STOCKPORT SAFEGUARDING ADULT BOARD

SAFEGUARDING ADULT REVIEW CONCERNING

'Ann'

OVERVIEW REPORT FOR PRESENTATION TO SSAB MEETING

20 September 2018

Independent Chair and Author Paul Cheeseman

Supported by Ged McManus

CONTENTS

1. INTRODUCTION

The Overview Authors and Panel Members would like to express their sincere condolences to Ann's family and friends on her tragic death.

1.1 This review is about Ann[1]. She died on 29 September 2017 in Stepping Hill Hospital, Stockport aged 77 years. She had been admitted there on 22 September 2017 from Chester House Care Home where Ann had lived for the past 15 years. The cause of her death was:

1a Sepsis

1b Left sided empyema and purulent pericarditis

1c Left sided bronchopneumonia

and could have been underlying for a long period of time. HM Coroner has determined that an inquest[2] will be held into her death.

1.2 Ann had a diagnosis of Chronic Schizophrenia. She suffered from several issues, including self-neglect, which was linked to her mental ill health. Ann had fixed ideas and delusional beliefs, and her symptoms related to this included paranoia around drinking water being poisoned.

1.3 In 2016, Ann spent periods of time away from Chester House and was compulsorily detained in a hospital under the Mental Health Act 1983. This occurred because Ann refused to take anti-psychotic medication. She had also been known to refuse other treatments.

1.4 Ann had daily rituals that included sprinkling urine around the room and over herself as she believed it acted as a protective measure. In the last few months of her life her level of self-neglect increased, and she started to smear faeces around the walls of her room. In the week prior to Ann's death, she had stopped leaving her room, and engaging with support around food and drink intake.

1.5 Ann was admitted to hospital after a member of staff from Chester House found her collapsed in her room there. North West Ambulance Service (NWAS), who attended the call to Chester House and conveyed Ann to Stepping Hill Hospital, submitted a safeguarding alert. They reported that she had faeces on her legs and they were concerned about the appropriateness of her placement. Stepping Hill Hospital also raised a safeguarding alert concerning Ann.

[1] The name Ann is a pseudonym (see paragraph 2.10.1)
[2] At the time this report was drafted HM Coroner had fixed the inquest date as 17 September 2018.

1.6 These alerts were considered by Stockport Safeguarding Adults Board who, in line with their statutory obligations[3], arranged for a review of the case and commissioned this report.

2. ESTABLISHING THE ADULT SAFEGUARDING REVIEW

2.1 Decision Making

2.1.1 The Care Act 2014[4] gave new responsibilities to local authorities and Safeguarding Adult Boards [SAB]. Section 44 of that Act[5] requires SAB's to arrange for a review of a case when certain criteria are met. These criteria appear in Appendix A.

2.1.2 On 29 November 2017, Stockport Safeguarding Adult Review Panel screened Ann's case and recommended to the chair of the Stockport Safeguarding Adult Board that the criteria had been met and that a Safeguarding Adult Review [SAR] should be undertaken. The Chair of Stockport Safeguarding Adult Board [SSAB] agreed and arrangements were made to appoint an independent chair.

2.2 Safeguarding Adult Review Panel

2.2.1 Paul Cheeseman was appointed as the Independent Chair and author on 27 December 2017. He is an independent practitioner who has experience of chairing and writing multi-agency reviews. He has never been employed by any of the agencies involved with this adult serious case review and was judged to have the necessary experience and skills. He was supported in the task by Ged McManus also an independent practitioner who brings the same experience.

2.2.2 The first of three panel meetings were held on 2 March 2018. The panel established key lines of enquiry and asked agencies for a chronology of contacts. These were discussed at subsequent meetings at which the learning was refined, and recommendations developed. Attendance at the meetings was good and all members freely contributed to the analysis, thereby ensuring the issues were considered from several perspectives and disciplines. Between meetings, additional work was undertaken via e-mail and telephone.

2.3 Panel Membership

2.2.3 The panel comprised of representatives from agencies involved in the care of Ann and the investigation of the safeguarding alert. A full list of panel members is provided at Appendix B.

2.4 Information provided to the Review

[3] S44 Care Act 2014-see section 2.1 post
[4] Enacted 1st April 2015
[5] The specific requirements placed upon a Safeguarding Board by S44 of the Care Act 2014 are set out in Appendix A.

2.4.1 The following table sets out which agencies provided written material to the review panel.

Agency	IMR	Chronology	Short Report
Pennine Care NHS Foundation Trust (PCFT)	✓		
Stockport NHS Foundation Trust	✓		
Chester House Residential Care Home		✓	
NHS Stockport Clinical Commissioning Group	✓		
Stockport Metropolitan Borough Council Adult Social Care	✓		

2.4.2 The following people were seen by the SAR Chair;

- Current owner and a registered provider at Chester House
- Acting Manager Chester House
- Assistant Manager Chester House
- Ann's sister and daughter

2.4.3 The care plan records relating to Ann are retained by HM Coroner in connection with an inquest into her death. The acting manager gave consent for the SAR panel to view these records. The SAR asked HM Coroner for permission to inspect the documents at her office in Stockport. The SAR Chair visited there on 11 June 2018 and inspected the documents.

2.5 Practitioner Focus Group

2.5.1 As part of the SAR, the Stockport Safeguarding team arranged a focus group for practitioners who had been involved in Ann's care to attend. This event took place on 27 April 2018. It was attended by eleven practitioners who

were involved in Ann's care including Community Psychiatric Nurses (CPNs), nurses, and staff from Chester House, a Consultant Psychiatrist and a GP.

2.5.2 The SAR is very grateful to the staff that attended. They contributed in an open and inclusive manner and one that demonstrated an understanding of reflective learning. The practitioner group identified several learning points, which are included within section 6 of this report.

2.6 Purpose of a Safeguarding Adult Review

2.6.1 Section 44 (5) of the Care Act 2014 specifies:

Each member of the Safeguarding Adult Board must co-operate in and contribute to the carrying out of a review under this section with a view to—

(a) Identifying the lessons to be learnt from the adult's case, and

(b) Applying those lessons to future cases.

2.6.2 SSAB added the following requirement:

'The review will focus on identifying how partner agencies could have worked together more effectively to prevent harm or abuse occurring. The emphasis should be on learning lessons from SAR and not to apportioning blame'.

2.6.3 The SAR was undertaken from that perspective.

2.7 Terms of Reference

2.7.1 Stockport Safeguarding Adult Review Panel identified the following focus, purpose and key line of enquiry. The analysis of these lines will be addressed in Section 5 of the report.

Focus

'The focus of the review is the extent to which professionals had sufficient information and understanding of the concerns about the potential for self-harm and injury and the nature and implications of Ann's needs'.

Purpose

'The review's purpose is to identify what learning and improvement is required in how services in contact with Ann provide effective help to adults who are vulnerable to self-neglect and have complex mental health needs'.

Key Lines of Enquiry

The review will identify in particular:

1. Understanding of neglect / self-neglect;
2. The normalisation of behaviour that could not be considered to be normal;
3. Lack of referral to safeguarding in the months prior to the death;
4. Understanding of capacity – with particular attention to the fact that Ann was not deemed to have capacity to choose to take her mental ill Health medication, but was deemed to have capacity to refuse medical treatment;
5. Consideration of physical health in mental health patients;
6. Interaction between mental health and physical health services;
7. Process of escalation when individual agencies need support from other agencies.

2.8 Period under Review

2.8.1 3 September 2015 to 29 September 2017.

2.9 Other Processes

2.9.1 Greater Manchester Police attended at Chester House after Ann's death. They completed an investigation and concluded there was no evidence of wilful neglect or ill treatment[6] in respect of Ann's care.

2.9.2 Following the post mortem, HM Coroner decided it was necessary to hold an inquest. A provisional date for this has been identified as 17 September 2018.

2.9.3 In view of the fact that a Safeguarding Adult Review (SAR) was commissioned, a decision was made that the S42[7] safeguarding investigation should cease as the SAR would now cover this remit.

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[6] It is an offence under S20 of the Criminal Justice and Courts Act 2015 for an individual who has the care of another individual by virtue of being a care worker to ill-treat or wilfully to neglect that individual.

[7] S42 of the Care Act 2014 applies where a local authority has reasonable cause to suspect that an adult in its area (whether or not ordinarily resident there)—
(a)has needs for care and support (whether or not the authority is meeting any of those needs),
(b)is experiencing, or is at risk of, abuse or neglect, and
(c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it.
The local authority must make (or cause to be made) whatever enquiries it thinks necessary to enable it to decide whether any action should be taken in the adult's case (whether under this Part or otherwise) and, if so, what and by whom.

2.9.4 The Care Quality Commission (CQC) made an unannounced visit to Chester House during August 2016. They carried out an inspection of the home over a four-day period. They identified multiple regulatory breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014, which related to medication administration, safeguarding service users from abuse and improper treatment, fit and proper persons employed, safe care and treatment, staffing, person-centred care, dignity and respect and good governance. They concluded the overall rating for the service provided by Chester House was 'Inadequate' and placed Chester House in 'Special Measures'.

2.9.5 CQC made a further unannounced visit to Chester House in February 2017. They carried out an inspection, which found that significant improvements had been made and all the regulatory breaches identified at the last inspection had been met. Chester House is now rated by CQC as 'Good'.

2.9.6 Where there are matters from the CQC reports that relate to aspects of Ann's care during the review period these are included within the analysis section of this report (section 5) and an appropriated cross reference is made to the CQC inspection report.

2.10 Family's Comments

2.10.1 The family of Ann met with the Chair of the SAR and a colleague. They selected the pseudonym Ann, which is used throughout this report. Their contribution appears within section 3 of this report.

2.10.2 When the panel had completed its work on the report, the Chair of the SAR wrote to the family of Ann and also spoke to them by telephone inviting them to consider and comment upon the report, a copy of which was sent to them by post. To date the family have not responded with any comments. Should the family wish to raise any concerns or questions in the future the SAR Chair will be very willing to answer them.

3. BACKGROUND

3.1 Ann-Family Perspective

3.1.1 Ann's family told the review that Ann was born and raised in the Manchester area and came from a family of four girls. She married and had a daughter and son. Not long after her son was born, Ann started to experience mental health problems and suffered from post-natal depression. Her family said it went undetected at first and Ann started to do strange things.

3.1.2 Her family said Ann's marriage broke down and she moved around to different places. She worked for a period as a waitress and liked engaging with customers although she had quite a lonely life away from work. Her family says she was a very private person.

3.1.3 Ann lived for a time in Blackpool and in the Whalley Range area of Manchester. However, she became quite poorly and went back home to live with her parents. Ann seemed to do quite well from that point and attended a 'day-centre' in the Edgeley area of Manchester. When her parents died, she continued to live on her own and was able to look after herself.

3.1.4 Eventually, her family say that Ann's mental health deteriorated. They believe she has always had capacity to make decisions and described her as being a 'savvy' person. Ann moved into residential care and eventually to Chester House around 2000. Because Ann did not always welcome visitors, particularly to her room, her family-maintained contact with her mainly by telephone with some occasional visits to Chester House.

3.1.5 Ann's family say that became her home and she was very happy there. They say her favourite time was Christmas. Ann lacked self-confidence although she was an able person, self-aware and someone who liked to dress and look smart. They say that for many years at the home Ann was responsible for her own decision making. She would go shopping and was quite independent. Her family says that, despite her mental health problems, Ann was an intelligent person.

3.1.6 Under the previous management arrangements at Chester House, Ann's family say she could come and go and make her own drinks in the kitchen. They say Ann did not like people visiting her room and she would always see them in the conservatory at Chester House. They say Ann had a very good relationship with the previous manager of the home who had been there for some years.

3.1.7 Ann's family say they noticed a change in Ann. She started to spend time in her room and would not go and speak to people. They feel that things changed for Ann when the management of the home changed. Ann's family feel that some of Ann's rights were restricted. They felt that Ann was treated as though she was stupid when, in fact, she was intelligent.

3.1.8 They gave an example and said that Ann's cigarettes were taken from her and the home tried to stop her from smoking. The family said that Ann lived for a cigarette and a cup of tea and this restriction had a big impact upon

her. After the previous manager left, her family say that Ann could not 'brew up'.

3.1.9 Finally, the family raised a concern with the SAR Chair about Ann's cause of death from Sepsis. They believe that someone should have recognised that she was suffering from it. The views of Ann's family are explored in detail within Section 5 (Analysis) of this report.

3.2 Chester House

3.2.1 Chester House Care Home is a residential home located in the Hazel Grove area of Stockport. It can provide care for up to fourteen adults with a range of needs. Within the 'specialisms' section of the home's listing on the CQC web-site[8], Chester House is described as;

'Accommodation for persons who require nursing or personal care, Dementia, Caring for adults over 65 yrs.'

3.2.2 Chester House is owned by a husband and wife who are described as the 'registered providers[9]'. They are both currently registered nurses and their registration details are recorded by the Nursing and Midwifery Council. The CQC carried out an inspection of Chester House in August 2016. The inspection resulted in the service provided by Chester House being rated as 'Inadequate'. This meant the service was placed in 'special measures.' At that inspection the CQC identified multiple regulatory breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014, which related to medication administration, safeguarding service users from abuse and improper treatment, fit and proper person's employed, safe care and treatment, staffing, person-centred care, dignity and respect and good governance.

3.2.3 Although Chester House was still Ann's home at the time of this inspection, she was not present while the CQC inspection took place. This was because she had been compulsorily detained in hospital (see paragraph 4.2.4 et al). While the SAR panel understands none of the CQC inspection specifically concerned the care of Ann, the SAR panel refer to it as it did impact upon the arrangements for the management of the home.

3.2.4 Following the CQC inspection, the registered manager left the service at Chester House on 20 December 2016. From that point onwards, Chester House has been managed by the two registered providers and an acting manager who is a qualified doctor.

3.2.5 A further inspection of Chester House took place in February 2017 following which the home received a rating of 'good'. During the period of that inspection, Ann was resident and would have been present at Chester

[8] http://www.cqc.org.uk/location/1-134138345?referer=widget3#accordion-1
[9] See Appendix C for a description of the meaning of registered provider.

