnecessary transitions into care homes. The size of this positive effect appears relatively modest and, given the risks, best practice suggests that prescription should be reserved for those with the most severe, complex and critical problems, often when non-pharmacological approaches have not been successful. It is clear that non-pharmacological approaches are seldom deployed. For each prescribing, dispensing or administration event, there was a 8-10% chance of an error occurring, and for monitoring, a 15% chance. This is as high, or worse, than for people living in their own homes or hospital, and generally care home residents have reduced resilience to the harm that can result from medication errors.

**Care Home Use of Medicines Study  
(CHUMS)**

Medication errors in nursing & residential care homes - prevalence, consequences, causes and solutions.

Report to the Patient Safety Research Portfolio, Dept of Health  
[www.haps.bham.ac.uk/publichealth/psrp/PS025\\_Project\\_Summary.shtml](http://www.haps.bham.ac.uk/publichealth/psrp/PS025_Project_Summary.shtml).  
In summary, the main findings were:

- residents (mean age 85 years) were taking an average of 8 medicines each
- on any one day 7 out of 10 patients experienced at least one medication error
- whilst the mean score for potential harm was relatively low, the results did indicate opportunity for more serious harm.

These are important findings. They strongly indicate there is considerable scope for improvement in how medicines are prescribed, dispensed, administered and monitored in residents and patients in residential care and nursing home settings.

**Appendix C**  
**Terms of reference for the SCR**



**Serious Case Review – Terms of Reference**  
**Mrs D N**

**Purpose**

1. The purpose of the Serious Case Review (SCR) concerning Dorothy is to establish whether there are lessons to be learned from the circumstances of her care at the home and is particularly concerned to learn whether organisations, both statutory and independent, worked together to safeguard and protect Dorothy's welfare and that of other people who displayed needs and difficulties similar to those presented by Dorothy.

Please note there is no suggestion that the death of Dorothy, who was a resident of the care home, was from other than natural causes.

2. The SCR will focus on how lessons learned from this case will be acted upon within individual organisations and by Solihull Safeguarding Adults Board, and how identified actions can lead to better interagency work on safeguarding.
3. In addition to learning about this case the Safeguarding Adults Board also wishes to use this SCR to learn about how to conduct SCRs in the future.

**Terms of Reference**

4. The scope of the SCR will cover the period of time when Dorothy was a resident at the home with particular reference to the period between 1<sup>st</sup> June 2008 to Dorothy's discharge on 16<sup>th</sup> February 2009. This SCR will also include ongoing multi agency working after Dorothy's discharge from the home up to 23<sup>rd</sup> May 2009 in relation to this home.
5. This SCR will specifically examine:
  - i. Whether there are lessons to be learnt from the circumstances of this case about the way in which local professionals and agencies worked together to safeguard Dorothy.

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- ii. If there were ways agencies could have worked more effectively with regard to Dorothy to safeguard her and others.
- iii. Whether agencies could have communicated and shared information about Dorothy's circumstances more effectively and whether this case raises any general concerns about difficulties in information sharing and communication.
- iv. If there were legal routes that could have been taken by any of the agencies that would have impacted in relation to safeguarding of adults.
- v. If there were any policy gaps that impacted in this case or on the action taken by the home or agencies.
- vi. Whether there are any equality and diversity issues in relation to this case.
- vii. If there were any culture, status or reputation issues that impacted in this case.
- viii. If the commissioning and contracting process was robust and fit-for-purpose throughout the Safeguarding Adults process.

This SCR will also:

- ix. Make recommendations to improve inter-agency working and to better safeguard vulnerable adults, particularly where the regulator has awarded a service 0 star rating and where an individual develops a Grade 4 pressure sore.
  - x. Identify if there are any preventative strategies Solihull could adopt at an early stage to help services that are struggling or where concerns about a service are identified by professionals so as to reduce or eliminate Safeguarding incidents.
  - xi. As this is the first SCR conducted by Solihull under these procedures this review will test out whether Solihull's new SCR process and procedures are 'fit for purpose' and to make recommendations for improvement.
6. Information will be collated from the Individual Management Reports (IMRs) from the agencies listed in point 12 below and analysed by the Panel and Overview Report Author.
7. The SCR Panel will review and amend these Terms of Reference as required during the course of the SCR and agree any amendments with the Safeguarding Adults Board.



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**The Panel**

8. Solihull Safeguarding Adults Board has commissioned Mrs Shirley Williams as the independent author of the Overview Report and independent Chair of the SCR Panel.
9. Mrs Shirley Williams is independent of all agencies involved in this case.
10. The Panel will be made up of:  
  
Mrs Shirley Williams – Independent Chair  
Sue Walton – Safeguarding Adults Manager – Advisor  
Kathy McAteer – Solihull Care Trust Community Services  
DCI Garry Billing – West Midlands Police  
Margot Warner – Executive Nurse – Solihull Care Trust  
David Williams – Private & Voluntary Sector Care Services Rep  
Anne Hastings – Chief Executive – Age Concern Solihull  
Fiona Burton – HoEFT
11. The Panel reserves the right to invite a Vascular Disease expert to a Panel meeting if required or any other expert as identified during the process.

