



# **South Tyneside Safeguarding Adults Board**

## **Serious Case Review into events at St Michael's View Care Home**

### **Executive Summary**

December 2013

# **South Tyneside Safeguarding Adults Board**

## **Serious Case Review into events at St Michael's View Care Home**

### **Executive Summary**

#### **Contents**

	<b>Page</b>
<b>1. Foreword</b>	<b>3</b>
<b>2. Introduction and Background</b>	<b>5</b>
<b>3. Terms of Reference and Scope of the Serious Case Review</b>	<b>6</b>
<b>4. Agency Involvement in the Serious Case Review</b>	<b>7</b>
<b>5. Engagement with Residents and Families</b>	<b>7</b>
<b>6. Findings and Analysis of the Investigation</b>	<b>8</b>
<b>7. Recommendations</b>	<b>9</b>
<b>8. Progress and Lessons Learnt</b>	<b>13</b>

## 1. Foreword

In May 2013, I was appointed as the Independent Chair of South Tyneside Safeguarding Adults Board. The Safeguarding Adults Board consists of key partner agencies which are tasked with ensuring that arrangements are in place to safeguard vulnerable adults. One of my first tasks was to oversee the monitoring of action plans from statutory agencies following events in 2010 at the St Michael's View Care Home run by Southern Cross Health Care Ltd.

A Serious Case Review was commissioned by the Safeguarding Adults Board to be undertaken by an independent author, whose findings were reported in full and accepted by all board members. It was clear that significant work had been undertaken by partner agencies. This work continues to progress and drive improvement forward. Improvements have been made to the way information between commissioners and the regulator is exchanged and monitored.

In 2010 an immediate priority of South Tyneside Council's newly appointed Chief Executive was to identify areas in need of strengthening. Significant work has been undertaken in the intervening period in implementing organisational changes and appointing personnel in key posts to ensure that Adult Social Care services, and in particular commissioning arrangements, are effective and robust.

At the time of Resident A's death in February 2010, the Care Quality Commission (CQC) did not undertake annual inspections of all care homes and St Michael's View had not been physically inspected since 2008. CQC subsequently changed its approach and now undertakes annual inspections of all care homes.

The care provider responsible for operating St Michael's View at that time, Southern Cross Healthcare Ltd, is no longer trading. From December 2011, St Michael's View was been managed by Countrywide Care Homes Ltd, and this provider has worked in partnership with safeguarding agencies to improve standards for residents.

It is clear that many of the failures in care standards whilst the home was managed by Southern Cross were the result of inappropriate practice and governance within that organisation. However, all agencies working with vulnerable service users must take collective responsibility to make sure such failures cannot continue to go unchecked. As Board members our heartfelt sympathy goes to the residents and their families who have been affected by these events in this Southern Cross care home.

Whilst systemic failures were identified in the Serious Case Review, it is also recognised that individuals were accountable for actions or lack of action. This resulted in criminal and professional proceedings being undertaken.

The Executive Summary of the Serious Case Review details specific actions, which are the result of a genuine desire by all key agencies to improve standards of care and support within care services.

The fundamental challenge still remains as to how we provide safe care for the most vulnerable members of society and how we do this in a way which ensures that dignity and compassion are integral to the way care services are delivered.

In seeking to publish this Executive Summary of the Serious Case Review, South Tyneside Safeguarding Adults Board believes that, whilst the journey to drive continuous quality improvement is still very much ongoing, we owe it to all service users, including the former residents of St Michael's View and their families and friends to demonstrate that lessons have been learned by all agencies.

As Independent Chair, and on behalf of the Safeguarding Adults Board, I commend this report and give assurances that the necessary improvements and actions outlined within will continue to be rigorously implemented and monitored to ensure that change is delivered.

**Dr Sue Ross**  
**Independent Chair**  
**December 2013**

## **2. Introduction and Background**

2.1 South Tyneside Safeguarding Adults Board commissioned a Serious Case Review following the death of Resident A at St Michael's View Nursing Home, South Shields, in February 2010. At the time of this incident the home was operated by Southern Cross Health Care.

2.2 South Tyneside's Safeguarding Adults Procedural Framework sets out defined criteria for consideration of commissioning a serious case review:

"A review will be held if an adult who is or may be eligible for community care services dies (including death by suicide) and abuse or neglect are known or suspected to be a factor in the death.