House. The most recent CQC report[10] following that inspection says about Chester House:

'Accommodation is provided on three floors, accessible by two stair lifts. There are twelve single bedrooms and two bedrooms that have the capacity to be used as shared rooms. However, at the time of this inspection the rooms occupied were all single occupancy. At the time of our inspection, there were eleven people living in the home. No en-suite facilities are available. The home has a lounge/dining room and a conservatory which is currently used as a smoking area as well as an outside garden to the rear of the property'.

3.2.6 The SAR Chair visited Chester House on 24 April 2018. As part of the visit, he met with one of the owners who is a registered provider, the acting manager[11] and the assistant manager. They helpfully provided important background information about the running of the home, which is included within section 4 and section 5 of this report and acknowledged appropriately. During this visit, the owner allowed the SAR Chair to visit the room that had been occupied by Ann while she was a resident there.

[10] http://www.cqc.org.uk/sites/default/files/new_reports/INS2-3071996428.pdf
[11] The Acting Manager is also a junior doctor (Senior House Officer-SHO) in the 2nd post-graduate year of training.

4. TIMELINE OF SIGNIFICANT EVENTS

4.1 Introduction

4.1.1 The following sub-sections set out the significant events prior to Ann's death. The source of the information is from records held by: Chester House Residential Care Home, Ann's GP, Pennine Care NHS Foundation Trust, Stockport NHS Foundation Trust and Stockport Metropolitan Borough Council Adult Social Care.

4.1.2 The history of Ann's residency in Chester House and her engagement with services is divided into five key practice episodes. Each episode is summarised, and the significant events set out in a table. The events are listed without commentary, which appears in section 5 of the report.

4.2 Key Practice Episodes[12]

Period One: 3 September 2015 to 3 August 2016

4.2.1 Ann took up residence at Chester House in 2002, and by period one had been there for around 13 years. She occupied a bedroom on the lower ground floor of the home. The room had a sink and Ann had the shared use of a bathroom and lavatory. Ann was ambulant, able to walk up and down stairs and dress unaided.

4.2.2 During this practice episode, it appears that Ann's behaviour would vary. On occasions, she would be compliant and then had periods when she would not eat and would shout at residents and staff. There were regular visits by community psychiatric nurses (CPN)[13] to the home and conversations with them by telephone.

4.2.3 During the latter part of this period, Ann increasingly refused to accept depot medication or the alternative of oral medication. A shadow was detected on her lung after a chest x-ray. Ann refused to have a follow up scan. She started to defecate in her bedroom. At the end of Period One, a decision was made to admit Ann to hospital.

[12] There are over 250 entries in the records for Ann. Only those records that are of most relevance (i.e. a specific event or a change in behaviour are listed). So, for example, Ann frequently left the home to go shopping and always returned safely, therefore not all these events are recorded.

[13] CPNs work outside hospitals and visit clients in their own homes, out-patient departments or GP surgeries. They can help to talk through problems and give practical advice and support. They can also give medicines and keep an eye on their effects.

TIMELINE OF SIGNIFICANT EVENTS

Date	Events
03.09.15	Ann was seen by CPN1 and the Consultant Psychiatrist. No significant change. Ann was hostile and irritable on occasions, and reluctant to cooperate with personal hygiene. She refused depot medication.
16.9.15	The registered manager of Chester House told CPN1, by telephone, that Ann had been refusing food for the past two days although she had accepted some drinks.
06.10.15	Ann was seen by CPN1. She was now eating and drinking. She declined to open her bedroom door to CPN1.
04.02.16	Ann's behaviour changed. She had become suspicious and was reported to be shouting at other residents.
09.02.16	CPN1 visited Ann. She was shouting 'go away'. Staff at Chester House said her behaviour had changed. However, they felt able to manage her care at this stage.
11.01.16	The Quality Assurance Officer (QAO)[14] visited Chester House and noticed a malodour. They discussed this with the registered manager. He said he suspected the source may be a particular resident and he would endeavour to resolve it.
15.03.16	Ann visited the shops and bought some pork chops, as she would often only eat food she bought personally.
16.03.16	The manager reported, by telephone, to CPN1 that Ann was unusually chatty and pleasant. However, she refused to see the GP.
23.03.16	Ann went out and came back by taxi. She regularly went out to the local shops and came back safely.
18.04.16	Ann was seen by CPN1 and was pleasant, chatty and friendly. She was slightly dishevelled, and there was a smell of urine from her room.
31.05.16	CPN1 was told by Chester House that Ann had stopped eating and drinking for a few days although she had now resumed.
17.06.16	CPN2 was told by Chester House that Ann had not eaten properly for 2-3 days, she was spending much time in her bedroom and neglecting her personal hygiene. She had noticeable weight loss and was refusing to see the GP. Advice was given regarding food and a fluid chart. CPN2 discussed Ann's case with a psychiatrist at the Meadows.
22.06.16	CPN1 visited Chester House. The manager was concerned about a change in Ann's behaviour over the last two weeks as her diet and fluid intakes remained a concern. Ann agreed

[14] The adult social care Quality team monitors, maintains and improves the quality of social care commissioned in Stockport.

	to see the GP and have her bloods taken. Ann reported hearing voices and was said to be uncooperative. She defecated and urinated on the floor.
23.06.16	Ann was discussed in a multi-disciplinary meeting (MDT) at the Meadows.
30.06.16	CPN1 visited Ann who refused to speak to her. Ann was seen by the GP and had a chest X-ray.
14.07.16	Ann was visited by a GP to discuss the results of her chest x-ray. She refused to see the doctor. She had an aggressive outburst shouting at staff 'stay out of my room'.
15.07.16	Ann was reviewed by her doctor and CPN1 from the Meadows. She was increasingly paranoid. She refused depot medication and blood tests. Ann said she would take oral medication. The chest x-ray disclosed a shadow and Ann refused a scan. As part of the review Ann's sister was contacted and said that Ann had been very happy at Chester House.
20.07.16	Chester House informed CPN1 that Ann had been refusing medication since 18.07.16.
21.07.16	An MDT was held at the Meadows and a decision made to admit Ann to Davenport Ward when a bed was available.
26.07.16	CPN1 visited Chester House. Ann refused to speak to her. She was still refusing to take oral medication. She required admission to hospital under the Mental Health Act 1983[15]. Chester House advised that they could manage Ann while this happened.
3.08.16	Ann was compulsorily admitted to Davenport Ward under S3 of the Mental Health Act 1983.

Period Two: 3 August to 12 October 2016

Summary

4.2.4 During this period, Ann was admitted to Davenport Ward at the Meadows Hospital in Stockport. This admission was compulsory and took place under S3 of the Mental Health Act 1983. While there, depot medication was administered, and Ann was kept under observation. She was given antibiotics for a chest infection.

4.2.5 During this period, the Care Quality Commission (CQC) carried out an inspection of Chester House. Because of lapses, it was placed in 'Special Measures' and Chester House agreed to voluntarily suspend the admission of placements. While she was away from Chester House, arrangements were

[15] See Appendix E which sets out in detail the arrangements that must be made so that a patient may be compulsorily detained under the Mental Health Act.

made to clean her room there and replace furniture. At the end of Period Two Ann returned to Chester House.

TIMELINE OF SIGNIFICANT EVENTS

Date	Events
10.08.16	Ann's case was transferred from CPN 1 to CPN2.
11.08.16 To 26.08.16	CQC notified Stockport ASC that their inspection of Chester House had been completed. Discussions took place during this period between ASC and CQC regarding the gaps that have been found. During August Bank Holiday the REACH[16] team was sent to support Chester House. (N.B. The REACH team would not normally provide this service in a care home, but it was tried in order to find a way of offering some support)
30.08.16	Ann was seen on a ward round at the hospital. She had had two depot injections. She was prescribed antibiotics for her chest infection. Ann smelled malodorous. She had two showers in the 27 days she was in hospital. She said she wanted to return to Chester House.
1.09.16	CPN2 contacted Chester House. They said they were happy to have Ann back there. Her bedroom was being cleaned and the furniture replaced.
9.09.16	Ann was referred for a chest x-ray/scan and was reluctant to go.
15.09.16	Ann was discussed at an MDT. The manager of Chester House asked CPN2 if they should consider DOLS[17] being put in place due to them trying to implement good hygiene. The MDT discussed this and determined it was not appropriate as Ann remained on S17 (1) Leave.
26.09.16	A meeting took place on Davenport Ward attended by the manager of Chester House, CPN2, Ann's Consultant and Ann. She was described as slightly unkempt and with a slight odour of not washing. She had reduced her smoking, from 40-60 cigarettes each day to 10-15. Discussions took place as to whether the restriction on cigarettes should continue at Chester House.
12.10.16	Ann returned to Chester House on two weeks leave from Davenport Ward.

Period Three: 12 October to 18 November 2016

[16]The REaCH [Reablement and Community Home Support] Neighbourhood Team offer short term support free of charge for people who need help to regain their confidence and independence

[17] Deprivation of Liberty Safeguards (DOLS) see Appendix F

Summary

4.2.6 During this period Ann returned to Chester House. Initially she seemed to settle in well, however there were still concerns about the maintenance of her personal hygiene. Ann consistently refused to accept the depot medication and eventually she was compulsorily returned to Davenport ward where she remained for treatment for the next month.

TIMELINE OF SIGNIFICANT EVENTS

Date	Events
12.10.16	Ann returned from Davenport Ward to Chester House. The same day she went to the shops and came back safely[18].
13.10.16	CPN3 received a telephone call from Chester House to say that Ann had settled back well. She was eating and sleeping OK although the home was having difficulty trying to maintain her personal hygiene. She had gone back to her old routine.
21.10.16	CPN3 visited Chester House. Ann would not engage and refused to accept the depot medication. CPN3 discussed the case with Ann's Consultant. Ann would be escorted back to Davenport Ward by the Home Intervention Team to receive the injection.
25.10.16	Ann received the depot medication on Davenport Ward and then was returned to Chester House.
8.11.16	Ann was seen by CPN3. She refused the depot medication. A plan was made for the Chester House manager to escort her back to Davenport Ward.
10.11.16	The plan to escort Ann back to the ward failed.
11.11.16	CPN3 and a ward sister from Davenport Ward attended Chester House. Ann refused the depot medication. She was told she would be returned against her will. The manager advised that Ann was eating and drinking well and was warm towards staff.
18.11.16	Ann refused to return to Davenport ward. The police were called, and Ann eventually left of her own accord and was taken back to the ward by the Home Intervention Team with a police escort.

[18] There are several occasions during this period when Ann went shopping alone and returned safely. Each occasion is not listed separately in this timeline. While Ann was away staff usually took the opportunity to clean her room.

Period Four: 19 November 2016 to 22 September 2017

Summary

4.2.7 During this period Ann remained on Davenport ward and then returned to Chester House. Here she seemed to settle back in well. She consistently accepted the depot medication which was administered by one of several CPNs. She was felt to be capable of leaving Chester House alone so that she could visit shops and the bank and return safely at the end of these visits.

4.2.8 Concerns remained about Ann's personal hygiene. There were an increasing number of references, by Chester House, to Ann neglecting her own care and refusing attempts by staff to support her showering or bathing. Her behaviour towards staff seems to have become more confrontational and on two occasions she used force towards them. There were an increasing number of references to Ann defecating and urinating in her room. When Ann was out of her room smoking in the conservatory or shopping staff used the opportunity to enter and clean it.

4.2.9 Staff from Chester House raised their concerns about Ann's lack of cooperation in relation to her own personal care. In response the Home Intervention Team (HIT)[19] were deployed on one occasion to assist Ann. Chester House also raised concerns with the QAO as they say they did not feel supported. Before these concerns could be passed on to the CPN, Ann was found in a collapsed state in her bedroom.

TIMELINE OF SIGNIFICANT EVENTS

Date	Events
19.11.16	Ann was a patient resident on Davenport Ward until 19 December.
15.12.16	The registered manager of Chester House terminated their employment and new management was put in place
19.12.16	Ann returned to Chester House. She was very pleasant to staff and was using words such as 'please' and 'thank you'.
20.12.16	CPN 3 visited and Ann who accepted her depot medication. Her mental health was reported to have improved.
20.12.16	Ann went shopping in Stockport and returned safely to Chester House. During December and January, she continued to regularly visit the shops. She spent most of her time in the conservatory smoking and the rest of her time in her room. Staff continued to use these opportunities to clean her room.

[19] The HIT team are provided by Pennine Care Older People's Mental Health Service.

3.01.17	CPN3 visited Ann. She accepted her depot medication. Staff reported she was doing well and had been out shopping.
14.01.17	While Ann was shopping staff entered her room to clean it and found urine and faeces on the floor.
17.1.17	Ann received depot medication and CPN4 took over responsibility for her case.
19.01.17	An MDT took place and the S3 requirement was rescinded.
25.01.17	Ann physically challenged a member of staff who tried to help her open a bottle of milk. She did not trust staff to give her food and drink and delusionary felt it was contaminated.
26.01.17	Ann tried to punch a member of staff who opened a door for her.
27.01.17	Ann was seen by a locum GP. She was feeling well and no concerns about her were raised. She declined an examination or a seasonal flu vaccination. She smoked 20-39 cigarettes a day and was given smoking cessation advice.
28.01.17	Staff entered Ann's room to clean it and found urine and faeces on the floor.
01.02.17	Ann received depot medication. She said she was happy at Chester House and had made friends with some residents.
03.02.17	A best interests assessor[20] reported concerns about the understanding of staff at Chester House regarding DOLS They said the home seemed 'chaotic'.
04.02.17	Staff reported a strong body odour from Ann. She refused assistance with her personal care. There are many references over the following months to Ann being offered and refusing personal hygiene care. Not all of these are repeated within this time line.
14.02.17	Ann was seen by CPN4. She was pleasant although quiet. CPN4 felt Ann sounded chesty. Staff reported no concerns.
28.02.17	CPN4 administered depot medication. Ann seemed clean and well kempt. She did not sound as chesty.
03.04.17	Until early April Ann continued to receive depot medication and appeared stable and no concerns were raised. On this date, staff from Chester House left a message for CPN4 saying Ann's diet had deteriorated, she seemed low and irritable with staff and residents. The staff were advised to check Ann's weight etc and the information would be discussed with Ann's Consultant.
12.04.17	CPN4 visited Ann and administered depot medication. Ann had been in conflict with another resident who she said was banging on the wall at night.

