An independent investigation into the care and treatment of Colin 2021/16905

April 2025

FINAL REPORT

Report Advisory Notice

This report deals with difficult subjects relating to care and treatment. We have made efforts to write ou report in a way which is not overly descriptive and limits the use of third-party and non-relevant personal information. However, there are instances where information is necessary, for example, wher it is relevant to quote the opinion of a doctor or where a specific act has been documented. We advise caution for those who may be triggered by reading information which might be distressing and ask that they are helped to read this report in a safe and supported way.

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Niche Health and Social Care Consulting is an independent management consultancy that specialises in supporting health care providers with all issues of safety, governance and quality, including undertaking independent investigations following very serious incidents.

Our Final Report has been written in line with the terms of reference for the internal investigation into the care and treatment of Colin. This is a limited scope review and has been drafted for the purposes as set out in those terms of reference alone and is not to be relied upon for any other purpose.

Events which may occur outside of the timescale of this review will render our report out-of-date. Our report has not been written in line with any UK or other (overseas) auditing standards; we have not verified or otherwise audited the information we have received for the purposes of this review and therefore cannot attest to the reliability or accuracy of that data or information. Where we cannot attest to the reliability or accuracy of that data or information, we will clearly state this within our report.

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USE OF ITALICS IN THE TEXT OF THE REPORT

The use of italics in the text of this report reflects direct quotations or reported speech

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Family impact statements

Niche places importance on giving families of patients the opportunity to provide a statement of how the circumstances of their loved one's death has impacted them. The following statements are from Colin's partner and his children and these reflect their overall views of the care and treatment he received and the impact of his death upon them.

Family statement 1

Many people die under the care of the NHS, having experienced great care in the weeks or years leading up to their death. However, many patients experience poor quality NHS care provision resulting from multiple factors, which often include poor leadership and system wide factors. Colin was one of the latter.

Colin was my much loved and treasured partner of some 20 years. He was not only loved by me but by so many others. He was an exceptional human. He was an achiever, attaining considerable success as a professional footballer, as a sailor and also in business. Despite all the success and prestige, he remained humble, kind and considerate to all. Throughout his life he was supremely active and fiercely independent.

Words cannot express the impact of watching the man that I loved deteriorate both physically and mentally in front me. I fought so hard to try and get Colin the care and treatment that he needed but to no avail. The system, broken as it is, was much stronger than me. Watching the neglect and indignity that Colin was subjected to has broken my heart and left indelible scars.

He went into hospital to get help, but within 19 weeks he was dead. Colin had been chemically coshed, deprived of his liberty, abused, bruised, starved and dehydrated. Ultimately Colin died whilst in the care of the state.

I had to fight hard to convince the NHS to commission this report and thank Niche for the investigation that they have carried out. Many issues have been covered but more exist.

I know exactly what went wrong in Colin's care and it must be brought out into the open to stop the same happening to others. No one should have to go through what Colin did. Colin's death was avoidable, and this report will now feed into the long-awaited coroner's inquest which will investigate this.

The report has concluded with recommendations so that lessons can be learned, and services will improve for others. I live in the hope that any recommendations made/learning, is translated into sustainable effective action that reduces risk to patients but sadly I won't hold my breath.

Family statement 2

Our beloved father, Colin, passed away peacefully at the age of 81, following a courageous battle with several challenging health issues, including Alzheimer's disease. We, as his children, experienced significant frustrations during this time. These included:

- Exclusion from decision-making: Confusion surrounding the designation of next of kin versus power of attorney resulted in our exclusion from critical care decisions and the overall care process.
- Influences from third parties: Non-professional interference impacted our father's care and well-being.
- Lack of inter-organisational communication: A critical breakdown in communication between healthcare providers and a failure to adequately review past hospital admissions hindered the effectiveness of his overall care.

We acknowledge that the current system of care for individuals with Alzheimer's, particularly those who remain physically fit, presents significant challenges. Our father's decline was rapid and unexpected, highlighting a crucial gap in the support available for this specific population.

We deeply appreciate the dedication and tireless efforts of the care providers who supported our father during this difficult time. We understand the immense pressures they face and recognise the limitations of the current system.

However, we believe that the current approach, which often prioritises medication to manage behaviour in physically fit individuals, may have inadvertently accelerated our father's decline. We witnessed first-hand the impact of heavy sedation, which we believe ultimately contributed to his accelerated passing.

This experience has been incredibly distressing and prolonged, with the coroner's inquest and subsequent delays in our father's burial adding to our grief. We hope that this investigation will lead to meaningful improvements in the care provided to individuals with Alzheimer's, ensuring that other families do not have to endure similar hardships.

1 Executive summary

Introduction

1.1 NHS England commissioned Niche Health and Social Care Consulting Ltd (Niche) to carry out an independent comprehensive review of the care and treatment that Colin received between January 2021 and his subsequent death in September 2021. This was to include the nature and extent of involvement of all agencies, private and NHS, that Colin had contact with dating back to the first contact with services in relation to symptoms of confusion.

Background context

1.2 Colin lived with his partner (ML) and had two children from a previous marriage. He had been a professional footballer and then became the Director of a freight forwarding business. He retired when he was 60 but remained active and enjoyed holidays abroad, gardening, cycling and occasionally going to the pub with his friends and family.

1.3 His past medical history included myocardial infarction (heart attack), hypertension (high blood pressure) and constipation. In 2012, Colin was diagnosed with colorectal cancer and was admitted to Broomfield Hospital for surgery. His stay was prolonged as he developed sepsis and delirium; however, on his return home he was able to resume his normal life.

1.4 As for many people, COVID-19 was a challenging time for Colin, and we have been told that he missed the social interaction with his children.

1.5 It should also be noted that ML had a significant and traumatic past experience with local mental health services which is relevant to this case and her response to some events within Colin's care pathway.

Summary chronology leading to the serious incident on 27 July 2021

1.6 Colin's memory issues were first noted by his General Practitioner (GP) in December 2020 and again in May 2021 four days before Colin was admitted to Broomfield Hospital on 25 May with a low heart rate.

1.7 During the admission Colin was assessed by the Essex Partnership University NHS Foundation Trust (EPUT) Mental Health Liaison Team (MHLT) and diagnosed with Alzheimer's disease. Following several incidents of violence and aggression, Colin was transferred to Goodmayes Hospital on 9 June 2021 and detained under Section 2 of the 1983 Mental Health Act (MHA)[1].

1.8 Colin remained on Stage Ward at Goodmayes Hospital until 17 June when a Mental Health Tribunal determined that he could be discharged home as requested by his partner ML with input from the EPUT Dementia Intensive Support Service (DISS).

1.9 Colin did not settle at home. On 21 June, he was accepted as a respite placement by Woodland View Care Home with support from the EPUT Dementia Intensive Support Team (DIST). The care home was unable to meet his needs, so he was transferred to Anisha Grange Care Home on 7 July with support from the North East London NHS Foundation Trust (NELFT) Dementia Crisis Support Team (DCST).

1.10 On 21 July, Colin absconded from the home and was returned by the police. The ambulance service were called, and it was determined that he required admission to hospital for an assessment of his cardiac function.

1.11 Colin was admitted to Basildon Hospital. He was assessed in the emergency department and transferred to the acute medical unit (AMU) and then Florence Nightingale Ward. On 27 July he

[1] https://www.legislation.gov.uk/ukpga/1983/20/contents. The MHA is the main piece of legislation that covers the assessment, treatment and rights of people with a mental health disorder.

became agitated after his family had visited. He stabbed himself in his abdomen with a pair of scissors, ran off the ward and fell over the rail of a first-floor landing in the cardiothoracic centre onto a glass table.

1.12 Colin survived the fall but did not recover from the injuries sustained. He was found to have an epigastric bleed which had to be embolised, but his condition deteriorated and he was transferred to the intensive therapy unit (ITU) on 4 August. Their interventions did not improve his physical health condition. He was transferred to Bulphan Ward on 3 September and discharged home with palliative care on 6 September. He died the following day.

Key findings

1.13 There is significant learning from this investigation which looked at the care and treatment that Colin received between January to September 2021. Detailed analysis of each care episode is contained within the body of the report and, where possible, we have endeavoured to answer the questions that Colin's children and partner have about the last nine months of his life (also see Appendix B).

1.14 It should be noted, however, that this was a complicated case, not least because of the multiple laws and case precedents around medical treatment decisions, but also because of the numerous moves that Colin experienced in this relatively short period. While the investigation has been comprehensive, it has not been possible to cover every minute of every day and there are some very specific questions that we have not been able to answer fully.

1.15 Following his initial admission to hospital, Colin was in receipt of care and treatment from 12 different care provider teams across six different care settings (Broomfield Hospital, Goodmayes Hospital, home briefly, Woodland View, Anisha Grange and Basildon Hospital) in a 60 day period (25 May – 21 July 2021). There was also a change of GP when he moved to the first care home. A further six moves were encountered in a 45 day period while at Basildon Hospital (emergency department, AMU, Florence Nightingale Ward, emergency department, Bulphan Ward, ITU and back to Bulphan Ward). See Appendix C for dates and teams involved.

1.16 Colin changed wards/placements and teams with no consistent person being involved in his care throughout this time other than his partner and his children. Many of these moves were unavoidable (for example, from the Emergency Department to the AMU to the receiving ward, or from Broomfield to Goodmayes Hospital) but there were also occasions when they could have been avoided (for example, at Broomfield Hospital when he was moved from AMU to Terling Ward which had available beds rather than being suitable for his care needs, and when he was accepted at Woodland View without a full assessment to ensure that his (and others) safety could be maintained). Furthermore, there were moves made during the night rather than in the day which should have been avoided (for example, within Broomfield Hospital when he was moved from AMU to Terling Ward at 2am and at Basildon Hospital when he was moved from the AMU to Florence Nightingale Ward at 1am). Colin was diagnosed with Alzheimer's disease[2] in early June 2021, but these frequent changes of environment will inevitably have increased his confusion. They also impacted the continuity of care, particularly as handovers between teams were often delayed or absent. COVID-19 visiting restrictions made communications with his family more difficult and this caused Colin additional distress.

1.17 The many changes were also stressful for ML and Colin's children who had to keep repeating information about Colin with little time available for relationship building with the many teams, psychoeducation or carer support. The visiting restrictions that were in place as a result of the COVID-19 pandemic made engagement between the staff and family all the more difficult at times.

1.18 Throughout these care periods, there was a clear escalation in Colin's confusion but also aggression and violence, and an increased preoccupation and obsession with leaving places and wanting to go home. Colin was placed in different geographical areas, came under different teams,

[2] Alzheimer's disease is a progressive disease, where dementia symptoms gradually worsen over a number of years. It can affect memory, thinking skills and other mental abilities.

and was self-funding when he went into residential care. These factors contributed to a lack of comprehensive care planning and meant that opportunities to assess and manage his risks were missed. There were also inconsistencies in relation to the proper application of the Mental Capacity Act 2005[3] (MCA), safeguarding, restrictive practices, incident reporting, communication and family involvement, with missed opportunities to have assessed Colin under the MHA. There were occasions when Colin was held within hospitals and care home settings without a legal framework; this was in breach of his human rights.

1.19 The chart on page 15 depicts the moves and the care teams involved in Colin's care. We have also included:

- the mental capacity assessments that were undertaken;
- the legal frameworks that were in use for detaining him (via Deprivation of Liberty Safeguards[4] or the MHA); and
- incidents of violence/aggression and absconsion where restrictive practices were employed that were reported in line with organisational policy and those that were not.

1.20 It is clear that many staff who cared for Colin were kind and caring, with significant efforts made to provide timely clinical care and to keep him and other patients safe. However, there were competing pressures and priorities for staff and at times unsuitable environments for the care that was required at any given point. System issues impacted the ability of staff to respond to Colin and his family's needs in a timely manner and at times to expected standards.

1.21 In addition to the detailed analysis, we have identified some key themes for improvement across Colin's care pathway in relation to the decisions that were made about his care, treatment and accommodation which apply to many of the organisations involved. There are an increasing number of patients presenting with dementia who are also physically unwell and it is evident that patients with a complex presentation such as Colin may require disparate care episodes across different organisations; however, key elements of the care pathway are required to be place, and policies/guidance complied with, to ensure that safe person centred care can be delivered. This investigation has highlighted what these might include and Figure 2 on page 16 sets out the key questions to be asked and mitigated. This will help to ensure that care teams are able to provide care to this cohort of vulnerable people with access to specialist advice, shared information and working with families within a legal framework.

1.22 Key themes and pathway points include:

1.23 **Physical health:** There were occasions, when Colin's physical health needs were marginalised. Timely medical assessments and interventions are essential to ensure that physical illness is not causing a psychiatric presentation. During these episodes of care, there were some examples of Colin's physical health needs being appropriately assessed and responded to including when first admitted to Broomfield and Goodmayes Hospitals; however, there were also many occasions when they were not.

1.24 Physiological observations (such as blood pressure and heart rate) should have been more consistently monitored and responded to. Equally, there were many occasions, particularly at Basildon Hospital, when Colin's physical needs, wound management and pain control were marginalised in favour of requests to have his mental health assessed and for him to be transferred to a mental health care setting. Colin's behaviour was challenging for staff to manage, but it was very evident, including to the EPUT MHLT, that Colin was clinically unstable soon after his fall on 27 July 2021.

[3] https://www.legislation.gov.uk/ukpga/2005/9/contents. The MCA provide a legal framework for acting and making decisions on behalf of adults who lack the capacity to make particular decisions for themselves.

[4] The Deprivation of Liberty Safeguards (DoLS) is the procedure prescribed in law when it is necessary to deprive of their liberty a resident or patient who lacks capacity to consent to their care and treatment in order to keep them safe from harm.

1.25 There were cumulative system failures to secure the right pathway for Colin after his fall, including reliance on the emergency department for monitoring him. There was also an absence of collective and assertive decision making and ownership by the specialty clinical teams particularly in relation to the embolisation of the epigastric bleed, commencement of analgesia for his pain, assessments of his abdominal wounds and appropriate antibiotics when his infection markers were raised. This was despite him having come to significant harm while in the care of the Trust. This caused delays in his treatment and contributed to his physical health deterioration.

Pathway point: Comprehensive physical assessment.

1.26 **Medications:** While medicines management at Anisha Grange Care Home could be improved, there were unsafe medicines management practices at Woodland View Care Home, Broomfield and Basildon Hospitals. Medicines prevent, treat or manage many illnesses or conditions and are the most common intervention in healthcare; however, across these care providers, there were multiple medication omissions due to drugs not being available, pain not being assessed, inadequate handovers and delayed discharge letters, with confusing or inadequate instructions on existing prescription charts.

1.27 The understanding, prescribing and administration of rapid tranquillisation and sedation was also poor, with many occasions in Broomfield and Basildon Hospitals when these medications were given without appropriate instruction or monitoring of Colin's vital signs (such as blood pressure, respirations and heart rate) to ensure no adverse effects to Colin; there was far greater understanding and application of the required medications, alternative interventions and monitoring requirements at Goodmayes Hospital where staff were more experienced in restrictive practices.

1.28 Haloperidol (an antipsychotic medication) was also prescribed when he became violent and aggressive during his stay in Basildon Hospital (in Florence Nightingale Ward on 24 July, after the embolisation on 28 July, in Bulphan Ward from 29 July-4 August, and in August on ITU). This should not have been used, particularly as the first choice of sedation, without a clear rationale and consideration of the risks and benefits being documented in the clinical records given Colin's cardiac history and its potential to trigger extrapyramidal symptoms.

1.29 Inappropriate prescribing and administration of Colin's medications caused physical distress and would have contributed to his increased agitation and the cognitive decline throughout his stay.

Pathway point: Medicines management and reconciliation.

1.30 **Dementia:** Tools designed to help staff understand and address Colin's care needs when he was diagnosed with Alzheimer's disease in early June 2021 were not employed or shared across care settings. Once a diagnosis of dementia has been made, it is essential that information about the person is gathered, and assessments made to ensure that individualised care plans can be devised. This includes gaining collateral histories from family members (and other care givers), and the use of documents such as 'This Is Me' which help staff to understand who the person really is, their likes, dislikes and daily routines. Use of these techniques can help to reduce distress for people with dementia and their carers.

1.31 While we can see some evidence of collateral histories being sought, information about Colin's preferences was not collated through use of a documented tool until he was admitted to Anisha Grange. An 'All About Me' document was then completed but it did not travel with Colin to Basildon Hospital. Staff at every stage of Colin's journey had to start again with their information requests and understanding of Colin. The absence of shared, written documentation meant that staff were unable to consistently deliver care that was tailored to his needs.

1.32 Additionally, referrals were not made to the Mid and South Essex NHS Foundation Trust Dementia Nurses at the point of diagnosis in Broomfield Hospital or when Colin presented with behavioural and psychological symptoms in Basildon Hospital. Specialist dementia nurses provide evidence based interventions, advice and support for the patient, their relatives and the staff caring for them. They can also provide support and advice regarding best interests decisions made on behalf of

patients who lack capacity; however, a referral was not made until late August 2021, two months after the diagnosis had been made, and by then Colin was in the ITU. Colin did not receive person centred care (see care planning below), distraction techniques were not employed until too late, and the reasons for his distress and agitation were not explored; referral to the Dementia Nurse may have helped in this regard.

Pathway points: Collateral histories and shared information. Referrals to specialist dementia nurses.

1.33 **Delirium:** Screening tools were not appropriately utilised for the assessment and management of potential delirium on admission to Broomfield and Basildon Hospitals. Delirium is an acute confusional state, usually with a fluctuating course, characterised by disturbed cognitive function or perception; it can indicate a serious underlying medical condition. The early detection of delirium is therefore important because it allows supportive care and treatment for reversible causes to be put in place as quickly as possible.

1.34 On admission to Broomfield and Basildon Hospitals there was a requirement for staff to screen Colin for delirium given his age and the history of fluctuating confusion; however, all potential causes of confusion were not assessed and the screening tools that were part of the assessment documentation were not employed. When Colin became unwell, increasingly confused and agitated after his fall on 27 July 2021, staff did not re-assess him to determine whether underlying physical health conditions (such as infections, constipation and pain) were the cause of his distress. Staff failed to identify and appropriately respond to the cause of his delirium which meant that Colin's physical and mental health continued to deteriorate unchecked.

Pathway point: Use of delirium screening tools.

1.35 **Nursing assessments and care planning:** Nursing assessments were incomplete and there was an absence of person centred care planning in all hospital care settings. The Care Quality Commission requires all providers to do everything reasonably practicable to make sure that people receive person-centred care and treatment that is appropriate, meets their needs and reflects their personal preferences. Nursing and risk assessments should be reviewed regularly, including on transfer between services, and clear care and/or treatment plans developed and made available to all staff and others involved in providing the care.

1.36 This is even more important when patients are confused, have a delirium or dementia. Individualised behaviour support plans need to be implemented for those known to be at risk of restrictive interventions[5] as in the case of Colin; however, in most cases there were examples of incomplete and incorrect assessments being undertaken, and we saw little evidence of family involvement or of individualised care planning for Colin other than at Anisha Grange Care Home, and to a lesser extent Woodland View Care Home.

1.37 This was particularly relevant at Broomfield and Basildon Hospitals. Colin had numerous different healthcare and security staff involved in his care and supervision, many of whom were locum or agency personnel, and it was essential for them to be able to divert Colin into activities or conversations that he enjoyed. However, there was a reliance on verbal shift handovers with an absence of written plans that would have helped staff to understand or anticipate Colin's care needs and keep him safe (for example, in helping them to understand how to keep him calm, how to distract him if he became agitated, or the approaches that could be used if he became violent and aggressive). Some behaviour charts were completed but without review or support from the mental health teams to understand the approaches which may have helped to prevent or de-escalate adverse behaviours or the triggers for these. It became clear to staff when reflecting on Colin's episode of care that he tended to become agitated when he wanted to leave, or after his family visited him as he wanted to go with them; however, this was not recognised or acknowledged while

[5] Department of Health: Positive and Proactive Care - reducing the need for restrictive interventions (2014).

he was on the ward in a way that was helpful in terms of staff being able to agree some strategies for diversion.

1.38 The absence of clear care plans forced a reliance on reactive restrictive practices rather than pro-active nursing care and treatment. It also made the building of trusted relationships difficult between ML and staff.

Pathway point: Comprehensive assessments and person-centred care planning.

1.39 **Mental Capacity Act (MCA):** Within Broomfield and Basildon Hospitals and the residential care settings there was inconsistent application of the MCA which requires decision specific assessments of capacity. When a person has dementia their mental capacity can change over time, it can also change in both the short term and the long term; for example, there might be days or even times of the day when the person can think more clearly. This means they may have capacity to make a decision sometimes but lack capacity at other times.

1.40 Colin presented with fluctuating confusion and was diagnosed with Alzheimer's disease in June 2021, yet formal assessments of Colin's capacity were not undertaken in all cases when key decisions were being made in relation to care, treatment and accommodation. There was a focus on assessments being undertaken in relation to discharge given that Colin wanted to repeatedly go home (see Deprivation of Liberty Safeguards section below), but there were also multiple decisions being made about his care, treatment and medication regimes yet only two capacity assessments relating to this; the first was when he was admitted to Goodmayes Hospital and the second was for a head scan that was required at Basildon Hospital. Care and treatment options were not sufficiently explored with Colin, and this resulted in treatment options and numerous medication changes without appropriate consent.

Pathway point: Correct application of the Mental Capacity Act.

1.41 **Lasting Power of Attorney**: ML's views as Lasting Power of Attorney (LPA) for health and welfare were not always considered when decisions about care and treatment were being made. In the absence of Colin having capacity, the law placed a duty on healthcare professionals to consult with his partner in accordance with the LPA that he had granted to ML. To meet the duty fully, this would have included all healthcare and treatment decisions.

1.42 Hospital clinicians, the EPUT MHLT and the community dementia support services ensured that they spoke with ML about their reviews either in person or via the phone, with numerous documented discussions about the medication regimes, including sedation and the use of haloperidol. While there was evidence of appropriate consultation in some cases, there were also occasions when treatments and particularly medications were not discussed with ML until after key decisions had been made and enacted (such as administration of sedation in all care settings other than Goodmayes Hospital and continuation of 'do not attempt cardiopulmonary resuscitation' status at Basildon Hospital). Colin's capacity was not always assessed (see above) and some decisions made were in direct conflict with ML's view. Her views as LPA were not always taken into account and when dissatisfaction with the medication regimes were expressed, best interests meetings, with documented outcomes, should have been held to agree the treatment plans going forward but were not in all cases. ML frequently challenged Colin's medical treatment as was her right, but applying the legal framework to establish best interests would have mitigated the potential for ML to make decisions that were not in Colin's best interests and should have been revisited frequently given the existence of ongoing objections made by ML and disagreements with family members. Failure to do this caused additional distress and anxiety for ML and meant that Colin potentially received care and treatment that might not have been in line with his beliefs and values.

1.43 Additionally, a financial capacity assessment was not undertaken despite multiple requests from ML. The LPA for property and financial affairs was registered for Colin on 8 February 2020. This named ML as the sole appointee but stipulated that she could only make decisions on Colin's behalf when he was deemed not to have mental capacity. Given the potential for Colin to be discharged home with privately funded carers or to go into a residential home setting, ML wanted to enact the LPA

given the costs of care that were to be incurred. She asked for a financial capacity assessment to be undertaken in some of the care settings, yet her requests went unheeded. This resulted in ML having to bear the costs of Colin's care but also caused significant distress to her; this again impacted on the relationships she had with the staff as she became increasingly frustrated with them.

Pathway point: Identification and involvement of the Lasting Power of Attorney.

1.44 **Deprivation of Liberty Safeguards (DoLS):** DoLS processes were not always followed by Woodland View Care Home, Broomfield and Basildon Hospital staff. The Deprivation of Liberty Safeguards are a part of the Mental Capacity Act which are used to protect patients who lack capacity to consent to their care arrangements if these deprive them of their liberty or freedom. However, where DoLS applications were made for Colin, we were unable to verify whether these had been authorised in all cases and many of the request forms were incorrectly or insufficiently completed without a supporting mental capacity assessment, description of the proposed restrictions or care plan. Support and advice from the safeguarding team was insufficient and there were periods of time when Colin was prevented from leaving his care setting or restrictions were applied without an appropriate legal framework.

Pathway point: Correct application of the Deprivation of Liberty Safeguards.

1.45 **Restrictive practice:** Least restrictive practices were not always employed by Broomfield and Basildon Hospital staff, and the potential harm caused by restraints was not assessed. It is recognised that emergency restraints might be necessary to prevent harm to an individual or others but if this is the case, a multidisciplinary team meeting should be arranged as soon as possible after to discuss the approach to the behaviour. This allows the team to consider what would be permitted in the event of further incidents that might necessitate further restraints.

1.46 Colin became agitated, violent and aggressive on many occasions. At Goodmayes Hospital, the model of care, staff skills, familiarity and knowledge of patients presenting with dementia appeared to have been effective in reducing the levels of aggression displayed by Colin. However, there was a tendency for Broomfield and Basildon Hospital staff to employ restrictive practices such as physical and/or chemical restraints and containment rather than always adopting other strategies to prevent and manage these behaviours. Colin was on anticoagulation medications for his cardiac function and may have bruised easily but body mapping was not undertaken after the restraints to determine whether any harm had been caused to Colin during the restraints, and meetings to discuss alternative approaches were not convened; this resulted in restraints continuing unchecked. Colin sustained a number of injuries during these restraints and was noted to have multiple bruises and some cuts to his body on discharge from Broomfield Hospital and during his stay at Basildon Hospital. It is also likely that these restraints, in the context of confusion, would have caused Colin considerable psychological distress.

1.47 We have seen no rota or register that would allow us to identify the staff that were booked to look after Colin on enhanced supervision, but physical restraints were invariably undertaken by security staff who had not received training from the Trust on these interventions. Instead, the Trust was reliant on the training that security staff had received through their Security Industry Authority (SIA) license which includes components of physical interventions but not in a healthcare setting. The training of security staff has since been improved and the Prevention and Management of Violence and Aggression (PMVA) level 2 training was introduced as a standard approach in March 2022 to replace the reliance on the SIA license.

Pathway point: Least restrictive practices.

1.48 **Incident reporting:** Restrictive interventions were not consistently incident reported at Broomfield and Basildon Hospitals and the serious incident involving the fall on 27 July 2021 was not appropriately investigated. Incidents and near misses that occur in the delivery of healthcare provide opportunities for investigation and improvement in systems and process to minimise the risk of recurrence. Physical and chemical restraints should be incident reported under these categories to

build an accurate picture of the extent of their use. The individual data can be used to help plan care more effectively and avoid needing to use restrictive interventions. Organisational data enables providers to understand the use of restrictive interventions in their settings and work on reducing these. Information is also important to allow wider oversight and learning; however, many of Colin's restraints:

- were reported under other categories or not reported at all meaning that the increasing numbers of restraints and harm to Colin and staff were difficult to quantify and respond to; or
- had insufficient supporting information to allow an understanding of whether the restraint was proportionate to the behaviours being displayed, whether other de-escalation techniques had been employed first, whether the staff involved were appropriately trained to undertake the interventions, and whether any harm had come to Colin because of the restraints.

1.49 The fall on 27 July was confirmed as a serious incident but the initial management review was significantly delayed and incomplete with an absence of analysis to determine whether any immediate actions to maintain patient safety and reduce the risk of recurrence were required or undertaken.

Pathway point: Incident reporting and investigation.

1.50 **Mental Health Act (MHA):** There were several occasions when requests for emergency psychiatric input or consideration for a MHA assessment should have been made sooner when Colin was medically stable. People who require urgent treatment for a mental health disorder and are at risk of harm to themselves or others can be detained under the MHA. Colin had been intermittently confused, was diagnosed with Alzheimer's disease and was experiencing periods of agitation, violence and aggression during periods of care when he had been deemed medically safe for discharge, when he was at home or in residential care. There were opportunities for an assessment to be considered:

- on 21 June when he was at home and found by the EPUT DISS team members to be over sedated having left the house the night before and returned by the police - no immediate action was taken by the team, but Colin was transferred by ML to Woodland View Care Home later that day;
- on 26 June following periods of agitation when he tried to hit a member of staff at Woodland View Care Home - DIST were contacted but advised the home to contact emergency services if he became agitated and/or aggressive again;
- on 19 July when he absconded from Anisha Grange, had three episodes of distress and had been physical towards members of staff - DCST were contacted and a professionals' meeting was planned to work together in managing the risks, but no immediate action was taken;
- on 25 July when Colin was on Florence Nightingale Ward at Basildon Hospital and began to hit staff, threatened other patients and threw a computer to the floor; and
- on 27 July when ML played a recording of Colin over the phone from the morning saying he wanted to kill himself.

1.51 Keeping Colin in care environments that could not meet his needs due to a lack of specialist expertise and skills in managing his agitation, without timely requests for emergency psychiatric input or consideration of a MHA assessment, resulted in harm to Colin and staff and was a potential risk to other patients/residents in all care settings.

Pathway point: Application of the Mental Health Act.

1.52 **Advocacy:** Independent advocacy was not provided in support of Colin or ML. Advocates are usually only provided when the person has no-one to support them but the MCA Code of Practice states there are also some circumstances where an Independent Mental Capacity Advocate (IMCA)

may be appointed on a discretionary basis; this includes adult protection concerns. Patients who have been detained under the MHA should equally be referred to an Independent Mental Health Advocate (IMHA).

1.53 Colin was increasingly confused, had been diagnosed with dementia and had received care under the MHA, with several references to his partner (who had LPA status) potentially not acting in his best interests. However, we can see no evidence of advocacy support being provided to Colin despite multiple requests being made by ML. Clinicians believed they were acting in Colin's best interests when decisions about care, treatment and accommodation were made, as did ML, but there were often conflicting opinions with little evidence of appropriate consultation with Colin. If initiated at an early enough stage in Colin's journey through the healthcare system (i.e., when initial frustrations became evident), independent advocacy may have helped to support his family but would also have helped to ensure that Colin's views were heard, and his rights upheld.

Pathway point: Access to independent advocacy support.

1.54 **Safeguarding:** The teams involved did not ensure that safeguards were afforded within the legal framework of the MCA but also the protections afforded by the adult safeguarding framework and policy. All health and social care staff have a responsibility to act if they become aware of safeguarding concerns such as physical or domestic abuse. While we can see evidence of some safeguarding advice being sought and referrals being made, we can see no evidence of these being responded to. There were also occasions when more could have been done by Broomfield and Basildon Hospital staff to safeguard Colin, particularly in relation to the restraints that were used during periods of violence and aggression. There were multiple reports of bruising to his body, yet referrals were not made, nor appropriate advice given by the safeguarding teams to ensure that appropriate and lawful restrictive practices were being employed. Harm was caused to Colin as a result of the ongoing and increased physical and chemical restraints.

Pathway point: Application of safeguarding frameworks.

1.55 **Handovers:** Handovers between services and teams were insufficient, delayed or absent in some cases. A good and effective handover is key to maintaining the integrity of information and patient safety. This includes not only ward handovers between day and night shifts but also between wards and other external agencies.

1.56 For Colin, some handovers were comprehensive and timely (for example, between EPUT Consultant Psychiatrist 1 and Stage Ward at Goodmayes Hospital, and between Stage Ward and the DISS); however, some were insufficient or sent several days after the transfer had been made (in particular, there was a very delayed handover between the medical team from Bardfield Ward at Broomfield Hospital to Stage Ward at Goodmayes Hospital and absence of a formal handover between AMU and Florence Nightingale Ward at Basildon Hospital).

1.57 This was compounded by organisations (and some teams within organisations) using different electronic patient record systems (for example, NELFT use RiO, while EPUT uses SystmOne and PARIS). Mental health records were accessed on different systems than physical health records, and some clinical care records were maintained in hard copy but with some entries also made via the electronic record. The handwritten records were not legible in all cases and, on many occasions, entries by the medical and the nursing staff were insufficient; for example, the rationale for ward moves and medication changes.

1.58 This combination of factors consistently made decisions and requests difficult to track and made care continuity within and between teams more challenging. The lack of effective handover between services also resulted in errors and medication omissions, for example, Colin started treatment for Alzheimer's disease while at Goodmayes Hospital, and this was continued and increased at Woodland View Care Home, but treatment had to be re-titrated at Anisha Grange.

1.59 This impacted the consistency of care, but also the physical and mental health treatment that Colin received. Furthermore, this increased ML's anxiety levels as she remained concerned about Colin's wellbeing and was labour intensive for staff as they tried to confirm the care that was required.

Pathway point: Effective handovers and interagency working.

1.60 **Family engagement:** Engagement and relationships with ML and Colin's children were impacted by COVID-19 but also the lack of a consistent care setting and no oversight of care. Family involvement is a critical component of patient-centred care that can improve patient outcomes, such as reducing the likelihood of relapse and hospital admissions. It also has important implications for patient safety.

1.61 As previously mentioned, Colin was accommodated in multiple care settings during a brief period, so ML and Colin's children had to engage with many different nursing and medical staff, all of whom had slightly different perspectives on Colin's healthcare needs and treatments. There were also visiting restrictions in the care homes and hospitals due to the pandemic. This increased ML's frustrations and anxiety levels and meant that she felt an even greater need to challenge the care that he received with a series of issues quickly eroding her confidence in staff. Despite numerous conversations with many of the ward doctors and nursing staff, ML felt that her views about the treatment that was being delivered to Colin were not heard and was increasingly distrustful about the appropriateness of his care. ML watched and recorded some conversations without consent and some staff told us they felt intimidated by her with occasions when she would become angry if they were not responsive to Colin's needs. There were some efforts by senior on-call managers to come and speak with ML, but more frequent, practical support was required for her and the staff on the wards. There were missed opportunities for carer engagement and assessment of carer needs, and the absence of a single point of contact across Colin's care pathway, in conjunction with an absence of written plans of care, meant that proactive planning did not take place.

Pathway point: Family engagement and single point of contact.

1.62 **Management of concerns:** Concerns raised by ML were not acted upon in a decisive manner. Raising a concern is not always easy for family members as they often feel that it may compromise the care that their relative may receive but it is the right thing to do as it is about safeguarding and protecting, as well as learning from a situation and making improvements. The response that is received can significantly impact the confidence they have in a service.

1.63 During Colin's care journey, ML raised a number of concerns to ward staff and community mental health teams. She also escalated these concerns in writing to each of the Trusts involved on a number of occasions (and as early as 11 June 2021). These were invariably re-directed back to the teams involved and we can see no evidence of serious issues being appropriately investigated or responded to. Failure to obtain a copy of the LPA at an early stage (and to keep it on file); failure to adhere consistently to the MCA in relation to capacity assessments, the administration of medications and restrictive practices; with an absence of appropriate escalation to a senior single point of contact, the safeguarding or legal team meant that Colin's care continued to be compromised throughout his care journey and caused ML to become increasingly distrustful of the staff involved in his care.

Pathway point: Investigation and response to concerns raised.