"Additionally, the Partnership will always consider whether a review should be conducted where:

- An adult sustains a potentially life-threatening injury or serious and permanent impairment of health and development through abuse or neglect; or
- An adult has been subjected to serious sexual abuse; or
- Serious abuse has taken place in an institution or multiple abuse is involved and the case gives rise to concerns about the way in which local professionals and services work together to safeguard adults."

2.3 The Serious Case Review Sub Group determined that the concerns surrounding care and practice at St Michael's View met the criteria for a Serious Case Review. A Serious Case Review is primarily undertaken with the intention to identify and share opportunities for learning across agencies.

2.4 An Independent Author was commissioned to prepare the overview report in relation to the review. This summary has been prepared on behalf of the Safeguarding Adults Board to set out the key issues identified in the report.

2.5 The report and recommendations prepared by the independent author were agreed and accepted by the Safeguarding Adults Board in April 2013. The timescale for the Serious Case Review initially took into account the criminal investigation by the Police but this did not delay immediate learning and improvement. The South Tyneside Coroner also opened and adjourned an inquest into the death of Resident A. This process remains ongoing. However the Coroner has recently agreed that the publication of this report would not prejudice the forthcoming inquest. Consideration has been given to the residents and families associated with St Michael's View in respect of the timing of the completion and publication of this report. Most recently this has included respecting the need for sensitivity relating to the closure of St Michael's View.

2.6 Following the death of Resident A, the police commenced an investigation into the circumstances that may have contributed to the death. These enquiries were subsequently widened to look at the provision of care and

support to all residents of St Michael's View during the year preceding the death of Resident A and thereafter. In addition the Safeguarding Adults Procedural Framework was implemented to address a number of emerging concerns relating to the care and support of residents at the home.

- 2.7 Following notification of the incident at St Michael's View, immediate measures were put in place to respond to the concerns and improve the delivery of care to residents within the home. Following evident failures in this Southern Cross Care Home, South Tyneside Council and partner organisations took the lead in affecting significant progress. A full investigation has taken place and action has been taken to implement practice recommendations identified both before and after the undertaking of an independent investigation. Work to monitor the implementation of the actions has been progressed.
- 2.8 The investigation identified systemic failings at St Michael's View. The investigation showed that, as well as failings in the management of St Michael's View, there were a number of areas for improvement across statutory services that were responsible for regulation, commissioning, monitoring and / or delivering services to vulnerable adults in St Michael's View. The investigation has therefore supported a whole systems approach to improvement.

### **3. Terms of Reference and Scope of the Serious Case Review**

- 3.1 The purpose, scope and terms of reference of the Serious Case Review were agreed through the Serious Case Review Sub Group and formed the parameters of the author's report. Terms of reference were determined as follows:
- To establish the lessons learned from the case about the way in which local professionals and agencies operated and worked together to safeguard vulnerable adults
  - To identify how the lessons will be acted upon and what would be expected to change as a result
  - To improve interagency working to better safeguard vulnerable adults
  - To review the effectiveness of Safeguarding Adults procedures, in particular the serious case review procedures
  - To establish what worked well, both within agencies and between agencies
  - To agree arrangements for monitoring the progress of any recommendations from the review through the Quality and Performance sub group
- 3.2 The Serious Case Review was asked to consider the following aspects:
- To undertake a whole systems review with specific focus on the roles of each agency identified in scope for the review

- To review the effectiveness of policies and procedures, systems and processes relating to organisation which were in place both before and after the events at St Michael's View
- Upon the completion of the review, to be able to identify clearly the influential factors that contributed to identified failings
- To establish lessons learned from the case about the way in which local professionals and agencies operated and worked together to safeguard vulnerable adults
- To identify how lessons will or have been acted upon and what is expected to change or has in fact changed as a result
- To consider the effectiveness of the safeguarding adults procedures in relation to managing the concerns and give further consideration to the appropriateness of the serious case review methodology in achieving the desired outcomes
- To make recommendations to improve interagency working to better safeguard vulnerable adults

#### **4. Agency Involvement in the Serious Case Review**

- 4.1 The review was undertaken and required information to be provided by the organisations listed below:

Northumbria Police  
 South Tyneside Council Adult Social Care  
 The Care Quality Commission  
 NHS South of Tyne and Wear Primary Care Trust  
 Northumberland Tyne and Wear NHS Foundation Trust  
 South Tyneside NHS Foundation Trust  
 The Coroner's Office for South Tyneside  
 Countrywide Care Homes Limited (Part of the Maria Mallaband Care Group)  
 The Nursing and Midwifery Council  
 The Health and Safety Executive  
 Northern Doctors Urgent Care Ltd  
 The Independent Safeguarding Authority

Individual Management Reviews (IMRs) were conducted within each agency as required by the terms of reference.

Southern Cross Health Care Ltd had ceased to operate by the time of the review and it was not possible to involve the company in the review.

#### **5. Engagement with Residents and Families**

- 5.1 Following the identification of the concerns at St Michael's View, South Tyneside Council and its partner organisations led in coordinating engagement with residents and families. Wherever possible, residents and families have been kept informed and up to date throughout this process.

## **6. Findings and Analysis of the Investigation**

- 6.1 Southern Cross Health Care operated at St Michael's View with a culture that had no effective measures in place to prevent abuse and neglect. There was a lack of clear governance, direction and oversight from managers, nursing and care staff. There was lack of effective workable policies and procedures. In addition there appeared to be a lack of awareness of whistle blowing procedures or any effective safeguarding training to support staff to raise appropriate concerns in line with their safeguarding responsibilities. Therefore the voice of the resident was not apparent.
- 6.2 The investigation identified that there were lessons also to be learned across wider services responsible for regulation, commissioning, monitoring and/or delivering services to vulnerable adults in St Michael's View which should have identified these problems earlier.
- 6.3 The review noted that hospital based processes could have been strengthened to recognise when safeguarding alerts should have been made when vulnerable adults were subject to repeated admissions to hospital from a care home.
- 6.4 In April 2009, the Commission for Social Care Inspection (CSCI) became the Care Quality Commission, with regulatory responsibility for Adult Social Care. At the time of Resident A's death in February 2010, the CQC still used the inspection methodology used by CSCI which did not require an annual inspection of every care home. The frequency of inspection took account of the service's star rating and self-assessment documentation completed by the provider. The most recent physical inspection of St Michael's View had been carried out in 2008. Following the events of February 2010, CQC carried out an inspection which downgraded the previous 2 star rating to zero stars. CQC now carries out annual inspections of all care homes.
- 6.5 It was identified that there was a need to strengthen commissioning, quality assurance and monitoring processes so that they are sufficient to identify and address opportunities for intervention when abusive or neglectful practice is suspected.
- 6.6 The review identified the importance of relatives having clear information about safeguarding protocols and where to get help external to the care provider when they had complaints about the care of their relatives.
- 6.7 The collective impact of consistently poor standards of care practice in St Michael's View, in particular with regard to the dignity and respect of residents, was evident. There were clearly unsafe, unhygienic and abusive practices carried out and an absence of individual and collective responsibility for management oversight, leadership and scrutiny. This suggests that these concerns were a Southern Cross Health Care organisational responsibility.



## **7. Recommendations**

7.1 This report has made a number of specific recommendations and suggested actions both locally and nationally in the following areas:

7.2 Countrywide Care Homes Ltd (care provider at St Michael's View since December 2011)

- Appropriate support from senior management and the directors of the company is essential
- Ensure that policy documentation is available and is user friendly and that staff are encouraged to read and understand the content.
- When external practitioners have an input into service delivery they should be introduced to appropriate staff, and the staff advised of the practitioners' involvement in service delivery with a view to preventing misplaced thoughts of a 'them and us' culture.

7.3 Care Quality Commission (CQC)

- CQC, in partnership with South Tyneside Council, should ensure that all relevant staff groups are clear about the different roles and responsibilities within the safeguarding system to ensure that information about concerns relating to regulated services is shared in the most effective and timely way
- CQC, in partnership with South Tyneside Council, should review the terms of reference of the information-sharing meetings and ensure that these are made available to providers, service users and stakeholders.
- CQC should review their systems to ensure that documentation is stored accurately and fulfils data protection requirements.
- CQC should direct the general public, who otherwise might look to CQC reports for information about residential care, to the variety of websites which contain this information, to enable residents and relatives to make informed choices about residential provision most suitable for their needs.
- CQC should not be solely reliant on a desk top review and should inspect care homes on an annual basis.
- CQC should revisit their current standards in order to attempt to incorporate qualitative standards in their inspections.