[20] The best interests assessor's role is not to authorise or scrutinise clinical decision-making in any way. It is to look at the conditions surrounding the provision of care or treatment and decide whether or not those conditions deprive the relevant person of their rights to liberty and security under Article 5 of the Human Rights Act 1998. Source: https://www.scie.org.uk

26.04.17	CPN4 visited and administered depot medication. Ann was pleasant and her mental and physical health appeared to be good. Her diet and fluid intake had improved.
10.05.17	CPN4 visited and administered depot medication. Ann appeared unkempt and sounded chesty with a cough. She did not want to talk about it.
24.05.17	CPN4 visited and administered depot medication. Ann was facially bright although CPN4 was concerned about her cough. Ann said she was not in pain and did not want to see the GP.
9.06.17	CPN5 took over the care of Ann and visited her. Chester House reported no problems.
23.06.17	CPN5 visited and administered depot medication. Ann was chatty, she said she felt well and had been out shopping and had fish and chips for lunch.
7.07.2017	CPN5 visited Ann and administered depot medication. She was in her room and CPN5 stated there was a noticeable bad smell downstairs where her room was located. Staff said Ann did not wash, refused showers and baths, urinated in cups and threw this around her room. Staff went into her room to clean it when she was absent having a cigarette. CPN5 discussed with staff a reward system to try and engage Ann.
21.07.17	CPN5 visited Ann and administered depot medication. Ann expressed some paranoid ideation and was still refusing assistance with personal care. CPN5 did not detect any body odour when administering the depot injection.
24.07.17	Chester House made a call to the duty social worker at Pennine Care. They said Ann was not accepting any assistance or prompts with her personal care and she had faeces on her legs. The social worker advised Chester House their concerns would be passed on to the CPN.
30.07.17	Chester House introduced a new policy that service users who wished to smoke should do so outside. Ann had been used to using the conservatory which was the designated smoking area and she refused to go outside to smoke. She told staff to go away and leave her alone.
3.08.17	CPN5 visited Ann and administered depot medication. Staff reported she was refusing showers, defecating in bags and smearing it on the wall. She was not engaging and had become abusive and threatened to pour boiling water over staff. Staff felt this was a safeguarding issue. Ann refused to converse with CPN5 who offered to make Ann a cup of tea. CPN5 advised staff to lock the kitchen to minimise cross infection. CPN5 also advised staff that HIT support workers should visit Chester House to assist with Ann's personal care.

7.08.17	A HIT support worker visited Chester House to assist Ann to shower. Because the boiler was broken this did not happen. The worker spoke to Ann about helping her to shower and gave her advice about personal hygiene. Ann said she did not want anyone touching her with dirty hands and the HIT worker agreed that protective gloves would be worn.
12.08.17	A HIT support worker visited Chester House. Ann agreed to have a shower, although would not allow the support worker to help her. Her clothes were very dirty and there was faeces and urine on the floor of her bedroom. Staff were advised to take the opportunity to clean Ann's room when she was not in.
14.08.17	Staff cleaned Ann's room while she was in it. She said, 'what do you think you are doing in my room'. There were two bags of rubbish which she refused to allow staff to remove. Her bedding was changed, and her shoes had faeces on them. Ann later removed the clean bedding and put it outside her room.
17.08.17	CPN5 visited Ann and administered depot medication. She was not as welcoming as before and would not answer questions. Ann smelt of faeces and had stains on her legs. CPN5 felt staff were reluctant to challenge Ann. CPN5 spoke by telephone to the manager of the home and suggested a plan regarding Ann's personal care should be drawn up and that staff should stick to it. CPN5 noted that a best interests meeting was to be convened and that deprivation of liberty (DOL) should be considered. CPN5 said they would discuss this with the consultant psychiatrist.
31.08.17	CPN2 visited Chester House to administer depot medication. Ann would not open her bedroom door and staff had to unlock it. CPN2 noted urine on the floor and that the room smelt offensive. Ann appeared clean and staff said she had washed and showered after much prompting. CPN2 gave staff two laminated cards which contained a plan for personal hygiene.
14.09.17	CPN6 visited Ann and administered depot medication. Ann initially refused this saying it caused her eye problems, this was a delusional belief. CPN6 noted a slight odour although there were no faeces on Ann's body.
15.09.17	The Quality Assurance Officer (QAO) from Adult Social Care visited Chester House. During a meeting with the assistant manager they raised issues with the QAO relating to Ann's smoking, personal care and hygiene. The QAO agreed to contact the CPN to discuss the issues as the assistant manager did not feel supported by the CPN. The QAO went on leave the next day and therefore did not have the

	opportunity to contact the CPN before Ann was admitted to hospital.

Period Five: 22 September 2017 to 29 September 2017

Summary

4.2.10 On 22 September 2017, Ann was found in a collapsed state in her bedroom at Chester House. An ambulance was called, and she was admitted to Stepping Hill Hospital. The crew from North West Ambulance Service (NWAS) were concerned about the conditions in which Ann was found and submitted a safeguarding alert. Stepping Hill Hospital also submitted a safeguarding alert. Ann was transferred to the Acute Medical Unit (AMU) in the hospital.

4.2.11 On admission to hospital a medical review disclosed that Ann had community acquired pneumonia, sepsis, acute kidney injury and rhabdomyolysis[21]. She received treatment for her condition and died in hospital on 29 September 2017. A post mortem determined the cause of her death was 1a Sepsis, 1b left sided empyema and purulent pericarditis, 1c left sided bronchopneumonia. HM Coroner's Officer referred Ann's death to Greater Manchester Police. They carried out enquiries and concluded there was no evidence that Chester House, their staff or any individual had wilfully mistreated or neglected Ann.

TIMELINE OF SIGNIFICANT EVENTS

Date	Time	Events
22.09.17	08.30	The Assistant Manager at Chester House asked Ann if she wanted a drink. Ann told her to go away and she spent the morning in her room.
22.09.17	09.45	The Assistant Manager checked on Ann and found she was lying on her bed.

[21] Rhabdomyolysis is a condition in which muscle cells break down and release a substance into the blood that can lead to kidney failure. Acute kidney injury (AKI) is a sudden episode of kidney failure or kidney damage that happens within a few hours or a few days. AKI causes a build-up of waste products in your blood and makes it hard for your kidneys to keep the right balance of fluid in your body. Sepsis is the body's overwhelming and life-threatening response to infection that can lead to tissue damage, organ failure, and death

22.09.17	11.45	A care assistant at Chester house noted that Ann was watching TV. She said she did not want anything to eat or drink and told the care assistant to go away.
22.09.17	14.05	The Assistant Manager found Ann on the floor of her room. She was not looking her usual self and was not responding to verbal instructions. Her vital signs were checked, and a 999-call made for an ambulance. Ann's bedding was smeared with faeces. Staff removed this and covered Ann with a clean blanket to maintain her body temperature.
22.09.17	14.18	An ambulance and staff from NWAS arrived at Chester House and attended to Ann. She was found to be hypoglycaemic with associated low blood pressure. She was cannulated and given fluids and glucose to increase her blood sugar. She was taken by ambulance to Stepping Hill Hospital. NWAS staff submitted a safeguarding alert to ASC later that day.
22.09.17	16.52	Ann was brought to the Emergency Department of the hospital where she was assessed and found to have left basal pneumonia, severe sepsis, acute chronic renal impairment and rhabdomyolysis.
22.09.17	23.07	Ann was transferred to the Acute Medical Unit[22].
25.09.17	09.17	Adult Social Care (ASC) received a safeguarding adults alert from NWAS. The alert had been raised at 17.32hrs on 22.09.17. In summary, the alert stated Ann had been found in her room, there was no bedding, no toiletries by the sink and few personal belongings in the room. There were flies in the room. Faeces were in the room and on Ann's legs. The NWAS crew felt that a review of her care was required as it may not be adequate or appropriate. A decision was made within ASC not to progress the alert to a referral and it was passed to the community mental health team.
25.09.17	15.35	ASC received a safeguarding adults referral from a staff nurse at Stepping Hill Hospital. The alert had been raised at 22.39 on 22.09.17. In summary the alert stated Ann had been found on the floor of the care home in very poor hygiene conditions, very smelly, with flies. She had very low blood pressure and redness from a pressure area from her time on the floor. The alert was progressed through to a

[22] There are many entries relating to Ann's care in Stepping Hill Hospital from this point onwards. They have not been included within this summary of significant events as they are not relevant to the terms of reference of this safeguarding review. The review panel are content that during this period Ann received the appropriate levels of medical care from Stepping Hill Hospital.

		referral which was assigned to the ASC safeguarding team.
29.09.17	14.35	Ann died at Stepping Hill Hospital

5. ANALYSIS AGAINST THE KEY LINES OF ENQUIRY

5.1 Introduction

5.1.1 Each key line is examined separately. Commentary is made using the material gathered during the SAR. This includes the family's views, discussions held by SAR members with individual practitioners, the views expressed during the practitioner event and the panel's own debates. Some of the material may fit in more than one key line of enquiry and, where this happens, a 'best fit' approach has been adopted to avoid duplication.

5.2 Key Line 1

Understanding of neglect / self-neglect.

5.2.1 The law in relation to the care of adults was changed by the Care Act 2014 ('The Act'). The Act replaced several different pieces of legislation and gave local authorities new functions to make sure that people who live in their areas;

- Receive services that prevent their care needs from becoming more serious, or delay the impact of their needs;
- Can get the information and advice they need to make good decisions about care and support;
- Have a range of provision of high quality, appropriate services to choose from.

5.2.2 Neglect is a form of abuse. There is no statutory definition of the term neglect. The Guidance gives some examples of acts or omissions that might comprise neglect. The SAR panel felt it was appropriate to use the interpretation used by Stockport Safeguarding Adults Board[23].

'Neglect is failing to provide an adequate standard of care. It may occur deliberately or by omission, and it includes:

- Failure to provide essential nutrition, clothing, medication and heating;
- Ignoring physical or medical care needs;
- Ignoring emotional care needs;
- Denying access to medical, psychiatric, psychological or social care;
- Failure to assess risk or to intervene to avert or reduce danger;
- Failure to access assessments or technical aids (e.g. hearing test/aids);
- Failure to access educational services;

[23]Page 15 Stockport Safeguarding Adults Board Safeguarding Adults at Risk. The Multi-Agency Policy (the 'Policy') for Safeguarding Adults at Risk & Multi Agency Operational Procedures for Responding to and Investigating Abuse. Fourth Edition – January 2016

- Failure to give privacy and dignity in delivery of care;
- Ignoring medical;
- Emotional or physical care needs;
- Failure to provide access to appropriate health, care and support or educational services;
- The withholding of the necessities of life, such as medication, adequate nutrition and heating'.

5.2.3 Factors that may indicate neglect include:

- Malnutrition, rapid or continuous weight loss, complaints of hunger or thirst;
- Dehydration;
- Poor personal hygiene;
- Untreated pressure sores;
- Indications of untreated medical problems;
- Signs of mal-administration of medication;
- Failure to provide hearing aids, mobility aids, glasses and dentures;
- Clothing and bedding dirty, wet, soiled, inadequate or inappropriate;
- Accommodation in poor state, inadequate heating or lighting;
- Failure to adhere to agreed care plans and risk assessments;
- Failure to ensure appropriate privacy and dignity
- A Person is exposed to unacceptable risk.

5.2.4 The Policy also includes specific reference to the issue of self-neglect;

'The term 'self-neglect' refers to an unwillingness or inability to care for oneself and/or one's environment. It encompasses a wide range of behaviours, including hoarding, living in squalor, and neglecting self-care and hygiene. Self-neglect is a difficult issue to address in practice, not least because people who self-neglect may not see that they are living with self-neglect. There are questions of personal choice and how to provide help and support to someone who may not want it. In addressing self-neglect under this policy and procedure the response must be proportionate to the risk of harm to the mentally capacitated individual'

5.2.5 Section 20 of the Criminal Justice and Courts Act 2015 (CJC Act) created the offences of ill-treatment or wilful neglect. It is an offence for an individual who has the care of another individual by virtue of being a care worker to ill-treat or wilfully to neglect that individual.

5.2.6 Immediately following the death of Ann, Greater Manchester Police (GMP) conducted an investigation. They found that at that time there was no evidence that the provider, the care home staff or any individual had wilfully mistreated or neglected Ann. A Detective Inspector from Greater Manchester Police has submitted a statement to HM Coroner outlining this finding, which will be considered when HM Coroner holds an inquest into Ann's death.[24]

[24] To be held on 2nd October 2018.

5.2.7 The scope of the work by GMP was the consideration of whether there was evidence of wilful mistreatment or neglect that might have fallen within the ambit of S20 of the CJC Act. There is no precise legal definition of the term wilful.

'Its meaning largely depends on the context in which it appears. It generally signifies a sense of the intentional as opposed to the inadvertent, the deliberate as opposed to the unplanned, and the voluntary as opposed to the compelled. After centuries of court cases, it has no single meaning, whether as an adjective (wilful) or an adverb (wilfully)'[25]

5.2.8 The SAR panel recognised that, while GMP found no evidence of wilful neglect, which did not exclude the possibility there may still have been neglect in the sense that it was inadvertent. The SAR panel therefore looked carefully at all the information that was available to it for evidence of inadvertent neglect and used the examples of neglect and factors provided within the Policy to frame their conclusions (see paragraph 5.2.2 and 3).

Findings in relation to Neglect

5.2.9 Ann's primary medical need related to her diagnosis of Chronic Schizophrenia. She was first admitted to a psychiatric ward in 1986. Many psychiatric hospital admissions followed until she was placed in residential care in 2000 and was transferred to Chester house in 2002. In February 2007, Ann was referred to Stockport Mental Health Liaison Service for Older People (henceforth referred to as the Older Peoples Service) at The Meadows[26]. She remained under their care until she died.