1.64 **Environment:** The acute hospital environment did not support improvements in Colin's mental health and wellbeing. It is well known that people with dementia often experience longer hospital stays, delays in leaving hospital and reduced independent living. Hospital admissions can trigger distress, confusion and delirium for someone with dementia which in turn can contribute to a decline in functioning.

1.65 One of the key aspirations of Challenge on Dementia 2020[6] that was published in 2015 was to create dementia-friendly hospitals. Mid and South Essex NHS Foundation Trust signed up to the Dementia Friendly Hospital Charter in 2018 and was awarded 'Working Towards Dementia Friendly Hospitals' status for 2022-23. However, in May 2021, Colin was accommodated in a side room at Broomfield Hospital which had a broken television and no radio, with workers outside hammering and drilling continuously. Basildon Hospital would have been similar, with the wards that Colin was placed in being busy and noisy during the day and at night, and staff having to remove his sink and other furniture from the side room of Bulphan Ward as these were broken during incidents and perceived as potential risks for Colin and staff.

1.66 It is likely that the environments of the mental health ward (and to some degree the care homes), with lounges, space to pace and garden areas were more beneficial for Colin. Such environments also have more ability than acute hospital wards to enable patients to orientate themselves to the time of day, with access to natural lighting and a clearer day and night routine.

Pathway point: Supportive environments.

1.67 **Clarity around palliative care:** There was inconsistent messaging around whether Colin was for active, palliative or end of life care. End of life care involves treatment, care and support for people who are nearing the end of their life. This can include ‘active treatment’ for some conditions which may cause discomfort (for example, antibiotics for infections). Palliative care, which may be a component of end of life care, relates to symptom management which can help a person to have a good quality of life and may on occasion include active treatment.

1.68 Colin was referred for palliative care when at Basildon Hospital in late August 2021; however, the purpose of the palliation as opposed to end of life care does not appear to have been adequately explained to ML. Communications around status were confusing and distressing for the family who believed that essential treatment had been withdrawn without their consent but was also unhelpful for the staff trying to manage his care. This impacted the decisiveness of the subsequent management plan for Colin.

Pathway point: Clarity on palliative and end of life care.

[6] https://www.gov.uk/government/publications/prime-ministers-challenge-on-dementia-2020

Figure 1: Schematic showing moves and application of legal frameworks

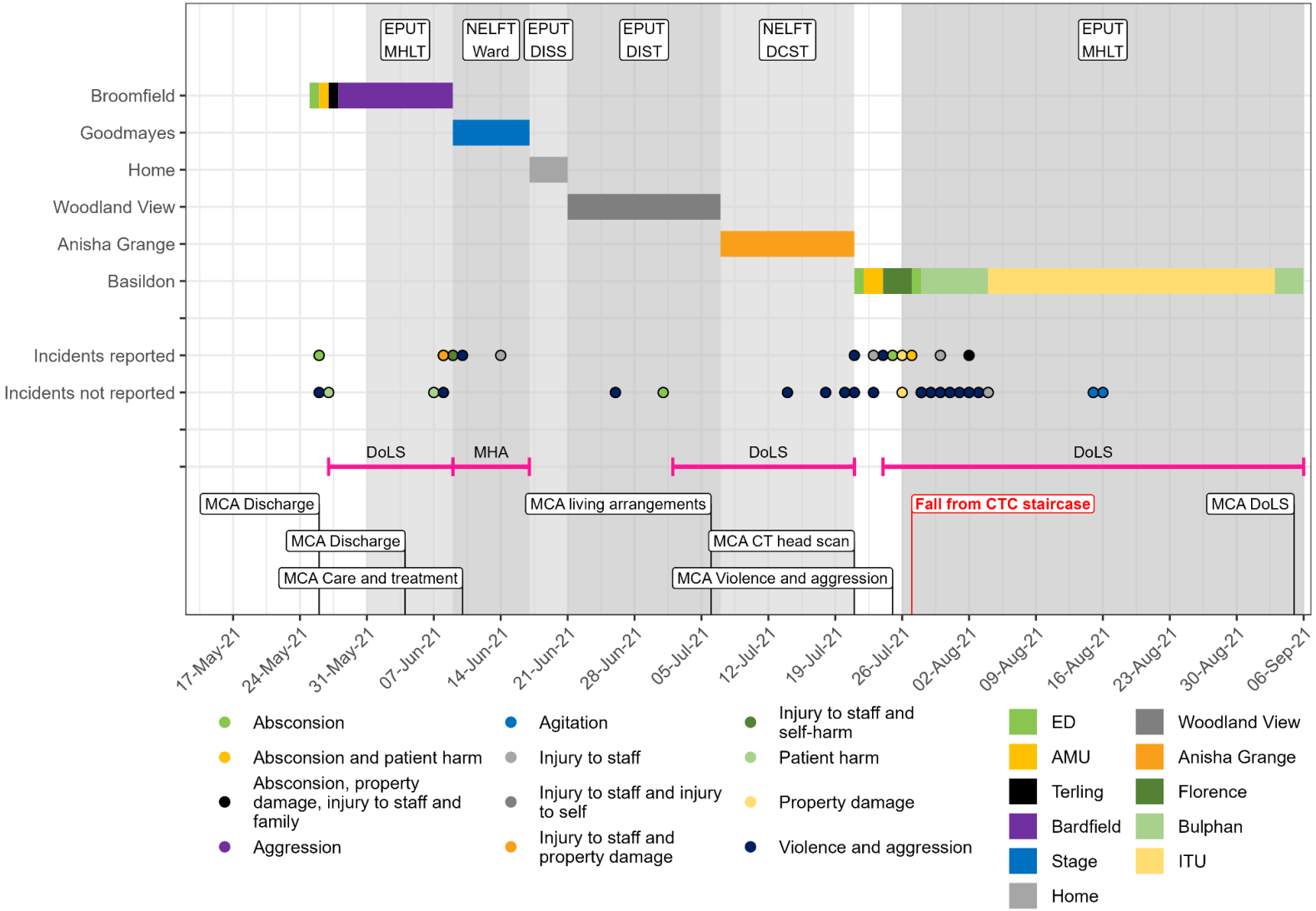
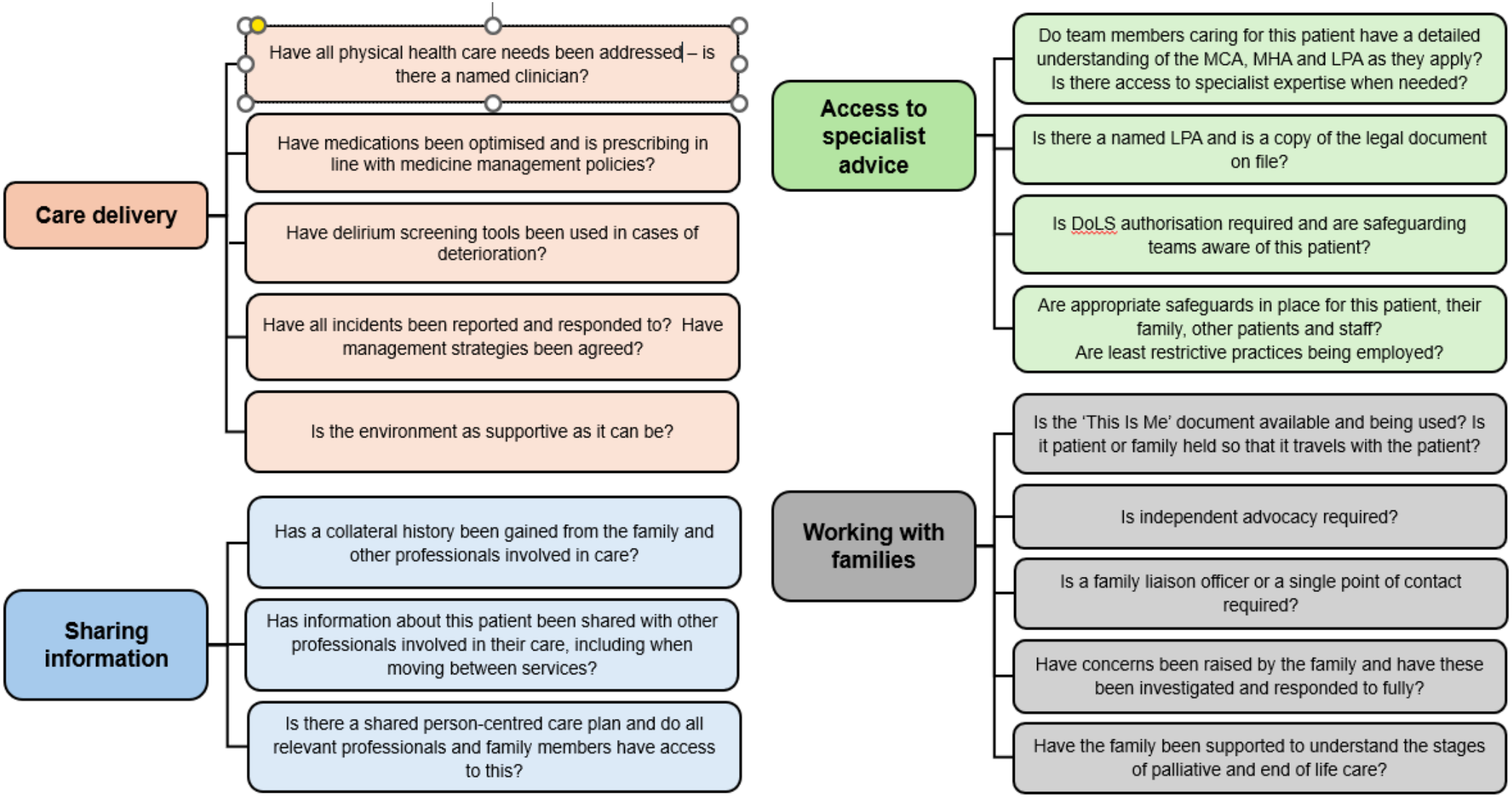


Figure 2: Summary of pathway factors and key questions for future planning



Recommendations

This independent investigation has made the following recommendations which are aimed at improving clinical practice. Many of these are about ensuring compliance with local or national policy and best practice guidance which already exists.

Recommendations for all stakeholder organisations

Recommendation 1

Information about Colin did not travel with him.

A 'This Is Me' (or equivalent care passport) document should be commenced in conjunction with the patient (where possible) and their carers when a diagnosis of dementia is given. This should be updated and refreshed throughout the patient's journey and shared with all health and social care professionals involved in their care.

Recommendations for all stakeholder organisations (other than Care Homes)

Recommendation 2

Care plans were not person-centred.

Patients with dementia (and/or delirium) must have person-centred care plans to ensure that care and treatment that is appropriate, meets their needs and reflects their personal preferences.

Mid and South Essex NHS Foundation Trust recommendations

Recommendation 3 – Clinical policies and procedures

Within Broomfield and Basildon Hospitals there were occasions when clinical policies and procedures were not complied with.

The Trust must ensure that the monitoring mechanisms within the following policies/procedures (or their equivalent) are achievable and being complied with, and that all policy/procedures are subject to regular audit or testing and staff trained in their use to ensure that required outcomes for patients are being achieved:

1. Medicines Management Policy in relation to the prescribing and administration of medications, and to include recording of allergies to medications, medication omissions, controlled drugs, sedation and rapid tranquillisation.
2. Medical Equipment Policy and checking the expiry dates of medical equipment/devices prior to use, particularly in relation to pressure infusion bags.
3. Care of Patients With Dementia Policy in relation to referrals to the Dementia Nurse, use of 'This is Me', care planning and unnecessary moves between wards.

4. Recognition and Management of Delirium Policy in relation to screening, medications management and care planning.
5. Observation/Enhanced Supervision Policy in relation to the roles, responsibilities and training requirements of security officers and other staff who undertake these tasks, record keeping and incident reporting (for staffing shortfalls and incidents of violence and aggression).
6. Record Keeping Policy in relation to nursing assessments, person-centred care planning and documentation of the rationale for key changes in care.
7. Admission, Discharge and Transfer Policy in relation to unnecessary moves between wards, internal handovers between wards and departments, and external handovers between Trust services and other organisations.
8. Palliative Care and End of Life Policy in relation to information sharing with the patient/family members and decision making.

Recommendation 4 – Mental Capacity Act

Within Broomfield and Basildon Hospitals there was inconsistent application of the Mental Capacity Act which requires decision specific assessments of capacity.

The Trust needs to ensure that key aspects of the Mental Capacity Act are subject to regular audit or testing and staff trained in its use to ensure that people without capacity are supported in key decision making and within appropriate legal frameworks. Key areas of focus include:

1. Capacity assessments and best interests decisions in relation to care and treatment, accommodation and finance.
2. Deprivation of Liberty Safeguards in relation to capacity assessments, documentation, the management of challenging behaviours and the use of restrictive interventions, and involvement of the safeguarding team.
3. Lasting Power of Attorneys and their involvement in key decision making.
4. Advocacy in relation to appropriate use and referrals.
5. Safeguarding adults in relation to referrals and the response to concerns raised

Recommendation 5 – Mental Health Act

There were several occasions when requests for emergency psychiatric input or consideration for a MHA assessment should have been made sooner when Colin was medically stable.

The Trust must ensure that patients who have behavioural and psychological symptoms receive a psychiatric assessment during or immediately after incidents of violence and aggression, with consideration of a Mental Health Act assessment if medically stable.

Recommendation 6 – Incident reporting

Incidents were not always reported or had insufficient information to allow a comprehensive investigation to be undertaken.

The Trust must ensure that the following policy is subject to regular audit or testing and staff trained in its use to ensure that required outcomes for patients and their carers are being achieved: • Incident Reporting and Management Policy in relation to restrictive interventions and the reporting of incidents of violence and aggression, and the management and investigation of serious incidents.
Recommendation 7 – Management of concerns **Concerns raised by ML were not always responded to or acted upon in a decisive manner.** The Trust must ensure that the following policy is subject to regular audit or testing and staff trained in its use to ensure that required outcomes for patients and their carers are being achieved: • PALS and Complaints Handling Policy in relation to the management of concerns and complaints raised by carers.
Recommendation 8 – Environment **The acute hospital environment did not support improvements in Colin's mental health and wellbeing.** The Trust should expedite the refurbishment of designated cubicles which can appropriately accommodate patients who have behavioural and psychological symptoms.

Essex Partnership University NHS Foundation Trust recommendations

Recommendation 9 – Clinical policies and procedures

Within the inpatient and community teams there were occasions when clinical policies and procedures were not complied with.

The Trust must ensure that the monitoring mechanisms within the following policies/procedures (or their equivalent) are achievable and being complied with, and that all policy/procedures are subject to regular audit or testing and staff trained in their use to ensure that required outcomes for patients are being achieved:

1. Medicines Management Policy in relation to the prescribing and administration of medications, and to include sedation and rapid tranquillisation.
2. Care of patients with dementia in relation to use of 'This is Me' and care planning.
3. Record Keeping Policy in relation to person-centred care planning.

Recommendation 10 – Mental Capacity Act

Within the community there was inconsistent application of the Mental Capacity Act which requires decision specific assessments of capacity.

The Trust needs to ensure that key aspects of the Mental Capacity Act are subject to regular audit or testing and staff trained in its use to ensure that people without capacity are supported in key decision making and within appropriate legal frameworks. Key areas of focus include:

1. Capacity assessments and best interests decisions in relation to care and treatment, accommodation and finance.
2. Deprivation of Liberty Safeguards in relation to capacity assessments, the management of challenging behaviours and the use of restrictive interventions, and involvement of the safeguarding team.
3. Lasting Power of Attorneys and their involvement in key decision making. Advocacy in relation to appropriate use and referrals.
4. Safeguarding adults in relation to referrals and the response to concerns raised.
5. Advocacy in relation to appropriate use and referrals.

Recommendation 11 – Mental Health Act

There were several occasions when emergency psychiatric input or a MHA assessment should have been considered when Colin was medically stable.

The Trust must ensure that patients who have behavioural and psychological symptoms receive a psychiatric assessment during or immediately after incidents of violence and aggression, with consideration of a Mental Health Act assessment if medically stable.

North East London NHS Foundation Trust recommendations

Recommendation 12 – Clinical policies and procedures **Within Goodmayes Hospital there were occasions when clinical policies and procedures were not complied with.** The Trust must ensure that the monitoring mechanisms within the following policies/procedures (or their equivalent) are achievable and being complied with, and that all policy/procedures are subject to regular audit or testing and staff trained in their use to ensure that required outcomes for patients are being achieved: 1. Care of patients with dementia in relation to use of 'This is Me' and care planning. 2. Record Keeping Policy in relation to person-centred care planning.
Recommendation 13 – Mental Capacity Act **Within Goodmayes Hospital there was some occasions when there was inconsistent application of the Mental Capacity Act which requires decision specific assessments of capacity.** The Trust needs to ensure that key aspects of the Mental Capacity Act are subject to regular audit or testing and staff trained in its use to ensure that people without capacity are supported in key decision making. Key areas of focus include: 1. Capacity assessments and best interests decisions in relation to finance. 2. Lasting Power of Attorneys and their involvement in key decision making. 3. Advocacy in relation to appropriate use and referrals. 4. Safeguarding adults in relation to referrals and the response to concerns raised.

Woodland View Care Home

Recommendation 14 – Clinical policies and procedures

Within the care home there were occasions when clinical policies and procedures were not complied with.

Woodland View Care Home must ensure that the monitoring mechanisms within the following policies/procedures (or their equivalent) are achievable and being complied with, and that all policy/procedures are subject to regular audit or testing and staff trained in their use to ensure that required outcomes for patients are being achieved:

1. Medicines Management Policy in relation to the administration of medications, and to include medication omissions, sedation and rapid tranquillisation.
2. Physical health monitoring including the requirement for and response to physiological observations.
3. Care of patients with dementia in relation to use of 'This is Me' (or an equivalent) and care planning.
4. Admission in relation to compliance with the criteria for acceptance to the home.

Recommendation 15 – Mental Capacity Act

Within the care home there was inconsistent application of the Mental Capacity Act which requires decision specific assessments of capacity.

Woodland View Care Home needs to ensure that key aspects of the Mental Capacity Act are subject to regular audit or testing and staff trained in its use to ensure that people without capacity are supported in key decision making and within appropriate legal frameworks. Key areas of focus include:

1. Capacity assessments and best interests decisions in relation to care and treatment, accommodation and finance.
2. Deprivation of Liberty Safeguards in relation to capacity assessments, documentation, the management of challenging behaviours and the use of restrictive interventions.

Recommendation 16 – Incident reporting

Incidents were not always reported in line with regulations and to facilitate a comprehensive investigation to be undertaken.

Woodland View Care Home must ensure that the following policy is subject to regular audit or testing and staff trained in its use to ensure that required outcomes for patients and their carers are being achieved:

1. Incident Reporting and Management Policy in relation to restrictive interventions and the reporting of incidents of violence and aggression.

Anisha Grange Care Home

Recommendation 17 – Clinical policies and procedures

Within the care home there were occasions when clinical policies and procedures were not complied with.

Anisha Grange Care Home must ensure that the monitoring mechanisms within the following policies/procedures (or their equivalent) are achievable and being complied with, and that all policy/procedures continue to be subject to regular audit or testing and staff trained in their use to ensure that required outcomes for patients are being achieved:

1. Medicines Management Policy in relation to the administration of medications, and to include sedation.
2. Physical health monitoring including the requirement for and response to physiological observations.
3. Safeguarding adults in relation to documenting the rationale for when safeguarding referrals are not required, as part of incident management processes.

2 Independent investigation

Approach to the investigation

2.1 NHS England commissioned Niche Health and Social Care Consulting Ltd (Niche) to carry out an independent review of the nature and extent of involvement of all agencies, private and NHS, that Colin had contact with dating back to the first contact with services in respect of his symptoms of confusion. The final agreed terms of reference for this investigation are given in full in Appendix A.

2.2 Niche is a consultancy company specialising in patient safety investigations and reviews. The independent investigation follows the NHS England Serious Incident Framework (March 2015)[7], key elements of the NHS England Patient Safety Incident Response Framework (August 2022)[8], and Article 2 of the European Convention on Human Rights and the investigation of serious incidents in mental health services[9].

2.3 Two members of the investigation team met with Colin's son and daughter on 7 June 2023, and with his partner on 1 August 2023. The scope and purpose of the investigation were explained to them, and the draft terms of reference shared. Questions about the care received by Colin were noted and have been addressed within the report where possible. These can also be seen at Appendix B.

2.4 During our investigation we met with 31 clinicians, practitioners and managers from:

- Mid and South Essex NHS Foundation Trust (MSE)
- Essex Partnership University NHS Foundation Trust (EPUT)
- North East London NHS Foundation Trust **(**NELFT)
- Woodland View Care Home
- Anisha Grange Care Home

2.5 We also visited the Basildon Hospital site and wards where Colin had been treated, including the emergency department.

2.6 We have not spoken with anyone from the local authority, as the social worker who was involved in Colin's care declined to meet with us. This is disappointing as further insights and learning may have been possible. We are aware, however, of the concurrent safeguarding adults review that is being undertaken and would hope that any omissions in our findings in relation to the responsibilities of the local authority are covered by this.

2.7 We have reviewed Colin's clinical records and other information (policies, procedures, incident forms and communications) provided by each of the relevant stakeholder organisations. Additionally, we received information from two GP practices which has been used for reference only; we did not interview their staff.

2.8 We have also reviewed clinical records, photos, statements and timelines that have been shared by Colin's partner (ML).

2.9 This investigation has covered over five months of community and hospital care, and it is difficult to trace exactly how all of the issues raised by Colin's partner (ML), Colin's children and staff were responded to. We have tried where possible to rely on documentary evidence but have also reflected some of the comments that have been received in interviews.

[7] https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf

[8] https://www.england.nhs.uk/patient-safety/patient-safety-insight/incident-response-framework

[9] https://assets.publishing.service.gov.uk/media/5a7f1c04ed915d74e33f4637/Article_2_advice_acc.pdf

2.10 The draft report was shared with the stakeholder organisations listed above. This provided an opportunity for the teams that had contributed significant pieces of information, and those we interviewed, to review and comment on the factual accuracy of our investigation.

2.11 The post-validated draft report was shared with ML and Colin's children to ensure that we have reflected their experiences and the evidence provided. This will be an emotionally challenging process for them.

Investigation quality control

2.12 At Niche we have a rigorous approach to quality standards. We are an ISO 9001:2015 certified organisation and have developed our own internal single operating process for undertaking independent investigations. Our final reports are quality assured through a Professional Standards Review process (PSR) and approved by an additional senior team member to ensure that they have fully met the terms of reference for the review. This report has been peer reviewed within Niche by experienced healthcare professionals prior to distribution.

3 Chronology and findings by care episode

3.1 The terms of reference for this investigation include an understanding of Colin's past medical history from January 2021 and the management of his physical conditions with regard to any potential impact on his symptoms of dementia or on management of his mental health. From January through to the hospital admissions later in the year, care was provided by several teams in multiple healthcare settings. For ease of reference, we have included in this section an outline chronology for each episode of care and our observations and findings for each of these. A number of these findings are pertinent to the 'pathway of care' within and between organisations, and they demonstrate some of the key themes that have been identified in the summary above.

Primary Care December 2020 – 25 May 2021

3.2 Colin was registered with Tiptree Medical Centre.

3.3 In December 2020, Colin started to experience some lower urinary tract symptoms, including frequency of micturition at night, and arranged to speak with the GP about these; however, he missed two scheduled appointments.

3.4 Following the second missed appointment, the GP spoke with ML and she mentioned that he had memory issues.

3.5 On 22 December, Colin was seen by his GP. Following an examination, the GP diagnosed benign prostatic hyperplasia (an enlarged prostate) as a cause for the urinary symptoms. Colin was prescribed tamsulosin[10] with a plan for this to be reviewed in six weeks.

3.6 His memory was also discussed at the appointment, and it was confirmed by Colin that his short-term memory was worse than it used to be. He was advised to discuss this with his partner ML, and if concerned they could book him in for a memory test.

3.7 On 21 May 2021, ML contacted the GP. She explained to the doctor that Colin had a poor memory and appeared confused on occasion, and that his heart rate was low at 30 – 50 beats per minute. The GP asked Colin to attend the surgery for blood samples to be taken; however, on 25 May (and before this had been arranged) ML checked his heart rate, which was low at 35 beats per minute, and he was admitted to Broomfield Hospital.

Commentary on this care episode and points for learning

3.8 The treatment and advice offered by the GP for Colin's urinary symptoms was in line with expected practice, although we can see no evidence of the tamsulosin being reviewed after six weeks. This review would have been helpful to determine whether there had been any improvements without side effects being encountered. It would also have provided a proactive opportunity to ask about Colin's memory issues so that early diagnostics could be commenced.

Broomfield Hospital and EPUT Mental Health Liaison Team 25 May – 9 June 2021

3.9 Broomfield Hospital is an acute district general hospital in Chelmsford, Essex. It is managed by the Mid and South Essex NHS Foundation Trust and provides a range of services including emergency department (accident and emergency), emergency medicine and surgery, elective surgery in most specialities, and maternity and paediatric services.

3.10 The EPUT Mental Health Liaison Team (MHLT) work at the Mid and South Essex NHS Foundation Trust hospital sites. They provide specialist mental health care in the physical health setting, enabling the emergency departments and wards to assess, manage and support mental health problems as they present or arise among people being cared for within the general health pathway.

[10] Tamsulosin is a medication that helps to reduce the symptoms of an enlarged prostate gland by relaxing the muscle around the bladder and prostate gland.

Emergency department 25 May 2021

3.11 On 25 May 2021 Colin complained of earache and feeling tired. Colin's partner (ML) took his blood pressure which was normal, and she checked his heart rate (HR) which was low at 35 beats per minute (bpm). ML called NHS 111[11] and the ambulance service was called.

3.12 On arrival at Colin's home, the ambulance crew noted that he had chest pain causing shortness of breath, and new confusion with onset six weeks prior.

3.13 Colin was conveyed by ambulance to the Broomfield Hospital Emergency Department. ML was not able to accompany Colin to the hospital due to COVID-19 restrictions.

3.14 Colin was assessed by the emergency department nursing and medical staff. An electrocardiogram (ECG) was recorded, and blood samples taken. He was referred to the medics and transferred to the acute medical unit (AMU) that evening.

Commentary on this care episode and points for learning

Physical health

3.15 On arrival at the emergency department at 3.11pm, Colin was assessed by medical and nursing staff. At triage it was documented that ML had noticed bradycardia (namely, a slower than normal heart rate) three days ago and that Colin had intermittent weakness and confusion with pain on both sides of his chest on inspiration. Physiological observations including temperature, blood pressure and pulse rate were checked and found to be within normal parameters. His Glasgow Coma Scale[12] (GCS) was 15/15.

3.16 The doctor who assessed Colin recorded an initial impression of bigeminy[13] and acute coronary syndrome (ACS)[14] following the recording of an ECG. Blood testing (including troponin[15] and D-Dimer[16]) and a chest X-ray (CXR) were requested with a plan to refer to the medical team.

3.17 Colin was seen in a timely manner and his presenting physical health condition appropriately investigated and responded to.

Medications

3.18 On attendance to the emergency department, it was noted that Colin was on a range of medications for his cardiac function, constipation and urinary symptoms. These included: aspirin[17], lacidipine[18], ramipril[19], senna[20], flutiform inhaler[21], tamsulosin (although not taking currently),

3.19 There were no changes made to Colin's core medications by emergency department staff, although it was recorded that aspirin 300mg had been taken by Colin at 1pm prior to his arrival and as advised by NHS 111.

[11] NHS 111 is a free-to-call single non-emergency number medical helpline.

[12] The Glasgow Coma Scale (GCS) is used to assess a patients' level of consciousness.

[13] Bigeminy is a heart rhythm that has an extra heartbeat between every normal one.

[14] ACS describes a range of clinical scenarios where the patient presents with prolonged chest pain at rest or on mild exertion with or without either ECG changes or myocardial injury.

[15] A troponin test measures the levels of troponin T or troponin I proteins in the blood. These proteins are released when the heart muscle has been damaged, such as occurs with a heart attack.

[16] A D-Dimer test is a blood test that checks for blood-clotting problems. A positive test suggests a blood clot or blood clotting problems.

[17] Aspirin may thin the blood and can decrease the risk of blood clotting.

[18] Lacidipine is a calcium channel blocker which helps to lower blood pressure.

[19] Ramipril is an ACE inhibitor type medication used to treat high blood pressure and heart failure.

[20] Senna is a natural laxative used to treat constipation.

[21] Flutiform is an inhaler which contains a steroid medication which can help to reduce swelling and inflammation in the lungs.

Care planning and risk assessment

3.20 On arrival at the emergency department, nursing staff completed an assessment document with physiological observations (normal), skin assessment (intact), pain score (zero) and cannula insertion (completed); however, many other sections of the 'first hour of care' document were either incorrect or incomplete, including:

- "*does the patient trigger sepsis*" was left blank (we note that this would have been 'no' based on the National Early Warning Score[22] (NEWS) of 0, but this is an important factor to consider in all patients presenting to hospital and particularly with Colin, as a change in mental state can indicate early signs of sepsis);
- "*is there an appointed power of attorney*" was left blank – Colin did not present as confused but had a history of increasing confusion so documenting this on admission was important given the cognitive decline that was to follow;
- "*does the patient have cognitive impairment/dementia*" was marked as 'no', with a record of him being alert and having no confusion despite it being documented that Colin had intermittent confusion at triage; and
- the urinalysis section was left blank, despite urine infections being a potential cause of confusion (particularly in older patients).

3.21 These omissions did not impact the decision to admit Colin to hospital, as he required his physical health concerns (bradycardia and chest pain) to be investigated; however, they are questions which should be explored with all presenting patients. Colin had a recent history of confusion, which may have been caused by delirium[23] or early stages of dementia. It was essential for a full and comprehensive screening to be undertaken in order to more fully understand the causative factors so that appropriate treatments or behavioural strategies could be put in place in a timely way.

Behaviour and presentation – Mental Capacity Act and safeguarding

3.22 The doctor (name not stated) who reviewed Colin in the emergency department documented an abbreviated mental test score (AMTS)[24] in line with the requirements of the assessment form for all patients aged over 65. Colin scored 9/10 (a score of 8 or less is marked on the form as requiring consideration of dementia) and he was found to be alert "*with no confusion*".

3.23 Colin's admission to the AMU was primarily centred on his cardiac events. His cognition (which was not assessed as a main initial concern given that he did not present as confused at the time of his examination) was further explored on transfer to the AMU.

Acute medical unit 25 – 27 May 2021

3.24 Colin was transferred to the AMU at 5.48pm on 25 May 2021, and was clerked by a senior house officer (SHO) at 8.44pm.

3.25 A referral was made to cardiology and Colin was reviewed on 26 May. After an ECG and medication changes, he was discharged from the cardiology service.

[22] The NEWS is based on a simple aggregate scoring system in which a score is allocated to physiological measurements, already recorded in routine practice, when patients present to, or are being monitored in hospital – the higher the score, the greater the deviation from the norm.

[23] Delirium (sometimes called acute confusional state) is a common clinical syndrome characterised by disturbed consciousness and a decline in cognitive function or perception which has acute onset (usually one to two days) and fluctuating course.

[24] The AMTS aims to rapidly assess elderly patients for the possibility of dementia and consists of 10 questions.

3.26 Colin was also reviewed by the consultant on the post-take[25] ward round. A management plan was documented, and this included the requirement for a dementia assessment and also the potential for a referral to old age psychiatry given Colin's recent history of confusion.

3.27 A capacity assessment was undertaken at 5.10pm on 26 May, which determined that Colin did not have the capacity to self-discharge against medical advice.

3.28 Later that evening, Colin absconded from the ward and was returned by security officers. He then became violent and aggressive and was administered an intramuscular (IM) sedative. From this point on he was assigned two security officers to always accompany him.

3.29 Colin was transferred to Terling Ward at 2am on 27 May.

Commentary on this care episode and points for learning

Physical health

3.30 At the point of handover to the AMU on 25 May, Colin's physiological observations were within normal parameters other than his temperature, which was slightly low at 36°C (NEWS 1).

3.31 He was clerked at 8.44pm by a Foundation Year 2 (FY2)[26] doctor, who noted Colin's presenting complaint as worsening confusion and bradycardia. A collateral history was requested from ML, which was good medical practice and in line with the Recognition and Management of Delirium in Adults Policy (2021), although the documentation did not include whether ML's status under lasting power of attorney[27] (LPA) was discussed. ML reported that, over the last few weeks, Colin had been getting more and more confused and had been complaining of chest pain for the past week, with a heart rate of 37– 42 bpm. She also described that there had been breath-holding episodes at night where Colin would be struggling for breath.

3.32 The FY2 doctor documented a comprehensive plan that included a cardiology review and a repeat ECG, as Colin's pulse rate was now greater than 110 bpm, with a suspicion of atrial fibrillation (AF).[28] They noted that a confusion screen had been undertaken and a CT head scan ordered, with referral to the memory and sleep apnoea clinics being required after discharge for further evaluation. It was recorded that Colin did not want a 'Do Not Attempt Cardiopulmonary Resuscitation' order[29], as per the information recorded by the ambulance crew who conveyed Colin to the hospital.

3.33 Colin's blood test results were within normal parameters, including his c-reactive protein (CRP)[30], white cell count (WCC)[31], troponin and D-Dimer, indicating that he did not have an underlying infection and had not had a myocardial infarction (also known as a heart attack).

3.34 An AMTS had been undertaken in the emergency department, bloods had been tested, a CXR performed, and a CT head scan was ordered, but we can see no evidence of the confusion screen that was referred to, despite this being marked as complete. Elements of screening were clearly undertaken (as above), but a checklist was not used or documented within the records to ensure

[25] A post-take ward round is a specific type of ward round, in which a senior doctor (normally the consultant) reviews the patients admitted to hospital as acute medical emergencies within 24 hours of admission.

[26] After completing an undergraduate medical degree, the next part of training as a doctor involves the two year foundation training programme. The training comprises foundation year one and foundation year two.

[27] A lasting power of attorney (LPA) is a legal document that allows an individual (known as the 'donor') to appoint one or more people (known as 'attorneys') to help them make decisions or to make decisions on their behalf. There are two types of LPA (health and welfare, and property and financial affairs) and individuals can make one type or both.

[28] Atrial fibrillation is a heart condition that causes an irregular and often abnormally fast heart rate.

[29] Do Not Attempt Cardiopulmonary Resuscitation means that if a person has a cardiac arrest or dies suddenly, there will be guidance on what action should or should not be taken by a healthcare professional, including not performing CPR on the person.

[30] C-reactive protein is produced by the liver, and if there is a higher concentration of CRP than usual, it's it is a sign of inflammation in the body.

