BUCKINGHAMSHIRE SAFEGUARDING ADULTS BOARD

SAFEGUARDING ADULTS REVIEW

Adult CC

Final Overview Report

Independent Author: Martin Bradshaw

CONTENTS

1. Introduction

1.1 Circumstances of Review

1.1.1 Adult CC was a 58-year-old man living in supported accommodation at 'Round Coppice Farm' provided by 'Enriched Care' in Buckinghamshire. He had a long history of schizophrenia and substance abuse. There was a fire in his bedroom on 10.4.19 and CC died as a result. The cause of death had not been formally established by the Coroner at the time of writing this report (July 2020).

1.1.2 A Large Scale Enquiry (LSE) investigating organisational abuse commenced in April 2019, following concerns for many other occupants of supported accommodation run by the same company. This review concluded in April 2020.

1.1.3 In June 2019, the Safeguarding Adults Sub Group agreed to initiate a Safeguarding Adults Review (SAR) in respect of CC. The first Panel meeting was held on 1.8.19, and Martin Bradshaw was confirmed as Author of this Overview report. He is a retired commissioning manager with extensive experience of mental health investigations and reviews.

1.2 Purpose of a Safeguarding Adults Review

1.2.1 Safeguarding Adult Reviews are undertaken when a vulnerable adult dies or is seriously injured and abuse and/or neglect is known or suspected to be a factor.

1.2.2 The purpose of a SAR is neither to reinvestigate nor to apportion blame, but to establish if there are lessons to be learnt to prevent such an incident happening again. The principal reasons for holding a review are to learn from past experience, and to improve future practice and multi-agency working. Safeguarding Adults Reviews have become a Statutory Duty since the Care Act 2014 came into force on 1st April 2015.

1.2.3 In Buckinghamshire the SAR Panel makes recommendations to the Buckinghamshire Safeguarding Adults Board (BSAB) chair. It manages the SAR process in accordance with the BSAB Policy and Procedures for Safeguarding Adult Reviews. The Panel considers whether a case meets the criteria for a SAR, applying the criteria as laid out in the Care Act 2014 and its accompanying guidance.

1.2.4 Having taken into account a range of factors, it was determined that this case met the criteria and a SAR was recommended and commissioned by the BSAB SAR subgroup.

1.3 Terms of Reference

1.3.1 The SAR has five broad aims:

- To reflect and learn from the incident, in order to improve future practice
- To develop more competent multi-agency practice in the long term
- To provide insights into underlying issues such as the impact of organisational culture on decision making
- To identify if processes or systems need to be changed or developed
- To strengthen the accountability of managers to take responsibility for the context in which their staff are working, and ensure adequate support

1.3.2 Specific areas of focus included:

- Information Sharing and Communication

- Mental Capacity/Consent

- Assessments/Risk Assessments

- Fire Risk

- Commissioning

- Substance Misuse

1.3.3 The timeframe for detailed review agreed by the Panel was 1st July 2017 to 10th April 2019 (date of death).

1.4 Scope and Exclusions

1.4.1 This SAR is primarily concerned with the actions of statutory agencies prior to the death of CC. It does not examine the recovery and investigation process following the incident, or the management actions taken by the Large Scale Enquiry to safeguard or re-house other tenants of Enriched Care.

1.4.2 A full SAR would usually include a contribution from the Provider of service involved in direct care or support of the subject. Crucially, this SAR does **not** consider in detail the actions or professional competence of Enriched Care, the Housing Provider.

1.4.3 The Proprietor of Enriched Care was subject to ongoing Police, Fire and Health and Safety investigations at the time of writing the SAR. A senior member of his staff was not available for interview, and key records had been seized by Police. Evidence from these investigations was not available to the SAR for procedural reasons. It was therefore not considered appropriate for the Proprietor to be invited to be a member of the SAR Panel, or for Enriched Care to produce an Individual Management Report (IMR) because of the ongoing criminal investigations. The outcomes for the SAR and any next steps will be considered by the Panel subject to final decisions on prosecution.

1.4.4 The Inquest into CC's death had not been held at the time of writing, so no cause of death has been formally recorded by the Coroner. The detailed circumstances of how he died are not covered in the SAR.

1.4.5 It was not possible to commission an independent Individual Management Report into Enriched Care, as this would potentially prejudice the ongoing Police investigations. A letter, along with a list of questions, was sent to Enriched Care by the Chair of the Safeguarding Adult Review Panel. The Provider response is included as an Appendix to this report.

1.5 Contributors to Review

1.5.1 Each statutory agency was invited to submit a chronology of involvement with CC, with the main focus on the 21 months prior to date of death. These chronologies were later combined to form a single record of events.

1.5.2 Agencies were also requested to provide Individual Management Reports using a standard format, to give a more detailed account of events and analyse the implications for the organisation.

1.5.3 Several agencies also contributed background reports and supplementary information and the Author is grateful for this assistance with the SAR.

The contributors to the Review were:

AGENCY	MAIN CONTRIBUTION
1. Berkshire Healthcare NHS Foundation Trust	IMR
2. Buckinghamshire Clinical Commissioning Group	IMR
3. Buckinghamshire Council, Safeguarding	IMR
4. Buckinghamshire Fire and Rescue Service	IMR
5. Oxford Health NHS Foundation Trust	IMR
6. Reading Borough Council	IMR
7. Thames Valley Police	IMR

1.6 Review Panel Members

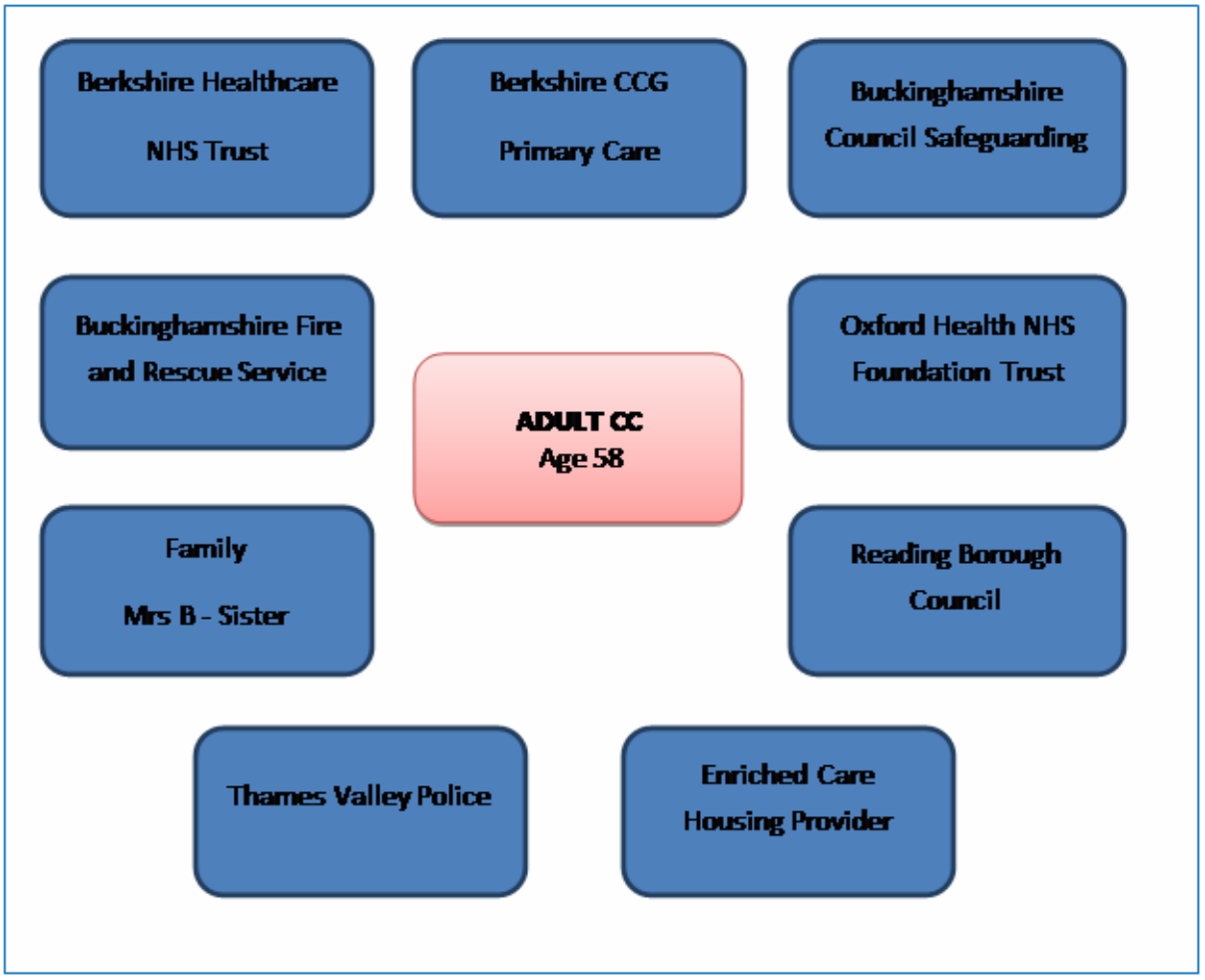
Agency	**Name**	**Job Title**
Buckinghamshire Council	Suzanne Westhead Elaina Quesada	SAR Chair SAR Chair July 2020 – present. Director of Adult Social Care, Operations
Buckinghamshire Safeguarding Adults Board	Vince Grey	Safeguarding Partnership Manager
Contractor	Martin Bradshaw	Overview Author
Berkshire Healthcare NHS FT	Jane Fowler	Head of Safeguarding
Bucks CCG	Dr Sarah Abbas	Named GP for Safeguarding
Buckinghamshire Council, Safeguarding	Julie Murray	Head of Service – Safeguarding Adults
Buckinghamshire Fire and Rescue Service	Joanne Cook	Community Safety and Safeguarding Manager
Oxford Health NHS FT	Moira Gilroy	Safeguarding Adults Manager
Reading Borough Council	Teresa Gravett-Smith	Safeguarding Lead
Thames Valley Police	Carl Wilson	Detective Inspector
Buckinghamshire Council, Commissioning	Paula Ivey	Commissioning Manager
Healthwatch	Barbara Poole	Lay Member