5.2.10 Throughout her engagement with the Older Peoples Service, Ann's care was managed under the Care Programme Approach[27] (CPA). Annual CPA Reviews were undertaken involving Chester House staff, Ann's CPN at the time, her Consultant Psychiatrist and her GP. Ann was invited to participate in these reviews although she would usually decline. Risk Assessments were updated during this process. If circumstances changed within this timeframe, a CPA Review could be held at any time.

5.2.11 The SAR review saw a significant number of entries in records provided to them by the Older People's Service, Chester House and Ann's GP practice relating to Ann's mental health needs. There is evidence within the records of regular visits by CPNs to Chester House to administer medication and of regular contact from Chester House to the Older People's Service seeking advice when there was a change in Ann's condition.

5.2.12 Ann was prescribed antipsychotic medication during the period of this review. She did not comply with a regime of oral administration of this

[25] https://legal-dictionary.thefreedictionary
[26] Stockport Mental Health Liaison Service for Older People is a service provided by Pennine Care NHS Foundation Trust. The Service is located at The Meadows Hospital in Stockport.
[27] The Care Programme Approach (CPA) is a package of care for people with mental health problems.

medicine and therefore she was prescribed a depot injection. The medicine she was prescribed was Fluphenazine Deconate (@Modecate) 100mg every 2 weeks. The medication is released slowly over this time[28]. CPNs visited Chester House every two weeks to administer this and monitor Ann's mental health. Her dietary intake and physical health presentation were also monitored at this time. Ann was never symptom free and her presentation fluctuated at times between being amenable and being paranoid and hostile. At times, she was floridly psychotic, and this manifested itself in delusional beliefs that became more entrenched

5.2.13 There were periods during when Ann refused to receive depot medication and this culminated in her compulsory admission to The Meadows in August 2016. The circumstances of this admission, and the decision making involved in, are discussed in more detail within section 5.4 of this report (post). The SAR panel concluded that Ann received regular and appropriate care in respect of her diagnosis of Chronic Schizophrenia. The SAR panel did not find any evidence to indicate that Ann's medical needs in respect of her diagnosis of Chronic Schizophrenia were inadvertently neglected.

5.2.14 Although Ann suffered from Chronic Schizophrenia, it appears to the SAR panel that she was for the most part in good physical health. She was ambulant, and capable of dressing unaided. While she was in residential care she was able to go out shopping, sometimes accompanied by a staff member and sometimes alone. She always returned to Chester House safely. Ann did not need the higher levels of support that other residents in residential care sometimes need.

5.2.15 Because of her diagnosis, Ann's emotional behaviour could fluctuate. She had always presented with delusional beliefs and her behaviour towards staff and other residents could fluctuate. On occasions records describe her as 'pleasant', 'bright' or 'chatty'. On other occasions, Ann would be withdrawn, and sometimes confrontational towards staff and other residents for no apparent reason. Staff from Chester House and the Older People's Service appeared to try hard to engage with Ann and respond to her emotional needs. The SAR panel recognise this was not easy to deal with and sometimes attempts to provide support such as helping to open a milk bottle, or a door, could be met with hostility.

5.2.16 Ann's main physical needs related to personal hygiene. The extent to which Ann self-neglected in respect of washing and showering will be discussed in more detail within paragraphs 5.2.24 et al. Because of her delusional beliefs, Ann refused to have her personal clothing washed. Instead, she would prefer to throw dirty underwear away and buy new ones. In later months, she stopped wearing underwear. Chester House staff washed her outer clothes when they could, however this caused Ann distress as she was

[28] Side effects are common and contribute significantly to non-adherence to therapy and tolerability to each drug varies between patients .There is no first line antipsychotic drug that is suitable for all patients .

convinced the water was contaminated. This distress manifested itself in abusive and threatening behaviour, both physical and verbal on occasions.

5.2.17 Ann was also very reluctant to allow staff to enter her room and would sometimes shout at them to get out. This made it difficult for staff to clean her room. They therefore used opportunities when Ann was absent, such as when she was smoking in the conservatory or had gone shopping. When this happened, they would enter her room, clean it and replace bedding. While Ann was an inpatient at The Meadows in September 2016, the management at Chester House had her room cleaned and replaced the furniture while she was absent.

5.2.18 Ann had been resident in Chester House for a long time. There was evidence from professionals and from Ann's family that she was happy there and regarded it as her home. In turn, staff members who spoke to the review expressed affection for Ann and regarded her as being very much a part of the family at Chester House.

5.2.19 There was ample evidence from the records seen during the review and from conversations with professionals that Chester House provided Ann with all the necessities of life she needed. Ann had a room on the lower ground floor of Chester House which, while basic, was adequate for her needs, and provided her with appropriate privacy and dignity.

5.2.20 Ann had fixed and delusional beliefs that meant she believed that food and drink she was provided with was contaminated in some way. Chester House has a kitchen and employs staff to prepare food. Because of her beliefs, Ann would sometimes go to the shops and purchase food herself (for example on 15 March 2016 she visited the shops and bought pork chops-see timeline of significant events period one). Because of this, Ann was also allowed to use the kitchen to prepare drinks because she did not trust others to make them, fearing they were contaminated.

5.2.21 There was evidence from within the records provided to the review that Ann would periodically stop eating and drinking. This was sometimes the trigger to her mental state relapsing, or as a direct response to feeling upset by something that had happened. There are several examples of this occurring throughout the review period. Ann's dietary and fluid intake, particularly in the immediate period before her death, is discussed in more detail within key line 4 in section 5.5 of this report.

5.2.22 The panel saw evidence that staff from Chester House recorded these changes in Ann's dietary habits. If Ann's behaviour continued in this way, then the records from both Chester House and the Older People's Service demonstrate that staff from the home always reported their concerns to the CPNs. The CPN would then monitor the situation and report to the Consultant Psychiatrist. For example, on 3 April 2017 staff from Chester House left a message for Ann's CPN stating her diet had deteriorated. They were advised to check her weight and the CPN said they would discuss the issue with Ann's Consultant (see timeline of significant events period four).

By 26 April 2017, Ann's mental and physical health had improved as had her diet and fluid intake.

5.2.23 The SAR felt that Ann was always provided with access to timely and appropriate medical, psychiatric, psychological and social care and there are extensive records to demonstrate this. The accommodation and services provided by Chester House met Ann's necessities of life[29]. She had her own room and was given privacy and dignity. When staff at the home identified factors that might have indicated neglect, such as Ann refusing food and drink, they responded in a timely and appropriate way. For example, trying to encourage her to eat or allowing her to make her own drinks and to go shopping for food herself. The SAR therefore concluded there is no evidence that any agency or individual neglected to provide Ann with an adequate standard of care.

Findings in relation to 'Self-Neglect'

5.2.24 Throughout the period of this review the SAR found abundant evidence that Ann self-neglected. There are many examples of this, which are discussed within this report and are set out within the timelines of the key practice episodes with section 4.2. Examples include Ann's reluctance and very often refusal to wash or shower; periods when she would not eat or drink; defecating and urinating in her room and refusing medical tests or interventions such as a scan.

5.2.25 The SAR recognised the advice from health professionals, that self-neglect can often be the result of mental illness. They felt it was clear that was the case with Ann. For example, her reluctance to wash and her unhygienic behaviour such as sprinkling her own urine around her room were very clearly linked to her delusional beliefs, which were a symptom of her Chronic Schizophrenia. Health professionals told the SAR panel that mental health causes of self-neglect can lead to an individual refusing offers of help from medical or social care services.

5.2.26 The SAR recognised that self-neglect is a complex and multi-faceted issue covering a broad spectrum of behaviours[30].

'Self-neglect is a difficult issue to address in practice, not least because people who self-neglect may not see that they are living with self-neglect. There are questions of personal choice and how to provide help and support to someone who may not want it. In addressing self-neglect under this

[29] Chester House was subject to inspections by the Care Quality Commission (CQC) and Stockport Adult Safeguarding and Quality Service (ASQS) team. The findings from their inspections about the quality of care provided by Chester House are set out within key line 3 (section 5.4) of this report.

[30] Page 15 Stockport Safeguarding Adults Board Safeguarding Adults at Risk. The Multi-Agency Policy (the 'Policy') for Safeguarding Adults at Risk & Multi Agency Operational Procedures for Responding to and Investigating Abuse. Fourth Edition – January 2016 Policy

policy and procedure the response must be proportionate to the risk of harm to the mentally capacitated individual'.

5.2.27 The SAR acknowledged this statement within the policy and considered whether the response of agencies and individuals was necessary and proportionate. The SAR felt a key issue was the extent to which Ann presented a risk to herself or others.

5.2.28 While many of Ann's behaviours might have been considered eccentric many of them did not present a risk to others. If they did, then the risk was relatively low, and it could be managed without the need for intrusive action or action that might be considered a breach of Ann's human rights.

5.2.29 So, for example, when Ann refused food and drink the response was one of escalation which included encouragement and then reports by Chester House to her CPN and then a doctor. Ann would not allow people into her room, which presented issues with cleaning. Again, the SAR recognised that Chester House adopted tactics such as waiting while Ann was away smoking to enter and clean her room rather than entering against her will and bringing about a confrontation. Allowing Ann to make her own drinks in the kitchen was an example of a proportionate response to her-self neglect which allowed Ann to maintain hydration.

5.2.30 It was only when Ann's behaviours escalated to a point at which they posed a risk to herself or others that alternative and more intrusive approaches were considered. For example, by July 2016, her mental health had declined significantly and to the point at which it was impacting upon her physical health[31]. At that point, Ann was admitted to The Meadows under Section 3 of the Mental Health Act.

5.2.31 The SAR felt that another appropriate response to Ann's behaviours concerned restricting her access to the kitchen. The family raised concerns about this, when they met the SAR chair, as they felt this was unnecessary. The SAR recognised the family's concerns, however, they felt the actions of Chester House were proportionate. It is clear her behaviour, defecating in her room and smearing it on the walls, was unhygienic. Restricting Ann's access to the kitchen was necessary to reduce the risk of spreading infection to other residents. It was proportionate in the sense there was evidence from the records that Ann was frequently offered hydration by staff members.

5.2.32 The SAR also considered Ann's smoking habits. Her family raised concerns about her access to cigarettes. Smoking is a significant health issue and is a known cause of poor health and death and for many years government and health professionals have engaged in work to tackle the problem. The SAR saw evidence, and heard from health professionals who attended the

[31] This issue and the response of agencies is discussed in more detail within key line at 4 section 5.5 post of this report.

practitioner event, that they had given advice to Ann about her smoking habits.

5.2.33 Ann did not wish to stop smoking although there is evidence that she reduced her smoking and, for a period, the interim manager at Chester House recalled that she stopped smoking. The SAR understand from conversations with the interim manager that the CQC raised issues about smoking. The conservatory at Chester House was a designated smoking area. Following discussions with the CQC, Chester House changed their policy and around August 2017, smoking was no longer allowed in the conservatory.

5.2.34 Ann refused to stop smoking in Chester House and this became an issue that was raised by Chester House with both CPN5 on 3 August 2017 and with the QAO on 15 September. The interim manager told the SAR they discussed Ann's smoking with the CQC and allowed her to continue smoking in the conservatory albeit this contravened the new policy[32]. The SAR felt this was an example of the flexibility that Chester House demonstrate when dealing with Ann's difficult behaviour. The panel did not find any evidence that Ann was denied access to cigarettes. Rather, there had been an attempt, in line with contemporary health policy, to try and encourage her to reduce or stop smoking.

5.2.35 In conclusion, the SAR saw evidence that Ann self-neglected in several ways. The SAR saw evidence that agencies and individuals responsible for Ann's care recognised the signs of her self-neglect. The SAR found that agencies responded in an appropriate way and adopted one of the five principles of the Mental Capacity Act 2005, that Adults at risk have the right to make decisions that others might regard as being unwise or eccentric. The SAR are satisfied that, in responding to Ann's self-neglect, agencies and individuals adopted approaches that were proportionate to the risk Ann presented to herself and others

5.3 Key Line 2

The normalisation of behaviour that could not be considered to be normal.

5.3.1 When Ann was transferred to the Older People's Service in 2007, an examination of her case notes indicated that her mental health had not changed significantly. Her delusional beliefs and behaviours regarding personal hygiene were reported consistently.

[32] Smoke free legislation covers the public areas of residential care homes and hospices. This means that sitting rooms, dining areas, reception areas, corridors and all other communal areas which are enclosed places and structures which are 'substantially enclosed' are legally required to be smoke free. However, management can designate a smoking room for residents (but not staff) if it wishes. A designated smoking room has to be fully enclosed by solid, floor to ceiling walls and meet the conditions outlined above. Staff are not allowed to smoke in a smoking room.

5.3.2 It was quite common for Ann to urinate in cups and then sprinkle this on doors, windows and frames. She did this in the delusional belief that it protected her. She also defecated into bags or smeared faeces onto the floor and walls while at Chester House. This behaviour was less common and only appeared to increase in frequency during the latter period of her residence at Chester House. There is no record that it ever occurred while Ann was a patient at The Meadows.

5.3.3 This behaviour could not be considered normal in any adult and would usually be cause for concern. However, it was clear to the SAR panel that Ann's behaviour was tolerated by Chester House staff and Mental Health Services: because this was Ann, and this was deemed to be normal for her, probably because it had been happening for so long.

5.3.4 The same registered manager had been in post at Chester House for many years. It appeared from what the SAR heard from practitioners and family that he developed a good understanding of Ann and sometimes accompanied her on her shopping trips. It appears that during his tenure Ann's behaviours were accepted. Staff appeared to tolerate what she did and developed strategies to work around her unusual behaviour such as waiting while she was out to enter and clean her room.

5.3.5 Ann was admitted to The Meadows on 3 August 2016, to receive her anti-psychotic medication. While she was a patient there, she expressed a wish to return to Chester House. CPN2 contacted the home and spoke to the manager. The manager said he was happy for her to return and, while she was absent, her room was being cleaned and furniture was being replaced.

5.3.6 Given the challenging behaviour that Ann displayed, and the steps that staff had to take to cope, the SAR panel felt that it might have been reasonable for Chester House to ask agencies to find an alternative placement for Ann. The SAR Chair discussed that option with the owner of the home and asked them whether they had considered it. He agreed it would have been easier to have taken that option, but was resolute that Chester House was Ann's home and that she should return as it was the fair and inclusive thing to do.