7.4 Local Authority - Adult Social Care

- Adult Social Care should investigate how well the Council's Escalation Policy is known and understood by the Safeguarding Partnership and address any communication gaps.
- Adult Social Care should work with provider services to enable them to undertake a self assessment as part of a safeguarding audit. This would strengthen their internal arrangements around safeguarding.
- Adult Social Care and the PCT continue to progress and build and complete the work that has begun in developing the joint protocol for reviews for jointly funded placements.

- Adult Social Care need to provide staff training in using the Quality Assessment Tool to ensure consistency of its usage and make sure assessors are suitable and able to address issues of concern. Work needs to be undertaken to make sure that appropriate written feedback is given to providers following the Quality Assessment and that this information is cascaded within the provider organisation.
- Adult Social Care need to rigorously quality check provider systems that are in place with specific reference to recruitment, training, supervision and appraisal processes. Assessors need to be properly trained to undertake this.
- Adult Social Care need to closely examine providers' quality assurance functions to ensure that they meet the standards of the Local Authority.
- Adult Social Care need to be directive and prescriptive with providers in undertaking safeguarding investigations in order that best practice is followed.
- Adult Social Care must review their Safeguarding Training in terms of its subject content to make sure that institutional abuse is given precedence in order to make all learners aware of the complexity of institutional abusive practice and how difficult this is to detect.
- Adult Social Care to co-ordinate and implement Compassionate Care Training throughout their directorate and provider sector.

#### 7.5 South of Tyne and Wear Primary Care Trust

- Programmes of timely annual continuing health care reviews are undertaken.
- A programme of joint monitoring visits to care home providers is undertaken annually.
- Financial penalties are enforced for care home providers who under-perform.
- The PCT (and its successor the CCG) review the capacity and resources of safeguarding and quality monitoring staff within structures.
- From April 2013 the CCG considers its future statutory obligations and representation within the Safeguarding Adults Board and Health and Wellbeing Board.
- The PCT (and its successor the CCG) must annually monitor the quality of clinical service provision which they fund and must not devolve this responsibility to the Local Authority.
- Consideration should be given to linking the Community Modern Matron and GP role to each residential nursing home. (Currently this process is working well within the Sunderland area).
- From April 1<sup>st</sup> 2013 the CCG will replace the PCT function. Transitional arrangements must be made to ensure that the good partnership which maintains standards and quality of care provision is maintained.
- The CCG need to ensure that Safeguarding Vulnerable Adults Training is mandatory and robust across the provision. This will require quality monitoring.

- General Practitioners require safeguarding vulnerable adults training with an emphasis on institutional harm. It is essential that this training addresses issues specific to whistleblowing.

#### 7.6 South Tyneside Hospital Foundation Trust

- The social worker review of the patient in hospital should have triggered a review of care package needs.
- Prior to 'boarding out' (internal patient transfers from ward to ward) staff must communicate and have in place an appropriate environment and suitable pressure relieving equipment available to meet specific patient requirements.
- A review of medical records must be undertaken in accordance with information governance guidelines under the accountability of the medical director.
- There should be monitoring of discharge planning documentation to ensure that this is fit for purpose and there must be duplication of key discharge documents to ensure that there are copies on file for each discharged patient.
- Family and patient involvement should be considered as part of the care management process by multidisciplinary team members to determine what support they require when deciding on appropriate accommodation for elderly relatives.
- Consideration must be given where repeated admissions of elderly vulnerable patients from Health and Social Care settings should prompt a 'trigger' to ask whether the care home is managing the needs of the patient. Home managers should be reminded that, when a patient's needs change, it may be more appropriate to request a review of NHS Continuing Health Care
- There needs to be a review of the Trust's 'boarding out' (internal patient transfers from ward to ward) process for patients with complex needs of both physical and mental impairment in order that patient-centred practice is adopted; this must not be resource-led.