1.7 Responsibilities to Families

1.7.1 Good practice requires families to be involved in the SAR process so that they can contribute as appropriate. The sister of CC (Mrs B) was contacted by the Oxford Health NHS Foundation Trust Investigation Team and invited to a meeting about her brother, but she declined. She did discuss some issues with the team by telephone on 5.6.19. A letter was also sent to Mrs B by the Chair of the BSAB on 7.8.19 offering involvement in the SAR, but Mrs B did not respond.

2 The Facts

2.1 – Genogram



2.2 Overview/Background – Birth to June 2017

This summary provides a general overview of key events. It is not exhaustive or independently corroborated.

2.2.1 - Family and Social History

CC was born on 22nd October 1960. He was the youngest of four siblings, with two sisters and one brother. There were no reported difficulties with gestation, birth and early development. CC went to school in Reading. When he left school at age 16, he had a job making spotlights. After six months he moved to work as a motor mechanic for the next two years. CC also gained a City and Guilds Certificate in Carpentry and Bricklaying. CC also made quite a few friends in the various locations that he lived and during his hospital stays he got on very well with a lot of people forging a small number of friendships.

2.2.2 Following the emergence of his mental illness, he was unemployed for some ten years. He worked as a cleaner from 2003-2005.

2.2.3 Little information is available about CC's family. He previously stated that he was estranged from most of them, but had regular contact with one sister (Mrs. B). CC is reported to have had one long term relationship. Mrs. B noted '*when my brother's mind was in a good place, he was a very intelligent and generous person and always had a joke up his sleeve to tell. Whenever I visited him whether in hospital or at the house he was living at, he always felt he had to give me something usually a bar of my favourite chocolate which he knew I liked…When he was not in a good place, he could be awkward towards the staff and liked to do 'his own thing' rather than be told what to do'*.

Forensic History

2.2.4 The first recorded conviction for CC was at age 13, when he was given a 3-year supervision order for burglary, theft and criminal damage. In 1980 he lost his driving licence after numerous motor offences, and then received a 6-month prison sentence in 1982 (age 22) for criminal damage and driving while disqualified. CC was fined in 1983 for driving while disqualified, and again in 1984 for possession of an offensive weapon. He received a 12-month conditional discharge in 2007 for common assault and criminal damage.

Physical Health

2.2.5 CC was reported to suffer from various skin problems, and to have been prediabetic. His cholesterol level was high when last seen by GP in January 2019. No other significant physical health issues are noted.

Mental Health up to June 2017

2.2.6 The first recorded contact with psychiatric services was when CC was 14. He was seen by Child and Adolescent Mental Health Services with "delinquent behavior", but no mental illness recorded at that time. His first admission to hospital was aged 23 with psychotic illness, possibly drug induced. He was also diagnosed with Personality Disorder.

2.2.7 CC was admitted to psychiatric care on ten occasions between 1988 and 2005. In one incident in 2001 he reportedly strapped petrol cans to himself and was in possession of bomb making equipment. In 2005 CC had a Forensic Assessment while admitted. The impression was of chronic psychotic illness with underlying personality traits of suspiciousness, bearing grudges and interpreting the actions of others as hostile.

2.2.8 In 2008 CC was placed on a Community Treatment Order (CTO) due to lack of compliance and engagement with community treatment. Two years later in 2010 he was recalled from the CTO and readmitted. He was isolating himself, had bizarre behaviour, flooded corridors, hid knives in his room and was microwaving paper. The diagnosis was Schizoaffective Disorder – mixed type.

2.2.9 There were multiple admissions to Prospect Park Hospital Psychiatric Hospital (run by Berkshire Healthcare NHS Foundation Trust) between 2010-2015, with almost continuous detention from 2013. Reports note that the behaviour of CC was aggressive at times, including damaging property and assaulting a member of the public while on leave. His diagnosis in March 2018 was Paranoid Schizophrenia.

Substance Abuse

2.2.10 The historic information available on substance abuse is limited, but discharge summaries note that CC had given inconsistent accounts of his drug and alcohol use over the years. He was known to have been admitted for alcohol detox in the past, and to have been aggressive towards staff during those admissions.

2.3 Detailed Chronology - 1.7.17 to 10.4.19 (date of death)

2.3.1 This Chronology is from statutory agencies and is not exhaustive. It does not include detailed input from Enriched Care, so is clearly incomplete.

2.3.2 On 18.7.17 CC's mental health had deteriorated, and he was transferred to a Psychiatric Intensive Care Unit (PICU) at Huntercombe Hospital, Roehampton. This is an independent sector psychiatric hospital. Following treatment and management in Roehampton he was later transferred to Prospect Park Hospital PICU under Section 3 on 15.8.17. CC was calm on arrival, but not compliant with assessment.

2.3.4 By 18.8.17, CC was more settled, but lacked capacity to make decisions about his treatment. He was reasonably calm for the next week, spending most of the time in his room. During this period (date unclear) his mood was lower and he was found smoking on the ward. The cigarettes were removed as per ward policy, and this made CC angry.

2.3.5 By September 2017, CC was being considered for discharge. He was taken to Focus House in Reading on 1.9.17 to see an example of Supported Accommodation, and behaved appropriately during the visit.

2.3.6 On 11.9.17 CC became aggressive towards ward staff when they encouraged him to shower and clear a lot of rubbish from his room. The tidy-up was abandoned due to his behaviour, and to allow him to settle. He continued to isolate himself.

2.3.7 On 18.9.17, CC confided in staff that prior to admission he had fallen asleep with his hand in the ashtray. There is no evidence to indicate that this incident was later communicated to Enriched Care staff as part of a fire/smoking risk assessment. The same day, CC was transferred from PICU to Daisy Ward in Prospect Park Hospital without any problems.

2.3.8 Ten days later (28.9.17), CC was taken by an Occupational Therapist (OT) to visit Supported Accommodation in Winchester. While the trip was uneventful, it is unclear from records if the accommodation was suitable or not.

2.3.9 On 10.10.17, CC had a Managers Hearing under S3, and remained detained. He still met the criteria for compulsory detention in hospital.

2.3.10 There was a Ward Round on 15.11.17, and it was agreed that CC could have 2 weeks trial leave under S17 to the Moat House in Iver. This was Supported Accommodation operated by Enriched Care. The Provider had reportedly confirmed that the placement was suitable for people with dual diagnosis of psychosis and substance abuse. There is no evidence that CC had visited the placement before agreeing to live there.