5.3.7 The SAR panel felt this approach demonstrated that Chester House, its owner and staff, felt that Ann was very much part of the 'family' there. As such, they were prepared to tolerate and make compromises for her behaviour. Health professionals and the SAR panel recognised that, if Ann was being considered for 24-hour care today, the behaviours she displayed would jeopardise her chances of a placement particularly in an elderly mentally impaired (EMI) residential setting.

5.3.8 It is clear Ann's behaviour was normalised by all involved in her care. They accepted this was the way she behaved. It seems the emphasis in Chester House, rather than being on trying to change Ann's behaviour, was upon trying to get her to accept her anti-psychotic medication. That ensured she could continue to keep her mental state and continue to reside where she wanted to be-at Chester House.

5.3.9 The SAR panel recognised that all involved with Ann's care, and particularly the staff at Chester House who had to deal with her eccentric behaviour, tried extremely hard to cope. They displayed high levels of tolerance, compassion and kindness. It was only after the long-standing manager left in December 2016, and an interim manager appointed that it was ever considered that Chester House may not be able to continue to meet Ann's needs. This only happened towards the last few weeks of Ann's residence there.

5.3.10 On 24 July 2017 staff at Chester House made a call to the duty practitioner in the Older People's Service. They told the social worker Ann would not accept assistance or prompts and that she had faeces on her legs. The social worker advised that the concerns would be passed to the CPN. On 3 August CPN5 visited Chester House.

5.3.11 A discussion took place concerning Ann's behaviour including a threat she had made to pour boiling water over staff. They felt this was a safeguarding issue. Until that time, Ann had been allowed to make her own drinks in the kitchen however, because of her poor hygiene there was concern that there might be cross-infection within the kitchen. CPN5 advised the staff to lock the kitchen to prevent the risk of this happening. CPN5 suggested a support worker from the Home Intervention Team should visit to assist with Ann's personal care.

5.3.12 The SAR panel felt the steps taken by Chester House on 24 July to escalate their concerns were reasonable. Ann's behaviour, while it had so far become 'normalised', was now starting to cause sufficient concern that the home felt the need for support. The advice from the social worker, to refer the matter to Ann's CPN was also reasonable, given this was not a medical emergency.

5.3.13 However, the SAR panel feel the period of ten days that elapsed between the call being made by Chester House and the visit by CPN5 was excessive. While there is no evidence the delay led to any harm coming to Anne, staff or other residents, there was the potential for harm. For example, the risk of cross-infection and the risk to staff from Ann's threat regarding boiling water. In addition, given how tolerant staff at the home had so far been of Ann's behaviour, the fact they felt the need to make a duty call should have led to earlier recognition that they needed support.

5.3.14 The Home Intervention Team (HIT) visited Chester House on 7 August, and again on 12 August. On the first occasion, they were not able to assist Ann to shower because the boiler was broken. On the second occasion, she reluctantly agreed to shower. The SAR panel recognised the delay in getting Ann to shower was unfortunate, although unavoidable, because of the broken boiler. It also seemed that the presence of external support seemed to spur Ann into complying, where Chester House staff were unsuccessful.

5.3.15 This was a point raised by professionals during the practitioner event. While recognising and applauding Chester House staff for the significant lengths they went to, some health care professionals felt they should have

challenged Ann's behaviour more. Staff from The Meadows said that, when Ann was a patient there, she did not display most of the unhygienic behaviour she engaged in at Chester House. She also always complied with her medicinal regime and never refused depot injections, which she frequently did in the home.

5.3.16 Reflecting upon their experience of Ann, staff from The Meadows felt that, while a patient there, Ann recognised that the key to her returning 'home' to Chester House was compliance. That recognition, had it been considered within a multi-agency meeting, might have led to a plan being developed to support Ann.

5.3.17 CPN5 returned to Chester House on 17 August 2017, five days after the last visit and five days since Ann's last shower. CPN5 noted that Ann smelt of faeces and that she had stains on her legs. The CPN also felt that staff were reluctant to challenge Ann and suggested they devise a plan for Ann's personal care, which they stuck to.

5.3.18 Following that visit, Ann's CPA was reviewed, and the risk assessment updated. The advice to keep the kitchen door locked was also reiterated. Those steps helped protect other residents from cross infection and staff from Ann's threat to pour hot water on them. The SAR panel felt that the assessment and plan was appropriate and proportionate.

5.3.19 CPN5 also recorded that a 'best interests'[33] meeting should be convened and that consideration of a Deprivation of Liberty (DOL)[34] should be put in place. The reasons for the 'best interests' meeting at this point was to discuss the risks and benefits of Ann remaining at Chester House. The SAR panel discussed this point and agreed that a 'best interests' assessment should not be arranged without a capacity assessment having first taken place. The panel questioned whether a presumption was made that Ann did not have capacity. If there was a belief that Ann did not have capacity, then her capacity should have been assessed and the findings recorded. That did not appear to have happened. Furthermore, the panel found that a DOLs assessment, which was also mentioned, also needed a capacity assessment to take place beforehand. That had not happened, and both these points were identified as gaps.

5.3.20 It was acknowledged that, at this point, Chester House staff were finding it difficult to care for Ann's personal hygiene issues and delusional beliefs. The notes recorded that CPN5 would discuss the issue with Ann's Consultant Psychiatrist. The SAR panel felt that discussing these issues with Ann's Psychiatrist was an appropriate step. However, a meeting was not convened to discuss Ann's case. The Older People's Service acknowledge that a discussion with the Consultant Psychiatrist should have taken place to review Ann's medication. The increase in Ann's anti-social behaviour may well have

[33] Mental Capacity Act 2005

[34] The issue in relation to the appropriateness of a DOLs is discussed within section 5.5 of this report.

been a sign that her mental health was relapsing. The reason those discussions did not happen appears to be because CPN5 was then absent on sick leave[35] immediately after this visit.

5.3.21 Because of this, CPN2 undertook the next visit to administer Ann's depot injection. CPN2 left two laminated cards with a plan for personal hygiene routine with staff: one for Ann to have in her bedroom and one for Chester House staff. Staff told CPN2 that Ann had showered and washed her hair independently after much prompting by them. There is no record that a discussion took place between CPN2 and staff at the home regarding the previous discussions with CPN5 and the planned 'best interests' meeting.

5.3.22 When CPN6 visited Ann on 14 September, they saw no evidence of faeces on her although they did note a slight odour. Staff from Chester House did not raise any concern and again there was no discussion about a 'best interests' meeting.

5.3.23 While Chester House staff did not raise the issue with CPN2 or CPN6, by the time the Quality Assurance Officer (QAO) visited on 15 September, it appears the staff were concerned enough to tell the QAO that they did not feel supported by the CPN. In response, the QAO agreed to contact the CPN to discuss the matter. That did not happen because the QAO went on leave the day after the visit and did not have an opportunity to contact the CPN.

5.3.24 The SAR panel recognise that the QAO may have considered the issues relating to Ann as long standing, and knew there had been ongoing engagement about them between Chester House and CPNs. Hence, it may have appeared there was no urgency to contact the CPN. The SAR feel it may also have been the case that Ann's behaviour had become 'normalised' hence reinforcing that lack of urgency.

5.3.25 The SAR panel understand the QAO has reflected on this and her practice would now be to raise such concerns as soon as possible, or to liaise with her line manager. The SAR feel it is important to stress there is no connection between Ann's death and Chester House's increasing difficulty in dealing with her unhygienic behaviour. However, it was clear there was now a point at which Chester House staff were struggling to cope. Key line 3 considers whether there should have been an earlier formal safeguarding referral.

5.3.26 Irrespective of that, the panel believe there were two missed opportunities on 17 August and 15 September for professionals from two different agencies to share information, which would have led to Chester House's concerns being escalated. Information sharing is a recurring theme in safeguarding and domestic homicide reviews and the SAR believe this case reinforces the need for that learning to be repeated.

[35]This was planned sick leave. The Pennine Care action plan at Appendix H recommends managers take responsibility for moving caseloads when there is planned sickness

5.4 Key Line 3

Lack of referral to safeguarding in the months prior to the death;

5.4.1 This section of the report sets out what was known by agencies in relation to safeguarding matters specifically in respect of Ann and more generally to Chester House while Ann was resident there.

5.4.2 Stockport Multi-Agency Safeguarding Adults Policy and Procedures is the local code of practice that has been formulated and agreed by the Safeguarding Adults Board in accordance with the Care Act 2014. All statutory organisations delivering Health and Social Care in Stockport, all organisations from which services are commissioned by the statutory Health and Social Care organisation and any other organisation working with adults at risk in Stockport should comply with this policy. The policy is an open source document that can be accessed through the internet.

5.4.3 The policy is not repeated in full here however, in summary, it places a responsibility upon an individual or organisation that suspects or receives a disclosure or allegation of abuse of an adult at risk to secure the individuals welfare and report their concerns. The Policy sets out the process for raising a safeguarding adult alert to Stockport Adult Social Care Contact Centre. The process for dealing with alerts follows six stages and is set out in Appendix F.

5.4.4 Section 3.1.2 of the Policy makes specific reference to provider managers of care provision (which would include Chester House). It states;

'Where an organisation is aware abuse has taken place, they have a duty to correct this and protect the adult at risk from harm and inform the local authority, CQC and CCG where appropriate'

5.4.5 The SAR is satisfied there is no record during the timescale of this review of an Adult Safeguarding Referral being made by Chester House or any other agency in respect of Ann. The remainder of this section considers what was known about Chester House and its compliance with the safeguarding Policy and whether they, or any agency, should have made a safeguarding referral in respect of Ann.

5.4.6 Stockport Adult Safeguarding and Quality Service (ASQS) ensures the Local Authority fulfils its responsibilities under the Care Act 2014 and the Mental Capacity Act 2005. They oversee the appropriate implementation of the Policy and procedures across Stockport, both by Local Authority staff and the partner agencies and services. During the period of this review, different Quality Assurance Officers (QAO), who worked within ASQS, were involved with Chester House.

5.4.7 Between March 2016 and September 2017, QAOs undertook seven visits to Chester House. The expected standard is for annual monitoring visits to be held, with pro-active visits bi-monthly (dependent on workload) to build and maintain provider relationships. Visits can be undertaken more frequently

dependent on the need of the provider at the time. During these visits, none of the QAOs recollect meeting Ann.

5.4.8 Between February 2016 and August 2017, no direct concerns relating to Ann were raised with ASQS either by the home manager or other visiting professionals. There is a note in the ASQS records that there was a discussion about a malodour at Chester House in February 2016. The manager at the time felt it may have been linked to a specific service user. There is no reference to that resident being Ann. However, in May 2016 an infection control report prepared for ASQS identified a need for wipeable furniture in Ann's room.

5.4.9 During the period of this review, three safeguarding alerts were raised with ASC at level 4/5[36] concerning events at Chester House. One of these was the safeguarding referral made by NWAS in respect of Ann following her admission to hospital on 22 September 2017. The other two referrals[37] related to other residents. None of the facts of those referrals related to issues that affected Ann's care. Following one of these other two safeguarding referrals a QAO met the manager of Chester House and the GP to explore working relationships and processes. The meeting established that monthly ward rounds (virtual and actual) were in place and a GP visiting book was put in place.

5.4.10 In August 2016, the CQC carried out an inspection of Chester House[38]. They found the home had not followed procedures in sending notifications to CQC although they had submitted safeguarding harm level logs to ASQS. They also identified the following other breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

1. Some medicines were not managed safely. We found there were not always clear, detailed written directions for the use of medicines to enable staff to apply prescribed creams as intended by their GP. This meant there was a risk prescribed creams may not have been applied when required, which could have resulted in unnecessary discomfort to the person;
2. We had concerns in relation to staff supervision because staff were not receiving supervision on a regular, ongoing basis and there was no evidence that staff had received an annual appraisal, this meant that staff were not being appropriately guided and supported to fulfil their job role effectively;
3. Recruitment processes required improvements to ensure only suitable staff were employed to work with vulnerable people;
4. Some of the routine safety checks had not been undertaken for example checks of window restrictors and nurse call bells. This

[36] See Appendix F for a description of these levels.
[37] One referral related to a resident who had choked on food, the other related to a discharge from hospital matter.
[38] The full inspection report can be found at:
http://www.cqc.org.uk/sites/default/files/new_reports/INS2-2453524887.pdf

meant the provider could not be sure people using the service were safe at all times;

5. We saw that some people's identified care needs did not have a corresponding plan of care to direct care staff on how to meet the individual care need. This meant there was risk that people could receive unsafe and inappropriate care;
6. There was not a systematic approach to determine the number of staff and range of skills required to meet the needs of the people who used the service. This meant people might be at risk of receiving unsafe and inappropriate care. We saw, and staff told, us that as part of their paid care hours they were expected to undertake cleaning, laundry and cooking duties. Staff told us they thought due to this they were sometimes too busy to spend time with the people living at Chester House Care Home;
7. People were not always supported to access regular, meaningful activities within or outside the home. This meant people were not always encouraged to meet their full potential.

5.4.11 As a result of the inspection, the overall rating for the service provided by Chester House was 'inadequate'. Chester House was placed in 'special measures'. The SAR carefully considered to what extent, if any, these failures might have impacted upon the care received by Ann. While the failings were serious, in as much as they led to special measures being implemented, it appeared that none of them related specifically to the care of Ann. Following the inspection, ASQS provided additional support to the home through their REACH service (short term rehabilitation and reablement service, delivered by Stockport MBC).

5.4.12 Work was undertaken to respond to the CQC report. In November 2016, an audit by ASQS reviewed the need for wipeable furniture in Ann's room. It was noted that her room could not be inspected as she was present and would not allow access. Assurances were provided by the home manager that the room had been redecorated, new flooring put in and that the carers were attempting to clean it more frequently.

5.4.13 In December 2016, the registered manager of Chester House resigned. An interim manager was appointed. In February 2017, by which time Ann was once again resident in Chester House, a further inspection was carried out by CQC. They reported that significant improvements had been made and all the regulatory breaches identified at the last inspection had been met. They rated Chester House as 'good', a rating still held by the home.