**Individual Management Reports**

12. The following agencies are invited to contribute to the SCR by submitting Individual Management Reports (IMRs):
  - The Home
  - Solihull Care Trust – Integrated Care Team South – to include adult social care, district nursing and tissue viability nurse involvement
  - Care Quality Commission
  - West Midlands Police
  - Solihull Care Trust – Commissioning and Care Contracts involvement
  - Dorothy's GP – Dr Stuart – Blythe Practice, Knowle
13. The IMRs should be carried out by someone who was not directly concerned with Dorothy or her family, or the immediate line manager of the practitioner/s involved. Where this creates difficulties, particularly for smaller organisations, they should make this clear in their IMR and document their efforts to provide some independence into the process.
14. The IMRs should be completed in the format provided.

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15. All IMRs must include a full chronology of significant events in the format provided.
16. Dorothy's family will be informed of this SCR by the Independent Chair – Mrs Shirley Williams with support from an officer from Age Concern Solihull. Dorothy's family will be invited to share their views via Shirley Williams and Age Concern Solihull.

**Timetable**

17. The Home – will be invited to produce an Individual Management Report to reflect their involvement with Dorothy in brief from her admission to the home to 1<sup>st</sup> June 2008 and in detail from 1<sup>st</sup> June 2008 until her discharge on 16<sup>th</sup> February 2009.
18. All other agencies will be invited to produce IMRs to reflect their agency's involvement in detail with Dorothy from 1<sup>st</sup> June 2008 – 16<sup>th</sup> February 2009 and with the home thereafter up to 23<sup>rd</sup> May 2009.
19. Where any of these agencies have had involvement with Dorothy prior to 1<sup>st</sup> June 2008 a summarised history of any relevant involvement, if records are available, should also be provided in the chronology.
20. All IMRs must be submitted to the Safeguarding Adults Manager electronically by: 18<sup>th</sup> September 2009.
21. All agencies submitting an IMR will have the opportunity to present their findings to The Panel on 8<sup>th</sup> October 2009.
22. The Panel will, having considered the IMR's and taking account of the agencies presentations agree the SCR outcomes on 22<sup>nd</sup> October 2009.
23. The final Draft Overview Report will be available for all agencies to comment on inaccuracies week commencing 9<sup>th</sup> November 2009. All agencies will have 7 days to notify of any inaccuracies or concerns.
24. The Final Overview Report will be circulated to all Safeguarding Adults Board Members week Commencing 16<sup>th</sup> November 2009. Dorothy's family will also be notified of the key findings.
25. An extraordinary Safeguarding Adults Board meeting will be convened on 24<sup>th</sup> November 2009 for the Overview Report to be presented by the independent chair and author, for the Board to discuss and for commitment to implementing the reports recommendations to be agreed.
26. Once the report has been presented to the Safeguarding Adults Board:

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- All agencies involved with the SCR will debrief their staff
- A face to face meeting with the home will be offered
- The Communication plan will be initiated
- An executive summary will be produced
- The report will be presented at the Care Trust Board and the Council
- The action plan will be monitored by the Safeguarding Adults Board until it is completed.

**Communications plan**

27. All public or media enquiries will be managed by the Care Trusts Communications team. All agencies, statutory, voluntary and independent, should re-direct any enquiries to the Care Trusts Communications Team. An Executive Summary of this SCR will be published on the Care Trusts website.
28. The action plan will identify how all agencies should report the SCR through their respective governance routes.

**Other issues**

29. **Parallel Investigations**  
There are no parallel investigations that will impact on this SCR such as independent health investigations, multi disciplinary suicide reviews, a homicide review or a prison and probation ombudsman investigation or a Coroner's Inquest, criminal investigation or proceedings related to this case or complaint investigation.
30. **Legal Advice**  
The Safeguarding Adults Board and The Panel will take legal advice where it is required.
31. **General Advice**  
General advice on Solihull's Serious Case Review procedure will be available from the Safeguarding Adults Manager.
32. **Other Local Authorities**  
At the time of agreeing these Terms of Reference there are no other Safeguarding Adults Boards with an interest in the case that this SCR is based on; therefore no formal notification to other Boards will be required.

However The Panel will keep this decision under review and will notify other Safeguarding Adults Boards of this SCR if it becomes evident they have an interest in this review.

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*These terms of reference have been agreed by Solihull Safeguarding Adult Serious Case Review Panel, the Chief Executive of the Care Trust and the Interim Director of Adult Social Services and Chair of the Safeguarding Adults Board.*