2.3.11 CC moved to the Enriched Care placement at Moat House the next day (16.11.17) on S17 leave. A handover report, medication list, risk assessment and care plan were given to the receiving staff.

2.3.12 The placement was reviewed by a Doctor after two weeks on 30.11.17. CC was discharged from the Section 3, and from Daisy Ward. The plan was for the case to be handed over to the Local Authority (Reading Borough Council), but this referral was apparently never made. A follow-up visit to Moat House was conducted by Reading Community Mental Health Team (CMHT). CC was low in mood, and ambivalent about taking his medication.

2.3.13 CC visited and registered with the local GP on 11.12.17, but did not engage and walked out after a short period. At some point after this date, CC moved to Round Coppice Farm, but no details are recorded of the reason for this change.

2.3.14 On Christmas Day 2017, Police were called to an altercation between CC and another tenant. There were no injuries, and staff said they were able to prevent escalation.

2.3.15. On Boxing Day 2017, CC was asked by staff not to smoke on the premises. An argument followed, CC became aggressive towards staff. There was an assault on staff, but no injury recorded. Police were called and CC was arrested. His mental state had apparently been deteriorating for two days. This had not been reported to CMHT, for reasons which are unclear.

2.3.16 Following an assessment in Custody, CC was detained under S2 of the MHA and admitted to Daisy Ward at Prospect Park Hospital on 26.12.17. He became increasingly aggressive the next day, and there was a serious altercation with staff about smoking after CC lit a cigarette indoors. A PICU assessment was requested due to the severity of his aggression. On 28.12.17 he was found to have a lighter in his pocket, and handed it to staff on request.

2.3.17 Later the same day (28.12.17) CC was found smoking a cigarette in his bedroom and the courtyard. He refused permission to hand over the smoking materials, and nothing was found after a search. He was again found smoking on 30.12.17, and suspected of smoking on 31.12.17.

2.3.18 Late on 31.12.17 CC became very aggressive when challenged by staff about smoking. He damaged a door and fire panels, then barricaded himself into the kitchen and lit a cigarette. He threatened to punch staff and was charging towards them. CC was reportedly overheard encouraging another patient to set fire to the hospital.

2.3.19 Following a documented assessment, CC was transferred to Sorrel Ward PICU at Prospect Park on 1.1.18. Records show that illicit smoking was a serious risk factor, with CC refusing to comply with rules, hiding sources of ignition and cigarettes. Threats of arson were also noted.

2.3.20 On 7.1.18 there was a kitchen fire at Round Coppice Farm attributed to use of a deep fat pan by persons under the influence of drink or drugs. Although CC was in hospital at the time, this incident raises questions about general fire risks and supervision at the premises.

2.3.21 Buckinghamshire Fire and Rescue Service (BFRS) conducted a preliminary Post Fire Audit at Round Coppice Farm on 10.1.18, and gave advice on immediate action required. BFRS was told (in error) that the premises were registered as ‘residential’ with the Care Quality Commission (CQC).

2.3.22 CC was reported as smoking in the PICU bathroom on 11.1.18. A search was conducted and a lighter and other contraband was found. He was hostile and aggressive towards staff during and after the search.

2.3.23 Following a Mental Health Act assessment, CC was detained under S3 on 22.1.18. He was noted to be hostile to most staff, racially and verbally abusive. Staff had difficulty in removing ripped bedding from his room after reminding him on several occasions about the hygiene implications.

2.3.24 Police received an anonymous call on 8.2.18 about drink and drug abuse at Round Coppice Farm, naming CC among others. CC was an in-patient at Prospect Park Hospital at the time.

2.3.25. While on S17 leave on 10.2.18, CC purchased cigarettes and matches, and was found to be hiding a box of matches on return to the hospital on 10.2.18. It is not clear if this incident was reported to staff at Round Coppice Farm.

2.3.26 Buckinghamshire Fire and Rescue Service conducted a detailed audit at Round Coppice Farm on 12.2.18, and total capacity was noted as 11 tenants. The property was not CQC registered. No specific Fire Risk Assessment was in place, although fire had been included in the general risk assessment, which was noted as not suitable or sufficient. Problems included staff not properly trained in fire response, roles not defined, self-closers needed on many doors, emergency lighting insufficient, alarm system inadequate and insufficient extinguishers. A formal letter was sent to Round Coppice Farm on 15.2.18 by Buckinghamshire Fire and Rescue Service.

2.3.27 After a period of trial leave, CC returned to live at Round Coppice Farm on 8.3.18 after a Depot injection. His S3 was discharged. This stay in hospital had been over two months, including periods in PICU. A follow-up check visit was made on 13.3.18, and CC said that his room had been broken into.

2.3.28 A placement review was conducted by a Reading CMHT Social Worker at Round Coppice Farm on 25.5.18. CC had accepted two Depot injections without incident since his return. He reported not getting on well with staff, who were 'always on at me to do things'. The Risk Assessment completed by the CMHT Social Worker did not specifically cover smoking, although this had been identified as a risk. Smoking cessation was offered and refused. CC needed constant prompting to get up, and to get washed and dressed.

2.3.29 A week after the review (1.6.18), CC's mental state was deteriorating rapidly. There was some confusion about which team Round Coppice Farm should contact for help. A call was made by Round Coppice Farm staff to the Crisis Response Team (East), but he was out of their area. The call was transferred to Reading CMHT. CC was reported to be aggressive, damaging property, not sleeping and was non-compliant with medication. A Care Coordinator visited on 1.6.18 and Police were also called, noting that standards of care were falling short. An Adult Protection report was completed by TVP, but submitted with the name transposed. No report was actually received by Adult Social Care. There was further confusion about a Mental Health Act assessment. CC accepted medication and settled down. Agencies had some discussion as to where support should come from. The Reading CMHT Care Co-ordinator was advised to contact the South Oxfordshire Approved Mental Health Professional (AMHP) service, but in the event no assessment took place.

2.3.30 CC was seen by his Care Coordinator from Reading CMHT in mid-June (14.6.18). He was anxious and irritated, and alcohol consumption was increasing. CC agreed to have his depot injection two days early.

2.3.31 On 15.6.18, Buckinghamshire Fire and Rescue note that Enriched Care had been instructed by Chiltern and South Bucks District Council to register the property as a House in Multiple Occupation (HMO). Occupancy had been noted as 11 tenants in February 2018, and the regulations require HMO registration if 5 or more unrelated people live in the same property.

2.3.32 On 14.7.18, CC refused his Depot medication, saying he wanted his GP to give the injection. After various attempts to get CC to have his Depot, he eventually attended a hospital clinic on 23.8.18. and accepted the injection.

2.3.33 Buckinghamshire Fire and Rescue visited Round Coppice Farm on 16.7.18 to check progress on fire precautions. Installation of a new fire alarm system was in progress, but there were no self-closers on several doors and other doors were not fire resistant. The front door required manipulation of two devices to open it. No new Fire Risk Assessment had been produced. A commissioning certificate for the new alarm system was issued on 30.7.18.

2.3.34 CC was assessed on 12.10.18 by a mental health practitioner from Berkshire Crisis Team. His mental state had been deteriorating for several days, and his room was in a state of neglect with food packaging and rubbish on the floor. There were empty 2 litre bottles of cider in the room. After considerable confusion between Berkshire and Buckinghamshire AMHP services, Emergency Duty Team and Berkshire Crisis Team about case responsibility, a partial MHA assessment was conducted on 13.10.18. CC was seen by two Doctors, but later refused to engage with the AMHP and the assessment was aborted. CC was restless with increased aggression, and believed there was imminent danger of nuclear war. He had not slept for several days and was drinking increased amounts of alcohol. The Doctors assessing under the Mental Health Act noted that care responsibility had slipped between Reading CMHT and Chiltern CMHT.

2.3.35 After much more discussion about case responsibility, CC was finally removed from Round Coppice Farm by Police late on 14.10.18, and taken to the Whiteleaf Centre OHFT under a S135 Warrant. He was intoxicated and incoherent, and placed in seclusion due to the level of aggression to staff. Behaviour was bizarre, sexually disinhibited, confused and chaotic. A Section 2 detention order was later made and CC was admitted to Sapphire Ward at Whiteleaf Centre. His agitation and aggression subsided over the next few days, but he remained delusional.