5.4.14 As set out earlier at paragraph 5.3.23, during a visit to Chester House, a QAO was advised by the deputy manager that they felt unsupported by the CPN for Ann. The deputy manager was concerned about issues relating to her smoking and personal hygiene. The QAO agreed to contact the CPN when she returned from leave. That did not happen as Ann was admitted to hospital a week later on 22 September 2017.

5.4.15 The SAR panel have carefully considered the information provided by the statutory agencies. They have found no evidence anywhere to suggest that Ann was neglected by virtue of a failure to provide her with an adequate level of care. The risks that Ann presented to herself and others were understood and were appropriately managed. Consequently, the SAR conclude there was no necessity for any agency to submit a safeguarding alert.

5.4.16 However, there was evidence that Chester House were starting to find it difficult to respond to some of Ann's behaviour. Although probably not at the level of a safeguarding alert, Chester House's concerns required a response. The SAR felt the decision to hold a best- interests meeting was an appropriate and incremental response to Chester House's concerns. Had it gone ahead then it might have achieved the same outcome as a safeguarding referral that progressed to level three probably would have (i.e. it would have led to a discussion or meeting about Ann's needs).

5.4.17 The SAR felt that, as the best interests meeting did not go ahead, then that was the point at which Chester House could have considered submitting a safeguarding referral. That did not happen. The SAR heard that the interim manager did not realise that a safeguarding referral could have been made and had tried, unsuccessfully, to get support from within Stockport ASC. Frustrated by the lack of progress it was then that the interim manager raised concerns with the QAO on 15 September 2017.

5.4.18 Stockport ASC has since advised the panel that they cannot find a record of these calls for support. The panel has not been able to reconcile this. The panel wonder whether the interim manager's calls may have been made to other departments in Stockport Council given that the interim manager did not realise that a safeguarding alert could be made to ASC.

5.4.19 The SAR have no criticism concerning the actions of Chester House. They tried hard to raise concerns. The interim manager demonstrated at the practitioner event that she had a good understanding of safeguarding issues. However, she did not appreciate at the time that a safeguarding referral would have been the appropriate means of escalating the home's concerns.

5.4.20 The SAR believe this case identifies two important pieces of learning for practitioners and providers. Firstly, about the need for timely communications when concerns are raised. Secondly, about the need to increase understanding that safeguarding processes are an appropriate escalation step when concerns have not been appropriately addressed.

5.5 Key Line 4

Understanding of capacity – with particular attention to the fact that Ann was not deemed to have capacity to choose to take her mental ill Health medication, but was deemed to have capacity to refuse medical treatment.

5.5.1 Appendix C sets out the principles of the Mental Capacity Act 2005 (MCA 2005). Ann suffered with Chronic Schizophrenia for several years. Her condition did not mean that, per se, she lacked capacity. She was ambulant and had the physical and mental ability to make decisions to go shopping, visit her bank, make purchases and order a taxi when required. Ann also had good verbal communication skills and could articulate her wishes. While her behaviour was sometimes eccentric, and was even described as anti-social, that did not mean she lacked capacity.

5.5.2 Because of her condition it seems that Ann disliked and often refused medical interventions. At best, she would reluctantly accept depot medication, tolerated some CPN visits and agreed to minimal contact with her Consultant Psychiatrist during CPA Reviews.

5.5.3 Ann also made choices in relation to her physical health that others might consider unwise. An example of this were when the results of an x-ray disclosed a shadow on her lung. She refused to attend hospital on 1 July 2016 for a CT scan and refused to provide a blood sample. On this occasion, health professionals assessed that Ann had the capacity to refuse these tests.

5.5.4 However mental capacity;

'Is time and decision specific. This means that a person may be able to make some decisions but not others at a particular point in time. For example, a person may have the capacity to consent to simple medical examination but not to major surgery. Their ability to make a decision may also fluctuate over time[39]'

5.5.5 An example of how health professionals reached a different conclusion in relation to Ann's mental capacity occurred when she refused to take anti-psychotic medicine. In July 2015, Ann refused to accept her depot injection. She said she did not believe she needed to take it and that she was experiencing unwanted side effects. Ann was reviewed by her Consultant Psychiatrist in September 2015, and staff from Chester House confirmed there had been no deterioration in Ann's mental health. The Consultant decided that a further assessment without antipsychotic medication would be tried. The Consultant says that Ann understood this decision.

5.5.6 CPNs continued to visit Ann at Chester House and monitor her mental and physical health. CPN1 made several visits to Chester House and had several telephone calls with staff there between September 2015 and July 2016. Ann's mental health started to deteriorate significantly, and this impacted upon her physical health as she had reduced her diet and fluid intake.

5.5.7 Ann refused to take any oral medication and, following a visit by CPN1 when Ann refused to speak to her, a decision was made by her Consultant

[39] Page 24 Stockport Safeguarding Adults Board Safeguarding Adults at Risk. The Multi-Agency Policy (the 'Policy') for Safeguarding Adults at Risk & Multi Agency Operational Procedures for Responding to and Investigating Abuse. Fourth Edition – January 2016

Psychiatrist that she should be admitted to The Meadows under Section 3 MHA 2005[40]. This occurred on the 3 August 2016. On that occasion, it was concluded that Ann did not have capacity. The reason for that was because Ann's mental health was now impacting upon her physical health in as much as her diet and fluid intake had reduced. This put Ann at risk and it was deemed that Ann had no insight into her health problems.

5.5.8 While she was detained in The Meadows, Ann again refused to have a chest x-ray and have bloods taken although she did agree to take antibiotics. Throughout her admission, her Consultant Psychiatrist, Ward Staff, Junior Doctor and CPN all tried to persuade Ann to attend for an x-ray. Appointments were made and had to be cancelled. Ann told staff that she was not worried about the outcome, did not want to know what was wrong with her, and thus did not see the point in going.

5.5.9 At this time, Ann was subject to detention under S3 MHA (1983). However, that detention was made specifically because of Ann's declining mental health and in order for it to be assessed. Hence her detention would not have warranted or justified her being forced to attend for an x-ray, MRI scan or to have bloods taken.

5.5.10 In reaching that conclusion the guiding principles of the Mental Health Act 1983 (MHA 1983)) need to be considered. That is;

i. Empowerment and Involvement

Involve patients as much as possible in planning all aspects of their care and treatments.

ii. Respect and Dignity

Respect patients, families, carers and friends.

iii. Purpose and Effectiveness

Help people get well.

iv. Efficiency and Equity

Make fair and efficient decision.

5.5.11 Under the MHA (1983), and the MCA, a proportionate response to a situation needs to be considered. The question for clinicians is what is a proportionate response? The Code of Practice from the MCA (Paragraph 6.47) advises that it means using the least intrusive type and minimum amount of restraining to achieve a specific outcome in the best interests of the person who lacks capacity.

5.5.12 Section 6(4) of the MCA states that someone is using restraint if they:

- Use force or threaten to use force to make someone do something that they are resisting or;

[40] See Appendix E

- Restrict a person's freedom of movement, whether they are resisting or not.

5.5.13 At the practitioner's event professionals discussed the issue of restraint. There was a unanimous view that the extent of restraint that would have been required to force Ann to have an x-ray or MRI scan would have been extreme. It would have been a wholly disproportionate response and a clear breach of her human rights and would possibly have constituted an assault upon her.

5.5.14 Likewise, practitioners also discussed the level of intrusion or restraint that could have been exercised in response to some of the other risks that Ann presented to herself or others. For example, her refusal to shower or wash. Practitioners felt that, while there were risks in such unhygienic practices, again the level of restraint that would have been required to force Ann to shower would have been wholly disproportionate to the risk. It would have been cruel and possibly dangerous to Ann and the staff involved. They could not think of any examples in their professional experience when it had been necessary to use restraint in such circumstances.

5.5.15 The SAR noted that within the records provided there was reference on 15 September 2016 for the need to consider Deprivation of Liberty Safeguards (DOLS) in the future. This occurred during a multi-disciplinary meeting attended by health professionals. The meeting concluded that, at that time, DOLS was not appropriate.

5.5.16 The SAR has considered the issue of DOLS in relation to Ann. The Supreme Court decided that when an individual lacking capacity was under continuous or complete supervision and control and was not free to leave, they were being deprived of their liberty. Except for the period during which Ann was lawfully detained within the ambit of S3 of the MHA, they did not see any evidence that Ann was deprived of her liberty.

5.5.17 While at Chester House, Ann was free to come and go as she wished and went shopping on her own. On many of those occasions, she was not under supervision. Ann had her own room and her desire for privacy and her right to exclude others from entering was respected. The only restriction that the SAR could see was when the kitchen was locked to prevent Ann entering and thereby risking cross infection. The SAR felt that was an appropriate response to the risk. It was not a denial of Ann's liberty.

5.5.18 In conclusion the SAR are satisfied that practitioners had a good understanding of the MCA and the MHA as they applied to Ann. They found that practitioners appropriately applied the five principles of the MCA. When the risks Ann presented to herself or others increased, practitioners escalated their response in a way that was appropriate and necessary. Practitioners demonstrated clear reasoning as to why Ann was considered to have capacity to refuse medical treatment. Equally, practitioners were able to demonstrate clear reasoning as to why Ann was compulsorily detained under S3 MHA. This was because her mental health had worsened to such a

degree that her physical health was at risk and she lacked insight into her health.

5.5.19 With that exception, the SAR found no evidence that Ann was deprived of her liberty nor that it should have been considered necessary. The SAR also recognised that it would have been wholly disproportionate, a breach of her human rights and potentially an assault had restraint been used on Ann to force her to have an x-ray or take a shower.

5.6 Key Line 5

Consideration of physical health in mental health patients.

5.6.1 The SAR found evidence from the documentation made available to them, and from conversations with professionals, that attention was paid to Ann's physical health. Older adults often have complex physical health conditions. They may suffer from chest infections and urinary tract infections, which can cause an acute change in presentation and have a direct impact on a person's mental health.

5.6.2 Before any diagnosis of mental illness, physical health screening is undertaken to exclude an organic cause. Hence the monitoring of a person's individual's physical health is as important as the monitoring of their mental health. If there is a change in presentation noted and particularly if this is an acute onset, any physical health cause is nearly always considered.

5.6.3 Ann suffered from a chesty cough for many years. This was attributed to the fact she smoked up to 60 cigarettes a day. On occasions, Ann suffered from chest infections. On 30 June 2016, Ann was given a chest x-ray. This disclosed a shadow on her lung, however she refused to have a scan. She was prescribed antibiotics. Ann was also encouraged to have bloods taken. Ann took the antibiotics and while in hospital was also persuaded to reduce her smoking to 10-15 cigarettes a day.

5.6.4 Ann never stopped smoking completely. Staff from Chester House say that for a short period during the latter part of her residency there she did stop smoking. She claimed she could not afford to buy cigarettes because the bank had stopped paying her interest. It is not known whether that was the case or whether it was a delusional belief on Ann's part. Professionals speculated at the practitioner event that the condition of Ann's lungs may have been such that she simply could not smoke. Smoking was an issue that caused Ann some tension that may have contributed to some of her changes.

5.6.5 It is clear from the records that when staff at Chester House had cause for concern about Ann's diet, fluid intake or weight they informed the CPN. In turn, the CPN considered if this was due to any physical health reason

before assuming it was caused by Ann's relapsing mental health. Staff at Chester House, the CPNs and Ann's Consultant Psychiatrist encouraged her to see the visiting GP. When discussing this issue, the panel recognised the importance of not compartmentalising physical and mental health. Instead, there is a need to look at the full person holistically instead of them having to move between services for support. The panel felt there was some learning here.

5.6.6 On occasions Ann would see the visiting GP and, on some occasions, she refused to engage with them and would either not admit them to her room or would refuse to come out. Ann was last visited by a GP on 3 April 2017. This was when Ann was refusing to eat or drink and was isolating herself in her bedroom. Staff from Chester House contacted CPN4 for advice. They advised staff to contact the GP.

5.6.7 The GP visited Ann in the afternoon and advised staff at Chester House to maintain her hydration and, if there was no improvement in 3-4 days, to contact the doctor again. Later that day Ann asked for water and juice. The following day Chester House recorded that Ann was drinking although still refusing food. Two days after the doctor's visit Chester House recorded that Ann's diet and fluids were adequate[41].

5.6.8 There is no indication that Ann refused food and fluids again until 17 September 2017. On that date she refused food and drink although, by the afternoon, she had taken some soup and tea. She took food again on 18 September. On 20 September Chester House recorded that Ann refused to be seen by a doctor for her poor dietary and fluids intake.

5.6.9 That was the last entry relating to the need for medical care recorded by Chester House before Ann was taken to hospital on 22 September 2017. The last occasion that Ann was seen by a health professional was on 14 September 2017, when CPN6 administered a depot injection. CPN6 did not document any concerns about Ann on that occasion and neither did Chester House raise any concerns.

5.6.10 On 21 September 2017, Chester House recorded that Ann 'ate half of her toast and had a drink of tea' she also had tea at 17.00hrs. The following day Ann was asked at 08.30hrs if she wanted to eat and drink. She told the assistant manager of the home to 'go away'. At 11.45hrs a member of staff asked Ann if she wanted anything to eat or drink. She said she did not and

[41] The panel heard that the practice GP for Chester House attended the practitioner event. The GP felt that GPs should be more involved in care homes. The GP practice concerned has recently merged with another and GPs there are looking at starting rounds at care homes. The panel felt that was welcome progress and a way in which GPs could ensure they kept an overview of residents, particularly those who might not have seen a GP for some time or, like Ann, refused to have contact.

told the member of staff to go away. At 14.05 hours that day, Ann was found on the floor of her room and an ambulance was called.

5.6.11 The SAR panel conclude there was appropriate consideration by all agencies involved of both Ann's physical and mental health needs. It was not unusual for Ann to refuse food and drink and when she did the SAR panel are satisfied that Chester House responded appropriately either by contacting a CPN or a doctor.

5.6.12 The condition that led directly to Ann's death was 1a sepsis. The intermediate cause of her death was 1b left sided empyema and purulent pericarditis. The underlying cause of her death was 1c left sided bronchopneumonia.