[31] A white cell count measures the number of white cells in your blood. White blood cells are part of the immune system. They help a body fight infections and other diseases. When people get sick, their body makes more white blood cells to fight the bacteria, viruses, or other foreign substances causing the illness. This increases the white blood count.

that all aspects which may have contributed to Colin's intermittent confusion had been considered such as alcohol[32] (the notes mentioned that Colin "*drinks*" but the number of units was not indicated), medications (he was on several medications: see comments below regarding tamsulosin), constipation (he had a history of constipation and was on laxatives but was found to be constipated five days later), hydration status, urinary or other infections (Colin was known to have an enlarged prostate which caused outflow issues, but a urine sample was not sent for testing until two days after admission – we note on 28 May, microscopy results indicated no evidence of infection).

3.35 We can also see no evidence of a 'single question to identify delirium' (SQiD)[33] or the 4AT[34] being undertaken, which was a requirement of the Recognition and Management of Delirium in Adults Policy (2021) for patients with an acute change in mental status (for example, change in cognition and behaviour, which Colin had). The SQiD was not included on the Broomfield Hospital Emergency Department assessment document (it is a set question on the Basildon Hospital forms, but it would appear that standardisation of documentation following the merger of the hospitals[35] into the one organisation had not yet occurred) and therefore there was no prompt to consider the SQiD or 4AT test. ML had described Colin's increasing confusion over the last few weeks which can occur with dementia but can also be indicative of an underlying physical health problem.

3.36 At 9.50pm on the morning of 26 May, Colin was reviewed by a consultant cardiologist who noted that Colin was not confused at that time and that bradycardic ectopics[36] were likely to be from his right ventricular outflow tract.[37] The cardiologist reviewed that medication that Colin was taking and stopped the pre-admission lercanidipine[38] and started verapamil[39] 120mg twice a day. He requested an echocardiogram as an inpatient and stated that if this was normal then Colin could go home from a cardiology point of view with follow up by the community heart failure team.

3.37 At 3.50pm, the post-take ward round was undertaken by AMU Consultant 1. The AMTS was repeated which was good practice; the score had reduced from 9 to 7/10, and they documented a primary working diagnosis of "*likely dementia"* (in addition to the bigeminy), that a dementia assessment was required, and to consider referral to old age psychiatry. Additional elements of the plan included that Colin's vitamin B12 and folate[40] would need to be checked, which was in line with dementia screening requirements which are included in the Trust's Care of Patients With Dementia Policy (2020).

3.38 The echocardiogram was undertaken that day, and at 5.20pm Colin was reviewed again by the cardiologist, who noted that Colin was now disorientated and confused. Echocardiogram results indicated an ECG rhythm of sinus rhythm with bundle branch block morphology with ectopics and that Colin had a low ejection fraction[41] (25 per cent) with dilation of the right ventricle and atrium. His medications were reviewed again (see medications section below), and he was to be referred to the outpatient heart failure team but was deemed to be fit for discharge from cardiology. This was a responsive and comprehensive review.

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[32] Long-term drinking can cause confusion and cognitive decline.

[33] SQiD is a simple prompt question which asks, "*Is this patient more confused than before?*" Asking the question on a regular basis can identify changes in a patient's condition, which could potentially be delirium.

[34] The 4AT is a simple and short (<2 min) delirium detection tool.

[35] Mid and South Essex NHS Foundation Trust was formed on 1 April 2020, following the merger of three legacy Trusts: Basildon and Thurrock University Hospitals NHS Foundation Trust, Mid Essex NHS Trust and Southend University Hospital NHS Foundation Trust.

[36] An ectopic heartbeat is a type of irregular heartbeat. It happens when your heart contracts (beats) too soon.

[37] A ventricular outflow tract is a portion of either the left ventricle or right ventricle of the heart through which blood passes in order to enter the great arteries.

[38] Lercanidipine is a drug used to treat high blood pressure.

[39] Verapamil is medication used for the treatment of high blood pressure, angina, and supraventricular tachycardia.

[40] Vitamin B12 or folate deficiency anaemia can cause a wide range of symptoms including problems with memory, understanding and judgment (cognitive changes).

[41] Ejection fraction is a measurement, expressed as a percentage, of how much blood the left ventricle pumps out with each contraction. Normal is 45 – 75%. A result of < 25% indicates severely impaired heart function.

3.39 On transfer to the AMU, Colin had been nursed in a bed with cardiac monitoring which he tolerated for a short time, but then started to wander. He declined the cardiac monitoring from the evening of 26 May; by this time, he had been reviewed and discharged by the cardiologists and it was agreed that he did not need continuous monitoring.

Medication

3.40 Colin was admitted to hospital on a range of core medications for his cardiac function and was also taking laxatives for constipation. It was noted on the initial clerking that Colin had also been commenced on tamsulosin three weeks previously and had then started to feel generally unwell. He had stopped taking the medication three days before his attendance at hospital and reported feeling better since then. Tamsulosin was correctly re-prescribed as there had been no instruction from the GP for this to be discontinued, but it was omitted by the ward staff, which was appropriate given the reported side effects. However, advice was not sought from the urologist about recommencing or replacing this medication until 9 June, another two weeks later (see commentary in medication sections of Terling Ward and Bardfield Ward episodes of care). Earlier advice should have been gained given the urology problems that Colin had experienced historically.

3.41 Colin was reviewed by the cardiologist on 26 May. In response to the echocardiogram results, they stopped the verapamil, started bisoprolol[42] and spironolactone[43] and asked for the aspirin and ramipril to be continued. These prescription changes were made on 26 May, but we can see no signature on the drug chart to confirm that the ramipril, spironolactone and bisoprolol were given on 27 May. The Administration of Medications Policy (2021) states that drugs must not be omitted if unavailable and should be obtained without delay. The medications were not classified as critical[44] within the Trust formulary, and Colin's physical observations were monitored and were largely within normal parameters, yet Colin went without his core medications until the morning of 28 May.

3.42 The community heart failure team was to follow up Colin after his discharge from hospital, but the urgency was not stated and we can see no reference to any instructions for monitoring of Colin's physical health given the changes in medication either through a follow-up ECG while an inpatient (given the episodes of bradycardia that had been experienced) or through blood testing (given that renal function should be checked within a month of commencing spironolactone[45]). Blood tests were undertaken when Colin had been admitted to hospital and were within normal range but were not checked again during this admission. Similarly, Colin's ECG was not repeated until just prior to his transfer and this was abnormal (see comments in the Bardfield Ward physical health section for comments on ECGs).

3.43 On the evening of 26 May, Colin absconded from the ward and became agitated on his return. He became aggressive and violent soon after. A stat (single) dose of 1mg oral lorazepam[46] was prescribed and given at 6.10pm, but IM administration (1mg) was then required at 7.49pm as he remained agitated, was striking staff members and was unwilling to take the medication orally. This prescribing was in line with the Emergency Control of the Acutely Behavioural Disturbed/Excited Delirium Patient: Rapid Tranquillisation Policy (2021); the sedation needed to be given in an emergency situation due to the risk of harm to self and others (although please see comments in the behaviour and presentation section below regarding incident reporting and physiological observations).

3.44 We also note that an additional stat dose of lorazepam was prescribed on 26 May "*if needed due to violence*". Again, this was in line with the Rapid Tranquillisation Policy which indicates that a

[42] Bisoprolol is a beta blocker medicine used to treat high blood pressure (hypertension) and heart failure.

[43] Spironolactone is used in combination with other medicines to treat high blood pressure (hypertension) and heart failure.

[44] Critical medications include those that could potentially result in harm to the patient when administration of doses is delayed.

[45] https://cks.nice.org.uk/topics/hypertension/prescribing-information/spironolactone

[46] Lorazepam belongs to a group of medicines called benzodiazepines.

maximum of 4mg can be given daily. It was helpful for staff to have a prescription to hand in the case of an emergency, although it was not required that day.

3.45 The doctor appropriately requested advice from the psychiatric specialist registrar (SpR) after these events and it was agreed that antipsychotics should be avoided if possible due to "*benzo hyperirritability*[47]". It was agreed that Colin would be prescribed as required IM lorazepam 0.5mg four hourly (maximum 2mg per day) but that clonazepam[48] or olanzapine[49] could be considered if needed. This prescribing was in line with the Initial Pharmacological Management of Agitated Behaviour Symptoms Arising from an Underlying Delirium in Adults guidance (2021); however, the doctor did not document that ML had been informed of the advice from the psychiatrist, or of the prescribing regime. We can also see no evidence of a capacity assessment being undertaken at this time. Colin was administered IM lorazepam in an emergency situation, but the planned IM doses should have been discussed with him. A capacity assessment had been undertaken at 17.10 in relation to discharge (see comments in behaviour and presentation section below) but, given his confusion, there should also have been a capacity assessment to determine whether he was able to make decisions about his care and treatment before further medications were given. However, we can see no evidence of this prescribing regime being discussed proactively with Colin, or with ML as his attorney under LPA (who would have had to be consulted if he was found to not have capacity).

<u>Care planning and risk assessment</u>

3.46 On transfer to the AMU, a "*48-hour nursing documentation*" assessment was commenced. Colin's skin integrity (intact), nutritional status (low risk of malnutrition), infection status (none), falls risk (low) and activities of daily living were assessed but there were also sections of the form that were left blank or were incorrect. This included:

- That Colin was not presenting with mental health issues or cognitive impairment despite the history of intermittent confusion. This meant that there was no expectation for staff to identify whether there might be mental capacity issues to consider.
- That Colin was an absconsion risk and might be a person with an immediate and significant likelihood to suffer harm, self-harm, or be a threat to others, but with no description of this in the records, despite this being a requirement of the form.
- The amount of alcohol consumed was left blank despite it being noted in the medical clerking that Colin "*drinks*" (see comments in the physical health section, above).
- The AMTS was not completed. Although undertaken by the clerking doctor in the emergency department, this is also a requirement of the nursing documentation (to be repeated during the stay). Completion at specified intervals would have helped the medical and nursing staff to determine whether Colin's confusion was worsening (or improving).
- The elimination section of the activities of daily living assessment included that Colin was continent but did not include that he was prone to constipation (and taking laxatives) or that he had urinary outflow problems caused by an enlarged prostate. Constipation is known to cause confusion and urinary retention and both can be painful and distressing; these are factors that should have been considered for Colin given his history of confusion so that his bowel movements and urinary output could be monitored accordingly. These were both found to be issues in the following days.

3.47 It was appropriately documented that care plans were not required for sepsis or pressure damage; however, there were no other care plans initiated for Colin other than one labelled "*requiring inpatient [sic]*". This care plan included that staff should introduce themselves to Colin and orientate

[47] An abnormally high or uninhibited response to stimuli as a result of benzodiazepine medication.

[48] Clonazepam belongs to a group of medicines called benzodiazepines.

[49] Olanzapine belongs to a class of drugs known as atypical antipsychotics.

him to the ward, undertake care rounding[50] to ensure he felt safe, plan for safe and timely discharge, and ensure all medications were administered. The plan did not include physiological observations to be recorded to a stated frequency despite Colin having been admitted with bradycardia, or to observe for signs of delirium given that he had presented with intermittent confusion.

3.48 We can see no evidence of other care plans being initiated either from admission or after the incidents of violence and aggression on 26 May. The Delirium Management Pathway includes that patients presenting with a new onset of challenging or risky behaviours should have organic factors such as pain, constipation and urinary retention assessed and optimally managed. Colin had a history of confusion and was prone to constipation and urinary retention, but there was no plan of care to help staff understand the monitoring that was required (namely, bowel movements, fluid intake and output). Also, while behaviour charts and night needs assessment forms were commenced in order to understand any triggers for the agitation, violence and aggression, and responses to interventions in line with good practice, there was no plan of care to help the nursing and security staff who had been assigned to Colin to proactively prevent or manage any adverse behaviours.

Behaviour and presentation – MCA and safeguarding

3.49 On 26 May Colin was reviewed by a core trainee doctor who documented a collateral history from ML which was in line with the Recognition and Management of Delirium in Adults Policy (2021) and the screening process for dementia. This included that Colin had been suffering from confusion for the last two to three months, and that there had been some day and night reversal (namely, more awake at night than in the day). ML described Colin's aggression towards her, explaining that Colin tried to "*side tackle*" and "*kick her*". She stated that Colin also tried to block her bank account and sometimes got into confrontations with the public. The doctor carried out a repeat AMTS with a reduced score of 7/10 (compared to 9/10 when in the emergency department). They explained to ML that Colin's presentation was possibly dementia and documented that Colin was currently felt to have capacity, but given the safeguarding issues (with episodes of aggression noted towards ML), "*where would he go if he self-discharged*?"

3.50 The core trainee doctor contacted the safeguarding team for advice in relation to the aggression towards ML and concerns about her safety on Colin's discharge. This was in line with the requirements of the Safeguarding Adults Policy (2020) which states that "*all staff have a responsibility, regardless of grade or position, to take action if they become aware of safeguarding concerns (such as physical or domestic abuse)*". The safeguarding team suggested a mental capacity assessment and a Deprivation of Liberty Safeguards[51] (DoLS) procedure in line with the requirements of the MCA given that Colin wanted to go home despite the concerns about his cognitive function.

3.51 These actions were discussed in the consultant post-take ward round that afternoon (3.50pm). The plan was to wait for an old age psychiatry review. AMU Consultant 1 spoke with an old age psychiatrist that day and it was agreed that the "*MCA to remain in place until reviewed by the safeguarding team*". This was a good example of timely and appropriate interagency working, but it is not clear what this meant as "*MCA*" cannot be "*in place*". Capacity assessments are only valid for a material decision at a point in time; if capacity changes, or if the treatment needs to change, then new capacity assessments, and subsequent 'best interests' decisions, should be made.

3.52 At 5.10pm a mental capacity assessment was, however, undertaken to determine whether Colin had the capacity to self-discharge against medical advice. This was completed by the core trainee doctor initially with the AMU Consultant 1, but a reassessment was also undertaken with another doctor (grade not stated). This was good practice in line with the Trust's Mental Capacity Act Policy

[50] Care rounding is a structured process whereby nurses in hospitals carry out regular checks with patients, usually hourly or two-hourly, using a standardised protocol to address issues of positioning, pain and personal needs.

[51] The Deprivation of Liberty Safeguards is the procedure prescribed in law when it is necessary to deprive of their liberty a resident or patient who lacks capacity to consent to their care and treatment in order to keep them safe from harm.

(2021). All sections of the form were completed in full, and this included that Colin did not have the capacity to make decisions about discharge and that ML as attorney under LPA was happy with the plan that had been agreed, namely, to further investigate and manage his confusion. The form stated that Colin may require sedation "*as a last resort*" if he became a risk to self or others. ML has said that she was not consulted and had not agreed to the forms of sedation that were proposed.

3.53 When it had been determined that Colin did not have the capacity to make decisions about discharge, a DoLS authorisation request should have been requested, but this was not completed, and Colin continued to be held on the ward without a legal framework.

3.54 Later that evening, Colin absconded from the ward and attempted to climb the wall near the magnetic resonance imaging (MRI) suite. He was returned by security staff and reviewed by the core trainee doctor who noted that he was confrontational and agitated. He was offered oral lorazepam at 6.10pm which he was reluctant to take; he eventually accepted the medication after a lot of encouragement. He remained agitated and was then noted to be striking out at the security staff, "*punching and swiping at legs*". He was given IM lorazepam at 7.49pm as he refused a second dose of oral lorazepam. Physical restraint was required by "*multiple security guards*". The notes state there was no body language to warn staff of Colin's behaviour, which showed "*rapid volatility*".

3.55 The incidents of violence and aggression were incident reported (on 27 May, the day after the incidents occurred) in line with the Policy for the Management of Incidents and Serious Incidents (2019) but the Datix[52] form (165074) that was completed does not include the job role/grade of the staff member submitting the form and we were unable to ascertain who this was. [We also note that a duplicate form (165219) was submitted on 31 May but with the addition of a sentence in the action taken which read "*Minimum force used in a three man team to ensure patient's safety was monitored at all times*"]. Security officers were involved, and a chemical restraint was administered by the nursing staff, so both teams should have submitted their own incident reports. The form was categorised as a restrictive intervention with a sub-category of chemical restraint, but a physical restraint by the security staff was also referenced. The report stated that "*the patient was restrained when he began to swing his fists at staff … patient was placed on a trolley*", but the method and duration of the physical restraint was not included despite this being a requirement of the Broomfield Hospital Restrictive Interventions Policy. Furthermore, names were not included, so we have been unable to determine whether they had the required prevention and management of violence and aggression (PMVA) training (or other relevant training) to allow them to undertake these interventions. The Datix form did not include whether ML had been informed of the incidents or of the chemical and physical restraints.

3.56 Additionally, the Trust's Rapid Tranquillisation Policy (2021) includes the requirement for physiological observations to be monitored following this form of sedation: "*monitor pulse, blood pressure, temperature and respiratory rate every 3-5 minutes for the first hour then hourly until there are no further concerns*". However, we can see no evidence of physiological observations being increased in line with these requirements after administration of the lorazepam. The policy recognises that patients may not be cooperative enough to manage a set of observations, and this may have been the case for Colin; however, non-contact observations (such as respiration rate and pallor) should, at a minimum, have been recorded to ensure there were no adverse effects from this medication.

3.57 Recognising the potential for further instances of violence and aggression, permission was sought for "*[agency] guards to bed sit*" Colin, and we can see reference to two security guards being in attendance with Colin from this time.

3.58 We note, however, that the Trust's Deprivation of Liberty Safeguards Policy (2021) states that "*if there is evidence to suggest that an individual may not be able to make a specific decision, this should be discussed with medical staff so that a mental capacity assessment can be undertaken. If it is proven that an individual does not have the capacity to make the decision to remain in hospital*

[52] Datix is an electronic system which allows staff to report patient safety incidents and risks.

to receive treatment, the person is subject to continuous control and supervision and is not free to leave, then a DoLS application should be filed in the patient's medical notes."

3.59 The mental capacity assessment had confirmed that Colin did not have the capacity to make decisions about his discharge, but a DoLS authorisation had not been requested at this time; Colin was therefore detained during this episode of care without a legal framework. This was in breach of his human rights under article 5: "*Everyone has the right to liberty and security of person. No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law*"; the procedure prescribed by law in this case would mean section under the Mental Health Act (MHA)[53] or DoLS. A DoLS was required given Colin's lack of capacity, but there should also have been consideration of an emergency psychiatric review given the violence and aggression that had been displayed and the associated risk to Colin and also other patients and staff.

Terling Ward 27 May – 28 May 2021

3.60 On 27 May 2021 at 2am, Colin was transferred to Terling Ward. The ward's primary speciality was renal, but it also had COVID-19 bays.

3.61 At 2:30am, a Deprivation of Liberty Safeguards (DoLS) authorisation request was completed.

3.62 Colin became agitated five hours later and cut his arm during an altercation with a security officer. He left the ward and had to be escorted back by the security officer and other members of the team.

3.63 On 27 and 28 May, Colin was reviewed on the daily ward rounds and was declared medically fit for discharge on 28 May pending a review by old age psychiatry.

3.64 On 28 May at 3.35pm, Colin was transferred to Bardfield Ward.

Commentary on this care episode and points for learning

Physical health

3.65 Following his transfer to Terling Ward, Colin was reviewed by ward doctors on the afternoons of 27 and 28 May. The results of his echocardiogram were explained to him but ML has said they were not explained to her (this would have been best practice given Colin's fluctuating capacity), and it was confirmed through CXR that he had small bilateral pleural effusions[54] but with no consolidation; there was no comment about any treatment that was required for these pleural effusions, but medications had been prescribed for his heart failure.

3.66 On 27 May, it was also documented that Colin was now having trouble voiding urine and that advice would be sought from urology for an alternative to tamsulosin to manage Colin's benign prostatic hyperplasia (Colin had been prescribed tamsulosin prior to his admission and had stopped taking it, as he thought it made him feel unwell). The referral to urology was appropriate but this was not actioned until 9 June at 9.55am, 13 days later. This delay was unacceptable.

3.67 A urine dipstick and culture were also requested (ML said this testing was prompted by her query), but as mentioned previously, his urine should have been tested on admission due to the history of confusion. It was documented by the medics that Colin had his bowels open on 27 May, but we can see no reference to constipation being considered as a potential additional cause for the difficulties that he was experiencing. This is relevant as we can see no evidence of Colin's bowel habits being monitored by nursing staff (see comments in care planning section below) and Colin was found to be constipated three days later.

[53] In most cases when people are treated in hospital or another mental health facility, they have agreed or volunteered to be there, but there are cases when a person can be detained (sectioned) under the Mental Health Act (1983) and treated without their agreement.

[54] Pleural effusions result from the accumulation of fluid in the pleural space surrounding the lungs, often due to congestive heart failure.

3.68 Blood test results and physiological observations were within normal parameters during this episode of care and the doctors confirmed that Colin was medically fit for discharge on 28 May but was waiting for a review by old age psychiatry so he could be transferred to a care of the elderly ward.

Medication

3.69 As stated above re tamsulosin.

Care planning and risk assessment

3.70 A new inpatient nursing document was commenced on transfer to Terling Ward. As with the AMU, elements such as safeguarding (concerns noted), absconsion (risk acknowledged), pharmacology assessment, pain (none), nutritional status (low risk of malnutrition) and skin integrity (intact) were completed in full; however, there were also sections of the form that were left blank or were incorrect:

- The section asking about there being an appointed power of attorney was left blank. It should have been noted that ML was attorney under lasting power of attorney (LPA) for health and welfare and for property and finance. This would have allowed staff to request a copy of the relevant documents from ML so that they could ensure they were valid and kept for reference when relevant decisions were required in line with the Trust's Mental Capacity Act Policy (2021).
- Cognitive impairment was marked as 'no' despite Colin having a history of confusion, a recent abbreviated mental test score (AMTS) of 7 and a recorded episode of violence and aggression the previous day.
- The 'what matters to the patient' section was left blank, including information about any particular care requests or contact with family, which was important to understand given that Colin had a history of confusion.
- The amount of alcohol consumed was left blank despite it being noted in the medical clerking that Colin "*drinks*" and was intermittently confused. This was important information to collect, as long-term drinking can cause confusion and cognitive decline.

3.71 As with the AMU, there were several care plans appropriately marked as not being required (infection/sepsis, respiration, communication, pain, hydration, mobility). The 'requiring inpatient' core care plan was initiated, but on this occasion all items were to be considered including the recording of physiological observations and to observe for signs of delirium, which was appropriate for Colin's presentation, although frequency of observations were not stated.

3.72 We note, however, that the 'elimination (bowels)' care plan was also marked as not required despite Colin having had a history of constipation and concerns being raised by ML about this. Colin's typical bowel habit was described as 'normal' on the form but with no qualifying statement about what 'normal' meant for him. As stated previously, monitoring bowel function was important for Colin as constipation can be a cause of confusion. We note that Colin was found to be constipated shortly after his transfer from Terling Ward to Bardfield Ward.

3.73 Similarly, the 'elimination (bladder)' care plan was also marked as not required, with Colin's typical bladder function described as 'normal' but with no information about his history of urinary retention (due to an enlarged prostate) and the fact that he had stopped the tamsulosin medication that had been prescribed for this condition. Given his history of confusion, Colin's urine output should have been monitored in the short term so that an assessment of his fluid intake and output could be assessed.

3.74 Following on from the AMU, behaviour charts were completed in order to understand any causative factors for agitation, violence and aggression, but there was no plan of care to help the nursing and security staff who had been assigned to Colin to mitigate or manage any adverse behaviours in the short-term.

Behaviour and presentation – MCA and safeguarding

3.75 Colin was transferred from the AMU to Terling Ward at 2am on 27 May. At this time, the ward's primary speciality was renal; however, the ward also had COVID-19 bays (red bays had patients with confirmed COVID-19, green bays had patients who did not have COVID-19, and amber bays had patients who were suspected of having COVID-19 but were awaiting confirmation via swabs).

3.76 The Policy for the Transfer of Patients (2021) states that "*out of hours transfers are those that occur between 23.00 and 07.00. It is accepted that assessment units may need to transfer patients throughout the night to ensure Emergency Department flow and safety. However, it is recognised that such transfers are far from ideal and negatively impact on the psychological status of some patient groups, particularly the confused, the elderly and those with dementia or a learning disability and should be avoided unless: the patient's condition deteriorates necessitating a transfer out of hours; or the operational demands of the organisation make such a transfer unavoidable*."

3.77 The policy requires any decision to transfer out of hours and the rationale for it to be documented in the patient's health record; however, we can see no nursing or medical entry to support moving Colin at that time (i.e., 2am) or the reasons for transferring him to that particular ward. He was noted to be asleep at midnight, so it was likely that he would have to have been woken up for the transfer. He was known to have a history of confusion and had been agitated the day before, requiring sedation to settle him. The move would have been unsettling for him and will have potentially added to his confused state. The rationale for the move should have been documented and incident reported if not justified on clinical or capacity grounds.

3.78 This is relevant, as four hours later (at 6.40am) Colin was noted to be pacing up and down the ward and then rushed to the front door. He was stopped by security staff who had been allocated to supervise him due to the potential for violence and aggression, and it was recorded in the notes that the security guard and Colin fell on the floor and Colin cut his arm.

3.79 At 7am Colin forced the front door open and left the ward. Additional security came to assist him back to the ward, but he declined. After requesting some fresh air and a walk, Colin attempted to escape by climbing a fence. Security intervened (it was documented that seven members of security staff were present) and escorted Colin back to the ward "*with some resistance*". We can see no evidence of a chemical restraint being requested or administered at this time; however, the attendance of seven security staff would appear to be overly restrictive and would have been intimidating for him.

3.80 At 7.40am while having his arm dressed, Colin expressed a desire to "*jump out of the window and escape*". He was reassured and advised to remain calm until seen by a doctor.

3.81 These were all significant events, but we can see no evidence of these incidents being reported on Datix or of ML being proactively informed about the restraints or harm caused to Colin. ML visited Colin that day and said she was "*shocked*" to find that he had bruises and skin tears on both arms and wrists; a call should have been made by the nursing staff soon after the events had occurred rather than waiting for her to visit.

3.82 There was also no record in the nursing or medical notes of the people involved or the types and duration of restraint/'handling' that might had been employed to bring Colin back to the ward or how he came to be on the floor with the security officer. We have been unable to determine, therefore, whether appropriate and proportionate restrictions were used or if the staff involved had the required prevention and management of violence and aggression (PMVA) training (or other relevant training) to allow them to undertake these interventions.

3.83 Although available on the two-hourly care rounding charts, a body map was not completed after these incidents to confirm whether the restraints had caused any bruising or harm to Colin (in addition to the cuts to Colin's hand). All his injuries should have been documented but also reported as safeguarding concerns given that harm had occurred to an adult at risk (namely, having care and support needs'). The Trust's Safeguarding Adults Policy (2021) describes physical abuse as "*the*

non-accidental infliction of physical force that results (or could result) in bodily injury, pain or impairment including … restraint or inappropriate physical sanctions". It states that all staff have a responsibility, regardless of grade or position, to take action if they become aware of safeguarding concerns (such as physical or domestic abuse); however, the injuries were not fully documented and safeguarding advice was not sought.

3.84 In relation to these restrictions, a mental capacity assessment had been undertaken on 26 May regarding the decision to discharge Colin, but a DoLS application form was not completed until after he had been transferred to Terling Ward. This was completed by an on-call doctor at 3.30am on 27 May. This was expected practice given that Colin wanted to leave the ward and had been assessed as not having the capacity to make the decision regarding self-discharge; however:

- It is unclear why there was no consideration of a MHA assessment given the potential for violence and aggression, rather than deprivation of liberty under the MCA.
- The form did not indicate (on the front page) whether the application was for a standard or urgent authorisation, although the form did include an urgent authorisation request which was to expire on 2 June.
- The purpose of the request did not reference the deprivation of liberty or relevant decisions to be taken; instead, it said that Colin was "*aggressive and violent … MCA in place, safeguarding team suggested DoLS for patient*". MCA cannot, however, be "*in place*" as capacity assessments are only valid for a material decision at a point in time. There was also no reference to the care and treatment that Colin required, and we can see no evidence of a care or treatment plan being attached to the referral.
- The proposed restrictions were not stated (the form said "*patient is confused, violent and aggressive … requires DoLS authorisation*") and did not include that security staff would be with him at all times or that restraints (chemical or physical) may be required.
- The section on information about interested parties and persons to consult was left blank, as was the section that asked if interested persons had been informed of the DoLS. This was despite ML being noted to have LPA for health and welfare. The form was completed at 3.30am and it would have been inappropriate to have contacted ML at that time; ward staff should have proactively informed her of the request at a more sociable hour but did not.

3.85 At 2pm on 27 May, Colin was reviewed on the ward round by a doctor (grade not stated) who queried "*cognitive and behavioural impairment caused by dementia or other cause*". The doctor explained to Colin that the staff and his family were concerned about his memory, and that an old age psychiatry assessment was required along with transfer to a care of the elderly ward. The referral to old age psychiatry was appropriate given Colin's presentation but should have been expedited given the absconsion from the ward and the incident of violence and aggression the previous day. While it was more appropriate for Colin to be cared for on a care of the elderly ward, the transfer meant yet another (third) move for Colin in a very short (36 hours) period of time and would, again, have been unsettling for him.

3.86 Also on 27 May, ML asked for a copy of the mental capacity assessment and DoLS authorisation request given her status under LPA. The doctor explained that this was done by a formal request process. She also requested a capacity assessment to help her to manage Colin's financial affairs. The doctor said they could not provide this as the capacity assessment was for health and medical needs only. These responses were unhelpful for ML who should have been fully informed (and involved where possible) in the capacity assessments and DoLS requests for Colin. The MCA Code of Practice[55] states in Chapter 7 that "*Before making a decision under a personal welfare LPA, the attorney must be sure that … the donor lacks the capacity to make the particular decision or the attorney reasonably believes that the donor lacks capacity to take the decisions covered by the LPA*

[55] https://assets.publishing.service.gov.uk/media/5f6cc6138fa8f541f6763295/Mental-capacity-act-code-of-practice.pdf

(having applied the Act's principles)". We note "*the attorney must be sure*", so the assessment should have been shared (or undertaken with ML present) so that ML understood why the care team felt he lacked capacity.

3.87 We can see no evidence of a Trust policy which helps to ensure that relatives and LPAs have access to correct and up-to-date information in a timely manner.

3.88 In relation to the query about finances, we note that an LPA for property and financial affairs was registered for Colin on 8 February 2020. This named ML as the sole appointee but stipulated that she could only make decisions on Colin's behalf when he was deemed not to have mental capacity. An assessment was therefore required in relation to whether Colin had the mental capacity to manage his finances. ML asked the doctor in good faith, and rather than saying he could not do this, the request should have been directed to a social worker, who could have undertaken the financial capacity assessment for Colin.

3.89 ML wrote to the Trust's chief executive officer (CEO) the same day given her frustration at not being supported in her request for a financial capacity assessment. This was responded to on 31 May by the interim deputy director of nursing who advised that she had forwarded the concerns to her nursing colleagues; however, we can see no evidence of this issue being resolved during this episode of care or admission. This continued to be a source of frustration for ML over the next two months; she should have been supported to resolve this issue at her initial request in line with the requirements of the MCA.

3.90 Additionally on 27 May, a safeguarding adult concern form was completed by a member of nursing staff in relation to Colin's aggressive behaviours. It included that there was a "*requirement to ensure that Colin would need to be safe when he was at home*". It is unclear about the actual purpose of this referral and who they thought was at risk (namely, Colin or ML as his partner). We can see no evidence of the safeguarding team responding to this concern.

3.91 On 28 May, Colin was reviewed by another ward doctor (grade not stated). On examination, they found that Colin had an AMTS of 4/10. This was a significant decline from the score in the emergency department and while Colin was on the AMU (9 and 7 respectively). The notes state that Colin was medically fit for discharge but that if he could not go home following occupational therapy, physiotherapy and an old-age psychiatry review, then he would be transferred to a care of the elderly ward. As stated above, this would be Colin's third move in three days. It is likely that Colin's frequent moves and changes to his environment and personnel contributed to his cognitive decline.

Bardfield Ward 28 May – 9 June 2021

3.92 On 28 May 2021 Colin was moved to Bardfield Ward at 3.35pm. This was a care of the elderly ward.

3.93 On 30 May, Colin was referred to the EPUT Mental Health Liaison Team (MHLT), which advised that Colin should not be discharged until seen by the team.

3.94 On 31 May, Colin was reviewed by the MHLT nurse, who planned to discuss his case with the old age psychiatrist.

3.95 On 1 June, it was confirmed on the consultant ward round that Colin was medically fit for discharge pending the old age psychiatry review.

3.96 On 2 June, Colin was reviewed by the MHLT old age psychiatrist and liaison nurse. Regular lorazepam was prescribed with a request for behavioural charts to be completed.

3.97 On 4 June, the integrated discharge team received a referral from the ward.

3.98 Also on 4 June, the MHLT undertook a mental capacity assessment, with the ward consultant present. This concluded that Colin did not have the capacity to make decisions about discharge from hospital.

3.99 On 7 June, the integrated discharge team came to assess Colin but were told that he was awaiting a mental capacity assessment. They advised the ward to re-refer if there were any concerns.

3.100 Overnight Colin became violent and aggressive and was given IM lorazepam.

3.101 On 8 June, there was a multidisciplinary team (MDT) meeting with ML present. It was agreed that Colin might need an admission to an acute psychiatric ward rather than a residential/nursing home given the incidents of violence and aggression. Private sector options would be explored but a MHA assessment would be required.

3.102 Overnight Colin became violent and aggressive again and was given IM lorazepam.

3.103 On 9 June, a MHA assessment was undertaken with an agreement that Colin should be detained under Section 2[56] of the MHA. The only (nearest) available NHS bed was at Goodmayes Hospital.

3.104 Colin was transferred to Goodmayes Hospital at 3.20pm.

Commentary on this care episode and points for learning

Physical health

3.105 Colin was transferred to Bardfield Ward on a Friday (28 May) so did not receive a routine medical review over the weekend. At 7.45pm on Sunday 30 May Colin was, however, seen by a FY2 doctor due to right iliac fossa abdominal pain. On examination, the doctor found Colin to be constipated and suppositories were prescribed. Colin was already on laxatives for constipation, but additional regular or as required aperients were not prescribed despite ML raising concerns about ongoing constipation and Colin having difficulty voiding urine. The medical records indicate that Colin had his bowels open on 27 May, but we can see no evidence of bowel charts being commenced to ensure that Colin's constipation had resolved. This is relevant as constipation is linked to acute states of confusion and delirium in the elderly hospital population; also, if someone has dementia, constipation is likely to make their dementia symptoms worse.

3.106 Colin was reviewed by the ward doctors each weekday. During ward rounds Colin's ongoing confusion was noted along with the CT head scan results which indicated age-related changes but with no acute intracranial event. A repeat abbreviated mental test score (AMTS) gave a score of 7/10 on 1 June, and it was re-confirmed that Colin was medically safe for discharge pending the psychiatric review (requested 30 May and undertaken on 2 and 4 June).