2.3.36 On 25.10.18 CC was visited in hospital by staff from Round Coppice Farm. He remained deluded and paranoid with some racist statements. It was noted that he was eating and drinking well, compliant with medication and was less aggressive.

2.3.37 By 1.11.18, CC had improved, was ‘bright in mood and pleasant on approach’. He was able to have escorted leave outside the hospital, but remained chaotic and thought-disordered. On this day he was found to have matches in his possession, but surrendered them without a problem. Four days later he was again found smoking, and another lighter was confiscated.

2.3.38 On 6.11.18 CC was found lighting ‘bits of plants on fire in his bedroom on the ward’. The reason for this is not clear in the notes, and no action appears to have been taken regarding risk assessment. 3 days later (9.11.18) he was assessed under the MHA and detained under S3. Notes record that he was guarded and suspicious on interview, lacking capacity and insight.

2.3.39 In November 2018, Berkshire Healthcare NHS Foundation Trust continued to fund the placement while CC was in hospital, and retained full responsibility for the quality of care commissioned for CC. During November 2018, Reading CMHT raised concerns with the BHFT Out of Area Placement Service (OAPS) about Round Coppice Farm. Three clients placed there had frequently relapsed and required re- admission to hospital. It was thought that the placement was not able to support Service Users adequately. The placement for CC was subsequently terminated by OAPS while he was in hospital. The Reading CMHT Service Manager was reportedly asked to give notice to the provider, and it was then the responsibility of the Reading CMHT Care Co-ordinator to give notice to the provider and follow up in writing. It is not clear from the IMR or subsequent correspondence why termination did not take effect as intended.

2.3.40 By the end of November 2018, CC had improved considerably on the ward. He had several successful periods of escorted and unescorted leave, and spent most of his time in his room, sleeping a great deal. Ward staff had some concerns about how Depot medication would work if he was discharged; it had been unreliable in the past. Round Coppice Farm had agreed to have him back, some 6 weeks after his admission to Whiteleaf Centre. A multidisciplinary review was held on the ward on 29.11.18, and it was agreed that CC could be discharged back to Round Coppice Farm on S17 leave that day. He had recovered to baseline mental state and was relatively stable. The placement was technically terminated by then.

2.3.41 A 48-hour follow-up visit was made to Round Coppice Farm by OH staff (30.11.18). CC presented as stable in mood and mental state. He had lost his keys and staff were looking for them. Risks were deemed to be low to CC and others.

2.3.42 On the 5.12.18 and about a week after returning to Round Coppice Farm CC called Police, saying he was locked alone in a Taxi and going to set himself on fire. He sounded drunk. The driver returned shortly afterwards, having bought cigarettes, and no further action was taken. The next day (6.12.18) Round Coppice Farm staff telephoned the Oxford Health AMHT Chiltern Step-Up Team with concerns about CC's mental state. The request was that he was returned to hospital. His behaviour had been escalating with increased agitation, and he had bought a saw which was removed from him. Round Coppice Farm staff later called the Police to report CC being aggressive, and that a staff member had locked himself in the staff room for safety. The manager arrived to help and the situation was resolved without police attendance.

2.3.43 The Care Coordinator from Reading CMHT visited Round Coppice Farm on 7.12.18 after CC had been abusive on the phone. He presented as irritable, and was drinking alcohol from a can. Unit rules were enforced, and he was told to hand over all alcohol.

2.3.44 On the 10.12.18 an attempt was made on by a Reading Borough Council (RBC) Locum Social Worker to arrange to see CC for a Care Act Assessment, and to consider funding under S117. A visit was booked for 27.12.18, but the appointment was cancelled by CC. The placement continued to be 100% funded by Berkshire Healthcare NHS Trust until the death of CC in April 2019.

2.3.45 Round Coppice Farm staff made several telephone calls to BHFT in December 2018 and early January 2019, and were advised to contact Buckinghamshire CMHT. CC had been transferred to Buckinghamshire CMHT on 6.1.19. Staff were concerned about increasing aggression by CC, damage to property, agitation and rambling speech. Raw chicken was being hoarded in his room. The Buckinghamshire CMHT Care Coordinator visited by appointment on 23.1.19. CC did not want the Nurse to enter his room. Depot was given. Staff reported that he was very abrupt with them, but less aggressive than before. He was drinking alcohol most days at that stage.

2.3.46 On 11.1.19, a joint visit was made to Round Coppice Farm by Thames Valley Police and a Safeguarding Social Worker from Buckinghamshire County Council Safeguarding Adults Team (Mr A). This followed the death (from natural causes) of a different Service User. General comments by the Social Worker were that filing was disorganised, and neither of the staff could access support plans on the computer. The condition of Service User's bedroom was poor, with insufficient furniture, unkempt and untidy conditions and a vessel of urine in the room. The medication charts were in place and accurate. During the visit, the fire alarm was activated. The visitors were not instructed what to do by staff, who appeared to have no idea how to respond to the alarm.

2.3.47 Following the visit, Mr A deemed it necessary and proportionate to write to all four Authorities which were funding placements at Round Coppice Farm. The intention was to ensure 'the Authorities were satisfied the service could meet the needs for which they were commissioning'. He informed them that the care planning and recording were not sufficiently robust for the level of need. The practical fixtures were very poor, based on observation of communal areas and one bedroom.

2.3.48 CC was visited as planned by the Buckinghamshire CMHT Care Coordinator on 22.2.19. CC said he was well and not drinking as much. He did not want staff to enter his room. He accepted his Depot. About 10 days later CC called the Step-Up team (5.3.19) to say he was relapsing and feeling paranoid. He was visited at home the next day by the Care Coordinator (6.3.19), who advised support staff about use of PRN medication. They did not appear to have a clear understanding about the use of medication.

2.3.49 CC was arrested by Police on 12.3.19 after threatening staff and causing criminal damage to doors and CCTV. He had drunk a bottle of whisky and was highly intoxicated. CC was released under investigation, but died the following month before the investigation was completed. A referral was made to Bucks Safeguarding Team by Police. The Round Coppice Farm Manager was contacted, and a letter was written by Chiltern District Council to CC about his anti-social behaviour.

2.3.50 The Buckinghamshire CMHT Care Coordinator attempted to review the case at Round Coppice Farm on 20.3.19, after recent violent episodes. CC refused his Depot, or to come out of his room, and the Manager of Round Coppice Farm did not attend. However, CC did attend an outpatient appointment five days later on 25.3.18, and accepted his Depot. His presentation was hostile and he did not engage with the Nurse.

2.3.51 CC was finally assessed for funding by Reading Borough Council on 1.4.19, after a long series of delays. The Care Act documentation was noted on the Individual Management Report to be incomplete, with no further details. It was subsequently recorded as required on the 'Mosaic' system. Notes indicate that CC was a smoker, hoarding rubbish and had set fire to another resident's clothes. However, fire risk is not specified or explored further for risk management. The placement was recorded as meeting CC's needs. CC wrote to his Social Worker immediately after the visit, making positive comments about the previous worker who placed him at Enriched Care. In the letter, he states that *'I hope that over the next year thru knowing you my situation here improves'*. There was no indication of any suicidal intent. There is no evidence in the Reading Borough Council IMR that 'Ordinary Residence' was considered as a factor, and it is not clear why the assessment was conducted by Reading Borough Council when CC had been a permanent resident in Buckinghamshire for over a year.

2.3.52 On 4.4.19 CC was arrested by Police after allegedly breaking a CCTV camera with a bottle, and threatening staff with broken glass. Staff had locked themselves in the office for safety. While in Custody, CC was reviewed by the Liaison and Diversion Mental Health Practitioner on 5.4.19. He appeared to be suffering from use of alcohol, but he was well oriented and talkative. He had some possibly paranoid ideas about the CCTV camera at Round Coppice Farm. There was no obvious thought disorder, and CC appeared able to follow the conversation, engaging well with the interview. He was calm and polite throughout. CC was not overdue for his Depot and '*did not present as being in acute mental health crisis*'. Risk to self was deemed to be Low and CC denied any intent to self-harm. Risk to others was Moderate due to history of violence when unwell, increasing with intoxication. There was no current intent to harm others.