5.6.13 The underlying cause of Ann's death could have been present over a long period of time. An x-ray of Ann on 15 July 2016 had disclosed a shadow on her lung. Ann had refused a scan and had been prescribed anti-biotics. Ann was known to have a chesty cough although there had been no concerns about this since May 2017.

5.6.14 From the records the SAR panel have seen, and from conversations with staff at Chester House, it does not appear there was any change in Ann's physical condition in the days and hours before her collapse that should reasonably have been identified and responded to. Sepsis is a condition that needs to be treated as a medical emergency. The signs and symptoms can be of an acute onset and can affect multiple organs or the entire body. Sepsis is a condition that is always triggered by an infection.

5.6.15 The SAR panel are satisfied there is no link between Ann's unhygienic behaviours and the underlying cause of her death. When Ann refused food and drink on the day she was found collapsed the SAR panel believe it was reasonable to consider that this was simply part of Ann's normal behaviour caused by her fluctuating mental state. It does not appear to the panel that there were any other indicators the staff at Chester House could have been reasonably expected to have identified that day that might have signified that Ann's physical health had changed and that she was dangerously ill.

5.6.16 When Ann was found collapsed, the immediate actions of Chester House in tending to her and summoning an ambulance were appropriate. The subsequent actions of NWAS staff and staff at Stepping Hill Hospital were also appropriate and in line with the response that would be expected in a patient with a condition such as Ann had.

5.7 Key Line 6

Interaction between mental health and physical health services.

5.7.1 The SAR are satisfied there was appropriate interaction between mental and physical health services during some aspects of Ann's care. For example,

there was evidence in correspondence between the Older People's Service and Ann's GP practice. This usually happened following Ann's annual CPA review or following a change in her medication.

5.7.2 If there were any concerns regarding Ann's physical health when she was seen by the Older People's Service, then these were addressed during the review and highlighted in the correspondence. The SAR felt that when Ann was a patient within the Meadows, there was clear evidence of that interaction. Ann had a chest x-ray in July 2016 and it disclosed a shadow on the lung, however, she refused to have a scan. Her clinicians at the Meadows recognised that Ann could not be compelled to undergo further and more intrusive tests. Ann's clinicians were concerned about the shadow and, even though the purpose of her stay at the Meadows related to her mental health, they also treated Ann with antibiotics for the shadow. When she was discharged from the hospital the GP practice was sent a summary from the ward stating that Ann had a chest infection.

5.7.3 The SAR panel felt there was less evidence of the interaction between mental and physical health services when Ann was resident at Chester House. Ann was seen by several different CPN's during that period. The SAR felt the focus of many of those visits was the administration of the depot medication. The SAR recognised that, while maintaining mental health was the primary issue, there could have been more consideration within the notes from the visits about Ann's physical well-being.

5.7.4 The panel recognised there were reasons for that disparity. For example, the frequent change of CPN may have made it difficult for clinicians to build up a relationship with Ann. She had a complex personality and needs and to fully understand her as a person required frequent visits and experience of her. The panel recognised that was not easy to achieve, particularly given Ann's reluctance to engage. Clinicians struggled to get Ann to accept the depot medication when they visited and it maybe that, having achieved that goal, clinicians felt their task in relation to Ann's health had been achieved. In considering that proposition, the panel wish to be clear, that does not suggest they believe there was any neglect of Ann's wellbeing.

5.8 Key Line 7

Process of escalation when individual agencies need support from other agencies.

5.8.1 The process for escalation in relation to patients that are open to the Older People's Service is through a 'duty service' that is provided between Monday and Friday every afternoon. This consists of a Mental Health Practitioner who is available to take calls from service users, carers, relatives or GP's about an individual. The caller is put through to the Duty Officer or a message is left for a call to be returned that day. This is only if the Care Coordinator for the service user is not available.

5.8.2 The calls that are received can vary in terms of their intensity; from routine to requiring urgent advice and immediate response. If the matter is judged to be routine, a message is left for the Care Coordinator and documented in the case notes. If urgent, then appropriate action is taken, depending upon the situation. Discussion takes place with the Team Manager if the matter is urgent. As already discussed within paragraph 5.3.10 et al, Chester House staff made a duty call concerning Ann. The response to this was to pass the information to the CPN.

5.8.3 Outside of regular working hours, there are several options available that can be taken by carers, relatives and service users if they have any concerns. These include contacting the GP or Mastercall[42], contacting the Local Authorities Out of Hours Service, Contacting the Police or attendance at A&E for a mental health / physical health assessment. This information was provided on the CPA documentation which Chester House staff received from the CPN.

5.8.4 As outlined within this report, there was generally good communication, information sharing and inter agency working between the Older People's Service, GPs, ASQS and Chester House. Ann was managed under CPA and her treatment was reviewed in line with agency's policies. When concerns arose, they were generally resolved by face to face contact or a telephone call. For example, Chester House would contact Ann's CPN when her diet or fluid intake fluctuated.

5.8.5 The only need for escalation occurred towards the end of Ann's residency in Chester House and this has been examined in detail within paragraph 5.4.14 et al. The process for escalation should have been a 'best interests' meeting. That did not happen for the reasons discussed in that section of the report. Attempts by Chester House to escalate the matter through a QAO were not successful either. The SAR has already commented that there is a need for timely communications when concerns are raised and to increase understanding that safeguarding processes are an appropriate escalation step when concerns have not been appropriately addressed.

[42] Mastercall is a company that is contracted to provide the link to the out of hours GP service.

6. LEARNING

6.1 Collectively, the practitioners' event and the SAR panel identified the following learning. A narrative sets the context for each piece of learning. Where a piece of learning links to a recommendation a cross reference is included.

Learning 1 (Panel Recommendation 1 and 2) (Agency Recommendation 2)
Narrative
Ann was cared for by thirteen CPN's, two Psychiatrists and an Associate Specialist. She had complex needs and had difficulty engaging with staff. This was particularly the case when she was in Chester House and was reluctant to accept Depot medication. The focus of visits there by CPN's was very much upon persuading Ann to accept her medication. Delivering that task meant that Ann's wider well-being issues, such as her refusal to wash and shower, were not always considered. This may explain why the HIT team were only deployed on one occasion to assist with Ann's personal care.
Learning
Consistency of workers involved in the care of patients like Ann is important. Complex cases such as this require a small team approach. A smaller team with regular visits from the same professionals such as CPNs will lead to building better relationships and communications with patients and staff at care homes. This in turn will ensure there is earlier and more frequent deployment of specialist resources such as the HIT team.

Learning 2 (Panel Recommendation 1 and 2)
Narrative
Ann frequently declined to see a GP. The arrangements in place were for GP's to undertake a 'virtual' round of Chester House. Consequently, there was limited face to face contact between Ann and her GP.
Learning
Virtual rounds mean that, in complex cases such as this, GPs rely entirely upon what they are told by care home staff. Consequently, they do not see residents 'face to face' which means GPs lose an opportunity to have a conversation with a resident and make an assessment, even if they then decline to be examined.

Learning 3 (Panel Recommendation 1 and 2) (Agency Recommendation 1)
Narrative
Ann's case was complex and on occasions, the documentation that was completed in respect of her was limited in content. Some of the documentation was not explicit enough about Ann's presentation. For example, when CPNs visited Chester House it was not always clear from the documentation what they had found out about Ann when they visited. (i.e. a visit on 11 November 2016 was recorded as 'Nurse came from meadows to administer depot injection. She refused to have the injection')
Learning
Clearer and more explicit written records about a patient's health needs assists communication between staff and agencies. It ensures staff that may not be specialised in mental health issues build a better picture of the patient and their needs. Such an approach aligns with the philosophy behind the 'Goals of Care'[43] approach.

Learning 4 (Panel Recommendation 1 and 2) (Agency Recommendation 2)
Narrative
When Ann's mental health started to decline in July 2017, there should have been earlier consideration of a multi-agency meeting. The need for a multi-agency meeting was lost when the CPN involved was absent on sick leave.
Learning
A multi-agency approach to dealing with complex cases such as Ann's ensures that a robust and workable plan can be owned, understood and shared by all agencies

Learning 5 (Panel Recommendation 2)
Narrative
There were lapses in timeliness evident in this case. For example, the period of ten days that elapsed between the call from Chester House to the Older People's Service on 24 July 2017 and the deployment of a CPN. Another example was when the QAO may not have realised the urgency

[43] Goals of Care is an enhanced case management record that has been introduced and is now in use by the NHS and Stockport ASC. It is a way of identifying what patients want to achieve and assists clinicians to focus upon achieving those goals.

of the assistant manager's needs, following their conversation on 15 September 2017 these were not passed on because the QAO went on leave.
Learning
It is important to understand the urgency of a caller's need and ensure appropriate and timely responses are put in place.

Learning 6 (Panel Recommendation 1 and 2) (Agency Recommendations 3, 4 and 5)
Narrative
There were references within this case for the need to consider DOLS and 'Best Interests' meetings which suggests there may have been concerns that Ann lacked capacity. However, there is no record a mental capacity assessment took place.
Learning
Before moving to 'Best Interests' or DOLS, a capacity assessment must always be carried out and the results recorded in line with the Mental Capacity Act.

Learning 7 (Panel Recommendation Two)
Narrative
Staff from Chester House sought support to assist with Ann's personal care and hygiene, which included contacting the Older People's Service and raising concerns with the QAO. They did not feel well supported and say they had difficulty in escalating their concerns. The Acting Manager did not appreciate that the Adults Safeguarding process could have been used as a way of escalating her concerns.
Learning
Staff involved in the care of adults should have a good understanding of the processes that are available to escalate concerns including when and how to use the Stockport Adult Social Care Safeguarding Referral Process.

7. GOOD PRACTICE

7.1 The SAR panel felt that staff from Chester House appeared to show commitment, dignity and respect for Ann and provided her with the best care they could. It was important to Ann to stay there. It was her home and was the least restrictive option for her.

7.2 While the SAR did not find any examples of good practice in other agencies, they did feel there were examples of competent practice by sstaff, which generally complied with policy.

8. CONCLUSIONS

8.1 Ann had been mentally unwell for many years with a diagnosis of Chronic Schizophrenia. In a letter to Ann's GP in 2015, her Consultant Psychiatrist said that, accepting that there were some limitations in the care provided due to Ann's mental health, Chester House staff were providing her with the best care they could. The Consultant felt it was important to Ann to stay in her current environment and it was believed to be the least restrictive option for her. Ann appeared to be happy at Chester House, she had lived there for many years. She regarded it as her home and staff there regarded her as part of their family.

8.2 The SAR agreed that the long-term placement of Ann in Chester House was the most appropriate way in which to care for her. It was in line with the guiding principles of the Care Act in that it was proportionate to the risks that Ann's condition presented. Ann had her own room, where she could maintain her privacy, her liberty was not restricted, and she frequently went out shopping and returned safely to the home.

8.3 Ann's mental health was managed within the Care Plan Approach. For the ten years before her death Ann was visited on a regular basis by CPNs and Consultant Psychiatrists. Pennine Care NHS Foundation Trust identified that during this period thirteen CPN's, two Psychiatrists and an Associate Specialist were involved in Ann's care. The SAR agreed with Pennine Care's finding that the number of CPNs allocated to Ann's care was not acceptable.

8.4 Because of her condition Ann had difficulty engaging with staff. Continuity of workers such as the CPNs might have improved communications with Ann. It would also have helped staff at Chester House build more of a relationship with them and improved the flow of information. CPNs were very focussed upon the task of trying to get Ann to accept her depot injection. While that was of course important, the SAR felt that health professionals needed to consider the wider picture in relation to Ann's care. Lack of continuity of CPNs may have been one of the factors that led to that happening.

8.5 The SAR felt it was clear that Ann's mental illness led to her self-neglecting. Ann's self-neglect manifested itself in several ways. For example, she would refuse to eat and drink. Staff at Chester House recognised this when it happened and ensured it was reported to CPNs and when necessary to a doctor. Ann's refusal to accept a scan when a shadow was detected on her lung was another example of self-neglect.

8.6 The SAR recognised that clinicians at The Meadows tried hard to persuade Ann to accept tests when the shadow was discovered. Safeguarding Policy recognises that self-neglect is a difficult issue to address and there are questions of personal choice. The SAR felt the response of clinicians, by trying to persuade Ann to accept these tests rather than compelling her, was appropriate and proportionate. Even though Ann was compulsorily detained under the MHA, the use of restraint to compel Ann to have a scan would

have been disproportionate, a breach of her human rights and potentially an assault. Clinicians adopted the best alternative in prescribing anti-biotics.

8.7 The SAR felt that clinicians and staff at Chester House understood the Mental Capacity Act and followed its guiding principles. While Ann was mentally unwell that did not mean that she lacked capacity. Her capacity did fluctuate and there appeared to be an appropriate response when this happened. For example, Ann's mental health declined when she refused to accept medication in July 2016. This manifested itself in her physical health; she refused to eat and drink and her weight fell. It appeared that Ann did not have insight into her condition and this led to Ann being admitted to The Meadows under S3 of the MHA.

8.8 The SAR felt that Ann's, sometimes eccentric, behaviour became normalised with most agencies. She had lived at Chester House for many years and it seems that staff there became used to her behaviour and adapted to it. For example, allowing her to buy her own food and make her own drinks because of her delusional beliefs. The exception to the normalisation of Ann's behaviour appeared to be when she was a patient at the Meadows. On these occasions Ann's behaviour appeared to be different. She did not seem to engage in some of the more eccentric behaviour she displayed in Chester House. The SAR felt the reason for that might have been because Ann recognised that compliance within the hospital regime would mean she was likely to be discharged more quickly back to Chester House: a place she liked, and which was her home.

8.9 Ann's family felt that the change of management at Chester House at the end of 2016 seemed to impact upon her. They cited the cessation of smoking in the conservatory and restriction on the use of the kitchen as steps that Ann did not welcome and that may have impacted upon her behaviour. The SAR panel felt that Chester House staff had tried hard to cope with Ann's behaviour. However, between July and September 2017 there is clear evidence her mental state deteriorated, and the home had difficulty managing Ann's needs. Her behaviour became more unhygienic and restricting her use of the kitchen was a sensible and appropriate response that protected other residents from the risk of cross infection. Ann would not comply with the policy on smoking. It was a policy that applied to all residents and staff and not just Ann. The SAR did not feel those actions amounted to Ann being deprived of her liberty.