#### 7.7 Northumberland Tyne and Wear NHS Foundation Trust (NTW)

- Review work commissioned by the Strategic Health Authority (SHA) Safeguarding Cluster Network - which has developed auditable practice standards.
- Consider the use of evidence logs linked to CQC Essential Standards which require ongoing assessment.
- Share lessons learnt across Health and Social Care
- NTW to liaise with Adult Social Care regarding behaviour management training in order to develop a co-ordinated consistent approach to practice across South Tyneside in order to develop quality standards around this.

#### 7.8 Northern Doctors Urgent Care Ltd (NDUC)

- NDUC need to ensure that all employees abide by their own protocols and procedures relating to any call out to residential care homes.
- NDUC need to provide all employees with relevant safeguarding adults training.

#### 7.9 Nursing and Midwifery Council (NMC)

- The NMC need to ensure that they communicate effectively to external stakeholders about the need for early referral to the NMC where there are public protection and patient safety issues.
- The NMC to review the length of time taken to resolve cases involving nurses who are in disciplinary proceedings.
- The role of the NMC needs to be made more visible within care homes for both staff and relatives.

#### 7.10 Health and Safety Executive (HSE)

- The outcome of the review will be circulated to the relevant sector leads in the HSE.

#### 7.11 Coroner's Office

- At a local level the monitoring of those deaths in care establishments can be reinforced by a central reporting of all deaths in such establishments to the Coroners
- In order to be effective, policing practice should not undermine the morale of the care providers or inhibit the execution of their work, nor undermine the confidence of the users of the service or their families in that service.
- To develop, with Northumbria Police, a co-ordinated approach force-wide that ensures retrieval of relevant records covering the 48 hours prior to any suspicious death. The coroner will need to liaise with coroners throughout Northumbria to co-ordinate this.

#### 7.12 Northumbria Police

- Complex investigations require a multiagency approach to ensure that there is professional knowledge and expertise across all disciplines.
- In considering the circumstances of a sudden death the attending officer should examine the care plan for the 48 hours immediately prior to death for any omissions, deletions or alterations or any other text which suggests there is evidence that third party involvement has caused, contributed or accelerated the death. In such cases a Detective Inspector should be called to the scene to allow an assessment as to whether the death is suspicious or non-suspicious.
- A copy of the care plan for 48 hours immediately prior to the death together with a copy of the report to the Coroner should be delivered to the Protection of Vulnerable People (PVP) Duty Detective Sergeant.

- The PVP Duty Sergeant will contact partner agencies in order to convene a rapid review meeting. The purpose of the rapid review meeting will be to allow for at least 2 medical practitioners to have clinical oversight of the medical records to assess whether the provision or neglect of medical care has caused, contributed or accelerated the death. Any such findings will be referred to a Senior Investigating Officer (SIO) for further consideration as to whether the death is to be treated as suspicious or non-suspicious. The result of the review meeting will be passed to the Coroner.
- Northumbria Police policy should reflect the specific considerations relevant to responding to the report of a sudden death within a care setting and raise awareness with all frontline officers.
- A requirement has been set by this Serious Case Review that retrieval of records within 48 hours following a sudden death in residential care homes be implemented force-wide and not just be specific to South Tyneside. Liaison via HM Coroner will be essential in this transition.
- The Senior Investigating Officer (SIO) role needs to consider the timeline from the point at which an organisation takes over the running of any establishment for which there is a complex investigation.
- The police must re-consider both roles of CQC and HSE in any residential home investigation when subsequent evidence is uncovered, in order to make sure that the relevant investigative areas are addressed appropriately.

#### 7.13 Safeguarding Adults Board

- Within complex safeguarding investigations, the learning from children's investigations should be incorporated into investigative practice.
- The Local Safeguarding Adults Board must co-ordinate and swiftly implement Serious Case Reviews that run parallel to criminal investigations in order that the lessons learned can be implemented sooner.
- The Local Safeguarding Adults Board should give consideration to the continuing professional development of the Safeguarding Managers' Role within the authority in order to keep apprised of best practice.

Agencies involved are aware of these recommendations and arrangements are in place to report on progress to the Safeguarding Adults Board. The Board will continue to provide oversight and scrutiny of ongoing progress and actions of partners through appropriate monitoring arrangements.