2.3.53 CC was seen by an Appropriate Adult while in Custody on 5.4.19. He appeared 'stable and chatty' and was released under investigation, being taken home by Police car.

2.3.54 CC wrote to his sister (Mrs B) on 5.4.19 recounting his experience in Custody. He told her 'My date is 27.11.24. That's when I plan to die…. So about 4-5 years left in the mad uncle'. The letter was confused and bizarre, but does not indicate immediate suicidal intent. When subsequently contacted by the OH Investigation team, Mrs B said '*I know my brother never intended taking his own life as he was very much looking forward to a shopping trip we were going on a few days later and he asked me if we could make a day of it…. He always looked forward to my visits'.*

<u>Fatal Incident</u>

The following account is incomplete, and does not include evidence from Round Coppice Farm, Thames Valley Police or Fire Service investigations.

2.3.55 During the evening of 9.4.19, CC was noted by staff to be intoxicated, staggering in a 'zig-zag' motion. He was threatening towards a member of staff.

2.3.56 Police received two telephone calls from CC at 22.38 and 23.03 on Tuesday 9.4.19. He said that he had been locked in his room by staff. Round Coppice Farm was contacted, and staff said that CC was drunk, had lost his keys and that he would be helped to find them in the morning. They would not go to speak to him as he could be aggressive when drunk. The call taker spoke to CC and told him to go to sleep, that it would be sorted out it the morning. The incident was closed, then briefly reopened at 23.59 after CC rang the Metropolitan Police about the same issue.

2.3.57 Around 00.30, 10.4.19, CC contacted staff to ask for his key. They went to his room with the spare key, tried to open the door but were unable to unlock it. The fire alarm then went off; staff could smell burning but not see any smoke. They then went outside, could see smoke coming from the roof and dialed 999 for the Fire Service. Staff apparently tried to break down the door to CC's room, but there was an obstruction behind the door and they could not get in. TVP later confirmed that the room could not be locked from the outside, and that the keys were found in the bedroom.

2.3.58 At01.00 on 10.4.19, Buckinghamshire Fire and Rescue had a call from a Round Coppice Farm landline reporting smoke from a roof, but the specific location of the fire was not known. Fire Service and Ambulance attended the scene, and CC was rescued from his room at 01.35 hrs on 10.4.19. CPR was initiated. He was later confirmed deceased (details unknown), having suffered the effects of smoke and heat.

2.3.59 The other residents of Round Coppice Farm were relocated to Moat House and the area was declared a crime scene (reasons unknown). Oxford Health NHS Foundation Trust was informed by Police of the death at 07.11 on 10.4.19, and Next of Kin were informed the same day.

2.3.60 A Safeguarding Strategy meeting was held on 12.4.19, led by Buckinghamshire County Council Safeguarding Adults Service. It was agreed to commence a Large Scale Enquiry to review the safety of other tenants of Enriched Care in various locations.

General (Undated) Description of Conditions at Enriched Care in April 2019

2.3.61 In the absence of chronology or an IMR from Enriched Care, or any other significant information about conditions at Round Coppice Farm **before** the fire, the Author requested background from Mr A (Buckinghamshire Safeguarding Adults Team). He had visited the establishment on two occasions prior to the fire. The first was after a meeting with Police about the number of Service Users going missing, and complaints from neighbours. The second visit (jointly with Police in January 2019) related to the death of a different service user from natural causes. Mr A was also involved in the Large Scale Enquiry. The following comments by Mr A give an overall indication of the regime, but are not specifically about CC unless noted otherwise. This was not a formal inspection. Mr A subsequently reported his concerns to all four purchasing authorities which were funding placements at the establishment (see paras 2.3.46-47 above).

i) Records were poor; it was not possible to establish who was actually living at Round Coppice Farm at the time of the fire.

ii) Frequent faults were recorded in the call point/smoke alarm test log, with 'work in progress' often noted in the Action column.

iii) Frequent comments were made about the need for more fire extinguishers

iv) On 8.1.19 and 19.3.19, all [Service Users] refused to go to the assembly point during fire drills. This appeared to be a persistent problem, and it was unclear what action was being taken by management to rectify the issue.

v) A fire/fire exit door was recorded as being faulty from 28.1.19 to 30.3.19.

vi) There was a weekly 'room check' form, but guidance on how to use it or act was not available.

vii) There was possibly no bedframe in CC's room, based on pictures taken immediately after the fire by Buckinghamshire Fire and Rescue Service. CC may have been sleeping on a mattress on the floor. This is disputed by the Proprietor.

viii) The admission and readmission process was vague, and staff were apparently not consulted about admissions. There was no indication that client mix, staffing, risk levels or personal histories were reviewed to reflect changing needs. Staff 'were informed that 'X' is moving in tomorrow…' In May 2018 another Service User was sectioned to Prospect Park Hospital, and subsequently returned to Round Coppice Farm in spite of reservations about safety from family, Social Worker and Round Coppice Farm staff.

ix) Handover forms did not give an accurate record of who was actually in the building at any one time.

x) There was little evidence of staff training in mental health issues, and how to refresh or develop skills in supporting Service Users with challenging behaviours.

xi) Information from Care Programme Approach (CPA) documents was not cross-referenced into Support Plans or Risk Assessments, and the opportunity to review and discuss individual needs in team meetings was consistently lost.

xii) There did not appear to be formal management monitoring or governance in place prior to April 2019.

xiii) Incident Forms were not consistently completed in other Enriched Care services, and the 'management oversight and review' section had not been completed after the incident in 15 out of 17 forms.

xiv) Induction Process appeared to be completed in one day, and was not considered to be safe practice. There was no consistent 'shadowing'.

3 Analysis

3.1 The following limited analysis is based on reports and information available to the Author in July 2020. Crucially, the Inquest into CC's death had not been held. For procedural reasons, few details were available to the Author about the manner and cause of death, CC's behaviour and management at Round Coppice Farm, or the circumstances at Round Coppice Farm in the days and weeks before the fatal incident.

3.2 In the absence of more specific information, it would appear that there are at least three possible scenarios pertaining to CC's death:

a) Some form of accident, for example an electrical fault

b) An accident where the fire was inadvertently caused by CC while intoxicated, possibly smoking under the influence of alcohol or drugs or in a psychotic state. The fire may have been exacerbated by the state of CC's room, and the door lock may have been defective, so contributory negligence by Round Coppice Farm may be a factor.

c) A deliberate act of self-harm or suicide by CC.

3.3 This analysis is based on an incomplete chronology without Provider information. No IMR was produced by the direct Provider of service (Enriched Care), and evidence from Police interviews was not accessible for procedural reasons. Crucial details of the support and care given (or not) to CC were not available.

Information Sharing and Communication

3.4 It appears from the electronic OH care notes that staff at Round Coppice Farm were frequently unsure which team was responsible for CC's psychiatric care, and how they should seek assistance when his behaviour deteriorated. It is not clear if this resulted from a failure of Round Coppice Farm management to give information to staff, or if the NHS did not give the proper guidance as to where such support should come from. As part of the response given by Enriched Care, it was stated that "This was an emergency placement and we had extremely limited background information and the social worker went on long term leave. We continued to chase but nothing was coming forthwith which left us vulnerable as to the specific support provision".

3.5 Communication was insufficient between NHS teams, and between NHS and the Local Authority. There was confusion and disagreement between Teams as to funding, and where support should come from at any given time.

Transfer of Care

3.6 There were clearly some problems with the transfer of CPA responsibility between teams when CC moved out of area. Transfer did not happen in a timely way, and professionals were not confident in arranging formal CPA transfer. There was significant restructuring going on at this time, which compounded the practitioner confusion about case responsibility. There were delays in treatment on more than one occasion as a result.

Mental Capacity/Consent

3.7 Mental capacity was not considered in detail in the IMRs, although it was mentioned in passing. CC was repeatedly assessed under the MHA and detained on several occasions during the period under review. He almost certainly lacked the capacity to take sound decisions for much of this period about smoking and fire risk. This issue needs to be considered further when the detailed evidence is available in relation to the management and support given to CC at Round Coppice Farm.