3.107 A ward urinalysis on 2 June indicated that Colin did not have a urine infection, and routine COVID-19 screening (on days one, three and five of Colin's admission to hospital, in line with Trust requirements) yielded negative results.

3.108 On 3 June, it was noted by ML that Colin had bruising on his right lower abdominal quadrant (near to his pre-existing hernia); medical staff believed this to be a result of the enoxaparin[57] injections that he had been receiving. This was reviewed by a doctor, who examined Colin and directed staff to observe for changes in the size of the bruising and to call the doctor again if there were further concerns. We can see no evidence of this being referenced again; the enoxaparin medication was discontinued the following day but with no rationale included in the medical records. The bruising was not included on a body map despite one being readily available on the daily rounding charts that were completed for Colin.

3.109 There were no other physical health concerns recorded in the medical notes during this admission, but in a MDT meeting with ML on 8 June, EPUT Consultant Psychiatrist 1 suggested prescribing risperidone[58] (0.25mg once daily) in addition to Colin's lorazepam. The side effects were

[56] A person can be detained under Section 2 MHA if they have a mental disorder, they need to be detained for a short time for assessment and possibly medical treatment, and it is necessary for their own health or safety or for the protection of other people.

[57] Enoxaparin is an anticoagulant medication used to prevent and treat harmful blood clots. This helps to reduce the risk of a stroke or heart attack.

[58] Risperidone is a second-generation antipsychotic medication used to treat a number of mental health disorders including schizophrenia and psychosis,

communicated to ML in line with the requirements of the MCA and her status as LPA: these included the risk of falls, an increased risk of stroke and the potential for cardiac side effects, so an ECG would need to be undertaken before commencing this medication. ML stated that she would prefer the lorazepam to be increased and would like more time to look into risperidone.

3.110 On 9 June a conversation at 9am between Bardfield Ward Consultant 1 and ML referenced a query by ML about Colin's heart condition. The consultant re-confirmed that Colin had impaired cardiac function but with no current symptoms of heart disease. We note that an ECG was recorded at 10.20am but we can see no evidence of this being reviewed before Colin was transferred to Goodmayes Hospital that afternoon. This was a significant omission as it indicated signs of atrial fibrillation. The ECG should have been reviewed by the medical staff to confirm that there had been no significant changes, and the review should have been documented in the clinical record given the potential for risperidone to be prescribed. On 25 May the AMU doctor had queried atrial fibrillation but the echocardiogram on 26 May recorded sinus rhythm with ectopics. Medication changes or further investigations should have been initiated prior to Colin transferring to psychiatry if he was going into and out of atrial fibrillation. Not only did this cause additional time to be invested by the Goodmayes Hospital staff in trying to understand the treatment required for the 'new' atrial fibrillation, but this could also have been harmful to Colin, with an increased risk of stroke if left untreated. (See comments regarding 'new' atrial fibrillation in the physical health section of the Goodmayes Hospital episode of care).

3.111 The discharge summary that was completed for Colin from Bardfield Ward was not sent to Goodmayes Hospital until 14 June, five days after he had been transferred. This was unacceptable practice given Colin's medical history, changes in medication since admission and underlying cardiac disease. Additionally, under the 'dementia score' section it stated that Colin did not have dementia and that there had been no concerns about his cognition on this admission (although in the clinical summary there was reference to worsening confusion, a referral to the psychiatric team and a diagnosis of Alzheimer's disease). It also included reference to a safeguarding alert having been made ('family is cause for concern') but with no qualifying information to help the Goodmayes team or the GP understand what these concerns might be. In relation to his physical health, the letter included that Colin had been seen by the cardiology team, who had changed his medication, but there was no reference to the ECG that had been recorded prior to transfer to Goodmayes Hospital.

<u>Medications</u>

3.112 Colin continued to receive his core medications on transfer to Bardfield Ward and we can see no evidence of omissions other than when he declined to take some of his medications on 8 June.

3.113 As stated in previous sections, it was documented in the ward round on 27 May that Colin was having trouble voiding urine and it was noted that advice would be sought from urology for an alternative to tamsulosin to manage Colin's benign prostatic hyperplasia (Colin had been prescribed tamsulosin prior to his admission but had stopped taking it as he thought it made him feel unwell). The referral to urology was appropriate but contact was not made until 9 June at 9.55am, 13 days later. The FY2 doctor had a conversation with the urology specialist registrar (SpR), and it was stated that although tamsulosin was not known to cause cognitive problems, it could be switched to alfuzosin. We note, however, that the tamsulosin was recommenced on 4 June before this opinion was gained (as a night-time dose rather than a morning one), potentially as a result of Bardfield Ward Consultant 1's ward round. We can see no rationale for the recommencement of tamsulosin being documented in the clinical records, or instruction about observations being required for potential intolerance given that Colin had referenced this making him feel unwell previously.

3.114 We also note that, following the advice from the urologist on 9 June, alfuzosin was prescribed (2.5mg twice daily) but the tamsulosin was not discontinued. This incorrect prescription chart was shared with Goodmayes Hospital. Not only did this cause additional time to be invested by the Goodmayes Hospital staff in trying to understand the correct prescribing regime, but this could also

have been harmful to Colin if the medications had been given[59] (we note Colin was transferred before his medications were due, so he did not receive the double dose).

3.115 Colin was reviewed by EPUT Consultant Psychiatrist 1 on 2 June. Having spoken with ML, they noted that Colin appeared to be more agitated in the evenings, with physical aggression towards ML. It was documented that due to Colin's cardiac problems, he would not be suitable for an acetylcholinesterase inhibitor,[60] so a regular low dose of oral lorazepam was prescribed (0.5mg) to be given at 6pm in response to this observation.

3.116 While it is recognised that there are occasions when pharmacological interventions are required, benzodiazepines such as lorazepam can increase paradoxical agitation (some older adults become disinhibited or more restless when given these drugs, confusion can increase and there is a potential for cognitive decline to be accelerated – also see comments regarding benzo hyperirritability in the medications section of the AMU episode of care above). Understanding the causes of adverse behaviours and addressing them before offering regular treatment can prevent things getting worse and prevent any harm. Behavioural charts were requested for Colin, but we can see no evidence of planned distraction techniques being employed, which may have helped to orientate Colin or prevent and manage his episodes of agitation and aggression before use of this regular medication.

3.117 During an episode of violence and aggression on the night of 7 June (see details in behaviour and presentation section below), Colin was given 1mg lorazepam orally at 12.20am. This had been prescribed on 30 May as an as required oral medication (0.5 – 1mg) to be given when agitated/aggressive. Following repeated episodes of violence and aggression, Colin was also given three stat doses of 1mg lorazepam the following evening/night (IM at 10.25pm on 8 June, IM at 2.30am and orally at 6.10am on 9 June) but only after the nursing staff had queried the potential administration doses with the medical staff and pharmacy. This was good practice as Colin would have had 4mg lorazepam in 24 hours, whereas the instruction on the prescription by EPUT Consultant Psychiatrist 1 had included that Colin should have a maximum as required dose of 2mg in 24 hours. The doctor who prescribed the lorazepam spoke with the medical registrar on call and the pharmacist, and it was agreed that up to 4mg could be given in line with BNF maximum dosing instructions. (See comments below regarding physiological observations.)

3.118 On 8 June, the regular dose of lorazepam was increased to 1mg following the episode of violence and aggression by Colin. These prescriptions were discussed with ML as attorney under LPA which was in line with the requirement of the MCA although we can see no evidence of similar discussions with Colin or of a capacity assessment to determine whether he had the capacity to make decisions about his care and treatment (see comments in the behaviour and presentation section of Terling Ward above).

<u>Care planning and risk assessment</u>

3.119 On transfer to Bardfield Ward, some aspects of the nursing assessment documentation were updated in line with good practice. This included Colin's nutritional assessment (low risk of malnutrition) and skin assessment (intact but bruising to both hands – the cause of this was not stated).

3.120 However, the care plans that were commenced on Terling Ward were not updated or added to during Colin's stay on Bardfield Ward. This was despite:

- Colin experiencing constipation on 30 May and requiring suppositories. There were several requests in the evaluation and review sections of the nursing assessment document for staff to

[59] The British National Formulary includes a caution when using tamsulosin with alfuzosin as this may cause a reduction in blood pressure.

[60] In patients with mild-to-moderate Alzheimer's disease, monotherapy with acetylcholinesterase inhibitors (such as donepezil hydrochloride, galantamine or rivastigmine) are first-line treatment options.

'monitor bowels' but a stool chart and care plan were not commenced to describe the monitoring required or the actions to be taken to help prevent further constipation.

- Colin reporting that he was having difficulty passing urine on 1 June. A bladder scan showed 103ml residual urine and it was noted that the difficulties were potentially related to constipation but that he had also not been taking his tamsulosin, which had been prescribed previously for urine retention due to an enlarged prostate. Staff were advised to "*monitor his bladder at night*", but fluid intake and output charts were not commenced and there was no care plan to ensure that staff understood the monitoring required.

- Colin continuing to have security staff present at all times but without a plan of care to help them (or nursing staff) to understand what interested him, which activities might help to distract him from wanting to go home, the approaches that might help to prevent him becoming agitated, violent and aggressive, or the types of restrictive practices that could be employed. ML said that Colin was accommodated in a side room with a broken television and no radio. He did not read, the lighting was very bright during the day and the windows frosted, with workmen outside hammering and drilling continuously (Colin confirmed this to EPUT Consultant Psychiatrist 1 during an assessment on 2 June). It would therefore have been all the more important for staff to know how to keep Colin from becoming bored and agitated by being confined to his room and the corridor of the ward. The MHLT queried Alzheimer's disease as being the cause for Colin's confusion on 2 June, and the Trust's Care of Patients With Dementia Policy (2020) describes some key principles for patients with dementia. These include requiring staff to liaise with family and carers to establish normal routines, to use 'This is Me'[61] to personalise care, and to try to identify what triggers a patient's particular mood or behaviour and what interventions might help to resolve them. We can see no evidence of normal routines being discussed with the family or the 'This is Me' booklet being completed at this time.

- During Colin's stay there were several incidents involving restraint by the security officers who were with Colin, including one occasion when they fell to the floor (circumstances not described). Two-hourly care rounding charts were maintained each day but the body maps that were included on these forms were left blank and all of the two-hourly entries from 1 June state that skin inspections were not undertaken, including prior to transfer to Goodmayes Hospital (this is relevant as bruising was noted by the receiving team).

3.121 On 8 June, during a conversation with EPUT Consultant Psychiatrist 1, Bardfield Ward Consultant 1 and the ward sister, ML told the team that Colin had mentioned feeling suicidal and that he had a belt and a razor in the room. ML was told that this would be communicated to the security and nursing staff, who would remove the objects from his room; however, ML said that when she visited the next day the items were still in his room, so she took them home. At the time of the disclosure to staff, it was clear that ML was indicating significant risk for Colin. His mental state should have been re-assessed to determine his mental capacity and suicide risk; however, we can see no evidence of the MHLT or medical and nursing teams having a discussion with Colin to ask him about his suicidal intent and to determine whether there was an urgent need for the MHA assessment to be undertaken that day. A risk assessment should also have been undertaken in response to the concerns raised and his room searched to ensure that potentially harmful items had been removed (including an assessment of ligature points). Colin's levels of observation should then have been reviewed with consideration about whether a side room was the best environment for him. We can see no evidence of these actions being undertaken; this left Colin at risk of self-harm.

<u>Behaviour and presentation –MCA and safeguarding</u>

3.122 On 29 May, ML contacted the ward and asked to be involved whenever the psychiatric team wanted to make a decision about Colin's care and treatment. She explained that she had lost her son in a

[61] 'This is Me' is a booklet which can be used to record details about a person who cannot easily share information about themselves. For example, it can be used to record: a person's cultural and family background; important events, people and places from their life; their preferences and routines. This helps health and social care professionals to deliver care that is tailored to the person's needs.

mental health care facility and would prefer Colin to go to a care home rather than a psychiatric ward.

3.123 She also requested to see the paperwork that gave the hospital the right to keep him in the hospital and asked why he was given lorazepam on 26 May. This request was escalated to the site manager, but we can see no evidence of a response to these queries in the medical records that have been shared with us. It was documented that ML raised similar concerns the following day: she told staff that she was not happy with the decision to keep Colin in hospital until he was reviewed by the MHLT. The response by the hospital was contrary to her role as LPA/nearest relative[62] and her rights regarding information about Colin's health and welfare, care and treatment.

3.124 At the time of these requests, Colin had been declared medically fit/safe for discharge by the ward doctors, although the consultant did include that this was pending a mental health review. A mental capacity assessment had been undertaken and a DoLS authorisation requested, which provided a legal framework for preventing Colin from leaving the hospital, although in both cases these tasks should have involved ML as Colin's attorney under LPA, but did not.

3.125 However, there is no evidence in the clinical records of staff helping ML to understand the DoLS criteria. At this time, it should have been explained to her that as attorney under LPA, she could have made the decision to take Colin home. If the team felt that this would not be in Colin's best interests, a formal best interest meeting would have been convened to discuss the options with ML and Colin. If ML continued to disagree with any of the actions or deprivation of liberty pending assessment, legal advice would need to have been gained (with escalation to the Court of Protection if necessary).

3.126 The referral to the MHLT was made on 30 May and Colin was assessed by a nurse the following day. The records do not indicate whether ML had been present at that time, although it was documented that she was offered a carer's assessment which she declined (ML has said, however, that she was not offered a carer's assessment). The nurse discussed the case with EPUT Consultant Psychiatrist 1, who assessed Colin with a different liaison nurse on 2 June with ML present. As part of the assessment, a collateral history was taken from ML who stated that Colin had a six to eight-month history of cognitive functional decline. She also informed the consultant that Colin's presentation worsened in the evenings and admitted feeling scared of him and anxious about taking him home: "*she feels very frightened of him and frightened for her own safety*".

3.127 It was explained to ML that the CT head scan showed global atrophy and medial temporal atrophy and that it was most likely that he had Alzheimer's disease given these results and the history of confusion: "*He has presented to hospital with cardiac problems and newly diagnosed heart failure. It is likely his current mental stale and presentation is partly due to a delirium now resolving. However, due to his brain scan report and collateral history gained … the most likely diagnosis is that of Alzheimer's disease*."

3.128 The consultant requested the ward undertake a mental capacity assessment to assess Colin's understanding about discharge from hospital. Also, for day and night needs charts to be completed alongside behavioural charts, and a referral to the integrated discharge team for consideration of an inpatient bed with a plan to refer Colin to the dementia intensive support team on discharge. There was also a note to speak with Colin's children. EPUT Consultant Psychiatrist 1 wrote a very comprehensive letter to Colin's GP which summarised her assessment and the plan for Colin (although we can see no evidence of this being copied to Colin, or to ML as his attorney under LPA for health and welfare, despite this being a requirement of the 200b Department of Health's Copying Letters to Patients – Good Practice Guidelines).

3.129 The management plan and correspondence with the GP was in line with the requirements of the Care of Patients With Dementia Policy (2020). Referral to the Trust's dementia nurse was also

[62] The nearest relative is a family member who has certain responsibilities and powers if you are detained in hospital under the Mental Health Act. These include the right to information and to discharge in some situations. The law sets out a list to decide who will be your nearest relative. This can sometimes be changed.

required, but we can see no evidence of this being actioned; this meant that advice and support was not available from this expert resource for Colin, his family and also the staff on the wards.

3.130 Additionally, at the point where a dementia diagnosis was made, an alert should have been added to Colin's medical records in line with the requirements of the dementia policy so that staff would be aware of his dementia if he was admitted to hospital at a later date, but this was not actioned either.

3.131 On 2 June, a request was made for a seven-day extension to the urgent DoLS authorisation. This meant that Colin continued to be deprived of his liberty under the legal framework of the Mental Capacity Act (MCA).

3.132 On Thursday, 3 June at 12.30pm, the flow coordinator contacted ML about discharge plans. ML said she was going to look at care homes but was unaware of the process required. Advice was given and ML agreed for the integrated discharge team to be involved, as she was keen to get Colin into a placement before the weekend. The flow coordinator explained that most homes had a COVID-19 protocol to follow for admissions, and they may not accept new admissions over the weekend, but that it might be possible to aim for a discharge early the following week.

3.133 On 4 June at 2.09pm, a mental capacity assessment was carried out by EPUT Consultant Psychiatrist 1, with a MHLT nurse and Bardfield Ward Consultant 1 present. They concluded that Colin did not have the capacity to make decisions about discharge planning. An Addenbrooke's Cognitive Examination-III (ACE-III)[63] formed part of the assessment, which showed a score of 64/100, and a best interest decision was recorded: this included that "*a home discharge would be supported with care and the dementia intensive support service input if agreeable to ML. If not, placement in a residential home would need to be considered.*" The diagnosis of Alzheimer's disease was confirmed to ML, and she was told that Colin was now on regular lorazepam, which was having a good effect.

3.134 ML has said that she disagreed with this view (although it is not documented in the medical records at this time) as she felt the medication was making him more agitated and aggressive, but also "*itchy, sweaty, hostile and extremely confused*". These are not known to be side effects of lorazepam, and we can see no reference to these symptoms being observed by staff when completing the behaviour and rounding charts. However, we can see no evidence of Colin's capacity being assessed in relation to decisions regarding his care and treatment and it was not documented that he consented to this prescription. If Colin was deemed not to have the capacity to make these decisions, as attorney under LPA, ML had the right to refuse treatment, and if the team had disagreed, they needed to hold a best interests meeting, but we can see no evidence of this being fully explained to her.

3.135 Colin's daughter was visiting at the time and stated a preference for her father to go home with support if possible. ML confirmed that she could not manage him at home and had already asked a residential home to come and assess him on 7 June. She said she was prepared to fund this in the first instance but was also keen for him to be assessed for continuing healthcare funding.

3.136 On 6 and 7 June, however, ML emailed EPUT Consultant Psychiatrist 1 requesting "*… as Power of Attorney for my partner's affairs, please be advised that I wish the Trust, yourselves to have no further communication with the family regarding Colin and all communication to be actioned with me and me alone*."

3.137 EPUT Consultant Psychiatrist 1 contacted Adult Safeguarding Lead 1 for advice about these communications, which was good practice. The safeguarding lead confirmed that the best interests decision should be made with ML as attorney for health and welfare rather than Colin's children, even if they had different views, but they also advised the ward to confirm this through the legal department. We can see no evidence of the legal team being contacted at this time.

[63] ACE-III is a brief cognitive test that assesses five cognitive domains: attention, memory, verbal fluency, language and visuospatial abilities. The total score of the ACE-III is 100, with higher scores indicating better cognitive functioning. The ACE-III has been validated as a screening tool for cognitive deficits in Alzheimer's disease and frontotemporal dementia.

3.138 On 7 June, EPUT Consultant Psychiatrist 1 then discussed the emails with the ward consultant and ward manager, and they agreed that they would, together, call ML that day; however, they received no reply. Later that day, the ward manager spoke with ML, who had arranged for a care home (Colne House) to assess Colin, but she had also been thinking that perhaps he was too well for a care home and that she may be able to manage him at home with medication. Options of care and support were discussed but no decision was made at that time, and we can see no reference to the involvement of Colin's children being raised.

3.139 On 8 June, the EPUT Associate Director of Safeguarding advised the MHLT and ward that if the family members had different views regarding best interests decisions, they would need to involve the Court of Protection and their legal department. This was the correct advice and in line with the MCA; however, the Associate Director of Safeguarding also advised the team that as a MHA assessment was being carried out the next day, referral to Court of Protection was not necessary. Given the concerns, it would have been good practice for the team to have resolved the family differences and held a best interests meeting while Colin was being treated at Broomfield Hospital. If the family and LPA remained in disagreement, a Court of Protection referral might have been needed, or even a challenge to the best interests decision making of the LPA.

3.140 Having been more settled for several days (although constantly wanting to go home, particularly after having visitors), it was decided on 7 June that Colin no longer needed security present; however, he became aggressive again in the early hours of 8 June and "*headbutted*" a security officer who attended the ward, barricaded himself inside another patient's room and significantly damaged a door. This incident was reported (165544) by the security team in line with the requirements of the Restrictive Interventions Policy. This included that Colin was restrained "*both standing up and on the floor*"; however, there was an absence of detail about the type and duration of restraints, including how Colin came to be on the floor, how long he had been restrained for, and the position that he was being held in (for example, supine, which could have increased the risk of aspiration, or prone, which could have increased the risk of suffocation). The names of staff were not included on the form, and it is therefore not possible to identify whether they had the required prevention and management of violence and aggression (PMVA) training or other relevant training to allow them to undertake these interventions. There was also no detail about the impact on the patient whose room Colin barricaded himself within or on the damage to the door and which room this had been.

3.141 Although signed as being given, it was ML's view that Colin had not received his regular lorazepam on the evening of 7 June. She said she witnessed it being put in a pot and being left in his room but that it had not been taken. We are unable to substantiate this. As before, however, these incidents of violence, aggression and barricading himself in another patient's room should have been reported to the adult safeguarding team given the risks to Colin (through multiple restraints) and to other ward patients.

3.142 Ward Manager 1 called ML at 7.10am to inform her of the incident. She also told ML that the care home would need to be informed and would now be unlikely to accept him. ML confirmed that she did not want Colin to go to a mental health hospital and was advised to attend the ward later that day so that options could be further considered with the medical, psychiatric, nursing and integrated discharge teams.

3.143 On 8 June at 4.20pm, a meeting was held involving EPUT Consultant Psychiatrist 1, Bardfield Ward Consultant 1, the MHLT team manager, Ward Manager 1, a member of the Integrated Discharge Team and ML. Colin's aggression from the previous night was discussed. The team suggested that taking Colin home presented ML with significant risk and this was explained to her. It was also likely that a care home would not accept him given the level of aggression and need for two security guards to be present. The option of admitting Colin to an acute psychiatric ward was discussed during this meeting. The doctor explained this would require a MHA assessment as Colin would be unable to consent to an informal admission.

3.144 ML explained her personal experiences and said that she was reluctant for Colin to be admitted to a bed within EPUT and did not want to travel too far to visit him. The MHLT agreed that they would explore options in the private sector but would consult with her before a bed was agreed. ML asked the ward manager to contact Colin's daughter to inform her of the decisions that had been made.

3.145 ML emailed EPUT Consultant Psychiatrist 1 after the meeting to say that she would be comfortable with Colin going to The Priory in Chelmsford (this was accommodation selected by ML, but Colin did not meet their criteria for admission). She said that she would also like an advocate to be arranged for him; however, there was no time to initiate this request before Colin transferred from Broomfield Hospital.

3.146 On the evening of 8 June, Colin became agitated again, and at 6.50pm he started spitting water at the security staff and was hitting out. Security staff tried to calm him, but they had to restrain him six times including to his bed when it was noted that he cut his finger "*from glasses*". The types and duration of the restraints are not described, and we can see no evidence of an incident report being submitted despite this being a requirement of the Restrictive Interventions Policy. This should also have been reported as a safeguarding concern given that harm occurred to an adult at risk (namely, Colin having care and support needs).

3.147 At 10.30pm, Colin became aggressive again and hit the security officers that were with him. This incident (165648) was reported by a security officer in line with the requirements of the Restrictive Interventions Policy under the category of security incidents and sub-category of assault (clinical, patient to staff). The form included that Colin had hit his hand on the wall, which resulted in a small skin tear on his left hand and that chemical restraint had been required in consultation with the on-call doctor (see details in medication section above). As before, this should also have been reported as a safeguarding concern given that harm had occurred to an adult at risk (namely, Colin having care and support needs). Another incident report (165657) was also submitted for the same events under the same categories and included that Colin had been aggressive on the ward on two separate occasions but "*on the second shout, the two agency security officers had both been hit in the face by the patient*".

3.148 A third incident report (165656) was submitted by the nursing staff in relation to the chemical restraint (which was administered without physical restraint) but did not include whether Colin's observations had been recorded following administration of the lorazepam in line with the requirements of the Rapid Tranquillisation Policy (2021), namely, for physiological observations to be monitored following sedation, and to "*monitor pulse, blood pressure, temperature and respiratory rate every 3-5 minutes for the first hour then hourly until there are no further concerns*". We can see no evidence of physiological observations being increased after administration of the lorazepam. The policy recognises that patients may not be cooperative enough to manage a set of observations, and this may have been the case for Colin; however, non-contact observations (such as respiration rate and pallor) should, at a minimum, have been recorded to ensure there were no adverse effects from this medication.

3.149 On 9 June at 10am, a MHA assessment was carried out by EPUT Consultant Psychiatrist 1, an approved mental health practitioner (AMHP)[64] and an independent Section 12 doctor.[65] This was good practice in line with the MHA and was an appropriate response given the behaviours displayed by Colin and the risk to self and others.

3.150 It was documented that Colin had received 4mg lorazepam through the night and was "*somewhat drowsy but responsive and able to engage in conversation for the assessment*". The quality of the conversation is challenged by ML (through video evidence of Colin prior to the assessment) given his drowsy state around this time although she was not present during the assessment itself. Colin was interviewed and then the team spoke with ML separately afterwards. During the discussions

[64] AMHPs are mental health professionals who have been approved by a local social services authority to carry out duties under the MHA. They are responsible for coordinating assessment and admission to hospital if a person is sectioned.

[65] Section 12 approval means a doctor can recommend compulsory admission for assessment or treatment under the MHA 1983.

with Colin, it was noted that he did not remember details about his diagnosis of dementia and there was also evidence of short-term memory deficits during the assessment. It was agreed that Colin should be detained under Section 2 of the MHA.

3.151 ML spoke with Ward Manager 1 after the assessment. She was unhappy with the outcome, believing Colin's presentation to be due to his lorazepam. EPUT Consultant Psychiatrist 1 accepted that Colin was slightly drowsy, and said that although the medication may have made him a little more confused, it could not be the cause for Colin's overall presentation. ML was told that Colin needed to be admitted to an inpatient psychiatric bed but began shouting at the MHLT and ward manager "*demanding a bed in an area of her choice*" when told that the only one available was at Goodmayes Hospital. (The shouting was incident reported (165701) under the category of security incident and sub-category verbal abuse/aggression to staff.) ML had been advised of her rights as nearest relative[66], and she stated that she (and Colin) wanted to appeal the section. She said she would prefer to take Colin home and pay for private security guards. Further discussions were had with ML, and it was confirmed that the mental health bed office would repatriate Colin when a dementia bed became available.

3.152 ML also asked again if the MHLT could give written confirmation of his lack of capacity regarding finances. It was explained to her that the capacity assessment was for decisions relating to discharge and she could request a copy once finalised. Although she was referred to the Office of the Public Guardian[67] in relation to this query, it would, again, have been helpful if someone could have sat with her to fully understand her concerns or put her in contact with a social worker who would have been able to help with this task.

3.153 As mentioned above, during Colin's stay there were several incidents involving restraint by the security officers who were with Colin, and he also cut his hands on at least two occasions. EPUT Consultant Psychiatrist 1 noted bruising to Colin's arms during the MHLT assessment on 2 June; there were reports from ML of bruising being apparent on Colin during this admission; and an email from Goodmayes Hospital to the MHLT on 10 June said that he transferred to them on 9 June "*covered in bruises*". These injuries should have been fully documented in the medical and nursing records, incident reported and a safeguarding referral made given that these injuries were sustained during the hospital stay.

3.154 We note that incidents that involved restraints and which were reported via Datix were reviewed at a restraint panel to ensure robust scrutiny of the incidents and to identify any learning. The panel reviewed the restraints that had occurred on 26 May and on 8 and 9 June. They concluded that the restraint on 26 May had been appropriate, proportionate and the least restrictive option and that the restraints on 8 and 9 June had been managed well. However, it is difficult to understand how the panel reached these conclusions without some of the information listed above (for example, the names of staff involved in the restraints, their training, the reason for using the restraints rather than alternative less restrictive options, the type and duration of restraints, and whether the person or anyone else experienced injury or distress).

3.155 ML was concerned about Colin's deteriorating mental health and the force of the restraints that had been employed in Broomfield Hospital resulting in bruising. On 11 June, she wrote a letter of complaint to the CEOs of MSE, EPUT and NELFT and included that she had not been listened to despite holding LPA attorney status for health and welfare and had not received copies of Colin's mental capacity assessments and other relevant documentation. We have seen no evidence of responses being made to these letters of complaint from any of the Trusts, but it is our view that many of her complaints were valid.

[66] 'Nearest relative' is a legal term and means the patient's family member who has certain rights and powers under the MHA.

[67] Office of the Public Guardian (OPG) helps people in England and Wales to stay in control of decisions about their health and finance and make important decisions for others who cannot decide for themselves.

Goodmayes Hospital 9 June – 17 June 2021

3.156 Goodmayes Hospital is a mental health facility in the London Borough of Redbridge. It is managed by the North East London NHS Foundation Trust (NELFT).

Stage Ward

3.157 Colin was admitted to Stage Ward at Goodmayes Hospital in the late afternoon of 9 June 2021 under Section 2 of the Mental Health Act (MHA) from Broomfield Hospital. Stage Ward is an older adult acute mental health service that cares for men who are deemed to be frail and usually aged 65 and over, although younger adults may be admitted when appropriate, typically with early onset dementia.

3.158 Colin was accompanied by two ambulance crew members and the approved mental health professional (AMHP) who had helped to undertake the MHA assessment. His family and partner had been advised that they could not visit at that time as a period of COVID-19 isolation would be required.

3.159 During the night shift of 9 June, Colin was very confused and disorientated. He threw himself at the walls and kicked the doors. Oral rapid tranquillisation medications were given.

3.160 On 10 June, a senior medical review was undertaken by the consultant psychiatrist who determined that Colin lacked capacity in relation to his treatment.

3.161 Colin also had an occupational therapy screening and was to be assessed once medically optimised.

3.162 On 11 June, an ECG recording was taken and shared with the consultant geriatrician from Broomfield Hospital, for a medical opinion.

3.163 On the night of 13 June, Colin became confused and sat on another patient's bed. When asked to move he punched a member of staff on the jaw. The emergency response team was called, and they directed him back to his bed.

3.164 On 14 June, the ward received the medical discharge summary from Broomfield Hospital.

3.165 ML wrote to the hospital managers asking to discharge Colin from 18 June, as she did not believe the ward was the best place to help him. Colin was relatively calm and settled at this time.

3.166 On 15 June, at 1pm, ML joined the ward round via Microsoft Teams. Memantine[68] 5mg once daily was prescribed for Alzheimer's disease.

3.167 On 17 June Colin's Mental Health Tribunal[69] was held. Colin, ML and Colin's son were present. The tribunal concluded that Colin could be discharged home to ML's care.

3.168 At 2pm, there was a Care Programme Approach[70] (CPA) meeting. It was confirmed that Colin's Section 2 was to be rescinded that day.

3.169 Colin was discharged home.

3.170 On 24 June, Colin's discharge summary was sent to the GP.

[68] Memantine is a medication used to slow the progression of moderate-to-severe Alzheimer's disease.

[69] The Mental Health Tribunal is an independent panel whose role is to hear applications and references for people who have had their liberty restricted under the MHA 1983. These include patients who are detained in a hospital as well as those who are living in the community but subject to legal restrictions under the MHA. The tribunal has power to discharge patients.

[70] The term Care Programme Approach describes the approach used in mental health care to assess, plan, review and coordinate the range of treatment, care and support needed for people in contact with services who have complex care needs.

Commentary on this care episode and points for learning

Physical health

3.171 During this short admission Colin's medical records were dominated by discussions, calls and emails relating to various physical health issues. Much of this was because of the lack of a clear handover and delayed discharge information received from Broomfield Hospital.

3.172 A routine but comprehensive physical examination of Colin was completed after admission by the duty doctor on the evening of 9 June. Multiple bruises of various colours were noted over bony prominences, suggestive of injuries sustained at different points in time (see comments in care planning and risk assessment section below regarding action in relation to these). Bruising consistent with enoxaparin injections was also noted. An abdominal examination was undertaken and documented as normal. Physical observations showed a slightly low blood pressure (110/67) and a raised heart rate (HR) of 99 bpm; oxygen saturations and temperature were within normal ranges. Routine blood testing and an ECG were not completed at that time given Colin's agitated presentation and the lack of immediate concerns regarding his physical health.

3.173 The duty doctor noted that no information was available to them from Broomfield Hospital on the patient care portal regarding physical health treatment, although there was mental health information from the MHA assessment and a full letter from EPUT Consultant Psychiatrist 1 who had assessed him there. The old age psychiatrist also gave a verbal handover to the ward, and this included information about Colin's CT head scan results: Alzheimer's disease, his cognitive decline over the last six to eight months and previous threatening behaviours to ML. The duty doctor called Broomfield Hospital for a discharge summary and ward staff agreed to email this across, but the document was not received until five days later.

3.174 The initial plan outlined by the duty doctor was comprehensive and included instructions to complete an ECG and blood tests when Colin was agreeable, for staff to check his blood pressure prior to antihypertensives being given, to complete food, fluid and bowel charts and to monitor his urine output.

3.175 During the afternoon, routine blood samples were taken, and an ECG completed as requested by the duty doctor. The ECG showed changes consistent with atrial fibrillation. The team doctor contacted a Broomfield consultant geriatrician (name redacted in the clinical records) for advice, requested a repeat ECG and discussed his findings with NELFT Consultant Psychiatrist 1.

3.176 Colin was seen by NELFT Consultant Psychiatrist 1 on the afternoon of 10 June. He was orientated, knew his age and usual living arrangements with his partner. Colin was able to engage in a discussion about the diagnosis of Alzheimer's disease and the plan to find a placement closer to home. When reviewing Colin, NELFT Consultant Psychiatrist 1 questioned the medication that he had been prescribed at discharge from Broomfield Hospital and asked that this also be discussed with the Broomfield geriatrician. Having received incomplete information, the team doctor resorted to contacting EPUT Consultant Psychiatrist 1 who had conducted the MHA assessment, with queries relating to potential atrial fibrillation and anticoagulation, and requested a medical team discharge summary. EPUT Consultant Psychiatrist 1 had passed this request to the medical team at Broomfield.

3.177 A multidisciplinary ward review on 11 June noted the medical concerns and made a plan to chase further information from Broomfield Hospital and to liaise with the consultant geriatrician regarding anticoagulation for Colin given the finding of atrial fibrillation. The consultant geriatrician replied by email and suggested possible atrial fibrillation with ventricular ectopics[71]. They advised a repeat ECG, which was undertaken. There was further contact the same day with EPUT Consultant Psychiatrist 1 regarding cardiac investigations and concerns about the lack of medical history. The pharmacist also noted the lack of information received from Broomfield Hospital and there were

[71] An ectopic heartbeat is a type of irregular heartbeat which happens when the heart contracts (beats) too soon.

discussions with medical staff about the benefits and risks of several medicines previously prescribed.