## 8. Progress and Lessons Learnt

- 8.1 Two members of staff from St Michael's View were subsequently prosecuted and convicted, one for the wilful neglect of Resident A and the other for serious abuse against several other residents.
- 8.2 NMC Fitness to Practice Hearings, held in February 2013 and then in June, July and August 2013, regarding nine former nurses at the home, have resulted in sanctions.

- The manager of the home (registered nurse) has been struck off the nursing register
  - The deputy manager of the home (registered nurse) has been struck off the nursing register
  - One other former nurse has been struck off the nursing register
  - One former nurse was given a one-year suspension order
  - Two received a one-year conditions of practice order
  - One has a six-month conditions of practice order
  - One has a four-year caution order
  - One case has been adjourned for the future
- 8.3 The interface between the Local Authority Safeguarding and Commissioning Services, Health and CQC are now strong. Regular bi-monthly information sharing meetings are held, where intelligence and information is considered to ensure effective partnership working. Early warning signs are carefully considered when alerts are raised by risk notifications, complaints or anonymous referrals.
- 8.4 CQC have continued to regulate and inspect St Michael's View rigorously and improvement is evident against the essential standards for quality and safety as outlined in Section 20 of the Health and Social Care Act 2008. CQC now undertakes at least one annual inspection of all registered care homes in England.
- 8.5 The Local Authority has led on intensive work with care home providers to improve quality standards including the introduction of a comprehensive Quality Standards Framework and Quality Monitoring Tool.
- 8.6 Considerable work has been undertaken by South Tyneside NHS Foundation Trust to strengthen the identification of safeguarding concerns regarding vulnerable adults who are subject to repeated admissions to hospital from a care home.
- 8.7 The Safeguarding Adults Unit has a key role in raising awareness of safeguarding adults, ensuring that members of the public know where to access advice and support and where to report their concerns. Public information is available in a variety of formats.
- 8.8 The ongoing innovative work being jointly developed and initiated by the safeguarding and commissioning services focuses on prevention, compassion in care and the service user's experience of care, incorporating wider learning from Serious Case Reviews. It provides further assurances about the measures that the council is taking to tackle the root causes of poor practice so that compassionate care giving is at the heart of service provision and the service user's experience.
- 8.9 Local Authority Commissioners have implemented strategic and operational systems and processes that give assurance that care establishments provide choice and control to service users. They also

promote independence and offer value for money, whilst managing and mitigating safeguarding risk.

- 8.10 The strengthened commissioning arrangements enable oversight of plans for developing the provider workforce and supporting staff to have the right skills and capabilities to offer the best possible service.
- 8.11 Work is taking place to ensure appropriate oversight and support to residential and nursing homes including the establishment of guidance which enables the safeguarding team to build intelligence, identify and monitor concerns.
- 8.12 Work required to improve the delivery of care and support in St Michael's View was immediately identified and improvements commenced in advance of the start of the Serious Case Review. This meant that significant work undertaken by the Local Authority and partner agencies could be clearly evidenced against the Serious Case Review findings. This work has continued to be taken forward in the midst of significant organisational changes throughout the Public Sector. Since January 2010 key changes that have strengthened governance and partnership working include:
- Strengthening of the management structure within Adult Social Care
  - Regular information sharing meetings involving Local Authority Commissioning, Safeguarding Services, Health and the Care Quality Commission
  - Establishment of a local Health and Wellbeing Board
  - Appointment of an independent chair of the Safeguarding Adults Board
  - Establishment of a Clinical Commissioning Group (replacing the South of Tyne and Wear Primary Care Trust).
  - Appointment of a safeguarding specialist within the Clinical Commissioning Group
- 8.13 South Tyneside Safeguarding Adults Board will continue to provide the necessary oversight and governance of both the recommendations outlined in this report and the ongoing work required to strengthen and improve services to safeguard vulnerable adults now and in the future.
- 8.14 The Safeguarding Adults Board recognises the impact of the events on residents and families at St Michael's View. The Safeguarding Board wishes to assure staff, service users and their families, and members of the public that lessons have been learnt. Once again empathy and condolences are sincerely expressed, on behalf of the Board, to the residents and families affected.