Assessments

3.8 The Reading Borough Council assessment in April 2019 apparently noted various fire incidents in relation to CC, but did not specify or further explore the fire risks in terms of his future management. In January 2019, the Safeguarding Social Worker had formally written to four purchasing Authorities expressing serious concerns about Round Coppice Farm. One of these Authorities was Reading Adult Mental Health Team in respect of CC, but Reading Borough Council was not contacted. There had been a formal Safeguarding referral by Police in March 2019. It was noted that the environment was *'not suitable, subject should not be living where he is. The staff have been unable to control [his] behaviour'*. However, on 1.4.19, the RBC assessment indicated that the '*current placement is meeting [CC's] needs'*, and did not appear to take account of the recent and serious safeguarding concerns. It is not clear from the limited IMR supplied by Reading Borough Council if the assessment was sufficiently thorough, or considered fit for purpose. It is also not clear how much consultation was undertaken with Round Coppice Farm staff, who had repeatedly expressed their inability to cope with CC's behaviour, and had resorted to locking themselves in the office for their own protection on at least three occasions (14.10.18, 11.12.18 and 4.4.19).

Fire Risks

3.9 It is not possible to give a detailed analysis of the fire risk issues without access to the Buckinghamshire Fire and Rescue or Thames Valley Police investigations, or information from Round Coppice Farm staff about how fire risks were handled.

3.10 The available IMRs do not review the fire risk issue in detail. However, there is significant anecdotal evidence in the chronology that the risk of fire was high for CC. He often used alcohol to excess. He had lit fires in his hospital room twice in the two years prior to his death (Cambian Churchill Hospital on 13.7.17, and Whiteleaf Centre – 6.11.18). CC had also made at least two explicit threats to set the ward or himself on fire. There were many documented incidents where he smuggled cigarettes and matches or lighters into his room, in contravention of smoking and fire safety policy. It is not yet known how he behaved at Round Coppice Farm in relation to smoking restrictions.

3.11 Anecdotal and informal evidence from the Safeguarding Social Worker suggests that fire safety arrangements at Round Coppice Farm were below standard, with reports of insufficient extinguishers, poorly trained staff, inadequate alarms, excessive rubbish in rooms and ineffective evacuation procedures. It is not clear if CC was allowed to smoke in his room or not, if he was issued with fire retardant bedding, or if he was compliant with any smoking restrictions at Round Coppice Farm. The actual state of the bedroom at the time of the fire is not clear from the available IMRs.

3.12 From information available to Berkshire Healthcare NHS Foundation Trust staff in clinical notes, it should have been clear that CC presented a high risk of deliberate or accidental fires. He had repeatedly threatened and actually set fires, and repeatedly smuggled smoking materials into wards when in hospital. It is not possible to state at this point how much of this information was communicated to Round Coppice Farm management, or how far the fire risks were communicated down to the Round Coppice Farm staff. There is no record of the fire risk being entered in to the risk assessment. In the response given by Enriched Care, they state "There was no information provided to us about any fire risks that CC posed and if this was the case, there would have been specific risk assessments in place to support CC and the staff".

Commissioning

3.13 A central question for the SAR is to consider if this was an appropriate placement for CC. He was a high-risk dual-diagnosis patient with frequent relapses in psychosis and aggressive behaviour.

a. Was the placement commissioned properly according to reasonable standards, and did it initially meet the needs of CC?

b. Once difficulties were experienced with managing the behaviour of CC, did Commissioners respond properly and take appropriate action?

3.14 CC was 100% funded by the NHS at Round Coppice Farm from November 2017 until his death in April 2019, with some gaps for hospital admissions. The Berkshire Healthcare NHS Foundation Trust commissioning arrangements for the placement of CC at Round Coppice Farm were poorly documented, inconsistent and seriously ineffective. The process is exhaustively described in the Berkshire Healthcare NHS Foundation Trust IMR and follow-up clarification notes. It is not possible at this stage to make any firm connections between the way the placement was purchased and the death of CC. However, it is clear that commissioning practices in Berkshire Healthcare NHS Foundation Trust at the time fell far short of reasonable care purchasing standards.

3.15 Documentation is not available to show how the placement was selected or what pre-placement checks were made on standards at Round Coppice Farm. It is not clear if the 'commissioning checklist' was completed. The original placement assessment was for Moat House, not Round Coppice Farm, and CC was apparently moved to Round Coppice Farm without the knowledge of the purchasers. There must be serious questions to be addressed about how a Supported Living environment such as Round Coppice Farm could ever have been appropriate for a complex and hostile patient like CC with significant relapse history. The risks of fire, aggression and challenging behaviour were chronic and very high. Even highly trained NHS PICU staff had great difficulty controlling and managing the fire risk behaviour presented by CC.

3.16 Supported Living environments have relatively low staffing levels and most staff are unlikely to have high levels of training in the management of challenging behaviour. Staff only have limited powers over smoking and the hoarding conditions within bedrooms.

3.17 There did not appear to be any credible system of accreditation or ongoing quality monitoring for a service which was supporting extremely vulnerable tenants with severe and enduring mental illness. The Care Coordinator is apparently expected to monitor and feedback to the monitoring team. However, it is not clear if the Care Coordinators understood their monitoring role, beyond providing clinical support to their patient. There was no evidence to indicate that Care Coordinators were checking fire precautions or staff skill levels.

3.18 The Out of Area Placement Service had expected the case to be transferred to the Local Authority for ongoing monitoring. When the transfer did not take place in a timely fashion, the OAPS was not apparently aware of this and did not put other monitoring arrangements in place.

3.19 CC was living in a different location to the placement originally specified, yet the commissioning body (Berkshire Healthcare NHS Foundation Trust) was unaware of the change.

3.20 Operational staff from Reading CMHT quite properly raised concerns in November 2018 about the failure of Round Coppice Farm to provide adequate support for a number of tenants. CC was then returned (in error) to the placement later the same month. On interview, the OAPS Manager denied that there were any concerns about the placement or patients, even though his/her own Service had terminated the placement. This discrepancy has not been explained.

3.21 The Placement Service later became aware of the ongoing placement and re-started payments to prevent CC becoming homeless. There is no evidence that urgent action was then taken to source an alternative placement, and CC remained in an apparently unsafe setting without additional quality checks for over three months until his death. It is not clear why Reading CMHT and Buckinghamshire CMHT continued to support CC in a terminated placement, when Reading CMHT had already raised serious concerns about Round Coppice Farm.

<u>Substance Misuse</u>

3.22 There is very limited evidence or comment in the current IMRs in relation to substance misuse. CC clearly presented more of a challenge to nursing and support staff when he was intoxicated. When the evidence from Round Coppice Farm investigations is available, it will be essential to review the substance misuse issue in detail. It will be important to know:

- What efforts were made by Round Coppice Farm to modify or control substance misuse?

- How compliant or otherwise CC was with alcohol and drug restrictions?

- How the behaviour of CC changed when intoxicated

- What risk assessments were conducted by Round Coppice Farm regarding substance misuse?

Was the Death of CC Avoidable?

3.23 It is not appropriate to make definitive statements about the death of CC prior to a formal Inquest. However, anecdotal evidence suggests that the quality of support and care at Round Coppice Farm was below standard. If the safeguarding concerns had been heeded promptly, and the placement terminated as expected, then CC would have been in a different care environment, where the fire and behavioural risks may have been potentially managed in a more coherent and effective way.

Good Practice

3.24 Following the accidental fire on 7.1.18, Buckinghamshire Fire and Rescue Service responded promptly with immediate checks on fire safety, and then followed up in an appropriate and persistent manner to ensure that the necessary improvements were made.

3.25 After the death of another resident, the Safeguarding Social Worker (Mr. A), responded promptly after visiting the premises. He took firm and pro-active measures to inform commissioning Authorities of his concerns about the establishment, and potential risks to all tenants.

3.26 The clinical support offered to CC and Round Coppice Farm staff was fairly comprehensive, in spite of the various confusions about which team was responsible. Berkshire Healthcare NHS Foundation Trust staff were persistent in making sure that CC had his Depot injections during the review period, and in arranging his return to hospital when required. There may have been some delays in hospital readmission, which will become clearer when Round Coppice Farm interview data is available.

3.27 Ward staff were persistent in repeatedly checking and confronting CC about smoking materials because of the extremely high fire risks.