3.178 A further ECG completed that day similarly suggested atrial fibrillation and more calls were made to the consultant geriatrician and the medical trainee at Broomfield Hospital, who confirmed no previous atrial fibrillation and clarified the medicines prescribed. The Broomfield Hospital discharge summary had not yet been completed. Additional emails sent to the consultant geriatrician advised treatment changes to antihypertensive treatment and treatment of atrial fibrillation; anticoagulation[72] treatment was appropriately started.

3.179 Routine blood and urine testing during this admission showed no signs of underlying infection.

3.180 Further discussion and changes to medical treatment were made on 14 June by the Stage Ward team doctor in consultation with the consultant geriatrician. The discharge summary from Broomfield Hospital was also received that day; this was five days after Colin's admission to hospital. The team at Goodmayes Hospital acted promptly and sought expert advice for the unexpected and new finding of atrial fibrillation. They were also proactive in resolving the discrepancies in prescribing advice and this enabled treatment of Alzheimer's disease to be initiated (see medications section below). However, the handover from the Broomfield Hospital medical team to the Stage Ward psychiatric team was inadequate and delayed, with different and conflicting medication charts and instructions causing additional work for the staff. We can see no direct evidence of harm to Colin at this time, but his atrial fibrillation went untreated and he was put at risk of stroke for longer than was necessary.

Medications

3.181 Colin arrived on the ward with a copy of the medicine chart that had been used at Broomfield Hospital, but this conflicted with the discharge medication supplied. The admitting doctor queried the multiple conflicting sources of medication information and asked for a pharmacy review the next day in line with good medical practice.

3.182 On 11 June there were several communications with the medical trainee on Bardfield Ward at Broomfield Hospital and with the consultant geriatrician. There was some confusion about whether Colin had previously been in atrial fibrillation (see above) and also significant confusion about the medications for his cardiac function and urine retention.

3.183 On 12 June ML phoned the ward to ensure Colin was on a laxative. The staff informed her that a laxative had been prescribed. Colin was already taking senna tablets at night, and Fybogel had previously been prescribed at Broomfield Hospital but was unavailable, so Movicol was written up 'as required', which was good prescribing practice. A care plan relating to constipation was also initiated; this included the information received from ML.

3.184 On 14 June, following advice from the consultant geriatrician, Colin was commenced on apixaban[73] for the atrial fibrillation, recommenced on the bisoprolol for his hypertension, and taken off the aspirin (now that he was to be on apixaban) and the alfuzosin (as he was already on tamsulosin for his urinary difficulties caused by an enlarged prostate; we note that the alfuzosin was never administered during this care episode).

3.185 The lack of a comprehensive handover from Bardfield Ward had the potential to adversely impact Colin if incorrect medications had been administered. This was also time consuming for the Stage Ward staff, who had to repeatedly communicate with Broomfield Hospital staff in the absence of written documentation (including the discharge letter, which only arrived five days later).

[72] Most patients with atrial fibrillation should receive long-term oral anticoagulation to decrease the risk of ischemic stroke and other embolic events involving blood clots. For most patients, the benefit from anticoagulation outweighs the associated increase in the risk of bleeding.

[73] Apixaban is an anticoagulant medication used to treat and prevent blood clots such as deep vein thrombosis and pulmonary embolism.

3.186 This was a short admission of eight days in total. During that time, Colin was generally reported to be settled during the days but more confused and agitated in the evenings when he was often reported to be trying the doors and wanting to go home.

3.187 Colin was initially prescribed 'as required' lorazepam 0.5mg for "*rapid tranquillisation*". This was given orally on the night of his admission when Safewards[74] interventions had been ineffective, with reference to Colin banging his body and head into the wall, saying it was blocking his way. Under two hours later, Colin became agitated and aggressive again and was witnessed moving furniture around, being verbally abusive, kicking doors and taking things from other patients' rooms. Safewards interventions were attempted again but with no effect, so he was given oral 'as required' promethazine[75] 25mg (which was also prescribed for rapid tranquillisation), and he settled two hours later. This prescribing and administration of medications was in line with the Trust's Rapid Tranquillisation Policy, which requires staff to attempt de-escalation measures prior to oral medication (lorazepam or promethazine) being given. Physical observations were also increased, with Colin's blood pressure, temperature and pulse recorded at 7.23pm, 10.30pm and 2.10am, and visual (non-contact) observations of respiration and consciousness recorded at 9.15pm, 9.30pm, 9.45pm, 11.45pm, 12am, 1am and 1.45am. These were fully documented on the electronic patient record system and rapid tranquillisation/oral sedation forms were completed in line with Trust policy.

3.188 Colin's medication was changed on 10 June to a regular dose of oral clonazepam 0.5mg twice daily, taken in the morning and at teatime. In addition, a lower dose of 'as required' oral promethazine 10mg was prescribed, although this did not include instructions for use. Beyond the lack of instruction, this prescribing practice reduced the need for rapid tranquillisation although we note that benzodiazepines such as clonazepam can increase paradoxical agitation (some older adults become disinhibited or more restless when given these drugs, confusion can increase and there is a potential for cognitive decline to be accelerated). This prescribing was early on in Colin's stay, when the causes of his adverse behaviours had yet to be fully understood. Attempting other non-pharmacological interventions would have been preferrable before regular medications were prescribed.

3.189 The promethazine was given on nine occasions during this admission, but six instances of this are not reported in the nursing notes, so there is no record of why this was needed. Five of these instances are recorded on the prescription chart in the same time period as other regular night-time medicines suggesting it may have been used as night sedation.

3.190 On 13 June, during the evening, Colin was calm and settled. He was not given the as required promethazine and woke just after midnight agitated and paced the corridors. He opened other patients' bedrooms, believing he was in his own home and said he was looking for his daughter. He accepted oral medication (promethazine 10mg) at 12.35am. He then entered another patient's room, sat on the bed and refused to leave. He punched a member of staff on the jaw. Additional staff attended and Colin was directed to his room. At 1.30am it was noted that he "*turned his bedroom upside down*" and claimed that people had come to attack him; he had rung his partner saying he had been attacked. He could not remember this incident when asked in the morning.

3.191 During the day on 14 June, Colin was described as presenting as relatively calm and settled, with no irritability or aggression observed. In the evening, staff noted that he asked them to call the police as he was concerned about his wife. His prescription chart showed that 10mg promethazine was administered at 4.29pm. He was also asking to leave the ward and for directions to Dartford. He accepted promethazine 10mg at 9.25pm but remained awake for much of the night.

3.192 During the ward round on 15 June, it was confirmed that there had been no episodes of restraint on Colin or use of IM medication since admission. As the issues around Colin's physical health had

[74] Safewards is an initiative that aims to reduce violence and aggression on acute inpatient psychiatric wards using 10 interventions: clear mutual expectations, soft words, talk down, positive words, bad news migration, know each other, mutual help meetings, calm down methods, reassurance, and discharge messages.

[75] Promethazine is used in adult mental health services for the management of disturbed behaviour. In many cases it is likely to be considered a first line option in cases where either a benzodiazepine or an antipsychotic (used as a tranquiliser/sedative) is inappropriate.

been resolved, it was agreed to start treatment which may slow the progression of Alzheimer's disease. Memantine[76] 5mg was prescribed, with risperidone as an option to be considered at a later date if needed. This was in line with national best practice guidance.[77]

Care planning and risk assessment

3.193 NELFT has an overarching Clinical Risk Assessment and Management Policy. This emphasises the importance of gathering and recording detailed information about historical and current risks, including gathering information from carers and families.

3.194 Nursing staff completed an admission document for Colin when he transferred to the ward on 9 June. This included collateral history from ML with reference to her confirming that there had been a cognitive and functional decline in Colin in the past six to twelve months. This included that Colin had shown aggression towards her, and that this behaviour had become worse in the last three months.

3.195 They also completed a risk assessment and documented no risks identified for self-harm or suicide (despite Colin previously saying he would jump out of a window at Broomfield Hospital) but included two bullet points relating to incidents at Broomfield Hospital under the heading about risk of being aggressive or violent towards others. The remaining sections, which related to individual and family strengths, key risks summary, risk incidents and risk formulation, were left blank.

3.196 Risk management plans were documented on 9 June for risk of harm to others (due to violence and aggression), in relation to the bruising that had been observed on his body (and to prevent further bruising), infection prevention and control (relating to COVID-19), symptoms of pain and discomfort, and potential side effects of medication. However, there was no evidence of proactive family involvement in Colin's risk assessment and management plan, which would have helped ML to better understand the approaches to his care. There was reference to Colin lacking capacity and not having a copy of the care plans; these should instead have been shared with ML as his attorney under LPA but were not.

3.197 The risk assessment was updated under 'harm to others' following the incident of violence and aggression on 13 June in line with the requirements of the Clinical Risk Assessment and Management Policy, with staff noting that Colin "*can be verbally threatening*".

3.198 In response to the bruising being identified, nursing staff completed a body map of Colin on 10 June, showing areas of bruising to his forehead, left upper abdomen, both upper arms/elbows, right knee and the back of the right hand. This was in line with the NELFT safeguarding standard operating procedure which requires the use of body maps to document any injuries or marks seen on an adult (or child). The body map was, however, poorly completed, with little information about the size or specifics of these. We can also see no evidence of these injuries being reported as a safeguarding concern via the incident reporting system or of advice sought from the specialist safeguarding team. The discharge letter from Goodmayes Hospital on 17 June indicated that they believed this bruising to be related to physical restraints that were undertaken at Broomfield Hospital, but there was no further follow up to confirm this, and no safeguarding actions were taken. We can also see no evidence of the body map being updated on Colin's discharge home. This, in conjunction with inadequate initial body mapping, will have made it difficult for the ward to fully account for the bruising that ML reported to the police prior to his discharge from the ward and through a formal complaint to the Trust on 14 June.

3.199 Following on from the risk assessment process, initial care plans were devised for Colin on transfer to the ward. These related to MHA detention, discharge planning, physical health and aggression. Additional plans relating to personal care, medicines and constipation were developed on 13 June. These care plans were brief, consisting of a short description of need and then a sentence each for

[76] https://bnf.nice.org.uk/drugs/memantine-hydrochloride/

[77] NICE (2018) Dementia: assessment, management and support for people living with dementia and their carers. Recommendations 1.5.2 – 1.5.9. https://www.nice.org.uk/guidance/NG97/

prompts of patient/carer goals and views, treatment goals, patient strength and resources. Agreed actions within care plans should give direction to staff about how they will achieve the desired outcomes, but these did not provide sufficient detail to achieve this aim. For example, care plans note that Colin was "*on level 3 observations*" but there was no further detail as to what staff should observe for, what staff needed to be aware of, how specific situations may be managed, or how these observations were reviewed. Person-centred care could also have been further enhanced through the use of a 'This is Me' (or equivalent) tool to aid information gathering and sharing, but this approach was not utilised.

3.200 The risk assessment and care plans also did not assist staff in understanding or managing Colin's agitated presentation. For example, the care plan relating to aggression noted incidents of violence at the previous hospital, but with no reference to behaviour during the current admission. This was not updated following incidents or as staff got to know Colin. There were, however, frequent references in the nursing notes to the Safewards model, which is an approach to reduce levels of conflict and incidents in mental health inpatient settings, with some evidence of its effectiveness in older adults settings. Staff referred in the progress notes to being able to divert Colin into activities that he enjoyed, using outdoor and indoor space to walk with him, watching football on television, using soft speech and calmly communicating with him, but these strategies were not converted into meaningful care plans which staff could use (or share with ML and Colin's family) to help care for Colin.

3.201 The Trust's Safe and Supportive Observations Policy states that observations should be reviewed on a daily basis by nursing and medical staff. Throughout the admission, Colin was subject to one-to-one (level three) observations. These were reviewed by the multidisciplinary team (MDT) on 11 June, but no further review was documented. The policy also outlines that observation care plans should include issues of privacy, dignity and environmental dangers specific to observations. The care plan did not detail any of these. The observations should also have been recorded as part of the risk assessment but were not.

3.202 During Colin's stay on the ward, there was a recognition by the ward team of the pattern of Colin's behaviours which changed in the evening as a phenomenon known as "sundowning".[78] This was discussed in detail during the ward round on 15 June. While not specifically referenced in the nursing documentation, staff would have been familiar with this presentation and they appear to have managed this well for the most part, with recourse to low doses of as required medication at times. Rather than using a short-acting benzodiazepine, which carried higher risks of lowering blood pressure and reduced respiration, an alternative medicine (promethazine) was used, and at a lower dose than is used for adults, which was good practice.[79]

3.203 The model of care, staff skills and familiarity with and knowledge of patients presenting with dementia appeared to have been effective in reducing the levels of aggression displayed by Colin. It is likely that the environment of a mental health ward, with space to pace and a garden area, was also beneficial for Colin. Such wards also have more ability than acute hospital wards to enable patients to orientate themselves to the time of day, with access to natural lighting and a clearer day and night routine, which was also likely beneficial to Colin despite a relatively brief admission.

3.204 ML wanted to take Colin home on the day of the Mental Health Tribunal, which meant that the ward had very little time to prepare his discharge. On 16 June, in a communication with the clinical lead for the older adult service, the ward had confirmed that if Colin were to be discharged after his tribunal, then the behavioural, occupational therapy, financial and decision support tool (continuing healthcare) assessments would have to be arranged through the community team. When ML asked if Colin would need a bed downstairs at home, the consultant psychiatrist informed her that the ward had not had sufficient time to complete their assessments, but that the EPUT Dementia Intensive Support Service (DISS) would be visiting their home daily.

[78] https://www.dementiauk.org/information-and-support/health-advice/sundowning/

[79] https://bnf.nice.org.uk/treatment-summaries/dementia/

3.205 The risk assessment for Colin that was documented on 15 June at the ward round and in his discharge letter, confirmed that he had a low risk of non-compliance, high risk to self (confusion and physical aggression towards others, where he may injure himself in the process or be harmed as a result of retaliation), high risk to others (due to unpredictable unprovoked physical aggressive and violent behaviour) and high risk of absconding (as he could become confused and disorientated, particularly in the evening). This was appropriately conveyed to the community DISS during the discharge meeting on 17 June; ML was also aware of these risks and the team's views on discharge (namely, that the team did not recommend ML taking Colin home with carers yet and that initial placement in a nursing home would be advisable).

3.206 ML requested a mental health advocate on discharge (although the rationale for this is not stated) and for a social worker to be assigned to Colin, as a financial assessment would be required if he needed to go into a care home at any point. Advocacy referrals should, however, already have been made following the comments from the AMHP who undertook the MHA assessment (see behaviour and presentation section below) but also when Colin had initially been admitted under Section 2 and deemed to be lacking capacity; referral to an independent mental health advocate (IMHA)[80] is a requirement of the MHA 1983 Code of Practice[81], but we can see no evidence of this being enacted. In relation to the financial assessment, this should have been undertaken by a social worker. A social worker was involved after Colin's discharge home, but we can see no evidence of an assessment of needs for care and support[82] being completed, as we do not have their records, and they declined to be interviewed as part of this investigation.

3.207 EPUT DISS Consultant Psychiatrist 1 conveyed to ML and the Stage Ward team that, ideally, Colin could have done with more time to be assessed on the ward, and asked what ML would do if he became aggressive at home. She replied that she was in touch with security guards or would call the police. Had Colin remained on the ward, more comprehensive assessment and discharge arrangements/ support would have been possible (including, for example, provision of carers and ideas for sleeping arrangements for Colin as his bed was upstairs) although the DISS were responsive and visited Colin the day after discharge.

<u>Behaviour and presentation – Mental Capacity Act and safeguarding</u>

3.208 ML and Colin's children had been unable to visit him on Stage Ward due to COVID-19 visiting arrangements in place on the ward at the time. This was frustrating for the family and distressing for Colin, but they kept in daily contact by phone.

3.209 Colin was detained under Section 2 of the MHA throughout this admission. The AMHP report included concerns about ML, describing her as an attorney who may not always be acting in the best interests of Colin by obstructing access/contact with his children and restricting consideration of their views; the allegations of restrictions are refuted by ML. The AMHP recommended that an IMHA be sought to explore these issues.

3.210 This was confusing. Colin was entitled to an IMHA, but this would have been to support him as a detained patient. An IMHA is an advocate appointed to support individuals (known as '*qualifying patients'*) who are detained (or '*liable to be detained'*) under the MHA. The referral for an IMHA should have been automatic and made by the ward. This would have been in line with the MHA Code of Practice:

"*Duty to inform patients about the availability of IMHA services*

[80] The role of the Independent Mental Health Advocate (IMHA) is to support people to understand their rights and restrictions under the MHA, to understand their care and treatment options, and to make representations about these issues on their behalf.

[81] https://www.gov.uk/government/publications/code-of-practice-mental-health-act-1983 (Section 6.16)

[82] An assessment under the 2014 Care Act is an assessment of needs for care and support (including transition assessments), or an assessment of a carer's needs for support. The nature of the assessment will vary depending on the person and their circumstances.

6.15 Certain people have a duty to take whatever steps are practicable to ensure that patients understand that help is available to them from IMHA services and how they can obtain that help … This must include giving the relevant information both orally and in writing.

6.16 If a patient lacks capacity to decide whether or not to obtain help from an IMHA, the hospital manager should ask an IMHA to attend the patient so that the IMHA can explain what they can offer to the patient directly."

3.211 In this instance, however, a dispute regarding access or contact with family for an individual who lacks capacity would have required a different approach. As Colin had an LPA in place, any dispute regarding what was in Colin's best interest regarding such access should have first been discussed with his attorney under LPA (ML). If this had not resolved the concerns, then the care team had options and should have acted to safeguard Colin and consider his family contact. These options included:

- Discussing these concerns with the specialist safeguarding team within the Trust.
- Checking with Colin about his wishes for contact and communication with his children, and attempting to understand if this was his decision, if it had changed recently, and why.
- Discussing this with ML to understand her rationale behind the decision.
- Referral to an independent mental capacity advocate (IMCA)[83] to support Colin and to advocate on his behalf. Advocates are usually only provided when the person has no-one to support them but the Mental Capacity Act (MCA) Code of Practice states at 6.9 that "*There are also some circumstances where an IMCA may be appointed on a discretionary basis*". This includes adult protection concerns.
- Arranging for a best interest meeting with all involved (including an IMCA) to consider and discuss all the evidence to reach a mutual decision that was in Colin's best interest.[84] A best interests meeting would have been required to establish and record this, particularly if onward referral was required.

3.212 If a decision could not be reached, then the care team had the option to make an application to the Court of Protection for a ruling. It should also be noted that if the care team believed that ML as attorney under LPA was abusing her powers under the LPA, they would have been required to refer the matter to the Office of the Public Guardian.

3.213 Regardless of the AMHP instruction, the need for an IMCA or the requirements of the MHA, we found no evidence that Colin was referred to any advocacy service (IMHA or IMCA) during this admission or that any other actions were considered or progressed to ensure that Colin's best interests were being considered. This is relevant given the concerns that were to later emerge in relation to discharge and the recorded concerns that ML was again potentially "*not acting in Colin's best interests*".

3.214 Colin was assessed by the consultant psychiatrist on 10 June. The risk summary included that Colin had a moderate to high risk of aggression to others and "*lacks capacity in regards to his admission and treatment*" (we can see no evidence of a formal capacity assessment form being completed, but the notes in the clinical records were comprehensive). It was explained to Colin that the ward was trying to find him a bed closer to home.

3.215 On 14 June, ML rang the ward and requested to speak with the consultant regarding a transfer of care closer to home. When Colin had been admitted, there had been no beds available at his local

[83] https://assets.publishing.service.gov.uk/media/5a7eae52e5274a2e87db13a8/making-decisions-opg606-1207.pdf

[84] The Code of Practice suggests that most disputes should be resolved as quickly and painlessly as possible. The code provides advice throughout but chapter 15 deals specifically with disputes and in summary states: 'It is in everybody's interests to settle disagreements and disputes quickly and effectively, with minimal stress and cost… When disagreements occur about issues that are covered in the Act, it is usually best to try and settle them before they become serious'.

mental health trust and so he was transferred to Stage Ward under section 2 MHA. We can see no evidence of a transfer to a bed closer to home being explored by the ward, although there were discussions from this time onwards about Colin's discharge to a care home, which would have negated the need for an NHS bed if deemed appropriate by the team/tribunal that was to follow.

3.216 When discharge planning was later discussed, the EPUT DISS were invited to a ward round as they were to be the community team who would be involved when Colin left hospital. They arrived on the ward on 15 June, but ML requested for them not to be in attendance. NELFT Consultant Psychiatrist 1 conceded to this request, but at this point the team should have considered whether ML was acting in the best interests of Colin.

3.217 Section 1 of the MCA establishes the 'best interests' principle which underpins the entire MCA:

"An act done, or decision made under this Act for or on behalf of a person who lacks capacity, must be done, or made, in his best interests".

3.218 ML had the authority as attorney under LPA to determine whether the DISS team could attend the meeting; however, in this role she had to act in Colin's best interests. If the care team believed that ML as attorney under LPA was abusing her powers, they would have been required to refer the matter to the Office of the Public Guardian.

3.219 We note that the DISS was not the correct area team for Colin to have been referred to. Allocation for community support is by GP surgery location, and although Colin's GP was on a geographical border, the correct referral would have been to the Colchester Dementia Intensive Support Team (DIST) who Colin was transferred to when he moved to Woodland View Care Home at a later date. This error meant an additional and unnecessary change of team for Colin with continuity of care again being compromised. This would also have been frustrating for ML who had to build relationships with the new teams as they changed.

3.220 ML also asked that Colin not be invited into the ward round for the discussion as it may distress him, but NELFT Consultant Psychiatrist 1 explained that patients must be able to attend ward rounds. This was agreed and Colin did attend. This was expected practice based on enabling personalised care.[85]

3.221 At the meeting, NELFT Consultant Psychiatrist 1 explained Colin's presentation on the ward where he became more confused in the evenings and advised that the team did not recommend ML taking Colin home with carers yet and that an initial placement in a nursing home would be advisable. The consultant also raised the risk of violence to ML. ML told the team that she had identified a care home which may be suitable for him.

3.222 It was agreed that ML would not request to appeal his section, and a plan was made for a financial capacity assessment to be undertaken, for nursing staff to contact ML to obtain the contact details of care homes, to start memantine treatment for the Alzheimer's disease and to arrange a discharge planning meeting with DISS.

3.223 On 16 June, NELFT Consultant Psychiatrist 1 received multiple emails from ML which differed from the plan that had been agreed the day before. These related to financial capacity assessments, continuing healthcare (CHC) funding assessments,[86] medication, and also a request for discharge from the Section 2. A demand to complete a CHC assessment was included: "*ASAP. Before he is discharged. Not after. Please see this is sorted*", and a capacity assessment regarding finances: "*Please action a financial mental health assessment ASAP. (Needed for any care planning/fees moving forward)*". It was not possible to action the CHC assessment before the tribunal, which was

[85] https://www.england.nhs.uk/personalisedcare/what-is-personalised-care/

[86] NHS continuing healthcare (NHS CHC) is a package of care for adults aged 18 or over which is arranged and funded solely by the NHS. In order to receive NHS CHC funding, individuals have to be assessed by integrated commissioning boards (ICBs) according to a legally prescribed decision-making process to determine whether the individual has a 'primary health need'.

to be held the following day; however, the capacity assessment for Colin's financial affairs should have been expedited given that this was a request that had been made previously.

3.224 ML's emails also included plans to research care for Colin if he were to return home: "*I am still very unsure which way to proceed and will be researching how to care for [Colin] here at home as I'm finding it difficult to expedite a care home with the weekend looming*". ML indicated that the application to discharge Colin had not been rescinded as she was keen to see him and visit before this action was taken. There was also a request for a further meeting with NELFT Consultant Psychiatrist 1.

3.225 When Colin had first been detained under Section 2 of the MHA, ML had correctly been identified by the AMHP as the nearest relative. Under the MHA, the nearest relative has a specific power to 'order' discharge from Section 2 and 3. They must give the hospital managers 72 hours' notice of an intention to discharge the patient. Within those 72 hours, the responsible clinician[87] has the power to prevent discharge by issuing a barring certificate/barring order – they must certify that "*the patient, if discharged, would be likely to act in a manner dangerous to other persons or to himself/herself*". This is the only basis for preventing discharge.

3.226 NELFT Consultant Psychiatrist 1 discussed the case with the MHA manager for the Trust and documented in the clinical records that ML appeared to be acting in his best interest at this time and there did not appear to be grounds to bar her as the nearest relative. They asked the matron to make contact with ML regarding information about the queries she had raised around CHC funding arrangements and applications.

3.227 NELFT Consultant Psychiatrist 1 also contacted the clinical lead for older adult services and the consultant for the EPUT DISS. This was to raise awareness about the pending tribunal and application to discharge from the section. This was an example of good interagency communication. NELFT Consultant Psychiatrist 1 noted that the contingency plan if discharged by tribunal was "*behavioural assessment, occupational therapy assessment, DST,[88] financial assessment and funding would have to be arranged through the community team*".

3.228 Nursing staff from the ward attempted to contact ML to inform her that she could now book a visit to see Colin given his negative tests for COVID-19, but there was no response, and a message was left. Two further failed attempts were recorded in the nursing notes later that day. NELFT Consultant Psychiatrist 1 and the matron also attempted to contact ML without success.

3.229 On 17 June at 9.29am, NELFT Consultant Psychiatrist 1 updated Colin's clinical record and summarised a decision to bar the application for discharge made by ML. They outlined their concerns, particularly relating to the changes of plan and inability to engage ML in further discussion around planning.

"*The Partner who is the next of kin is making decisions based on her own loss due to mental health some years ago. Due to her past experiences, she is not acting in his best interest and not letting the team looking after him to complete the assessments, optimise his medication and plan for safe discharge. He remains aggressive and unpredictable on the ward. She wanted him to go to a care home in order to manage him in the community. The team have tried to engage with her all day yesterday (email sent to her by my secretary around the information requested, several calls and texts from the matron, I tried calling her yesterday and even tried this morning) in order to facilitate the process which she has not engaged with. She did not allow the dementia intensive support services in Essex [to] attend the ward round to facilitate the process. In my opinion she is not acting in his best interest and her decision making process is skewed by her anxieties around MH services*."

[87] The responsible clinician has overall responsibility for care and treatment for service users being assessed and treated under the MHA.

[88] The decision support tool (DST) is a national tool that has been developed to support practitioners in the application of the national framework for NHS continuing healthcare and NHS[-]funded nursing care (2022) (the 'national framework').

3.230 There were no other actions taken in relation to these concerns given the proximity of the tribunal (that day) to this decision being made. This would have been confusing for the tribunal to understand if communicated to them. On 16 June NELFT Consultant Psychiatrist 1 believed ML was acting in Colin's best interests, but a day later their view changed due to a lack of communication by ML (who may have been otherwise engaged; we also note that ML has said she did not receive any calls or an email asking her to contact the ward team at that time and evidence to support the texts and email being sent to ML have not been shared with us). Although there is reference in the tribunal papers to the Consultant Psychiatrist (and team) feeling that Colin would benefit from an extended stay, nursing home care or Section 17[89] leave, they should have been more assertive in the meeting about their concerns, or they could have referred the matter to the Office of the Public Guardian. Instead, the tribunal felt that ML's argument for transfer home was more compelling (despite robust discharge arrangements having to be confirmed).

3.231 On 17 June, at 1pm, the tribunal met to review Colin's detention. Their decision was that Colin no longer required detention under the MHA from 7pm that day. ML outlined the plan to care for Colin at home and that she had arranged for carers to be available at night, with security guard presence if needed. She said she would not hesitate to ask for help and outlined a contingency plan of arranging a care home placement if Colin could not be managed at home. NELFT Consultant Psychiatrist 1 had suggested that Colin could go home on Section 17 leave (which would allow for rapid re-admission if the discharge did not go to plan), but the tribunal's view was that ML "*had catered for every eventuality*" and that the criteria for continued detention was not met.

3.232 After the tribunal decision a discharge meeting was convened. This was led by NELFT Consultant Psychiatrist 1 with attendance from the advanced nurse practitioner, the DISS team, Colin, his partner and his son. EPUT DISS Consultant Psychiatrist 1 explained the remit of the service including out-of-hours support and arranged to visit Colin at home the following day. It was communicated to the DISS that Colin became more confused in the evenings, and this was confirmed by ML; however, when incidents of disturbed behaviour were discussed, ML said the consultant was exaggerating and blamed staff for pushing Colin in the incident where he had damaged his room. The DISS team provided their contact details to ML and agreed to make a referral for advocacy services (although we can see no evidence of this being enacted) and a social worker (as requested by ML).

3.233 Once discharge had been confirmed, the ward documented that it was too late in the day to order a discharge supply of medication. A prescription for overnight medications was completed for dispensing by a community pharmacy, with assurance that a full prescription would be available for collection the following day, but some mixed communications with the family meant that there were some omissions for that evening. This was distressing for ML and could have been detrimental to Colin's physical and mental health. Take home medications should have been prescribed at the point where staff knew there was a tribunal with a potential for discharge to be confirmed.

3.234 Throughout Colin's stay the consultant psychiatrist and other team members followed up ML's requests and worked with her to help overcome her reluctance to involve mental health services in Colin's care. The consultant psychiatrist ultimately barred the application to discharge Colin from the Section 2 because of growing concern that the discharge from hospital was too soon and driven by ML's reluctance to engage fully. Given this and the initial concerns raised by the AMHP that ML may not always be acting in Colin's best interests, actions should have been taken to safeguard Colin. Initial advice should have been sought from the Trust safeguarding team and a best interests meeting held with a referral to the Court of Protection highlighting the concerns about ML's role as an attorney prior to the mental health review tribunal being held. Further, if the care team believed that ML was abusing their powers under the LPA, they would have been required to refer the matter to the Office of the Public Guardian. It may also have been appropriate for the local authority AMHP

[89] Section 17 of the MHA 1983 allows for certain patients who are detained under the MHA to be granted "leave of absence" from the hospital in which they are detained for a specified or indefinite period subject to particular conditions specified in their leave care plan.

(on discussion with the consultant) to consider whether ML should have remained as nearest relative or whether the team should have considered displacing her.

3.235 The discharge summary was sent to the GP on 24 June; this was seven days after discharge from hospital. This included a request for the GP to arrange a 24-hour monitor (to assess Colin's ventricular rate and to exclude any actual bradycardia), and to perform an echocardiogram to rule out left ventricular dysfunction. This delay caused some confusion and anxiety for ML about Colin's physical health follow up (see comments in Woodland View Care Home physical health section).

3.236 We also note that on 11 June a letter was sent from the MHA Office at Goodmayes Hospital informing Colin that he was being detained for up to 28 days from 9 June under powers in Section 2 of the MHA. Although informed of her rights as Nearest Relative by the AMHP, the letter informing her of Colin's detention and rights was not sent until 21 June (four days after he had been discharged). This was an unacceptable delay, particularly given that she objected to him being detained.

Home/EPUT Dementia Intensive Support Service 17 – 21 June 2021

3.237 The Essex Partnership University NHS Foundation Trust (EPUT) Dementia Intensive Support Service (DISS) provides mental and physical care for people with dementia and memory loss.

EPUT Dementia Intensive Support Service 17 – 21 June 2021

3.238 Colin was discharged home from Goodmayes Hospital and discharged from Section 2 of the MHA on 17 June 2021.

3.239 ML was supported by three friends who came to stay at the house to help her settle Colin back at home.

3.240 Colin had been referred to the EPUT DISS and was seen four times between 18 and 21 including a medical review on 18 June.

3.241 Colin was transferred to Woodland View Care Home on 21 June.

Commentary on this care episode and points for learning

3.242 This was a short duration care episode so, unlike the rest of this report, we have not reported under separate headings.

3.243 Colin was seen by EPUT DISS Consultant Psychiatrist 1 and EPUT DISS Clinical Lead 1 at home on 18 June, the day after his discharge home. Colin engaged in the visit but did not recall being in hospital or that he had been discharged home the previous day. ML described that he became more confused after administration of his night-time medications "*and was sedated to such an extent that he could not get up in time to get to the bathroom and was urinating on the floor while he was on his knees*".

3.244 EPUT DISS Consultant Psychiatrist 1 requested a GP review relating to his blood pressure and heart rate, which were found to be low. They advised a slow titration and increase of the memantine but also stopped the promethazine prescription and reduced the dose of clonazepam from 0.5mg twice daily to once daily, as the doctor wanted to reduce the sedative effect which may have contributed to his fall. The afternoon dose of clonazepam was to be retained as was the 'as required' dose.

3.245 Recognising that there was good intent in trying to lessen the potential of falling, reducing medication the day after discharge from hospital appears to have been premature and risky, and we can see no evidence of this being discussed with staff from Goodmayes Hospital to confirm whether this might have been an appropriate course of action. Colin had been moved home, which would have been disorientating for him, and it was known (from the handover from Goodmayes Hospital) that he became more agitated at night with some episodes of incontinence at this time.

3.246 In line with some of the communications prior to discharge from Stage Ward, an initial plan was agreed for daily visits and referrals to be made for a carer's assessment, financial assessment and advice regarding a placement, along with referrals to the Alzheimer's Society and continence services. The DISS team also made plans to contact Colin's son to involve him in care and requested confirmation of lasting power of attorney (LPA) from ML. However, Colin was not under the care of the team for long enough for these referrals and plans to be actioned.

3.247 That night Colin was agitated and was given clonazepam and later promethazine by ML, despite this latter medication having been stopped earlier that day. Colin had fallen asleep on the sofa, later gone to bed and then had got up and fallen. It was noted by ML that he had been paranoid, he would not eat his meal and wanted hers, and he asked her friend to leave.

3.248 On Saturday, 19 June, the DISS senior nurse and support worker visited Colin. They noted the events of the previous evening, including the administration of medication that was no longer prescribed. ML told the team that she was hoping that Colin would be transferred to a care home on 21 June but added that if she could take him that day she would. Her friends asked what support would be available if Colin became agitated again and were told by the team to give medication as prescribed by the DISS doctor, to call DISS if in hours or NHS 111/999 if out of hours. They informed ML that they would visit the next day.

3.249 The EPUT Adult Safeguarding Policy notes that "*An individual, a group or an organisation may perpetrate abuse which can be deliberate or the result of ignorance, lack of training, knowledge or understanding*." It is likely that the sedation was given by ML without the intention of harming Colin, and we can see no evidence that deliberate harm was the considered opinion at the time or since. It seems then that ML gave the non-prescribed medication to try and 'manage' a difficult situation and that in doing so, she may have caused unintentional harm. A safeguarding referral should therefore have been made and ML's needs as a carer should also have been considered/assessed as a matter of urgency.

3.250 Colin was more settled overnight on 19 June and slept well.

3.251 On Sunday, 20 June Colin left the house in the evening and was brought back by police. He was described by ML as "*paranoid and intrusive*" and was given four doses of 'as required' clonazepam 0.5mg at intervals during the evening, a 10mg dose of promethazine and a further two doses of clonazepam 0.5mg at 12am and 8am on the morning of 21 June.