8.10 Ann would not allow staff into her bedroom and when CPNs visited, they administered the depot medication in the bathroom. Staff from Chester House cleaned Ann's room while she was out shopping or smoking. Because of Ann's behaviour CPNs did not visit her room. It would have been good practice if they had so that could have seen for themselves what condition it was in. This may have been one reason why assumptions were made that Chester House staff were continuing to manage this difficult and complex situation as they always had.

8.11 It was clear to the SAR that by 24 July 2017, when Chester House staff called the duty social worker at the Older People's Service, that they needed more support. The SAR felt a more timely and appropriate response was needed than the ten days it then took to arrange for a CPN to visit the home. The deployment of the Home Intervention Team was an appropriate offer by the CPN and they assisted Ann with a shower. However, that only happened on one occasion. The SAR felt it would have been best practice for visits from the Home Intervention Team Support Workers to have happened several times during a planned period to provide a more comprehensive assessment and support to Chester House staff.

8.12 The visit of the CPN on 17 August led to Ann's CPA being reviewed and her risk assessment updated. The planned 'best interests' meeting did not happen because of sickness absence. The SAR felt that was a missed opportunity to draw together the home and the agencies that were caring for Ann and to consider what steps needed to be taken in response to the decline in her mental health and the difficulties Chester House were now experiencing. A further missed opportunity to escalate concerns occurred when the assistant manager from Chester House raised concerns with a QAO on 15 September. The SAR also felt that if there was a need to hold a 'Best Interests' meeting their first should have been an assessment of capacity which was recorded in line with the requirements of the MCA.

8.13 Having not received the help and support they needed, the SAR felt Chester House would have been justified in making a safeguarding adults referral to Stockport ASC. That did not happen because, while the interim manager had a good understanding of safeguarding issues, they did not appreciate that a referral was an option for escalation. The SAR feels that is an important learning point from this review.

8.14 The receipt of a referral would not necessarily have produced any new solutions to the way in which agencies cared for Ann. It was clear to the SAR that there was already good engagement and regular reviews by clinicians in respect of her mental health. The SAR felt the real value of a referral would have been that it would have led to a strategy meeting being held within five days. This in turn would have allowed Chester House and all the agencies involved in Ann's care to come together and develop a more holistic plan to care for Ann. That plan would have ensured the home received the additional help and resources they needed to deal with issues such as Ann's hygiene and self-neglect.

8.15 Finally, while there is learning from this review, the SAR did not find any evidence that any agency or individual had neglected Ann by failing to provide an adequate standard of care.

9. PREDICTABILITY AND PREVENTABILITY

9.1 The SAR panel thought very carefully about whether Ann's death could have been predicted or prevented. As discussed in section 5.6 of this report, the condition that led directly to Ann's death was 1a sepsis. The intermediate cause of her death was 1b left sided empyema and purulent pericarditis. The underlying cause of her death was 1c left sided bronchopneumonia.

9.2 The underlying cause of Ann's death could have been present over a long period of time. It does not appear to the panel there were any indicators staff at Chester House could reasonably have been expected to identify on the day on which Ann was found collapsed, or the days before, that might have signified her physical health had changed and that she was dangerously ill.

9.3 The immediate actions of Chester House in tending to her and summoning an ambulance were appropriate. The subsequent actions of NWAS staff and staff at Stepping Hill Hospital were also appropriate and in line with the response that would be expected in a patient with such a condition. The SAR panel therefore conclude it was not reasonably possible to have predicted or prevented the death of Ann.

10. RECOMMENDATIONS

10.1 The SAR panel makes the following recommendations;

i. That Stockport Safeguarding Adults Board satisfy itself that agencies have delivered the recommendations identified within their individual agency action plans that are attached to this report at Appendix H;

ii. That Stockport Safeguarding Adults Board satisfies itself that agencies demonstrate they have considered the learning points identified within this review and have embedded the learning within their policies, training and practice or, if there is a gap, have plans to correct that gap.

APPENDIX A

SAFEGUARDING ADULT REVIEW CRITERIA

1. Section 44 Care Act 2014

Safeguarding adults reviews

(1) An 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).

(3) Condition 2 is met if—

(a) the adult is still alive, and

(b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

(4) An SAB may arrange for there to be a review of any other 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).

APPENDIX B

SAFEGUARDING ADULT REVIEW PANEL MEMBERSHIP

The Review Panel
SSAB Administrator
Service Manager – Adult Social Care, SMBC
Independent Chair and Author
Safeguarding Practitioner, NWAS
Director of Operations - Adult Social Care, SMBC
Named Nurse for Safeguarding, Pennine Care FT
Independent support to Chair
Designated Nurse for Safeguarding, CCG
Head of Safeguarding and Learning, SMBC
Named Nurse Adult Safeguarding Stockport NHS Foundation Trust
Detective Sergeant Greater Manchester Police
Business Manager Stockport Safeguarding Adult Board

Appendix C

Summary Registration Requirements Health and Social Care Act 2008[44]

Any person (individual, partnership or organisation) who provides regulated activity in England must be registered with the Care Quality Commission otherwise they commit an offence.

A provider is the legal entity responsible for carrying on the regulated activity. There are three types of providers;

- individual
- partnership
- organisation.

When applying for registration applicants need to determine which health and adult social care services they carry on. These are known as 'regulated activities'. In all, there are 14 regulated activities.

A registered manager is the person appointed by the provider to manage the regulated activity on their behalf, where the provider is not going to be in day-to-day charge of the regulated activities themselves. In most cases, a provider will need to have one or more registered managers. As a registered person, the registered manager has legal responsibilities in relation to that position. A registered manager shares the legal responsibility for meeting the requirements of the relevant regulations and enactments with the provider.

The person appointed as registered manager should be in day-to-day charge of carrying on the regulated activity or activities they apply to be registered for.

[44] Based upon guidance provided by CQC: http://www.cqc.org.uk/guidance-providers

Appendix D

Mental Capacity[45]

The Mental Capacity Act (MCA) is designed to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment. It applies to people aged 16 and over. It covers decisions about day-to-day things like what to wear or what to buy for the weekly shop, or serious life-changing decisions like whether to move into a care home or have major surgery. Examples of people who may lack capacity include those with:

- dementia
- a severe learning disability
- a brain injury
- a mental health illness
- a stroke
- unconsciousness caused by an anaesthetic or sudden accident

But just because a person has one of these health conditions doesn't necessarily mean they lack the capacity to make a specific decision. Someone can lack capacity to make some decisions (for example, to decide on complex financial issues) but still have the capacity to make other decisions (for example, to decide what items to buy at the local shop). The MCA says:

- assume a person has the capacity to make a decision themselves, unless it's proved otherwise;
- wherever possible, help people to make their own decisions;
- don't treat a person as lacking the capacity to make a decision just because they make an unwise decision;
- if you make a decision for someone who doesn't have capacity, it must be in their best interests;
- treatment and care provided to someone who lacks capacity should be the least restrictive of their basic rights and freedoms.

The MCA also allows people to express their preferences for care and treatment, and to appoint a trusted person to make a decision on their behalf should they lack capacity in the future.

People should also be provided with an independent advocate, who will support them to make decisions in certain situations, such as serious treatment or where the individual might have significant restrictions placed on their freedom and rights in their best interests.

[45] https://www.nhs.uk/conditions/social-care-and-support/mental-capacity/

Appendix E

Compulsory Detention Mental Health Act 1983

Admission for assessment.

(1) A patient may be admitted to a hospital and detained there for the period allowed by subsection (4) below in pursuance of an application (in this Act referred to as “an application for admission for assessment”) made in accordance with subsections (2) and (3) below.

(2) An application for admission for assessment may be made in respect of a patient on the grounds that— (a) he is suffering from mental disorder of a nature or degree which warrants the detention of the patient in a hospital for assessment (or for assessment followed by medical treatment) for at least a limited period; and (b) he ought to be so detained in the interests of his own health or safety or with a view to the protection of other persons.

(3) An application for admission for assessment shall be founded on the written recommendations in the prescribed form of two registered medical practitioners, including in each case a statement that in the opinion of the practitioner the conditions set out in subsection (2) above are complied with.

(4) Subject to the provisions of section 29(4) below, a patient admitted to hospital in pursuance of an application for admission for assessment may be detained for a period not exceeding 28 days beginning with the day on which he is admitted, but shall not be detained after the expiration of that period unless before it has expired he has become liable to be detained by virtue of a subsequent application, order or direction under the following provisions of this Act.

Admission for treatment.

(1) A patient may be admitted to a hospital and detained there for the period allowed by the following provisions of this Act in pursuance of an application (in this Act referred to as “an application for admission for treatment”) made in accordance with this section.

(2) An application for admission for treatment may be made in respect of a patient on the grounds that—(a)he is suffering from [F1mental disorder] of a nature or degree which makes it appropriate for him to receive medical treatment in a hospital; and(b)F2 (c)it is necessary for the health or safety of the patient or for the protection of other persons that he should receive such treatment and it cannot be provided unless he is detained under this section[F3; and (d)appropriate medical treatment is available for him.]

(3) An application for admission for treatment shall be founded on the written recommendations in the prescribed form of two registered medical practitioners, including in each case a statement that in the opinion of the practitioner the conditions set out in subsection (2) above are complied with; and each such recommendation shall include—(a)such particulars as may be prescribed of the grounds for that opinion so far as it relates to the conditions set out in paragraphs (a) and [F4(d)] of that subsection; and (b)a statement of the reasons for that opinion so far as it relates to the conditions set out in paragraph (c) of that subsection, specifying whether

other methods of dealing with the patient are available and, if so, why they are not appropriate.

(4) [F5 In this Act, references to appropriate medical treatment, in relation to a person suffering from mental disorder, are references to medical treatment which is appropriate in his case, taking into account the nature and degree of the mental disorder and all other circumstances of his case.]

Appendix F

Deprivation of Liberty Safeguards[46]

These safeguards provide protection to people in hospitals and care homes who do not have the capacity to consent to their care and treatment and the manner in which it is provide.

In March 2014, the Supreme Court handed down judgment in two cases: P v Cheshire West and Chester Council and P & Q v Surrey County Council.1 That judgment, commonly known as Cheshire West has led to a considerable increase in the numbers of people in England and Wales who are considered to be deprived of their liberty for the purposes of receiving care and treatment. The Supreme Court decided that when an individual lacking capacity was under continuous or complete supervision and control and was not free to leave, they were being deprived of their liberty. This is now commonly called the "acid test."

Any Adult at Risk who is detained without consent for the purpose of care or treatment should be deprived of their liberty via a legal means. The legal means available for such actions are a DOLS authorisation, detention under the Mental Health Act 1983, or an order by the Court of Protection.

Care Homes and hospitals must make requests to the Supervisory Body for authorisation to legally deprive someone of their liberty if they believe it is in their best interests. All decisions on care and treatment must comply with the Mental Capacity Act.

Stockport's Supervisory Body is managed by the Adults Safeguarding and Quality Service and can be contacted on 0161 474 3696. Referral forms must be sent to DoLSreferrals@stockport.gov.uk for new Deprivation of Liberty Safeguard authorisations.

[46] Page 14 Stockport Safeguarding Adults Board Safeguarding Adults at Risk. The Multi-Agency Policy (the 'Policy') for Safeguarding Adults at Risk & Multi Agency Operational Procedures for Responding to and Investigating Abuse. Fourth Edition – January 2016

Appendix G

Stockport Adult Social Care Safeguarding Referral Process[47]

3.6.1 Alert stage:

Managers should respond to all alerts on the same day they are brought to their attention by making contact with Stockport Adult Social Care Contact Centre or Stockport Out of Hours Service outside of office hours. When an alert is received by Stockport Adult Social Care Contact Centre, if appropriate it is passed on the same day to the relevant Social Work Team, Out of Hours Team or Pennine Care Access and Crisis Team or Adult Safeguarding and Quality Service.

3.6.2 Referral stage:

Following receipt of the alert the Adult Social Care Responsible Manager will make a decision on the same working day whether or not immediate action is required and if it requires investigation under this policy and procedure – if the alert does not meet the criteria for an investigation, the alerter should be notified of the decision.

3.6.3 Strategy Stage:

Strategy discussion/meeting– this is a planning meeting and should happen as soon as possible within five working days of receipt of the alert.

3.6.4 Inquiry/investigation stage:

Time scale for investigation is 25 days from receipt of the alert to allow time for the collation of investigation information prior to the case conference.

3.6.5 Case Conference and Protection Plan stage:

Case Conference meeting. This meeting is to discuss the investigation findings and will happen within 28 days (four weeks) from receipt of the alert to address the outcome of the investigation. If this time scale is not possible the reasons for any delay must be clearly reordered.

3.6.6 Review Stage:

Review meeting will be scheduled at the case conferences and may be required where the implementation of an adult protection plan requires monitoring (outside of the care management/care programme process)

[47] Ibid P48

Appendix H

Glossary of Terms

Abbreviation	Term
AKI	Acute Kidney Injury
AMU	Acute Medical Unit
ASC	Adult Social Care
ASQS	Adult Safeguarding and Quality Service
CCG	Clinical Commissioning Group
CJC Act	Criminal Justice and Courts Act 2015
CPA	Care Programme Approach
CPN's	Community Psychiatric Nurse
CQC	Care Quality Commission
DOLS	Deprivation of Liberty Safeguards
EMI	Elderly Mentally Impaired
GMP	Greater Manchester Police
GP	General Practitioner
HIT	Home Intervention Team
MCA	Mental Capacity Act 2005
MDT	Multi-Disciplinary Team
MHA	Mental Health Act 1983
NWAS	North West Ambulance Service
PCFT	Pennine Care Foundation Trust
QAO	Quality Assurance Officer
SAR	Safeguarding Adults Review
SMBC	Stockport Metropolitan Borough Council
SSAB	Stockport Safeguarding Adults Board