3.28 A Learning Review was arranged in the Reading CMHT focusing on the transfer of patients and the importance of CPA transfer. No patients are now transferred from this team without formal CPA process taking place.

3.29 TVP Officers attending Round Coppice Farm for unrelated matters raised Safeguarding concerns through formal Adult Protection reports on two separate occasions in June 2018 and March 2019. This demonstrated that Officers were knowledgeable about potential indicators of abuse, and that they took appropriate action to manage the concerns. However, for reasons which are not clear, the first referral never arrived and no further safeguarding action was undertaken in June 2018.

Points of Concern

Clinical Documentation

3.30 Although CC was well known to ward staff and CMHTs, the clinical documentation over the period of review was poor, and does not always provide a rationale for why decisions are made, or what information they were based on.

The SAR Terms of Reference ask for specific comment about several areas not covered elsewhere in this report:

Making Safeguarding Personal

3.31 It is not clear from the IMRs why the various Safeguarding concerns expressed by different agencies did not result in a safer environment for CC. The placement was actually terminated 4 months prior to his death after CMHT concerns. A Safeguarding Social Worker proactively contacted Authorities 3 months prior to the incident, and Police made Safeguarding referrals in June 2018 (not received) and again 3 weeks before the fire. CC was formally assessed by Reading Borough Council only 9 days prior to his death, yet the placement was approved for funding in spite of all the quality and safety warnings that were in the system.

Making Safeguarding Personal is a shift in culture and practice in response to what we now know about what makes safeguarding more or less effective from the perspective of the person being safeguarded. It is about having conversations with people about how we might respond in safeguarding situations in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety. [Making Safeguarding Personal Guide p.4]

3.32 There is little evidence that person-centred conversations were had with CC by Safeguarding professionals about the placement, and it does not appear that his 'wellbeing and safety' were enhanced after concerns were repeatedly expressed by different agencies over several months. There did not appear to be any one professional who joined up all the concerns about CC and his placement to give a true picture of the risks and take appropriate Safeguarding action.

Timeliness

3.33 There were long delays in professional staff taking necessary action at two key points during CC's stay at Round Coppice Farm.

3.34 CC was referred to Reading Borough Council by the CMHT for a Care Assessment on 23.10.18. The referral was accepted, but there was a series of delays due to Agency workers leaving, lack of capacity in the team, moving office base and prioritisation of other work. The work was not progressed, and the case was not finally assessed until over **five months** later on 1.4.19. This was just 9 days before CC died. There is no evidence to indicate if this delay was properly escalated by management.

3.35 Following concerns from Reading CMHT, the placement of CC at Round Coppice Farm was terminated by Berkshire Healthcare NHS Foundation Trust in November 2018, for reasons which are not explicit in IMRs, but are likely to relate to repeated relapses by similar patients. CC was still in the same (probably inappropriate)

placement some **four months** later at the time of his death. There is no evidence to indicate any form of urgent action being taken by Berkshire Healthcare NHS Foundation Trust to source alternative support.

Was Agency Action Adequate, Appropriate, and Responsive to Crises and Risks?

3.36 For reasons set out in para 3.34 above, the action taken by Reading Borough Council in relation to Care Act Assessment was neither adequate nor appropriate. If a thorough and person-centred assessment had taken place in good time, including a review of the various Safeguarding concerns, it is likely that CC would have been moved to a more satisfactory placement which could meet his complex needs.

Following the termination of placement in November 2018, the actions of commissioners and Reading CMHT were neither adequate nor appropriate. Once the error had come to light and Berkshire Healthcare NHS Foundation Trust started to fund the terminated placement again, there is no evidence that the situation was escalated or that alternative provision was being sought. This placed CC at unnecessary risk. The Reading CMHT separation between health and social care occurred prior to November 2018. With regards to understanding the position about the termination of the placement an email was sent from the RCMHT manager to Enriched care manager on the 8th November to advise him the placement for CC and 2 other patients had been stopped. A reply from the Enriched care manager was received on the 13th November to request a meeting. The RCMHT manager advised it would need to be set up for the week after but there is no evidence that this meeting took place.

3.37 Anecdotal evidence suggests that the actions of Round Coppice Farm in managing severe fire risks were neither adequate nor appropriate, but there is insufficient detail available prior to the Inquest to make a firm judgement on this point. There may be some issues around the late registration of Round Coppice Farm as a 'House in Multiple Occupation' (HMO). It appeared to take eight months for Round Coppice Farm to be licenced as an HMO, and tenants would probably be exposed to higher levels of fire risk before remedial works were completed. The required level of inherent fire safety of an HMO is likely to be better than in a non- HMO facility. As part of the response received from Enriched Care, it is stated that "There's a fire policy, risk assessment and evacuation plan. Drills were being undertaken also. Tenants would evacuate as appropriate as they did on the night of the incident but would often be challenging during drills as they did not see this as an emergency. After each fire evacuation drill, there was a resident meeting to acknowledge there proactive engagement and to highlight the importance of the drills".

Impact of Restructuring

3.38 There was substantial confusion between teams, agencies and Round Coppice Farm about where support should come from at critical points when CC was relapsing. Considerable restructuring was taking place in Berkshire Healthcare NHS Foundation Trust and the Reading Local Authority throughout the period of review, and the IMRs emphasise that the resulting role confusion contributed to the inconsistent and delayed service received by CC.

Level of Provision

3.39 There is a severe national shortage of Dual Diagnosis placements for patients being discharged from hospital. This gives commissioners very little choice of provision, particularly in a local area.

Lessons Learned

3.40 Commissioners to get some information from Provider immediately after a serious incident in future, regardless of Police investigation.

3.41 Possibly call a Safeguarding meeting earlier when significant problems are identified across multiple Users in same location.

Conclusions

4.1 CC was an extremely vulnerable patient, living with severe and enduring mental illness for around forty years. The service provided by Enriched Care and commissioned by Berkshire Healthcare NHS Foundation Trust did not provide sufficient or appropriate care and control to meet his needs.

4.2 The primary responsibility to supply a safe and effective service should rest with the Provider. Anecdotal evidence indicates that the service delivered by Enriched Care fell significantly below the expected standards.

4.3 The NHS commissioning and placement termination arrangements for CC were inconsistent and inadequate. Remedial action has now been taken by Berkshire Healthcare NHS Foundation Trust, and a 'Placement Flowchart' has been produced. Nine areas of placement process have been reviewed and monitored, with increased administrative capacity. Senior management oversight has been formalised. There is now a 'commissioning checklist' and Panel process to review and approve Out of Area placements.

4.4 There was a serious failure of safeguarding culture and practice across several agencies relating to the care and support of CC.

- Initial commissioning checks by Berkshire Healthcare NHS Foundation Trust prior to placement were apparently inadequate.

- Berkshire Healthcare NHS Foundation Trust termination arrangements failed completely once significant concerns had been raised.

- Extensive service failures were identified by the Safeguarding Social Worker in January 2019, and reported to purchasers, yet no urgent action appears to have been taken. In principle, a meeting with consideration for issues around safeguarding, commissioning and service provision should have been convened to discuss concerns.

- The placement was assessed by Reading Borough Council and confirmed as suitable to meet client needs, only nine days before the death of CC.

4.5 Every visit to a patient in a placement setting should have a reviewing and safeguarding element. The home environment, nature and demeanour of staff and interaction with other residents should be considered. Concerns should then be escalated to Buckinghamshire Council and remedial action taken. This did not

happen adequately with CC. The Safeguarding IMR does not adequately explore or review the apparent lack of Safeguarding action.

4.6 Action has already been taken by the Large Scale Enquiry with regard to other tenants of Enriched Care, but this has not been reviewed or evaluated in the SAR.

4.7 It has not been possible to comment in sufficient detail on most of the Terms of Reference, due to a lack of information from ongoing investigations or a Provider IMR. There are many unanswered questions (inter alia) about fire safety, alcohol management, staff training, risk assessment and potential self-neglect due to hoarding.

4.8 If further evidence in relation to Enriched Care remains unavailable after a reasonable period, consideration should be given to commissioning some form of independent IMR to cover the missing Provider perspective. Alternatively, a Commissioning and Safeguarding exercise could be initiated to review if the various changes introduced have resulted in sufficient improvement to service delivery at Enriched Care. There should be a joined up approach between Commissioning Authorities, as placements are made by a number of different purchasers.