3.252 When the DISS team visited on 21 June, they described Colin as over sedated and warned his partner not to give more clonazepam. ML said she was looking for a placement and could not meet his needs at home. As before, the team failed to complete a safeguarding alert relating to these medication incidents and there was a significant missed opportunity to alert the local authority to complete an urgent assessment due to carer breakdown, or to consider re-admission to hospital either through a MHA assessment or under DoLS. A care home was to be arranged but only as respite at this stage and any potential vulnerabilities for Colin (and ML) should have been flagged in case the respite placement failed or ML decided to bring him home again. The team also left him at the house with ML after their visit ended despite noting that excessive unauthorised prescription medications had been given to this vulnerable adult.

3.253 During this home visit, ML clearly identified that she was struggling to meet Colin's needs. There were concerns about the use of medication, Colin had been found wandering the evening before, requiring police intervention, and ML was looking for alternative placements. Given the concerns identified it would have been appropriate for the DISS team to consider whether Colin could remain safely at home. The rationale for their decision should have been recorded. If the team decided that Colin should not remain at home, or that he required support to remain at home, the team could have considered:

a) Whether Colin required an urgent placement in a respite care home for assessment. In this case, the DISS team could have helped to support a care home placement for Colin through joint working with the social worker, and if necessary, Colin could have been placed in a home

under MCA DoLS. Given the concerns raised by ML about managing Colin at home, the DISS team could have made an urgent (same day) referral to the local authority to consider whether Colin required respite care to prevent further harm/carer breakdown. This care could also have been provided at home or as an alternative placement but would have required both a social care assessment of need for Colin under Section 9 (or 11) of the 2014 Care Act and a carer assessment under Section 10 of the Care Act.

b) Whether Colin would have accepted an informal admission, or, if he lacked capacity, whether an admission under the MCA would have been appropriate. It is unlikely, however, that informal admission/admission under MCA was appropriate given Colin's risk history and presenting behaviour, but it should still have been recorded as considered.

c) Whether Colin met the criteria for an admission under the MHA. This would have required a referral to either their team consultant to start the assessment or, if out of hours, to the relevant duty/AMHP service to initiate an assessment.

3.254 Later on 21 June, Colin moved to Woodland View Care Home. This was arranged by ML as a two-week respite placement. He was discharged by the DISS, as he moved to a different team's catchment area (although they were the team that Colin should have already been under). The dementia intensive support team (DIST) in Colchester accepted Colin's referral and the plan for memantine titration was handed over to them.

Woodland View Care Home/EPUT Dementia Intensive Support Team 21 June – 7 July 2021

3.255 Woodland View Care Home is in Colchester and provides residential and nursing care, as well as care and support for individuals living with dementia.

3.256 The Essex Partnership University NHS Foundation Trust (EPUT) Dementia Intensive Support Team (DIST) provides intensive support to patients of any age with dementia and older people with a mental health diagnosis to prevent hospital admissions to both acute and psychiatric hospitals. The team works closely with health and social care teams to support patients to remain in their place of residence by providing assessment, diagnosis and treatment for up to six weeks.

Woodland View Care Home (Barchester Homes) and the EPUT Dementia Intensive Support Team, 21 June 2021 – 7 July 2021

3.257 On 21 June 2021, Colin was admitted to Woodland View Care Home as a respite placement.

3.258 On admission, Colin was transferred from the EPUT Dementia Intensive Support Service (DISS) to the EPUT Dementia Intensive Support Team (DIST).

3.259 On 23 June Colin's case was discussed in the DIST multidisciplinary team (MDT), and a management plan agreed. An internal handover meeting held on 23 June included that SystmOne notes from the DISS team had been received and stored on the records system.

3.260 EPUT DIST Doctor 1 visited Colin that afternoon at the care home. He became agitated after their visit and was given 'as required' clonazepam with good effect.

3.261 On 25 June, Colin's case was discussed in the DIST MDT again. The care home was to be asked to record daily physical health observations, his dose of memantine was to be closely monitored, and information regarding this medication sent to ML.

3.262 On 26 June Colin became agitated after his daughter had visited him.

3.263 On 29 June, the DIST visited Colin and then discussed the importance of DoLS with the care home staff.

3.264 On 30 June, there was a meeting with the social worker and one-to-one care was requested for Colin by ML. They recorded that the home had given notice on Colin and told ML that he would have to leave the following week.

3.265 Colin transferred to Anisha Grange Care Home (a specialist home registered to care for people with dementia) on 7 July.

Commentary on this care episode and points for learning

Physical health

3.266 On transfer to Woodland View Care Home, Colin's care was passed to a temporary GP due to the move in geographical area; although not their responsibility, the DIST staff were involved in arranging the registration and ensuring the GP was aware of Colin's cardiac history. They also assisted in performing an ECG which had been due to be taken at his own GP's surgery that week, they asked for a cardiology referral to be made for Colin and a review of his yellowing eyes following concerns raised by ML. There were, however, difficulties in getting a response from the GP about these requests, particularly as this was not Colin's permanent GP, and only in the home for respite. On 6 July it was confirmed that a cardiology referral had been sent to the community cardiology department on 11 June and that the GP surgery was still waiting to hear back from them.

3.267 During Colin's stay, a potential ear infection was initially reported by ML and noted by EPUT DIST Consultant Psychiatrist 1; the care home responded to this but did not feel it required a GP visit and the GP did not follow this up despite EPUT DIST Consultant Psychiatrist 1 asking the GP practice on several occasions for it to be reviewed (including examination by otoscope[90]). We can see no evidence of the yellowing eyes being followed up or of further concerns being raised in relation to these issues.

3.268 Charts from the care home records show that physiological observations were undertaken on 21, 27, 30 June and on 1, 3, 4 and 7 July 2021 despite a handwritten instruction (from 27 June) for daily recordings. These charts showed physiological observations that were broadly within normal ranges, although on occasion his blood pressure was higher than his normal reading.

Medications

3.269 Medicines reconciliation and medicines management was poor at the care home. The medicines administration charts and the nursing notes indicated that Colin's blood pressure and continence medications (ramipril and tamsulosin) were unavailable for a period of four days between 30 June and 3 July while arrangements were made for these to be restocked.

3.270 The records contain the discharge prescription from Stage Ward on 17 June noting a two-week supply of all medicines, so these would have run out by 31 June assuming they transferred with Colin from home. Colin had been admitted initially for a one-week respite period that was subsequently extended for another week. Although not classed as critical medications,[91] failure to give the ramipril could have had an adverse impact on Colin's physical health and may have been the cause of higher than normal blood pressure recordings; while omission of his tamsulosin may have caused urinary symptoms that would have been distressing to him, and this may have contributed to his agitation.

3.271 On 23 June, EPUT DIST Doctor 1 visited Colin at the care home. They recorded an impression of '*Alzheimer's type dementia'* with no positive findings for psychosis or depression. The doctor wrote a prescription for memantine 10mg to be given for seven days, with a plan to increase by 5mg over the following two weeks to a maximum dose of 20mg. The care home staff were asked about seeing any potential side effects from this medication in Colin, having been given literature on this subject; none were evident to them. This was good practice, but it would have been difficult for them to discern these side effects, which include balance being impaired, constipation, dizziness, drowsiness and hypertension. These were all features of Colin's presentation prior to this medication being started. We can see no evidence of a more formal checklist being used to assist

[90] An otoscope is a tool which shines a beam of light to help visualize and examine the condition of the ear canal and eardrum.

[91] Critical medications include those that could potentially result in harm to the patient when administration of doses is delayed.

staff in their assessment or other monitoring by the DIST to assess whether there were any side effects evidenced.

3.272 On 30 June, it was noted ML was concerned about the use of memantine, as she believed that it had been causing Colin more distress. The rationale for this was not documented, but in a letter to her on 1 July a DIST doctor wrote to confirm that ML had told him she was worried that giving him this medication would make him more aware and in the long run make him more distressed, as he did not want to be in the care home. The dose was increased to 10mg that day in line with the plan, but ML asked for the dose not to be increased further while she had discussions with the family. He advised that he had written a prescription (on an FP10[92]) for a three-week supply of 10mg and had also written to the GP to inform them that the memantine dose would remain at 10mg. On 24 June, the plan had been for the dose to increase by 5mg each week to a maximum dose of 20mg daily.

3.273 In relation to this request, ML was Colin's attorney under LPA for health and welfare under the MCA 2005. The role of a health and welfare attorney is to make decisions (or support the donor to make decisions), about issues such as their daily routine, medical care or accommodation. While decisions about medication fall within the remit of a health and welfare attorney, the attorney must be guided by the principles of the MCA 2005, including Principle 4: "*An act done, or decision made, under this Act for or on behalf of a person who lacks capacity must be done, or made, in his best interests.*" ML requested changes to Colin's medication that the care team agreed with, particularly as she wanted to also discuss these with Colin's children. It was therefore appropriate for the temporary pause in medication titration to be made.

3.274 As required clonazepam was given to Colin on nine occasions between 24 June and 5 July for agitation, with verbal assurance and de-escalation also being required. This was in line with prescribing instructions given.

Care planning and risk assessment

3.275 An initial assessment was completed by the care home staff on Colin's arrival. This included physical observations with completion of a Waterlow score[93] (low score but at risk for skin breakdown), Malnutrition Universal Screening Tool[94] (MUST) assessment (low risk of malnutrition), continence assessment and choking risk assessment (low risk); however, the prompt for body mapping was left blank. Records show that staff attempted to complete the mapping that evening but Colin was asleep. A body map was completed on 22 June showing "*dry scabs*" to Colin's upper left and right arms and redness above his right hand.

3.276 Fluid balance and food intake charts were commenced in line with the care home's expected practice; Colin had episodes of confusion and could not be relied upon to feed and hydrate himself sufficiently. Although some of these charts were incomplete, most indicate an adequate oral intake.

3.277 Care plans were also written for Colin (although not all dates of initiation or frequency of review were stated). These included:

- the promotion of a safe and therapeutic environment for Colin, with his love of football, being active and sociable captured within the plan and the need to find suitable diversional activities in liaison with the activities coordinator; and
- the promotion of his safety and wellbeing with reference to the bouts of violence, aggression and suicidal ideation.

[92] An FP10 is a prescription pad used by GPs and independent prescribers.

[93] The Waterlow Score is a method for assessing a patient's risk of developing pressure ulcers. It involves evaluating seven key factors that contribute to pressure ulcer formation.

[94] The 'Malnutrition Universal Screening Tool' was developed by the Malnutrition Advisory Group. It is the most commonly used screening tool in the UK.

3.278 It was helpful for staff to have these plans, and we can see evidence of staff trying to engage Colin in conversations and activities which may have helped to reduce his stress, although there were still occasions when his behaviour had to be responded to with the administration of medication.

3.279 Colin was also assessed by the DIST with consideration of relevant risk information, including suggesting a ground floor placement given previous statements by Colin about jumping from a window. However, Woodland View advised that the only rooms they had suitable for Colin were on the first floor and this was where Colin remained throughout his stay.

3.280 A comprehensive initial plan was developed by DIST within the MDT prior to their first visit to see Colin. This related to medication titration, communication with the care home regarding side effects, physical health monitoring, confirmation of LPA, consideration for DoLS and gathering of history. Colin's case was then discussed in the DIST multidisciplinary team (MDT), and a management plan agreed.

3.281 After this meeting, EPUT DIST Doctor 1 contacted ML by telephone to introduce himself and to enquire about Colin and gather more information in line with the plan that had been agreed. Physical health monitoring by the care home staff was, however, inconsistent and we can see no evidence of a capacity assessment being completed by the DIST so that a DoLS application could be made by the home.

3.282 In relation to care plans, there were two core care plans from DIST that were retained by the home:

- one was for protected characteristics, but these were not specified or relevant to Colin; and
- the other was a 72-hour consent and COVID-19 care plan, but the actions did not support achievement of the goals and there was no individualisation for Colin's needs.

3.283 There were no further care plans from DIST which would have supported the care home staff to understand the triggers for Colin's agitation, or to mitigate and manage the risks of violence and aggression. Other risk plans were, however, regularly updated within the team's electronic records. The care reviews included risk descriptors (such as evidence of neglect/vulnerability, physical health issues, hazards, violence and aggressive behaviours) with risk plans and management strategies supporting these domains. These included that Colin seemed to become agitated mainly in the mornings, early evening and after he was visited, but it is not clear how this was communicated to the staff caring for Colin or to ML, what the plans for mitigation were and whether these were aligned to the care plans described above for the promotion of a safe and therapeutic environment for Colin and the promotion of his safety and wellbeing.

<u>Behaviour and presentation – MCA and safeguarding</u>

3.284 Colin was accepted for a respite placement at Woodland View but without a full assessment being undertaken to ensure that the home could manage his care needs. Colin was a 'self-funder', so the usual local authority care assessments had not been completed. Face-to-face assessments were also impacted by COVID-19. ML had a conversation with the unit manager by telephone but the teams that had been involved in his care (such as Goodmayes Hospital and the DISS) were not consulted about his care needs, and there was no handover requested to ensure that staff at the home were able to keep him safe physically or during periods of distress.

3.285 We have now seen the criteria/policy for acceptance and were told that episodes of violence and aggression would have been a red flag and acceptance would have to have been considered on an individual basis. The unit manager said she had been told that Colin had been discharged from Goodmayes Hospital as he had not had any periods of aggression for a period of time. Colin's last recorded episode of violence and aggression had, in fact, been on the night of 13 June (only four days before discharge) when he had punched a member of staff in the jaw, but with multiple incidents reported before this. The risk assessment for Colin that was documented on 15 June at the ward round and in his discharge letter confirmed that he was a high risk to others (due to unpredictable unprovoked physical aggressive and violent behaviour) and was at high risk of

absconding (as he could become confused and disorientated, particularly in the evening). Had the care home been fully aware of Colin's history and previous incidents, good practice would have been for them to clarify his care needs before accepting him. A conversation with staff from Stage Ward at Goodmayes Hospital and the DISS would have supported the home to an informed decision about his suitability and whether they could meet his care needs while also maintaining the safety of other residents and staff.

3.286 On acceptance, Colin was thought to have variable capacity (although there is no record of how this was assessed), so he was admitted to a residential dementia bed on the first floor of the building rather than to the general residential community which was on the ground floor. Access was restricted by use of locked doors with keypad entry codes; however, a mental capacity assessment was not completed and there was no application made to the local authority for a DoLS authorisation despite Colin repeatedly asking to go home and trying to leave.

3.287 On 23 June, EPUT DIST Consultant Psychiatrist 1 emailed EPUT DISS Consultant Psychiatrist 1 asking for their perspective on the management of Colin, and whether the Alzheimer's disease diagnosis was provisional. They included that they were having trouble reading the clinical notes as the DISS used SystmOne while the DIST used Paris. They also requested similar information from EPUT Consultant Psychiatrist 1 but additionally asked if the Alzheimer's disease diagnosis that they had given had been discussed with Colin's family. This was an example of proactive interagency communication, but would not have been required if a timely, written handover/discharge summary had been available from the DISS.

3.288 On the afternoon of 23 June, EPUT DIST Doctor 1 visited Colin at the care home. After they left, Colin became agitated, wanting to organise a taxi, as he was concerned that someone at home was unwell.

3.289 On 26 June there was an incident where Colin had been shouting after his daughter had visited. He tried to hit a member of staff, who had to seek refuge in the ward office. We understand that an incident form was completed, although this has not been shared with us. Colin accepted oral clonazepam, but the home were concerned about what actions they would need to take if further incidents occurred. They called the DIST at 3.15pm and were told by the DIST nurse that clonazepam could not be given again until 5.30pm (it had already been given at 1.30pm). They advised that if care home staff were unable to keep him safe and he continued to be agitated and/or aggressive to contact emergency services (999).

3.290 This was inadequate advice to be giving the home. The call was made during the operating hours of the DIST, who should have undertaken an urgent assessment to determine his risk to self and others and if necessary completed a MHA assessment and/or moved Colin from the home.

3.291 On 27 June the DIST repeated the request for daily physiological observations to be taken and behavioural charts were left with staff to complete with a request to document all distressed behaviour and to call the police if Colin attacked staff. This again was poor advice. If Colin became violent during DIST working hours, they should have assessed Colin and made (and recorded) a decision regarding admission to hospital or an alternative placement.

3.292 Colin was also described as showing a lot of aggression about being "*locked up*" and was constantly asking to go outside later that day, but there is no evidence that the care home considered a DoLS application at that time. DIST staff reminded the home of the importance of a DoLS application on 29 June (eight days after Colin's transfer) so were aware that Colin was being unlawfully deprived of his liberty, which was in breach of his human rights. While it was not their responsibility to submit the DoLS application, they should have submitted a safeguarding form to the local authority to inform them of this breach in line with their safeguarding policy which states:

"*A safeguarding referral must be made in all cases where a person in a care home or hospital ward (who is not detained under the MHA) is deprived of their liberty and where a DoLS application has not been made.*"

3.293 On 1 July, Colin pushed the emergency button and left the care home. He returned when asked by staff but was agitated, so clonazepam was given. When called at 11.25am, the DIST nursing assistant again told staff to call the police if he became physically aggressive. Colin was not on a DoLS and was therefore '*detained de facto*'[95] and without a legal framework. If violent and aggressive, Colin needed assessing for suitability of the placement and moving either to a hospital ward or an alternative placement under a legal (MCA/MHA) framework. A DoLS application was eventually made on 2 July.

3.294 In relation to these behaviours, behavioural charts were completed from 26 June to 7 July and these included hourly updates about whether Colin was asleep, awake but calm, restless but not disruptive, restless and agitated, verbally aggressive and physically aggressive. These were the behavioural charts that DIST had referred to, but we can see no evidence of any episodes of aggression being recorded, with Colin being largely calm or restless (but not aggressive).

3.295 During this episode of care there were regular communications between the care home and ML, and also between the DIST and ML, with updates from the DIST being sent in writing to avoid any misunderstandings. There are also records of a detailed conversation with ML regarding behaviour suggestive of 'sundowning'.[96]

3.296 There was, however, some confusion in relation to the home serving notice on Colin. ML understood that the DIST had visited Colin and told the home that he was not suitable for their care; however, it was actually the home who confirmed their action to the DIST. There had been no recent episodes of violence and aggression, but Colin had periods of restlessness and agitation on a daily basis. This was clarified with ML and a meeting was held on 30 June with ML, Colin's daughter, the DIST nurse and two social workers to discuss ongoing care arrangements.

3.297 Colin had been receiving hourly checks from staff from arrival at the care home but (privately funded) one-to-one care was commenced after this meeting. We have been unable to determine the level of support offered by the social worker or whether a Care Act assessment was completed in order to obtain the necessary and correct level of support for Colin.

Anisha Grange Care Home/NELFT Dementia Crisis Support Team 7 July – 21 July 2021

3.298 Anisha Grange is a care home located in Billericay, Essex. It provides residential, nursing and dementia care services for older adults.

3.299 The North East London NHS Foundation Trust (NELFT) Dementia Crisis Support Team provides support for people with dementia/cognitive decline and their carers or care providers to manage a period of crisis and avoid possible admission to hospital where possible. They are a short term (up to six weeks) team to support the person/s through the period of crisis and refer on to appropriate long-term teams or back to their main care provider; for example, GP, care home, community mental health team or social care.

Anisha Grange Care Home (Hallmark Care Homes) and the Dementia Crisis Support Team (NELFT)

3.300 Colin was transferred to Anisha Grange Care Home from Woodland View Care Home on 7 July 2021.

3.301 An urgent application for a DoLS authorisation was made by the nursing home on acceptance to their residence.

3.302 On 8 July Colin was referred by the Anisha Grange Manager to the Dementia Crisis Support Team (DCST).

[95] De facto detention is when an individual is in theory free to leave an establishment but in practice cannot do so.

[96] https://www.dementiauk.org/information-and-support/health-advice/sundowning/

3.303 On 14 July, the DIST sent the GP a discharge letter which included information about his care and treatment and also medications. A letter was also received from the NHS continuing healthcare (CHC) team confirming that Colin was on their waiting list for an assessment.

3.304 On the night of 14 July, Colin became agitated, wanting to go home. He left through a locked door with force, punched a member of staff in the stomach and threatened them with a wooden stick. He settled after speaking with ML on the phone.

3.305 On 18 July, Colin became agitated in the evening and threw a cup down the corridor. The home contacted 999 due to Colin's behaviour towards staff, and they advised calling NHS 111 as he was calm at that time. NHS 111 advised the home to contact 999 immediately if a similar event occurred.

3.306 On 20 July, Colin became agitated, once more wanting to go home. He was given three doses of clonazepam, with poor effect, so the home staff contacted NHS 111 to ask for advice. They were told to give one more dose of clonazepam overnight and to discuss with DCST the following day.

3.307 On the same day, the GP sent an urgent cardiology referral, given that there had been no follow up since Colin's discharge from hospital.

3.308 On 21 July, Colin left through a garden gate and left the home, and police were called. Police returned Colin to the home and stayed until paramedics arrived to review him. Colin was taken to Basildon Hospital due to abnormal findings on his ECG.

Commentary on this care episode and points for learning

Physical health

3.309 We have seen no evidence of Colin's physical health being an area of concern during his stay at Anisha Grange, although on his admission, a query was raised by ML about his weight. ML noted that he had lost weight ("*by one to two stones easily*") in the last few weeks and that she would like this to be closely monitored. Colin's weight was recorded by the staff as 91.9kg (this had remained relatively static through his healthcare journey thus far) and he was assessed as being at low risk of malnutrition using the Malnutrition Universal Screening Tool (MUST). His care plan noted that he could eat and drink independently and that his weight would continue to be monitored (although the frequency was not specified). This was appropriate given his presentation.

3.310 In relation to physiological observations, Colin's temperature and oxygen saturations were recorded most days to determine early signs of respiratory distress, due to the COVID-19 restrictions.

3.311 The Anisha Grange care plan indicated that his blood pressure needed monitoring once a month, but physiological observations were also recorded by the DCST. On 10 July, the DCST recorded a sitting blood pressure of 134/98 [97]and a standing blood pressure of 119/91. These readings indicated a high blood pressure. On 11 July, at 7am, Colin's blood pressure was recorded by the care home night staff and found to be 169/130 sitting and 162/110 standing. This was checked again at 10am and showed a reduction to 106/61. A reading of 139/109 was recorded in the DIST notes following a telephone call with the care home. Some of these readings were significantly elevated but there was no indication of action to be taken in response to this although re-checking the blood pressure later in the morning of 11 July was good practice. Colin's BP was not recorded again by the care home despite these variances and Colin being known to have hypertension and heart failure (being treated with medications). The DCST did, however, record his blood pressure on their home visits on 14 and 16 July and the readings were within normal range (104/71 standing and 95/48 sitting, then 120/65 sitting and 103/70 standing, respectively). We can see no evidence of the very adverse readings being escalated by either Anisha Grange or via the DCST to the GP. Colin had been hypertensive and was receiving medications aimed at reducing his blood pressure. Medical reviews should have been requested but were not.

[97] Blood pressure is recorded with two numbers. The systolic pressure (higher number) is the force at which the heart pumps blood around the body. The diastolic pressure (lower number) is the resistance to the blood flow in the blood vessels between heartbeats.

3.312 The discharge letter was sent by the DIST, who had been caring for Colin at Woodland View Care Home, to Colin's new GP on 14 July (seven days after his transfer from Woodland View). This included that Colin had yet to be followed up by cardiology since his discharge from Broomfield Hospital and that this would need to be reviewed as he had moved multiple times since then. An appointment with cardiology was arranged but for three weeks hence, which was an expected response time.

3.313 Further to this, there were several documented entries by DCST about Colin's cardiac function. It was noted that the GP had requested an ECG to be undertaken while Colin was at home but that he had been too tired to attend the appointment, which was cancelled by ML. On 12 July the DCST asked for an ECG to be arranged (this was completed on 14 July). On 16 July, this was noted by the team doctor (name removed) to be "*unremarkable*", although on 20 July the documentation indicated that the results were abnormal (details not specified). The team noted that a cardiology opinion was being sought due to the potential requirement for commencing antipsychotics (risperidone), which could further impact Colin's heart.

3.314 ML was informed of the potential antipsychotic treatment options for Colin by the DCST, and on 21 July she requested an immediate cardiac review. The DCST and care home teams had explained to ML that their concerns were in relation to potential medication options, but it appeared that ML had gained the impression that there was something wrong with Colin's heart at that time. ML threatened to remove Colin and take him to hospital but also said she would seek a private cardiology opinion for Colin, if required. When staff would not email a copy of Colin's ECG report to her, she made reference to "*turning to the power of twitter*". A professionals meeting[98] was arranged for 22 July, but Colin had been admitted to hospital by this time.

Medications

3.315 While at Anisha Grange, Colin received all prescribed core medications, although his memantine was not commenced until 12 July due to unreliable information from the previous care home. Initial calls were made to the DIST, as medication and administration charts transferred with Colin did not match and the current doses for clonazepam and memantine were not clear. While a summary was obtained from the GP, the memantine was not being supplied by them as this had been initiated by the previous DIST doctor (memantine can only be supplied by a psychiatrist initially). On 9 July, NELFT DCST Doctor 1 had prescribed memantine 5mg daily with a plan to increase in two weeks' time, and as required clonazepam 0.5mg up to three times daily; however this was not administered until three days later. This dose was despite Colin having been on 10mg memantine daily from the end of June and this being included on the referral form from Anisha Grange, which also stated that ML had asked for this to be capped at 10mg.

3.316 In addition to his core medications, Colin was prescribed clonazepam 0.5mg as required for agitation up to three times daily with five hours between doses, when reviewed by the DCST on 9 July. This was to allow trends to be identified which might help with a prescription of more regular medication. Initially, the clonazepam was not required as, although restless, there had been no adverse events involving Colin nor periods of violence and aggression; however, on 14 July he became increasingly agitated. His medication was changed over the phone on 16 July by the DCST who commented that the 'as required' medication had not been used to maximum levels and should be given on a more timely basis (namely, when Colin started to become restless rather than fully agitated). An additional instruction included that he was to be given a regular dose of 0.5mg clonazepam at 4pm each day on 16, 17 and 18 July to prevent increased agitation in the evening over the weekend. This was to be reviewed on 19 July, but we can see no evidence of this review taking place (although the introduction of risperidone was referenced) and the increased dose continued to be given.

[98] Professionals meetings provide an opportunity for the healthcare professionals involved with an individual/family to come together not only to share information, but also to help determine the direction of a case and agree a plan moving forward.

3.317 On 18 and 20 July, Colin was increasingly agitated, and use of the clonazepam became more frequent. Advice about administration was sought from NHS 111 on one occasion as staff were concerned about the doses being given, but this medication was given on two other occasions without waiting for the prescribed interval of five hours. This can be seen in the table below:

Date	Time	Medication	Rationale for giving medication
18/7/21	3.43pm 9.36pm	Clonazepam 0.5mg Clonazepam 0.5mg	Regular 4pm dose (given early) Agitation
19/7/21	2.38pm 7.15pm	Clonazepam 0.5mg Clonazepam 0.5mg	Agitation Agitation
20/7/21	12.18am 8.37am 4pm 6.33pm 10.51pm	Clonazepam 0.5mg Clonazepam 0.5mg Clonazepam 0.5mg Clonazepam 0.5mg Clonazepam 0.5mg	Agitation Agitation Regular dose Agitation Agitation
21/7/21	9.07pm	Clonazepam 0.5mg	Agitation

3.318 Anisha Grange staff and managers escalated their concerns about Colin's agitation and the requirement for these medications to be administered to the DCST who discussed the potential requirement for additional medications (risperidone); however, a cardiology opinion was required given Colin's cardiac history, in line with NICE guidance. Colin was admitted to Basildon Hospital before this could be further considered.

Care planning and risk assessment

3.319 On admission to Anisha Grange, a full life history and 'All About Me'[99] booklet were completed with Colin in line with good practice. This was detailed and well-completed, including additional information from Colin's son and partner. Staff also completed an urgent referral to the DCST for their catchment area. We can see no evidence of a written discharge summary from the DIST who were supporting Colin at Woodland View being received, although notes on 9 July indicate that some information had been received from them about his care journey.

3.320 Initial care plans and assessments captured Colin's support needs and risks to self and others, with clear guidance for staff. There were care plans relating to constipation, heart failure (noting anticoagulation therapy), medical monitoring, mental health and wellbeing. Areas of potential concern for Colin were comprehensively captured and included the impact of COVID-19 visiting restrictions and not having personal pictures in his room (as this indicated a permanency, causing him distress and anxiety). 'Sightings' charts were also commenced. These required staff to note the location of Colin at set intervals and to describe his behavioural presentation.

3.321 On 16 July, funding by ML was agreed for one-to-one staffing to support Colin. A care plan was initiated in line with good practice and included helping Colin to remain active, engaging in physical and diversional activities which he enjoyed and was skilful at, and suggesting topics for conversation from the work undertaken on his life history.

3.322 Staff at Anisha Grange had completed a formulation regarding Colin's compulsion to try and leave, including themes and behaviours. They had noted him looking over fences in the gardens and trying codes on keypad locks. On 19 July, Colin left the building through a series of doors and an emergency exit, before jumping over a fence. He had been seen by a member of the estates staff who, along with a student nurse, stayed with Colin until he could be taken back to the home. Staff liaised with the DCST about future plans, including alternative medication, and it was noted that the

[99] 'All About Me' is a booklet with information about a person living with Alzheimer's Disease or another dementia. Sections are designed to help someone new to supporting the person to get to know them better. It outlines usual habits, daily routines, likes and dislikes.

DCST were arranging a multidisciplinary professionals meeting regarding Colin's placement for 22 July. Staff also requested an assessment under the Mental Health Act (MHA) due to Colin's increasingly risky behaviours, but this was not actioned by the DCST before Colin was admitted to hospital on 21 July (see comments below).

Behaviour and presentation – Mental Capacity Act and safeguarding

3.323 The Anisha Grange Manager assessed Colin at Woodland View on 6 July. His son was present with him, and information was also sought from the current placement staff. It was noted during the assessment that Colin wanted to get better and return home but that he also felt that he would rather be dead than living in his current position. The Dementia Care Manager assessed that Colin was orientated to time, person and place but did not have capacity to agree to care or accommodation at Anisha Grange (although it is not clear how this was assessed) and that a DoLS authorisation would be needed. ML was notified that this would be required in line with expected practice and an application to the local authority was completed.

3.324 Colin was referred to the DCST by the Dementia Care Manager who called the team to inform them of Colin's move to the care home. DCST staff did not have access to information from the previous DISS (as they were under a different trust), or the recent admission at Stage Ward (these services were provided by NELFT, but they used different records systems), and we can see no evidence of a formal handover or discharge summary being received from the DIST on transfer.

3.325 Colin was reviewed by NELFT DCST Doctor 1 on 9 July. The doctor had invited ML to be in attendance at the review in line with good medical practice but had received no reply from a message left on her phone. On examination they documented that Colin was disorientated in time and place. He scored 17/30 on a mini mental state examination (MMSE)[100]. The doctor noted an impression of "*dementia possibly with some elements of delirium due to frequent change in recent accommodation/environment*" with a medium risk of wandering and a low risk of physical/verbal aggression, self-neglect, suicide, self-harm and falls. The latter was despite a history of violent and aggressive incidents at Broomfield Hospital, Goodmayes Hospital and Woodland View Care Home. The plan was for clonazepam to be given up to three times daily, memantine to be introduced (see comments in the medication section), and that he would benefit from an ECG the following week (due to medication regime and underlying cardiac history). ML was informed of the review via a telephone call later that day.

3.326 Colin was placed on the red caseload[101] for the team, which meant that his case would be reviewed each day.

3.327 Behaviour charts were completed from 10 July at the request of the DCST with details of incidents, timings, any antecedents and additional information. These were completed in detail by staff. While we can see no evidence of a formal review of the documented information by the DCST, there are several references in the care home progress notes to themes being identified in Colin's behaviours including increased agitation after visits/calls from his family (as he wanted to go home) and in the evenings.

3.328 On 11 July, ML asked the home if a mental capacity assessment could be undertaken for Colin in relation to his finances, as she needed to register a power of attorney against the operating mandates for his bank accounts to pay for his care. As it would not have been appropriate for the care home to complete this assessment, the Dementia Care Manager requested an assessment by the GP who noted that an independent mental capacity advocate (IMCA) may need to be involved, although we can see no evidence of a referral being made. The GP declined to undertake the

[100] The mini mental state examination is a commonly used set of questions for screening cognitive function. Scores of 25 to 30 out of 30 are considered normal, while 21 to 24 is considered as mild impairment, 10 to 20 as moderate and below 10 as severe impairment.

[101] A zoning system is used to ensure that service users receive appropriate levels of support while they are using community mental health team services. Patients are split into red, amber and green zones and are discussed in a daily morning meeting to ensure management plans are in place.

mental capacity assessment due to the complexity of the case and noted that they would write to a geriatrician/memory service as a matter of urgency to undertake this task.

3.329 As mentioned in previous sections of this report, an LPA for property and financial affairs was registered for Colin on 8 February 2020. This named ML as the sole appointee but stipulated that she could only make decisions on Colin's behalf when he was deemed not to have mental capacity. An assessment was therefore required in relation to whether Colin had the mental capacity to manage his finances. ML asked the care home to undertake the assessment in good faith (as she had done with Broomfield Hospital, Goodmayes Hospital and Woodland View Care Home) but rather than this being requested of the GP, this should have been directed to Colin's social worker (particularly as the GP was unknown to Colin at this time). We can see no evidence of this assessment being completed before Colin's admission to hospital on 21 July. This was frustrating for ML and would have caused additional anxiety given the costs of Colin's care.

3.330 Further handover information was requested from the EPUT DIST on 12 July. The records show that a local GP registration was yet to be made. Provisional plans by the team were for potential discharge to the home address later that week, if Colin remained settled. There is no indication that this was discussed with ML or was her wish. The DCST were under the impression that Colin was admitted due to crisis and suicidal ideation, but it is not clear where this arose from, and may have been confusing to Colin if conversations were had with him in this regard.

3.331 During this period, the care home was struggling to manage Colin's frequent calls to family members throughout the day, whereupon he would be given different feedback about going home, which increased his agitation. Staff at the care home took the lead in arranging meetings with the family initially and with the team to ensure consistency in approach, although it was recorded by the DCST that ML was unable to adhere to the plan that had been arranged which was for her to speak with Colin twice daily at 11am and 4pm. She was speaking to him outside of this arrangement and it was noted that the calls were distressing Colin, as he then wanted to go home. However, ML has told us that she did not comply on only one occasion. Also that he was not meant to have his phone other than at these times so should not have been able to call her (we note that the home have said that there was never an agreement to remove Colin's phone from him as this would distress him too much). There is no record of this being further discussed with ML or of her reasons for the perceived non-compliance with the plan being discussed.