4.9 There appears to be limited understanding among key Berkshire Healthcare NHS Foundation Trust staff about how placements of vulnerable patients should be accredited, commissioned, monitored, reviewed and managed. Some staff did not appear to know the difference between registered and non-registered accommodation. There is a lack of clarity about the difference between clinical monitoring of an individual case, and routine monitoring of the environment, including staffing levels, skills, fire precautions and general management processes. This lack of knowledge needs to be addressed in Berkshire Healthcare NHS Foundation Trust and Reading Borough Council.

4.10 Berkshire Healthcare NHS Foundation Trust reports a shortage of appropriate residential or Supported Living Services for dual-diagnosis patients. Berkshire Healthcare NHS Foundation Trust and Local Authority partners should address the need for Market Development to ensure an adequate supply of this type of service in future.

4.11 There did not appear to be a formal initial contract between Berkshire Healthcare NHS Foundation Trust and Enriched Care for a 100% NHS funded placement.

4.12 The Author wishes to thank the family of CC for their involvement, and to express his condolences for their loss.

5. Recommendations

5.1 Buckinghamshire Safeguarding Adults Board to review the need for a revised SAR if/when further information comes to light within 2 years from the publication of this report. The Board should consider an independent IMR or expanded SAR to take into account details of care and support provided by Enriched Care prior to the death of CC.

5.2 Buckinghamshire Council should host and co-ordinate a Commissioning and Safeguarding exercise by all relevant placing Authorities into the current service delivered by the owners or directors of care provision services operated by the owner or director of Enriched Care. The outcome should inform decisions about current and future placements with this provider. This report to be completed within 4 months of the publication of this SAR.

5.3 Reading Borough Council and Buckinghamshire Council to review commissioning arrangements for funded placements to ensure that Care Act Assessments for such placements are timely and fit for purpose.

5.4 Berkshire Healthcare NHS Foundation Trust to undertake or commission an independent or peer quality monitoring exercise to review accreditation, the use of the 'Placement Flowchart', termination process and other changes introduced after the death of CC. A random sample of cases to be reviewed to check that patient needs have been appropriately met by commissioned services.

5.5 Berkshire Healthcare NHS Foundation Trust to review the contract and quality monitoring process in out of area placements, to ensure all necessary domains of funded services are specified and checked by Care Coordinators as necessary.

5.6 NHS and Local Authority commissioners to undertake Market Development of dual-diagnosis services to ensure adequate provision is available in the locality for patients with complex mental health needs and drug or alcohol dependence.

5.7 When a funding authority is commissioning a new placement outside of its own area, it should be essential that a reference is received from the host authority that clearly identifies any outstanding or historical quality or safeguarding issues prior to the placement going ahead. If an acceptable reference is not forthcoming then the funding authority must undertake a robust quality assurance visit in advance of commissioning the placement.

5.8 Buckinghamshire Council utilises the Provider Assessment and Market Management Solution (PAMMS) to monitor providers with whom Buckinghamshire Council has a 'live' contractual relationship. Consideration should be given to sharing the outcome of PAMMS assessments with other funding authorities that have people placed at those services, particularly if the assessment highlights areas of concern.

5.9 There is a 'Quality Improvement Project' underway in Berkshire Healthcare NHS Foundation Trust with regards to clinical documentation in the psychiatric in-patient services. It is recommended that this project identifies how improvements can be made to clinical documentation process and practice and that this learning is shared with partner agencies.

5.10 Partner Agencies have made a series of Recommendations in IMRs for improvement of process and practice. The Board should review all these Recommendations with partner agencies within one year of the publication of this SAR, to ensure that sufficient progress has been made.

Martin Bradshaw
SAR Overview Author

1st August 2020

6. Appendix

Appendix 1 – Details of Four Purchasing Authorities

H&F Treatment and Recovery Team, West London NHS Trust, Hammersmith
Bracknell Adult Mental Health Team, Church Hill House, Bracknell
Reading Adult Mental Health Team, Prospect Park Hospital, Reading
Windsor and Maidenhead Adult Mental Health Team, Nicholson House, Maidenhead

Appendix 2 – Response form Enriched Care

Q: What background information did Enriched Care have on CC prior to coming to Round Coppice Farm?

A: This was an emergency placement and we had extremely limited background information and the social worker went on long term leave. We continued to chase but nothing was coming forthwith which left us vulnerable as to the specific support provision.

Q: What was CC's behaviour like overall, and in the week before the incident?

A: Overall CC was a very well-mannered man. His behaviour was clearing deteriorating due to his relapse a week before the incident and appropriate input from the crisis team was being ascertained to which behavioural that the staff should be looking out for but this information unfortunately did not arrive on time.

Q: What were the living conditions like for CC? Type/size of room, standard of furnishing?

A: CC had a large double bedroom with Ensuite facilites with furniture provided by us as well as his own furniture and this setup suited CC well

Q: Are you aware if the lock on CC's room door was faulty? Was he locked in?

A: We had regular checks and his lock was working well at our last check prior to the incident. CC could not have locked himself in as all the doors were fitted with thumbturn turn locks which does not require a key to exit and the staff could enter the room if required (permission and if concerns raised by staff).

Q: What condition was the room in prior to fire? Was there rubbish? Did CC hoard items? If so how was this approached with CC?

A: The staff had become aware that CC's mental health was deteriorating in his mental state due to the relapse that he had the week before and had returned to the premises while on his base line of recovery. CC's room was in a reasonable presentable state which did not cause any due alarms.

Q: Had smoking been an issue with CC? If so, had staff taken any action to manage this problem? Were any risk assessments done on fire or violence?

A: CC was a smoker and that he had advised staff that he would like to quit smoking with the support of quit smoking cessation team and would often use a vape he would use in his room. There was no indication that CC had been smoking in his room as all residents had been advised that smoking was only permitted outside the property at a designated smoking area and this has been documented in the residents notes. There was a fire risk assessment in place.

Q: What did staff know about previous fire risks with CC?

A: There was no information provided to us about any fire risks that CC posed and if this was the case, there would have been specific risk assessments in place to support CC and the staff.

Q: Had there been other incidents with smoking and fire? Any suicide threats?

A: No incidents of such nature with CC.

Q: How significant was alcohol for CC? How much was he drinking, how drunk on the day?

A: CC consumed Alcohol regularly but was drinking more during this period of relapse. We are unsure of his consumption on the day as quite often CC would drink whilst in the community.

Q: What actions had Enriched Care taken linked to working with CC around his alcohol use?

A: When well, CC's consumption was relatively well managed but excessive drinking would lead to his relapse and the CPN was in process of having him re admitted.

Q: What policies and procedures were in place re fire precautions? Drills? Did tenants evacuate the building when instructed?

A: There's a fire policy, risk assessment and evacuation plan. Drills were being undertaken also. Tenants would evacuate as appropriate as they did on the night of the incident but would often be challenging during drills as they did not see this as an emergency. After each fire evacuation drill, there was a resident meeting to acknowledge there proactive engagement and to highlight the importance of the drills.

Q: What was the staffing at Round Coppice Farm? In general, and during incident? Was it adequate?

A: The team consisted of support workers and a team leader. The staffing was adequate at the time of the incident as the service was running at around 50% occupancy.

Q: What were skill levels of front-line and management staff?

A: Front line staff were trained and had the care certificate which covers 15 areas of care. They also had inductions carried out by Team leaders. The team leader held a NVQ level 5 in social care.

Q: Were staff afraid of CC? How did they deal with his outbursts? Did they avoid contact with him?

A: CC could be challenging when unwell and the staff were trained in supporting individuals that presented behaviour that challenges. Due to the increased behavioural being displayed, his CPN was initiating a re-admission. CC's outputs would only be verbal, and he would have bn guided back to his room to calm down. Distraction and de-escalation techniques were used to support CC. CC would increase his racist comments when becoming unwell, hence the CPN was initiating the re-admission process

Q: How were frontline staff supervised and supported by management?

A: Front line staff had the support of a team leader and directors whom would be on call. They would have regular supervisions and daily team handovers.

Q: Were Enriched Care supported by NHS staff? Did they know who to contact?

A: CC had a CPN who was in regular contact and we had all their contact details.