3.332 In addition to occasions when Colin became agitated, there were two more serious incidents involving violence and aggression. The first was on 15 July when he packed his bags and was looking to leave the home. He then breached a security door, punched a carer in the stomach and threatened staff with a wooden stick. The second was on 18 July at 10.30pm, when Colin threw a mug, which smashed, across the corridor at another resident's door, he punched a member of staff, and then started opening other bedroom doors. These incidents were reported within the home and to the duty team in line with the requirements of the care home's safeguarding adults policy. Although no specific harm occurred to another resident, it would have been good practice to also document whether there had been discussion or consideration of an adult safeguarding referral given the levels of violence displayed by Colin.

3.333 The DCST visits to review Colin were undertaken on 9, 10, 12, 14, 16 and 18 July. On the other days, telephone consultations took place with care home staff. Timely entries were made around contact with ML and in response to incidents while Colin was at Anisha Grange; however, the DCST responses and advice were not always helpful to the staff on duty. On 15 July, the care home called the DCST, asking for as required medication. A home visit was undertaken the following day, and it was agreed that clonazepam would be administered at 4pm each day over the weekend in addition to the as required doses. No other contingency plans were offered.

3.334 On 19 July at 1.50pm, the care home phoned the DCST, stating they had a crisis with Colin who had absconded from the building, had three episodes of distress and had been physical towards members of staff. Clonazepam had been given three times a day but was ineffective and his episodes of agitation had no visible trigger such that the clonazepam could be used in a different

way, as it was not to be given regularly. They requested attendance from a doctor to prescribe alternative/additional medication but were told that the team were awaiting feedback from a cardiologist about the potential for starting an antipsychotic (risperidone) given his cardiac history.

3.335 At 3.07pm, the DCST received a call from Colin's social worker who asked what the DCST were doing to support the home. They also noted that the care home were requesting a MHA assessment due to Colin's presenting risks. It was acknowledged that ML was "*against this due to personal view which may be in conflict with what is in [Colin's] best interest*" and that there may be the potential for a professionals meeting to work together in managing the risks, but no immediate action was taken in relation to the request from the home.

3.336 There was further discussion with ML on 20 July specifically about the possibility of admission to hospital to start alternative medication and to ensure monitoring given his cardiac conditions. ML stated that when Colin was discharged from hospital he was covered in bruises, and they had involved the police. In a later note that day there is reference to ML being "*highly anxious that [Colin] will be sectioned*". A professionals meeting was to be arranged to discuss the options for Colin on 22 July. While this was good practice, the delay in arranging this was too long. Colin had assaulted two members of staff over the course of 15 and 18 July and had posed a potential threat to the other residents. He had a history of violence and aggression, and the home escalated that they felt this to be a crisis. A MHA assessment should have been requested on 18 July (or 19 July at the latest). ML's consent was not required.

3.337 At 6.25pm on 20 July, the care home phoned the DCST, saying that they had made the decision to give Colin his clonazepam at 9am, 4pm and 9pm but that Colin was becoming more agitated, packing his bags and trying doors to leave, so a dose had been given at 2pm. They were concerned that there had not been five hours since the last administration but also that the full amount of his medication would be used before the night (which was when he normally became the most agitated). They were told they could give an early dose if they felt it was justified and were then advised to call NHS 111 to ask a doctor if an additional dose could be administered, if that became necessary (which it did).

3.338 This was raised as a concern by the care home staff with the DCST the following day and was to be discussed in the professionals meeting on 22 July, but on the afternoon of 21 July Colin was out in the garden area with staff and started looking for a way to leave. He assaulted four members of staff who were with him and threatened another resident, walked through the building and then left through a garden gate and left. Staff members followed at a distance and police were called. Colin had walked through woodland including a stream, then walked in the road unaware of traffic and began to bang on the doors of houses. Staff actions throughout this incident were focussed on maintaining Colin's safety and preventing him from coming to harm. Police attended and returned with Colin to the home until paramedics arrived to review him. Colin was checked and paramedics advised he needed to be seen at the hospital due to abnormal findings on his ECG. A member of staff accompanied Colin to the hospital. We have seen no evidence of the police or paramedics having completed adult safeguarding referrals for this incident in line with their policies.

3.339 The decision not to complete a MHA assessment following the series of incidents of absconsion, violence and aggression at Anisha Grange from 15 July onwards were significant missed opportunities to safeguard Colin, other residents in the home and staff. The escalation of aggression to staff and determinedness to leave, along with an ineffective medication regime, would exceed the thresholds for most nursing home care. This DCST provided daily input, but their support was insufficient as Colin's behaviours escalated and concerns were raised by the care home. The serious incident on 21 July, where several staff were assaulted and Colin was at risk of significant harm as a result of his departure from the care home, could potentially have been avoided.

Basildon Hospital and EPUT Mental Health Liaison Team 21 July – 6 September 2021

3.340 Basildon Hospital is an acute general hospital in Basildon, Essex. It is managed by the Mid and South Essex NHS Foundation Trust.

3.341 The EPUT Mental Health Liaison Team (MHLT) work at the Mid and South Essex NHS Foundation Trust hospital sites. They provide specialist mental health care in the physical health setting, enabling the emergency departments and wards to assess, manage and support mental health problems as they present or arise among people being cared for within the general health pathway.

Emergency department 21 – 22 July 2021

3.342 On 21 July 2021, Colin arrived via an East of England Ambulance Service ambulance at the Basildon Hospital Emergency Department at 3.44pm.

3.343 A mental capacity assessment was undertaken at 7.15pm for the CT head scan which was to be conducted under sedation due to Colin's presentation.

3.344 At 7.40pm he became very violent and agitated. Intravenous (IV) diazepam 5mg was given.

3.345 Medical clerking for admission to the AMU was completed at 10.45pm.

3.346 Colin was transferred to the AMU (Osler Ward) in the early hours of the following morning (4.50am) on 22 July.

Commentary on this care episode and points for learning

Physical health

3.347 Colin was conveyed to the emergency department from Anisha Grange Care Home via ambulance. His family were aware that he had been taken to hospital but were not in attendance with him. There is reference to a 'carer' being present and we understand that this was a member of staff from Anisha Grange who remained at the hospital for the rest of their late shift. Anisha Grange also offered support to be available for the night shift. This was good practice.

3.348 Colin was triaged through ambulance streaming and sent through to a 'majors' cubicle[102], given his presenting condition. Abrasions were noted to his arms where he had fallen into a thorn bush. A CT head scan[103] was requested, which was appropriate, as he was noted to have hit his head when he fell and had been confused. It was documented that the nursing home (Anisha Grange) were not happy to take Colin back and that it was likely that a (social) admission under the medical team would be required.

3.349 Colin was clerked for admission by a middle grade doctor[104] at 10.45pm. This was seven hours after his initial attendance. They documented Colin's past medical, surgical and mental health history, including "*vascular/Alzheimer's dementia*". The clerking concluded that Colin had progressive dementia with aggressive episodes and that infection needed to be ruled out. The management plan included a urinalysis (results were normal), blood tests, CT head scan, chest X-ray (CXR), department of medicine for older people/mental health liaison review, IV fluids, and to discuss resuscitation status with the family. Promethazine was to be considered and apixaban withheld until the CT head scan ruled out a subdural haematoma. This was a comprehensive medical review. There were, however, some omissions in the documentation, and in particular, there is no evidence that an abdominal assessment was undertaken; alcohol consumption was left blank as was the mental state assessment, including information relating to SQiD and 4AT single assessment tool. This was despite Colin presenting as confused. It was documented that infection needed to be ruled out and it could be assumed that this was part of a delirium screen, but this was not specified, and we can see no evidence of a checklist being employed to ensure that all other causes of delirium were similarly to be ruled out, including, for example, constipation, dehydration, alcohol or drugs and medications. Colin was known to have dementia, but other causes of acute confusion may have

[102] Majors cubicles are where patients most likely needing admission are treated in an emergency department.

[103] Computed tomography (CT) of the head uses special X-ray equipment to help assess head injuries, severe headaches, dizziness, and other symptoms.

[104] Doctors in speciality training programmes are known as middle grade doctors.

been causing additional behavioural issues and the absence of these assessments may have limited the diagnosis, treatment and onward management strategies available to staff and Colin.

3.350 The plan also included the need to discuss Colin's resuscitation status with the family "*ideally should not be for resuscitation*", although the rationale for this determination was not documented. The doctor included that Colin was for resuscitation at this time, and referencing consultation with the family was in line with national Resuscitation Council guidance and the Trust's Do Not Attempt Cardiopulmonary Resuscitation Policy (2021).

Medications

3.351 Colin was on a range of regular medications when he was admitted to the hospital. These included bisoprolol, lacidipine, ramipril, apixaban, tamsulosin, senna, flutiform inhaler and memantine.

3.352 At 7.40pm he became very violent and agitated. IV diazepam 5mg was given in line with the Trust's Emergency Control of the Acutely Behavioural Disturbed/Excited Delirium Patient: Rapid Tranquillisation Policy (2021).

3.353 A medication chart was commenced during medical clerking which included the medications that Colin had been taking pre-admission; however, this contained a prescribing error which went undetected and remained on one of the charts that was shared with the investigation, although was changed on the other. Colin had been prescribed as required clonazepam at Anisha Grange, but the admitting doctor wrote "*clonazapine*". This was of some concern as this prescription may have been confused with clozapine, which is an antipsychotic only prescribed by secondary care mental health services with a requirement for strict monitoring given that side effects are common and can have a profound effect on a patient's ongoing physical health. They also prescribed prn promethazine but there was no qualifying statement either in the notes or on the prescription chart about when this would need to be given. We note that neither drug was administered during this episode of care, but the "*clonazapine*" was a material error that could have had serious consequences for Colin if given, and we have seen no evidence of this being incident reported as a 'near miss'.

Care planning and risk assessment

3.354 Nil relevant to this episode of care

Behaviour and presentation – MCA and safeguarding

3.355 When Colin arrived in the department, a CT head scan had been requested by the medics and a mental capacity assessment was completed to allow the CT head scan to be undertaken. This was in line with the requirements of the Trust's Consent to Examination or Treatment Policy and also the Mental Capacity Act (MCA). The concerns which triggered the assessment were that Colin may have intracranial bleeding following his fall, but the capacity assessment did not include a description about how the assessment was carried out, how the decision was made or about any interaction with Colin (or his family) in relation to this. The section about the potential requirement for an independent medical capacity advocate (IMCA) was left blank as was the section about the best interest decision and involvement of family or lasting power of attorney (LPA) (it was stated that "*a carer*" was with Colin but not who – we understand this to have been a carer from Anisha Grange).

3.356 Colin became violent and aggressive at 7.40pm. He had been in the emergency department for four hours. It is recorded in the progress notes that he was given IV diazepam and an incident form was completed (2361) by the nursing staff in line with the Trust's Policy for the Management of Incidents and Serious Incidents (2019); this was categorised as "*safeguarding adults – chemical restraint*". The form states that "*security had to be called and assisted*"; however, it does not include whether any physical restraint was also required. An incident form was not submitted by the security team to clarify events. Absence of this information will have limited the ability of senior managers to understand whether proportionate restrictions were placed on Colin when reviewing the chemical

restraint Datix incident form, and we can see no evidence of this information being requested during their review.

3.357 The Trust's Managing Challenging Behaviours of Adults and the Use of Restrictive Intervention Policy (2021) includes that "*While the patient is receiving chemical restraint they should be closely observed and have their physiological parameters assessed using the early warning score system as frequently as decided by the nurse in charge to ensure that any complications of the medications are detected immediately*".

3.358 The Trust's Rapid Tranquillisation Policy (2021) is more specific about the requirement for physiological observations to be monitored following sedation: "*monitor pulse, blood pressure, temperature and respiratory rate every 3-5 minutes for the first hour then hourly until there are no further concerns*". We can see no evidence of physiological observations being increased after administration of the diazepam. The policy recognises that patients may not be cooperative enough to manage a set of observations, and this may have been the case for Colin; however, non-contact observations such as respiration rate and pallor should, at a minimum, have been recorded to ensure there were no adverse effects of this medication.

3.359 The medical clerking at 10.45pm included that "MCA2" was in place. MCA2 refers to a form which is used to record actions taken to make a best interest decision. However, we can see no evidence of a best interest decision being documented. This terminology also demonstrates a lack of understanding by the assessing doctor: although a capacity assessment had been undertaken, MCA cannot be 'in place' as capacity assessments are only valid for a material decision at a point in time.[105] If capacity changes, or if the treatment needs to change, then new assessments, and subsequent best interests decisions, should be made.

3.360 The clerking doctor also included in the management plan that Colin should be referred to department of medicine for older people/mental health liaison team but with no reference to a referral to the Trust's dementia nurse despite documenting that Colin had progressive vascular/Alzheimer's dementia. Early referral to this practitioner may have allowed a greater understanding of Colin's care needs (and those of his family) and may have helped staff on the wards to employ a wider range of approaches to prevent and manage his episodes of violence and aggression.

3.361 Colin arrived in the emergency department at 3.44pm and was transferred to the AMU at 4.50am. The reasons for this extended stay were not specified in the clinical records, and we can see no reference to his nutrition and hydration needs being met, but the length of time spent in this busy emergency department and the transfer in the very early hours of the morning would have been detrimental and unsettling for him.

Acute medical unit 22 – 24 July 2021

3.362 Colin was transferred to the AMU (Osler Ward) at 4.50am on 22 July 2021.

3.363 Later that morning, Colin was reviewed on the post-take ward round (time not stated). The problem list and/or differential diagnosis referenced dementia but also delirium and confusion.

3.364 On 23 July, the consultant-led medical ward round (time not stated) noted that Colin was alert and orientated. Diagnostic tests were reviewed, and an echocardiogram and repeat blood tests were requested.

3.365 Colin was reviewed by the cardiology team. No further cardiology input was indicated as an inpatient, but a request was made for the GP to refer Colin to the cardiology clinic when discharged.

[105] https://assets.publishing.service.gov.uk/media/5f6cc6138fa8f541f6763295/Mental-capacity-act-code-of-practice.pdf

3.366 At 4.45pm, Colin became agitated and tried to leave the ward. The nursing staff called security to assist them. On their arrival, he became aggressive and in response they restrained him. During this intervention he headbutted and bit one of the security staff on their arm.

3.367 Colin was transferred to Florence Nightingale Ward on 24 July, again, in the early hours of the morning at 1am.

Commentary on this care episode and points for learning

Physical health

3.368 During Colin's two-day stay on the AMU, he was reviewed by medics on three occasions.

3.369 Colin was initially reviewed on the post-take ward round on 22 July (time unspecified). His National Early Warning Score (NEWS) was 2 (due to an elevated heart rate of 125 bpm) and he was found to be sitting on his bed "alert and orientated". The CT head scan results showed nil acute, but the ECG results indicated atrial fibrillation with multiple ectopics[106] and his troponin blood levels were 22.[107] His blood results were reviewed, his condition assessed, and a comprehensive management plan listed. This included an increased dose of bisoprolol from 1.25mg daily to 2.5mg daily for his heart failure. A collateral history was to be obtained and there was a request for an echocardiogram, a cardiology review, given his cardiac symptoms, an abdominal ultrasound scan (the reason was not stated, with Colin's abdomen described as soft and non-tender on examination) and PSA[108] levels (given the history of enlarged prostate). As with the emergency department, we can see no evidence of a checklist being employed to ensure that all causes of delirium were to be ruled out, including, for example, constipation (although if present this would have been picked up on the ultrasound that was ordered), dehydration (blood test results indicated this not to be the case), alcohol, drugs and medications. The 4AT single assessment form remained blank.

3.370 Colin was also reviewed on a ward round the following day. A treatment escalation plan (TEP)[109] was completed. This indicated that Colin was for resuscitation in the event his heart stopped. Physiological observations and diagnostic results (including blood tests, the ultrasound scan, CXR and ECG) were followed up in line with good medical practice and commented on with a request to triage him to the department of medicine for older people. Colin was transferred to Florence Nightingale Ward on 24 July. This was a care of the older person ward and appropriate for his needs, although the time of transfer at 1am was not in line with the Trust's Care of Patients With Dementia Policy (2020) and would have been unsettling for Colin (see presentation and behaviour section below).

3.371 The request for a cardiology review was responded to within 24 hours. This was a timely and responsive intervention. Colin was seen by a cardiologist on the AMU who reviewed the echocardiogram results and documented mild left ventricular dysfunction, atrial fibrillation, ventricular ectopics and moderate mitral valve regurgitation[110]. A clear management plan was documented in his medical records, with betablockers[111], ACE inhibitors[112] and novel oral anticoagulants (NOACs)[113] recommended with no requirement for further inpatient cardiology input.

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[106] An ectopic heartbeat is a type of arrhythmia (irregular heartbeat). It happens when the heart contracts (beats) too soon. This can lead to extra or missed heartbeats.

[107] Troponin levels may be considered high if they are above 22 nanograms per litre for men. The higher the troponin levels, the higher the likelihood of heart damage.

[108] This is a blood test that measures the amount of prostate specific antigen (PSA) in a person's blood; this can help diagnose prostate cancer.

[109] A TEP allows doctors to discuss with patients what treatment they would like if they become very unwell when in hospital.

[110] Mitral valve regurgitation is the most common type of heart valve disease. In this condition, the valve between the left heart chambers does not close fully and blood leaks backward across the valve. If the leakage is severe, not enough blood moves through the heart or to the rest of the body.

[111] Beta blockers are medicines that lower blood pressure.

[112] Angiotensin-converting enzyme (ACE) inhibitors are medicines that help relax the veins and arteries to lower blood pressure.

[113] NOACs directly inhibit key proteases (factors IIa and Xa). Indications of these medications are the prevention and treatment of deep vein thrombosis and pulmonary embolisms, and the prevention of atherothrombotic events in the heart and brain of patients with acute coronary syndrome and atrial fibrillation.

Medications

3.372 The prescription chart for Colin included that he had no known allergies/adverse drug reactions, and we can see no evidence of any being recorded in the GP records that have been shared.

3.373 Colin was on a range of medications and had been on apixaban prior to admission. This was appropriately omitted given the risk of intracranial bleeding; however, other medications such as tamsulosin, bisoprolol, lacidipine, flutiform inhaler and memantine were signed as not available and omitted on 22 July. The clonazepam transcription error was corrected but not dated, signed or instruction for use given. The promethazine was prescribed for agitation and discontinued but not dated; the rationale for this being stopped was not included in the medical records.

3.374 It is known that patients going into hospital with chronic conditions are particularly at risk from loss of symptom control and associated negative health effects resulting from omissions. Although not classified as critical within the Trust formulary, the medication risk factors section of Colin's drug chart included heart failure, Alzheimer's disease, atrial fibrillation and benign prostate hyperplasia[114] as high risk/critical medicine. The Administration of Medications Policy also states that drugs must not be omitted if unavailable and should be obtained without delay, yet Colin went without his core medications for three days in some cases (this included 24 July as Colin was transferred to the Florence Nightingale Ward without a supply of medications). Colin's physical observations were monitored and largely within normal parameters but omission of his regular memantine and the as required clonazepam, which had been given during his stay at Anisha Grange, may have adversely impacted his mental health. We can see no evidence of these prolonged omissions being reported as incidents.

3.375 Colin was given IM lorazepam when he became violent and aggressive on 23 July. This was in line with the Trust's Rapid Tranquillisation Policy (2021). The policy also requires physiological observations to be monitored following sedation. The lorazepam was administered at 4.38pm and monitoring was attempted at 6.14pm and 11.07pm, but no physiological observations were recorded. As a minimum, Colin's respiration rate and pallor should have been recorded through non-contact observations at regular intervals in the first hour and for the period of sedation if other observations such as blood pressure, temperature and pulse rate were disturbing for Colin (or declined) to ensure no adverse effects from this medication. This chemical restraint was not incident reported despite this being a requirement of the Rapid Tranquillisation Policy (2021). Absence of this information will have limited the ability of senior managers to understand whether proportionate restrictions were being placed on Colin.

Care planning and risk assessment

3.376 On arrival to the ward, an inpatient nursing and risk assessment document was commenced by a nurse at 5am. It was noted that Colin was "*pleasantly confused*".

3.377 The nutritional assessment score was calculated using the Malnutrition Universal Screening Tool (MUST), and the moving and handling assessment completed in line with expected practice. Colin declined to have his pressure areas checked but a body map and nursing records include that he had a cut on his forehead and bruising over his arms. However, many other sections of this nursing assessment document were left blank or incorrect. For example:

- The alcohol use assessment was marked as 'never', although we have been told by Colin's children that he did enjoy an occasional drink ("*a couple of pints in the pub*"). There is also reference on 24 August 2021 to ML telling staff about three episodes when Colin became aggressive to her through alcohol prior to his admission to Broomfield Hospital. ML was not present on his arrival to the AMU, but this information should have been sought when staff spoke with her (or Colin's son and daughter) on the phone soon after his arrival. This was

[114] Benign prostate hyperplasia is the medical term to describe an enlarged prostate, a condition that can affect urinary flow.

important information to collect because long-term drinking can cause confusion and cognitive decline.

- The frequency of bowel movements, and urinalysis charts, were also left blank despite constipation and (urinary) infection being a potential cause of confusion and delirium. This is particularly relevant for Colin who had an enlarged prostate, was known to have a history of constipation and had been prescribed laxatives (senna) to be taken at night.
- The absconder risk assessment did not include that Colin had a history of absconding, even though he had been admitted to hospital as a result of "*escaping*" from the care home, or that he had cognitive impairment, despite dementia being recorded. Although "*closely supervised in case of absconding*", these inaccuracies resulted in a medium rather than high risk score, which would have required an assessment for increased supervision, and a daily review of his absconsion risk.
- The Falls Care Bundle[115] says "*AMTS[116] performed, score 0*" although we can see no evidence of a documented mental test being completed.

3.378 The 24-hour nursing care pathway documentation was commenced and completed for each shift, with a comment about Colin being confused and a "*wanderer*". Progress notes indicate that Colin was "*closely supervised*"; however, we can see no evidence of an assessment to support whether he should have had any extra support (such as one-to-one[117] nursing).

3.379 The Trust's Care of Patients With Dementia Policy (2020) states that, on admission, it should be established whether the patient has a known diagnosis, and if so, the date of diagnosis and type of dementia must be documented. An alert should then be added to the medical records "*by system manage person [sic] request from clinical staff*". Although not specified, we understand that this person is the site dementia nurse. However, the date of diagnosis was not stated, and the dementia nurse was not notified of Colin's admission until seven days later (this was after his fall from the stairs in the cardiothoracic centre later in his care episode, and only to request a dementia alert being put on the system, not for review). Colin's Alzheimer's disease diagnosis had been made while at Broomfield Hospital in June 2021, but an alert was not placed on his record at that time, and even if this had been done, we have been told that alerts do not carry over from other sites. The dementia nurse should have been informed of Colin's admission to the AMU, particularly when it became apparent that he was prone to episodes of violence and aggression. Involvement of this practitioner may have helped staff to proactively manage his challenging behaviour and provide holistic person-centred care.

3.380 The Care of Patients With Dementia Policy (2020) also requires staff to establish what the patient's functional and cognitive baseline has been prior to admission: "*A life history needs to be obtained to enable effective care planning, and to provide effective occupation and stimulation.*" However, we can see no evidence of a collateral history being obtained despite this being requested in the medical notes on two occasions. The 'All About Me' booklet had not been shared by Anisha Grange Care Home and the Trust's 'This is Me' document was not commenced. This meant that staff did not understand the longevity of his symptoms, his baseline condition or his care needs. It also meant that staff did not understand the concerns that ML had about sedation and the reasons for these concerns (these related to the death of her son but also Colin's experiences in Broomfield). Collateral information is essential when dealing with a patient suffering with dementia and delirium. To have the knowledge of how long problems are persisting and what has worked in the past or not is highly important when planning a treatment programme.

[115] The care bundle approach to preventing falls has been found to be effective at delivering improvements in processes of care that are important not only for falls prevention but for a patient's recovery and wellbeing.

[116] The abbreviated mental test score (AMTS) was introduced by Hodkinson in 1972 to rapidly assess elderly patients for the possibility of dementia. The test comprises 10 questions. A score of 6 or less suggests delirium or dementia, although further tests are necessary to confirm the diagnosis.

[117] One-to-one nursing is a term used for a registered nurse or health care support worker whose role it is to provide one-to-one nursing or observation care to an individual patient for a period of time.

3.381 Following his admission to hospital, DCST notes include a communication from the team to the MHLT social worker at Basildon Hospital, enquiring about a referral for Colin but that this had not yet been received. The team member advised the social worker to check on the system and informed her that if no referral had been made to check with the emergency department or general wards to see if one was required. They included that the DCST consultant would be happy for the team to contact her for more information regarding the patient. The DCST phoned Osler Ward on two further occasions on 23 July and were told that there would be no referral to the MHLT until Colin was declared medically fit.

3.382 The communications from the DCST were a good example of proactive interagency working. It would have been helpful, however, for their risk assessments and care plans to have been shared with Osler Ward, as their activity charts indicated that Colin would be agitated mostly between 9 and 10am and later in the day between 3 and 5pm ("*possibly due to sundowning*"[118]) and also after a visit from the family: "*staff mostly manage this with distraction, de-escalation and also prn*[119] *medication*". Equally, the Basildon Hospital staff should have requested this information when called. The incident that occurred at 4.45pm on 23 July (and other incidents of absconsion, and violence and aggression thereafter) could, therefore, potentially have been predicted and appropriate management strategies adopted to better mitigate the risks of harm to Colin and staff.

3.383 The Care of Patients With Dementia Policy (2020) further includes that it is essential that information is collated, and assessments are completed, to ensure individualised care plans for patients with dementia. An observation care plan was initiated but this was not individualised for Colin, and evaluation included comments such as "*obs[ervations] monitored and recorded*" rather than any helpful commentary about these.

3.384 For this episode of care there was an absence of individualised care planning which, if in place, would have provided a person-centred approach to Colin. Its absence meant that staff were unable to fully understand and manage Colin's behaviour or care needs, including what might trigger Colin to become agitated, what staff should observe for, what staff needed to be aware of, or how specific situations were to be managed.

<u>Behaviour and presentation – MCA and safeguarding</u>

3.385 From admission, it was recorded that Colin was closely monitored in a bay on the unit which '*always had a member of staff in… in case he absconded*'. We can see reference to one occasion when ML was asked to come in and sit with Colin, but she declined as he had been '*violent to her'*. Nursing records indicate that activity charts were commenced but we can see no evidence of these within the information shared and, as stated above, we can see no evidence of an assessment to support whether he should have had any extra support or 1:1 nursing.

3.386 The Trust's Policy for the Management of Incidents And Serious Incidents (2019) requires all incidents of violence and aggression to be reported. We can see no evidence of the incident that occurred on 23 July being documented within the nursing or medical records and nursing staff did not complete an incident form, but details are included in an incident form submitted by the security team (2585). This describes that when they were called the doors of the ward were locked and they restrained Colin. The form states '*this consisted of one guard either side of the patient with one hand on the upper arm and the other hand on his wrist. The restraint lasted approximately five minutes*'.

3.387 The Trust's Managing Challenging Behaviours of Adults and the Use of Restrictive Intervention Policy includes that following any occasion where a restrictive intervention is used, whether planned or unplanned, a full record must be made and incident reported including:

[118] Sometimes a person with dementia will behave in ways that are difficult to understand in the late afternoon or early evening. This is known as 'sundowning'. During this time the person may become intensely distressed, agitated and may have hallucinations or delusions.

[119] Sometimes medication may be required to be given 'prn' (Latin phrase for 'pro re nata'), meaning 'when required'.

- the names of the staff and people involved
- the type of intervention employed
- whether the person or anyone else experienced injury or distress

3.388 Documenting the type and duration of restraint was therefore good practice; however, the names of staff were not included on the form, and it is therefore not possible to identify whether they had the required prevention and management of violence and aggression (PMVA) training or other relevant training to allow them to undertake this intervention. The Trust introduced Level 2 PMVA training for all security staff from March 2022 and are rolling this out to bank security staff, but this was after these events occurred. We understand that body cameras are also now in use.

3.389 We also note that there were no body checks after the restraint to determine whether Colin experienced an injury or bruising during the restraint, and it is unclear what legal framework was being used to restrain Colin. The form states that security were called to the department '*for an aggressive patient under MCA'* and that '*MCA was completed by AMU Team'* but a patient cannot be '*under MCA'* and we can see no evidence of a capacity assessment being undertaken on this ward. The MCA does allow for restrictions and restraints, but only if they are in the best interests of the person, and only if it is necessary and proportionate to do so. In this instance, if Colin had been assessed as lacking capacity and requiring a deprivation of his liberty, the ward should have completed a DoLS application. The hospital (as the managing authority) could have authorised this application for up to seven days, while making a standard application to the supervisory body (the local authority) at the same time. This process would have protected Colin and ensured his lasting power of attorney (LPA) and family were involved in the discussions around his care and treatment. A DoLS application to support these restrictions had not been made and we can see no evidence of a care plan being devised to manage his behaviour or a referral being made to the dementia nurse to assist with this. Notably, the incident report was copied to the dementia nurses for Broomfield and Southend Hospitals but not Basildon Hospital.

3.390 We also note that Colin had an LPA for health and welfare (his partner, ML) who should have been advised of the medication that Colin was prescribed and the plans regarding treatment, but we can see no evidence of the sedative regime being discussed with her. The lorazepam was given in response to an episode of violence and aggression and there would have been no time to consult with ML before administration. However, she should have been informed of the incident after it occurred and future prescribing discussed with her. As LPA, ML was within her rights to refuse medication on Colin's behalf. If the team disagreed with any objections that she might have then they had the option to consider using MDT/best interests meetings, mediation and referral to the Court of Protection. If they determined ML was not acting in Colin's best interests, they should have made a referral to the Office of the Public Guardian.

Florence Nightingale Ward 24 – 27 July 2021

3.391 At 1am on Saturday, 24 July 2021, Colin was transferred from the AMU to the Florence Nightingale Ward. This was a care of the older person ward with 27 beds. He was escorted by security and the nurse in charge.

3.392 Shortly after transfer, Colin started to become very aggressive and agitated. Security were called and they helped to de-escalate the aggression.

3.393 A DoLS application was completed at 2.30am.

3.394 On 25 July at 1.35pm, Colin became agitated, angry and aggressive and left the ward on two occasions. On the second occasion he was found hiding in a bush by his daughter.

3.395 At 2.35pm, a doctor completed a mental capacity assessment, although it is not clear what this was for.

3.396 Later that evening, Colin was walking round the ward and began to hit staff, threatened other patients and threw a computer to the floor. Security staff were already in attendance, but additional security officers were requested.

3.397 At 12pm on 26 July, Colin was reviewed on the ward round and deemed to be medically safe for discharge (MSFD)[120]. The documented plan included a referral to rapid assessment interface and discharge (RAID) and the dementia nurse.

3.398 At 7.10pm, Colin's social worker called the ward and explained that Colin should not be discharged without a clear and concise plan.

3.399 At 8.32pm, Colin was assessed by a locum nursing member of the EPUT Mental Health Liaison Team (MHLT). The plan was to arrange a review with his partner or daughter present and to liaise with his community psychiatric consultant/team to look at discharge planning.

3.400 On 27 July at 7.40am, ML phoned the ward and told the member of staff that Colin had rung her and said he would kill himself. She requested medication be given to him.

3.401 At 11.15am, ML contacted the ward and was asked to bring in her lasting power of attorney (LPA) document. She played a recording of him over the phone from the morning saying he wanted to kill himself. ML said she would be visiting and would like to see a doctor.

3.402 ML attended the ward and met with the ward manager and a junior doctor, as she was concerned for Colin's safety.

3.403 ML left the ward at about 3pm. Colin became agitated and ML asked the staff to call security. After ML left, he ran into Bay 1, grabbed a pair of craft scissors from a trolley and attempted to stab them into his abdomen. A member of staff tried to stop him, and they ended up on the floor. The scissors were taken away from Colin who then got up and ran out of the ward. Security were requested to attend urgently.

3.404 Colin ran to the cardiothoracic centre and up the stairs. He was seen by several members of staff who said that he leaned over the rail of the first-floor staircase landing and fell onto a glass table in the restaurant area, which shattered on impact. An emergency call was responded to by the trauma team.

3.405 Colin was transported to the emergency department and arrived at 4.01pm.

Commentary on this care episode and points for learning

Physical health

3.406 Colin was admitted to Florence Nightingale Ward in the early hours of Saturday, 24 July. He had no outstanding medical interventions that were required other than a 24-hour cardiac tape that had initially been requested as an outpatient, but this was changed (time unknown) to inpatient. His physiological observations were within normal parameters as were his blood results other than his troponin level, but he had been reviewed by cardiology who determined that no further inpatient input was required.

3.407 At the time of Colin's fall in the cardiothoracic centre, he had been in the hospital for six days; however, we can see no evidence of a comprehensive collateral history being proactively obtained from the family or other agencies who had been involved with Colin's care prior to his admission, despite this being part of the medical management plan from 22 July. A collateral history might include the patient's physical and mental health, social circumstances and functional abilities. Understanding what is 'normal' for the patient across these different domains is vital for making diagnoses and deciding ongoing medical and social management, particularly when presenting with dementia or confusion, but this was not obtained for Colin.

[120] MSFD is a term used for patients who no longer require care in an acute hospital setting.

3.408 It was documented that Colin was MSFD on the ward round on Monday, 26 July.

Medications

3.409 Colin became agitated on transfer to the ward. Oral and intramuscular (IM) haloperidol[121] were prescribed for agitation despite clonazepam having already been included on his drug chart. The oral dose of haloperidol was for 2mg but with no maximum interval or daily dose specified, which is poor prescribing practice. The IM dose was for 0.5mg every two to four hours with a maximum of 5mg to be given daily. We can see no evidence of this being administered, with security and ward nursing staff being able to de-escalate situations without the chemical restraint. It was also discontinued but the date of this being stopped is not included on the chart. Although referenced as an option on the Trust's Rapid Tranquillisation Policy (2021), along with the Initial Pharmacological Management of Agitated Behaviour Symptoms Arising from an Underlying Delirium in Adults guidance (2021), caution is required when prescribing haloperidol in patients with severe heart failure, cardiac arrhythmias, cardiomyopathy, and medications that prolong the QT-interval.[122] Haloperidol should not, therefore, have been the first choice of sedation given Colin's cardiac history; lorazepam should have been prescribed instead.

3.410 On 25 July, Colin became violent and aggressive on two further occasions. Lorazepam 0.5 - 1mg oral/IM was prescribed with confirmation that this could be given alongside clonazepam, but with no minimal interval specified. A 1mg dose was given IM at 3.50pm, and then once more on 26 July when Colin became agitated again. This prescribing was in line with the Rapid Tranquillisation Policy but could potentially have been avoided if the clonazepam had been administered more regularly; the prescription included that it could be given three times daily with a minimum interval of six hours but did not include any instructions for use. Clonazepam was administered only once daily on this ward, at 8.45pm on 25 July, 8.50am on 26 July and at 8.10am on 27 July.

3.411 The Rapid Tranquillisation Policy also requires physiological observations to be monitored following sedation being given: "*monitor pulse, blood pressure, temperature and respiratory rate every 3-5 minutes for the first hour then hourly until there are no further concerns*", but we can see no evidence of physiological observations being increased after administration of the lorazepam on either occasion. The policy recognises that patients may not be cooperative enough to manage a set of observations, and this may have been the case for Colin; however, respiration rate and pallor should, at a minimum, have been recorded through non-contact observations.

3.412 We also note that, although a requirement of the policy, the chemical restraints were not incident reported other than on one occasion when ML raised her concerns about the administration of lorazepam (2749), which meant that the effectiveness and proportionality of the restraints could not be reviewed.

3.413 Furthermore, we can see no evidence of Colin's capacity being assessed in relation to decisions regarding his care and treatment and it was not documented that he consented to these prescriptions. If Colin was deemed not to have the capacity to make these decisions, as attorney under LPA, ML had the right to refuse treatment, and if the team had disagreed, they needed to hold a best interests meeting, but we can see no evidence that ML was involved in decisions around medication, or that her opposition was discussed or considered within the appropriate framework of the MCA. This was essential given that ML was strongly opposed to the administration of certain forms of sedation, including haloperidol and lorazepam. As attorney under LPA, ML should have been consulted and involved in every step of Colin's care journey.

3.414 As before, Colin was on a range of other regular medications, many of which were unavailable on his transfer to the ward and omitted on 24 July. From 25 to 27 July Colin received the majority of his medications, although the administration of senna and ramipril on the evening of 25 July was left blank and the flutiform inhaler was unavailable for the duration of his stay.

[121] Haloperidol is an antipsychotic medication. https://bnf.nice.org.uk/drugs/haloperidol/

[122] A prolonged QT interval is an irregular heart rhythm that can be seen on an electrocardiogram.

Care planning and risk assessment

3.415 On arrival on the ward, we can see no evidence of the inpatient risk and assessment document being updated and many sections of this document were left blank for the duration of Colin's hospital stay (see comments in the care planning and risk assessment section of the AMU care episode).

3.416 An Increased Nursing Supervision Trigger Tool chart was commenced but the assessment criteria and risk reduction strategy sections were left blank. '*1:4*' (one nurse for four patients) nursing supervision was recorded, including for 25 and 26 July, although Colin's daughter had been told that Colin was on one-to-one increased nursing supervision after his absconsion on 25 July. We can see no evidence of this being the case. The nursing records include that the staff nurse looking after Colin "*was not to leave the bay [*of four patients*] as he needed close supervision and that if they left the bay someone would need to replace them*".

3.417 On 27 July, the activity chart indicated that Colin was being provided with '*1:2'* (one nurse for two patients) nursing supervision but not why this change had been made. In all cases, from 24 to 27 July the charts listed Colin's activities (for example, wandering round the ward, sitting out of bed, settled) but did not include what he was actually doing at these points to keep him settled or whether there was anything which prompted any adverse behaviours. In relation to the nursing intervention, this included '*1:4*' or '*1:2'* other than on the afternoon of 27 July when actual interventions were recorded (for example, talking to patient, trying to encourage him to stay in the bay).

3.418 We also note that on 27 July, a Free from Harm Increased Supervision Trigger Tool was commenced. This was slightly different to the Increased Nursing Supervision Trigger Tool that had been completed when Colin transferred to this ward, and it included a checklist of tasks which the other did not. Commencement of activity chart was ticked 'yes' as was completion of the falls care pathway; however, commencement of 'This is Me' was left blank and this important document, which would have helped staff to understand Colin's care needs, was not completed during this episode of care. The initial assessment section was completed, and this indicated that Colin required increased nursing supervision, although the level required was signed for in each case (namely, '*1:1', '1:2'* and '*1:3/4'*), which meant that staff would not have been clear about the levels of supervision that were required.

3.419 The Trust's Care of Patients With Dementia Policy (2020) describes some key principles for patients with dementia, requiring staff to liaise with family and carers to establish normal routines, to use 'This is Me' to personalise care, and to try to identify what triggers a patient's particular mood or behaviour and what interventions might help to resolve them. However, when staff were asked in interview about the purpose of activity/supervision charts, they all stated that they were used as a justification for additional staffing and were unaware that they can also be used as a means to identify patterns of behaviour, triggers or successful de-escalation strategies.

3.420 The dementia policy includes that it is essential to have individualised care plans for this cohort of vulnerable patients, yet there were no plans of care that would have supported staff to understand what might have helped to prevent or reduce Colin's agitation should it occur, and the entries on the enhanced supervision charts would not have supported staff to understand what these might be. Colin was on enhanced supervision throughout this episode of care but there was no detail about how staff could ensure that Colin's care needs were met, what staff should observe for, what staff needed to be aware of, how specific situations may be managed or how these observations were reviewed. As before, there was an LPA in place, but this was not referred to, and the attorney was not consulted or involved in any discussions around Colin's care plan.

3.421 As with the AMU, we can see no record of proactive communications with the dementia crisis support team (DCST) who had been supporting Colin in the community until a phone call was received by a member of the community team on 26 July. The nursing records indicate a very brief (and incorrect) summary of Colin's stay at Anisha Grange and included that ML voice recorded staff

without their permission. (The content of the ward records do not align to the notes of the DCST staff member who noted that they "*discussed how the aggression had been present throughout both care home placements. Shared DCST contact details and to contact us if need be*.") They said they would call back after Colin had been seen by RAID; however, we can see no evidence of any helpful management strategies being shared with the ward, such as how he might be distracted when he became agitated or what some of the triggers to his violent episodes might be.

3.422 The Trust's Managing Challenging Behaviours of Adults and the Use of Restrictive Intervention Policy (2021) includes:

"*Prior to using any method of restriction a systemic and planned approach should be taken. Where possible, decisions concerning the use of restrictive intervention should be discussed with the multi-professional team, agreement made and documented in the patient clinical record. A risk assessment and care plan should be completed to ensure that the restraint used is appropriate and proportionate to the calculated risk of harm … In services where hospital security staff may be needed to respond to emergency situations to assist in the management of violent or aggressive incidents, they should also adhere to the provisions of the Mental Capacity (Amendment) Act 2019 (MCA) as well as to the Skills for Security good practice guidance*[123]*… It is recognised that emergency physical restraint is sometimes necessary to prevent harm to the individual or others. If this is the case, it is recommended that as soon as possible a multi-disciplinary meeting is convened to discuss the approach to the behaviour and for there to be consideration given to what is permitted in the event of further incidents happening that necessitate restraint again*."

3.423 At the point of transfer to Florence Nightingale Ward, Colin had a history of violence and aggression (while at Broomfield Hospital, Goodmayes Hospital, at home, and in the care homes), had become violent and aggressive on two occasions within the hospital (once in the emergency department, and once on the AMU) and again became violent and aggressive after transfer. It may, therefore, have been reasonable to expect that episodes of this nature might reoccur. However, we can see no evidence of risk assessments or care plans being initiated for Colin on admission to the ward or in response to his further three episodes of violence, aggression and absconsion. We can also see no evidence of:

- a multidisciplinary team (MDT) discussion (supported by senior managers, senior security staff, the dementia nurse, the MHLT or family and LPA) or a best interests meeting to assist the ward staff in agreeing an approach to managing Colin's behaviour;
- Colin's care plan and risk/supervision assessment being reviewed and escalated after the phone call on 27 July when ML played the recording of Colin saying he would kill himself.

3.424 Earlier advice would have allowed the team to consider how best to manage these severe behavioural and psychological symptoms of dementia (BPSD), namely, his violence and aggression, with prescription of more appropriate regular medications as recommended by NICE. Failure to respond in a timely way meant that Colin, other patients and staff were exposed to risk and harm that could potentially have been avoided through more appropriate interventions and management strategies.

<u>Behaviour and presentation – MCA and safeguarding</u>

3.425 There are several lengthy entries in the medical and nursing records in relation to telephone conversations between ML and the ward staff. Face-to-face engagement was limited by COVID-19 restrictions but also due to the hesitation on ML's part to visit Colin given his violence towards her, historically.

3.426 Colin was transferred from the AMU to the Florence Nightingale Ward at 1am. This was despite the Care of Patients With Dementia Policy (2020) stating that patients with dementia must not be moved within the ward or between wards unless clinically indicated between 8pm and 8am. The

[123] The Trust and Niche have been unable to locate this guidance.

decision to transfer Colin had been made at the 5pm capacity review meeting on 23 July, yet he was not moved until eight hours later. As mentioned before, this would have been unsettling for Colin, and shortly after transfer, Colin started to become very agitated. Security were called and they helped to de-escalate the aggression, although they did not submit an incident form and details of the de-escalation techniques employed were not included in the incident form (2612) that was submitted by the nursing staff, which was reported under the sub-category "*security attendance for restrictive intervention*". The local Restrictive Intervention Review section of the Datix was left blank and the form closed without further questions being asked.

3.427 We also note that, although Colin was escorted to the ward by a member of staff from the AMU, no handover had been given prior to his move, despite this being a requirement of the Transfer of Patients (Clinical Handover of Care) Policy (2021). The absence of a handover and specific care needs of Colin meant that he was placed in a bed (Bay 4) which did not provide optimal supervision and sight by the nursing staff, and he had to be moved again to another bed (in Bay 2) which was opposite the nursing station and in better view of the staff. This will have been additionally disorientating for Colin but also disruptive to the nursing staff and other patients and was included as a concern on the incident form that had been submitted.

3.428 When Colin arrived on the ward, the AMU staff member told the receiving nurse on Florence Nightingale Ward, "*MCA and DoLS in place*", but when the nurse checked, they could find no record of a DoLS application having been made. They completed a standard DoLS application form (with an urgent application authorised for seven days, to expire on 31 July) in line with the requirements of the MCA; however, this was incomplete and did not include information about ML being attorney under LPA nor whether interested persons had been informed of the request for a DoLS application. The description of proposed restrictions was very limited and did not indicate how this amounted to a deprivation of liberty (for example, physical or chemical restraint, complete and effective control over the care and movement of a person over a significant period). We have seen no evidence of a plan of care being attached despite this being a requirement of the request. There was a comment about "*MCA in place*" under the Mental Health Act (MHA) section, which demonstrates a lack of understanding about the MCA and the MHA. The form indicated that Colin lacked capacity, but we can see no evidence of an assessment to support this assertion.

3.429 We note that an incident form (2751) was submitted by staff on 25 July in relation to verbal abuse from ML during several phone calls to the ward, including her stating that she should have been informed before '*MCA/DoLS'* were put in place. This assertion was correct; the hospital should have documented their attempts to consult her about the application and to advise when it was made. However, the phone recording evidence that has been shared by ML with us does not corroborate any verbal abuse of the staff by ML.

3.430 Also on 25 July, Colin became very agitated and aggressive and ran off the ward. Security were called and they returned him to his bed. ML was contacted by the ward staff and asked if she would come and sit with him, but she declined due to his aggression.

3.431 Colin left the ward on a second occasion (when the doors were locked). Security, the police and ML were informed. He was returned to the ward after being found hiding in some bushes by his daughter (during which time he sustained multiple wounds on his legs). She returned him to the ward and stayed to calm him. The ward doctor prescribed lorazepam, which was given IM, one-to-one nursing supervision was to be commenced (although please see comments above in the care planning and risk assessment section), and the matron authorised a second visitor to sit with him. An incident form was completed by the nursing staff in relation to the absconsion (2738); however, the security staff did not submit an incident form to cover their attendance and support in returning Colin to the ward on the first occasion despite this being a requirement of Trust policy.

3.432 A Foundation Year 1 (FY1) doctor completed a mental capacity assessment after these incidents had occurred, but it is not clear what this was for. In the section marked "*what is the specific decision relevant to this MCA*", they wrote "*aggressive patient. Absconding. Aggressive to staff*". In the section describing why this decision could not be delayed, they again wrote "*Aggressive,*

absconding". As with many other mental capacity assessments for Colin, the independent medical capacity advocate (IMCA) and 'best interest decision' sections of the capacity assessment form were left blank, and the lack of understanding of the MCA and best interests decision processes would have meant that the capacity assessment was not valid for any decision-making purposes.

3.433 On return to the ward, the ward doctor prescribed IM lorazepam in consultation with the on-call registrar and 1mg was given IM, but ML contacted the ward to say that she did not want him to have this medication. The doctor was informed and replied that Colin had MCA/DoLS in place and that "*this isn't the partners decision, this is a medical decision*". This was incorrect. The mental capacity assessment did not include the purpose, and we can see no evidence of an assessment of Colin's capacity to make decisions about his care and treatment (other than for the CT scan when in the emergency department). Also, ML was Colin's attorney and held a valid LPA and could make decisions regarding medication (if it had been determined that Colin did not have the capacity in relation to this). As stated previously, if ML's requests were against the perceived medical opinion, the MCA makes provision for this through the use of best interests meetings/mediation and ultimately Court of Protection applications or referral to the Office of the Public Guardian.

3.434 In addition, the Trust policy on restrictive interventions notes at 7.8.4, page 21, "*When considering the use of chemical restraint, also assess if mental health input is required. When a patient is acutely disturbed a doctor must be called to assess the patient. If the doctor called is not a psychiatrist, consider whether a second opinion from a psychiatrist would be beneficial*". We found no evidence that a psychiatrist reviewed Colin during this admission. We also note that, although the DoLS application refers to Colin having poor safety awareness and that he could be aggressive towards self and others, it did not include the requirement for any form of chemical or physical restraint and there was no plan of care for this restriction. The ward nurse submitted an incident form at 7.25pm about the chemical restraint, but only following the conversation with ML. We can see no evidence of physical observations being increased after the rapid tranquillisation, despite this being a requirement of Trust policy.

3.435 The plan that was documented in the medical records after this incident, included, "*day team review – triage to appropriate dementia ward. Query Complex Case Management Team (CCMT) involvement*". However, we can see no immediate action being taken in relation to this plan.

3.436 Later that evening, Colin was walking round the ward and began to hit staff, threatened other patients and threw a computer to the floor. It was noted that Colin said, "*I want to kill*" (although ML believes he would have said "*I want to kill myself*"). Security staff were already in attendance, but additional security was requested. They completed an incident form (2775) which included that "*when they arrived a male patient was being held on the floor by a male member of staff. Security took the male by his arms holding his wrists and elbows, took the patient back to his bed and he was released … security held his arm for approximately one minute, the patient is under a DoLS*." Documenting the type and duration of restraint was good practice and in line with Trust policy; however, there was an absence of detail about how Colin came to be on the floor, how long he had been restrained on the floor, or the position that he was being held in (for example, supine, which could have increased the risk of aspiration, or prone, which could have increased the risk of suffocation). The names of staff were not included on the form, and it is therefore not possible to identify whether they had the required prevention and management of violence and aggression (PMVA) training or other relevant training to allow them to undertake these interventions. Bruises on Colin (location not specified) were noted by staff at the start of the shift but thought to be from the absconsion the previous day, but there were no additional body checks after the restraint to see if further injuries had been sustained.

3.437 IM lorazepam was also prescribed and given, and an incident form completed by the nursing staff (2776) for this chemical restraint in line with the requirements of Trust policy.

3.438 As noted above, we can see no evidence of a MDT meeting being convened despite the repeated incidents of violence and aggression, absconsion and Colin's threats to kill. This is a requirement of the Managing Challenging Behaviours of Adults and the Use of Restrictive Interventions Policy

(2021) in order to discuss the strategies available to the ward but was not actioned. Also, while Florence Nightingale Ward staff were used to dealing with patients who were confused, we found no evidence that Colin's consistent objection to being in hospital and his challenging behaviour related to his deteriorating mental health at any point triggered a discussion or consideration of the use of the MHA. Colin was an objecting patient who was being treated for a mental disorder (namely dementia) on an older person's ward. The team caring for Colin should have considered whether Colin's treatment and containment required detention under the MHA.

3.439 At midday on 26 July, Colin was found to be awake, alert and "*pleasantly confused*" during the ward round, which was undertaken by Elderly Care Consultant 1. Colin's physiological observations were within normal parameters, and he was deemed to be MSFD. The documented plan included an urgent referral to the MHLT and the dementia nurse. The referral was appropriate, given that Colin now required assessment for his mental disorder rather than any physical health conditions, but should have been made the previous day. We also note that the criteria for an urgent referral includes "*disturbance of mental state or behaviour posing risk to patient/others but not requiring immediate review*", whereas an emergency referral is required if there is an "*imminent risk to patient and* others" ("*and to page psychiatry liaison/on-call immediately*"). The referral referenced Colin being "aggressive/throwing chairs" and the incident the previous evening involved threats to other patients. On 26 July, the referral that was made should have been marked as an emergency.

3.440 We can see no evidence of the referral being made to the dementia nurse either on 26 or 27 July. A request for urgent support would have been appropriate given the behaviour that was being displayed by Colin.

3.441 Colin was, however, reviewed by a locum MHLT staff member at 8.30pm on 26 July. It was documented that Colin's family were not present and he appeared settled although poorly orientated. There is a record to say that the staff member read Colin's ward notes, but they made no comment about the incidents of violence and aggression or the risk that Colin posed to himself and/or others in his record. There had been a history of violence, aggression and absconsion prior to admission, with six incidents of the same over the six days in hospital; Colin had a mental disorder; he was being treated for that disorder; and he was objecting to this treatment and his containment in hospital: an urgent MHA assessment should have been requested following any of these occasions, but was not. A review of Colin with ML present was planned, although the time frames for this were not stated. As previously noted, we found no evidence that Colin was reviewed by a psychiatrist during this admission

3.442 Colin called ML on the morning of 27 July saying that he would kill himself, and a recording of this call was played to a ward member of staff. This did not prompt a conversation with the MHLT and should have. The MHLT were due to assess Colin with ML present, but no time had been specified and, following the review the previous evening, this was not marked as an immediate priority within the team. As noted previously, Colin should have been re-referred and assessed under the MHA.

3.443 We note that the DCST called the MHLT on 27 July for an update on Colin and it was agreed that DCST would discharge him, as the hospital team were now involved. The MHLT were unable to access any of the DCST records due to different electronic systems. A short plan from DCST discharge was emailed across but the MHLT follow-up review had not been conducted before the serious incident occurred that afternoon.

3.444 On the morning of 27 July, ML contacted the ward and was asked to bring in her LPA document. This was good practice in order to safeguard Colin; however, this should have been requested earlier in Colin's care journey and retained on file when it was first assessed that Colin did not have capacity and decisions were being made about his care and treatment.

3.445 ML visited the ward on the afternoon of 27 July, as she remained concerned about Colin. We can find no record of the conversation other than in the Initial Management Review that was undertaken after Colin's fall, where it was noted that ML spoke with a ward nurse and junior doctor. She explained Colin's history, how she thought his medications were affecting him and that she was

concerned about what was happening to him. It was explained that Colin was MSFD and waiting for a mental health review and that if MCA and DoLS were not in place, Colin would be able to leave the ward and staff could not stop him. It is noted that ML understood this; she requested a set of blood samples be taken from Colin for review, which the doctor agreed to be undertaken that day. Colin left the ward and fell in the cardiothoracic centre before these could be taken.

3.446 ML left the ward at about 3pm. Colin became agitated as he often did when visitors were leaving and ML asked the staff to call security. After she left, he started to walk up and down the corridor and tried to get out of the ward but could not. Instead, he ran into Bay 1, grabbed a pair of craft scissors from a craft/activity trolley and attempted to stab them into his abdomen. A member of staff tried to stop him, and another healthcare assistant (HCA) also tried to help. They ended up on the floor and the scissors were taken away from Colin, who then got up and ran out of the ward. Security were requested to attend urgently, but before they could intervene, Colin ran to the cardiothoracic centre and up the stairs. He was seen by several members of staff who said that he leaned over the rail (which was made of glass and steel) of the first-floor staircase landing and fell onto a glass table in the restaurant area, which shattered on impact. He was lying face up. An emergency call was responded to by the trauma team.

<u>The reporting and management of the incident in the cardiothoracic centre</u>

3.447 This incident is described in different ways in the clinical records (in incident reports 2977 and 2984) and in staff statements.

3.448 In relation to the fall, there is reference to Colin having both fallen and jumped, with additional comments about self-harm and a suicide attempt. There was no closed-circuit television coverage to corroborate the versions of events.

3.449 It is clear that Colin was on a mission to escape and that his mental capacity was impaired. Several staff have said that they witnessed him leaning over the rail and falling head first. We have not been able to definitively establish if his fall was intentional (i.e., that he understood the consequences of a fall from height), unintentional (i.e., that he had not appreciated the drop having determined to go over the obstacle) or accidental (i.e., that he could not stop the momentum of the fall after leaning over the rail).

3.450 Beyond the incident reports, an Initial Management Review was undertaken by a matron on 10 August 2021. This was 20 days after the incident despite the Policy for the Management of Incidents and Serious Incidents (2019) requiring this to be undertaken within three days of a serious incident being declared. This review was incomplete. In particular we note:

- The absence of an initial analysis to determine whether any immediate actions to maintain patient safety and reduce the risk of recurrence were required or undertaken; this section of the report was left blank. There is no evidence, for example, of the stairs being immediately assessed to ensure no potential risk to other patients.
- There was no description of the scissors. We have been unable to gain a full description or photo of the scissors that Colin stabbed himself with but have been told that they were craft scissors. A photograph or full description of the scissors should have been included within reporting to ensure they were appropriate for their use on the ward.
- The sections on the legal status of the patient and describing how staff involved were being supported were left blank despite this being a traumatic event and these details being a requirement of the form.
- There was reference to a safeguarding alert being raised but with no details or outcome despite this being a requirement of the form.

- The duty of candour[124] section did not include whether an initial verbal apology and explanation had been given to Colin (and his family) and we can see no evidence of this statutory requirement having been discharged within the medical records.
- The level of harm was not recorded (although recognised as a serious incident). This was reviewed by the Executive Review Group who stated that that this would be determined during an investigation. Colin had fallen from height, had embolisation of an epigastric bleed and was in ITU at that time; in our view, severe harm was evident.

3.451 A letter was sent to ML by the Deputy Director of Nursing on 12 August 2021 following a telephone conversation. The letter confirmed that a "*full internal investigation*" would be undertaken within 60 working days; it is our understanding that this was superseded by the Niche independent investigation process although we have seen no further correspondence from the Trust to ML in relation to this.

3.452 A health and safety concise incident investigation was, however, completed on 26 August 2021 for the stairs in the cardiothoracic centre. This was delayed due to staff sickness absence and was undertaken 31 days after the event but should have been sooner to ensure no immediate risk to other patients. This concluded that, although compliant with building regulations for handrails and stairway fall protection, the area did offer numerous opportunities for individuals who initiate a deliberate action of intention to self-harm via fall from height. Recommendations included:

- The Trust may wish to consider extending the height of the balcony barrier.
- The Trust may wish to consider removal of the coffee tables to reduce the risk of an object falling from height causing injury to the customers within the refectory.
- Patient safety team to review the incident and ascertain if patients who wish to self-harm are becoming an emerging future risk, and the likelihood of them being able to enter the area.

3.453 The health and safety investigation focused on deliberate self-harm rather than also considering that Colin may not have intended to fall from such a height. Annual CTC stairs and corridor assessments had been undertaken but the report did not include whether the handrails were at an appropriate height that contrasted with the surroundings in line with the requirements of the Building Regulations Approved Document K.

3.454 We visited the site and walked the route that Colin took before he fell. The optics of the staircase are such that when approaching the barrier, the top (transparent line) of the balcony exactly matches the window opposite, and there is an illusion that the atrium is not far below. At some angles the view can be interpreted (especially likely if someone is confused or visually impaired) as leading directly outside at the same level.

3.455 A review of incidents involving falls from height has confirmed that no similar incidents have occurred in the cardiothoracic centre. When asked about actions that had been taken in response to the health and safety investigation, the Trust confirmed that the recommendations had not been progressed although they advised that the Health and Safety Team now work alongside the clinical teams when undertaking reviews; for example, the Mental Health Lead Nurse will accompany the team. This is a change that has been in place since 2022 to improve the reviews and also to inform the risk assessments.

3.456 A further assessment was undertaken in February 2024 as a result of our enquiries. This found that there was a '*potential psychological element influencing an individual's decision to ascend the balcony from level 1 to the sunken refreshment seating area, with the risk being attributed to the transparent glass and contributing factors including an individual's intentional, circumstantial or inadvertent inclination to self-harm'*. Actions recommended in this report included visual and physical enhancements being made (etched or film frosting over the frontage and sides of the

[124] https://www.cqc.org.uk/sites/default/files/2022-12/20220722-duty-of-candour-pdf-version-FINAL-2.pdf

balcony's clear glass panels in line with Department of Health guidance Health Building Note 00-01 and Health Building Note 08-02) and also the installation of an upstand rail along the balcony frontage and side hand rail (suggested increase 20 to 30cm).

3.457 The design of the staircase and the clear glass panels of the balcony could, therefore, have been a contributory factor to Colin's fall (whether intentional or not), particularly as we have been told by ML that he was not wearing his glasses at that time, so his vision would have been impaired.

Emergency department 27 – 28 July 2021

3.458 Colin arrived in the emergency department at 4.01pm on 27 July 2021 and was placed in the resuscitation bay.

3.459 It was noted that ML was present with Colin for most of the afternoon, evening and night of 27 July, with Colin's son and daughter also in attendance at times.

3.460 He was taken for trauma CT scanning. He was agitated and kicked the theatre staff in the face. A 5mg dose of midazolam was given to allow the scan to be taken.

3.461 At 5pm it was noted that he was haemodynamically stable but became aggressive, pulled out the IV fluids that had been inserted and attempted to punch a staff nurse.

3.462 At 6.01pm, the CT results were reported and showed no trauma-related injury.

3.463 Colin was seen by the general surgery team at 6.50pm. They advised that the abdominal wound was to be managed by the emergency department and that Colin could not be admitted under the surgical team.

3.464 At 7pm, Colin's case was discussed with the emergency department consultant. Colin was noted to be haemodynamically stable at that point and was to be referred to mental health for further assessment.

3.465 At 7:50pm, Colin was discussed by the MHLT, who confirmed that he was medically unstable for assessment. There was a discussion with the emergency department consultant who requested that Colin be reviewed again by general surgery to see if a repeat CT abdomen scan was required.

3.466 At 8pm there was a discussion with the general surgeon on-call with a request to urgently review Colin.

3.467 At 8.20pm, a FAST scan[125] was undertaken by the emergency department consultant.

3.468 At 9.15pm, a consultant surgeon attended from theatre following a trauma call when Colin became hypotensive. On examination, Colin was found to have a "*massive abdominal wall haematoma*".

3.469 At 9.20pm, a haematology opinion was received.

3.470 At 9.45pm, Colin was found to be in urinary retention. He was catheterised with his and his relative's consent. This resulted in 520ml residual urine being drained.

3.471 At 10.30pm, Colin was taken for a repeat CT scan. His BP was 90/60 at this time.

3.472 At 11pm, the surgical specialist registrar (SpR) was informed of the CT images, which indicated a bleed into the abdominal wall. They noted that they were waiting for a formal report of the CT to decide on interventional radiology (IR).[126]

[125] A focused assessment with sonography for trauma (FAST) scan is a point-of-care ultrasound (POCUS) examination performed at the time of presentation of a trauma patient and is considered as an 'extension' of the trauma clinical assessment process, to aid rapid decision-making.

[126] Interventional radiology can help to treat a wide range of conditions by inserting various small tools, such as catheters or wires from outside the body. Interventional radiology can be used instead of surgery for many conditions.

3.473 At 11.30pm, Colin's blood pressure dropped. The transfusion service was called, a pelvic binder was applied, and two units of blood were requested from the flying squad[127].

3.474 Packed red cells were commenced at 1am, two hours after the request was made.

3.475 At 1.23am on 28 July, the CT results confirmed a large anterior abdominal wall right rectus abdominis[128] and subcutaneous haematoma with central acute haemorrhage. On review, the surgical team advised that interventional radiology (IR) would be contacted by them for embolisation[129] of Colin's right inferior epigastric artery. Colin was noted to be stable at that time.

3.476 At 1.42am, the on-call interventional radiologist (who was at home) was informed by the consultant surgeon about the bleed.

3.477 Over the next 30 minutes, the CT scan was shared and a decision to see the patient was made by the interventional radiologist. The IR team attended the emergency department but on review it was noted that he would not be a candidate for IR intervention unless it could be done under general anaesthetic as Colin had become aggressive. An anaesthetist who was present advised administration of 2mg midazolam. A decision was reached by the IR and surgical team to "*watch and wait*".

3.478 Colin was reviewed by ITU (time unstated) and also the anaesthetic team at 4.50am.

3.479 At 5am Colin was reviewed by the intensive therapy unit (ITU), surgical and IR teams where it was agreed that Colin would have the embolisation. The IR nurses had, however, been informed by the interventional radiologist that they could not intervene without general anaesthetic and had gone home just before 5am. It was then agreed that the procedure would be scheduled with the day staff at 1pm.

3.480 At 5.35am the nursing records include that Colin's abdomen was becoming more painful and swollen. His Glasgow Coma Scale (GCS) was 14/15. They contacted the surgical registrar to request analgesia and a review of Colin as the embolisation was not due to be undertaken until 1pm.

3.481 At 8.45am, the nursing staff bleeped the surgical consultant regarding pain relief, as analgesia had not yet been prescribed.

3.482 At 9.25am, Colin was reviewed by the surgical team, who had a discussion with ML about Colin's abdominal swelling that had increased overnight. The plan was to contact the anaesthetist to sedate Colin and attempt the procedure at 1pm.

3.483 At 9.57am, WhatsApp messages indicate that a theatre was being sought for IR and the anaesthetists needed to plan for a general anaesthetic for Colin.

3.484 At 12.01pm, the nursing records stated that Colin was to be transferred to Florence Nightingale Ward post procedure.

3.485 At 12.30pm, Colin was intubated for the IR procedure. The embolisation was undertaken and Colin was extubated[130] at 17.45pm. He started to wake up, tried to get off the bed and began to hit out at staff. He was given IM haloperidol and IV lorazepam and by 6.20pm had started to calm down.

3.486 Colin left recovery at 6.55pm and was transferred to Bulphan Ward.

[127] O rhesus-negative blood group can be transfused to any non-immunised patients. For this reason, O RhD-negative red cells, often called 'flying squad' blood or units, can be used in emergencies where group-specific stock is unavailable.

[128] Rectus abdominis, informally known as the abs muscle, is a long muscle of the anterior abdominal wall.

[129] An embolisation is a procedure used to stop the blood flow to a certain part of your body by blocking a small artery or vein.

[130] Extubation is removing an endotracheal tube, which is the last step in taking a patient from a mechanical ventilator.

Commentary on this care episode and points for learning

Physical health

3.487 Colin was conveyed to the emergency department in response to a trauma call after his fall. Trauma CT scans were undertaken, and results received within an hour of the scan being completed. These concluded that there were no acute intracranial findings, no acute bony injury to his cervical spine, no features of trauma to his chest, abdomen and pelvis or bones, allowing for degrading artefacts.

3.488 Colin was appropriately referred to the general surgeons for review of his abdominal and scalp wounds. '*Puncture wound exploration'* was requested by the emergency department doctor who documented that Colin had been seen by the surgical team. They had advised that the abdominal wound was too superficial (stab wound 1cm is documented on a body region findings chart) and that it was to be managed by the emergency department team. They also said that Colin could not be admitted under the surgical team (as Colin was a risk to other patients and himself), but that the emergency department team should speak with medicine on-call for admission. Colin was haemodynamically stable at this time.

3.489 At 7.15pm, foreign bodies (glass) were removed from Colin's scalp and his abdominal wound was dressed. Colin's case was then discussed with the MHLT, but they were unable to undertake a MHA assessment as his blood pressure had dropped and he was now clinically unstable. The on-call surgeon was called, and they requested venous blood gases to assess his haemoglobin (Hb)[131]. At 8.15pm results indicated that Colin's Hb had dropped from 145 (at 3.56pm) to 117 (the normal level for males is 140 to 190).

3.490 At 8.20pm, an emergency department consultant performed a FAST scan to help assess the cause of Colin's deteriorating condition, which was good practice. This identified an abdominal wall collection, and a surgical review was recommended. At 8.35pm, the general surgery registrar requested a repeat CT abdomen and pelvis scan to be undertaken.

3.491 At 9.30pm, Consultant Surgeon 1 who was on-call attended from theatre. Colin was found to have a "*massive abdominal wall haematoma*", and an active bleed into the abdominal wall was queried. They confirmed that an urgent repeat CT was required, and the management plan included IV fluids, a review of apixaban with haematology advice that Colin would need Beriplex[132] 2,500 units (to reverse apixaban) and fresh frozen plasma[133] (FFP). Haematology had also advised that the transfusion laboratory would need to be informed of the potential for a massive transfusion, crossmatch, repeat coagulation profile if going for surgery, and to monitor for haemodynamic instability.

3.492 Consultant Surgeon 1 recommended IR intervention for the bleed "*given Colin's risk factors*". He added that if this was not possible, then surgery would need to be considered. Colin was to stay in the resuscitation bay, as he was deemed unstable at that time, but there was no record to indicate that these options had been discussed with other team members or the family. The emergency department staff recorded that Colin was accepted under the care of the general surgeons.

3.493 At 11pm, Colin returned from the CT scan. His BP was 83/61, mean arterial pressure (MAP)[134] 55. 250ml of normal saline was given as a stat dose in response to this finding. The surgical SpR was informed of the CT images which indicated a bleed into the abdominal wall. They advised Beriplex,

[131] Haemoglobin (Hb) is the protein contained in red blood cells that is responsible for delivery of oxygen to the tissues. Low haemoglobin levels may be a symptom of several conditions, including different kinds of anaemia, cancer or internal bleeding.

[132] Beriplex is used for the emergency treatment of life-threatening haemorrhage.

[133] Fresh frozen plasma (FFP) is used for patients who are bleeding or at risk of bleeding, and where a specific therapy or factor concentrate is not appropriate or unavailable.

[134] Mean arterial pressure (MAP) measures the flow, resistance and pressure in a person's arteries during one heartbeat. It is a calculation that doctors use to check whether there is enough blood flow to supply blood to major organs. Most people need a MAP of at least 60 millimetres of mercury or greater to ensure enough blood flow to vital organs such as the heart, brain and kidneys. Doctors usually consider anything between 70 and 100 to be normal.

tranexamic acid and two litres of packed red cells to be given. They also noted that they were waiting for a formal report of the CT scan to decide on IR.

3.494 Use of an abdominal binder was also recommended by the surgical SpR, but this was not available. Staff were told to replace this with a pelvic binder, but Colin's son said it kept coming undone and medical notes indicate that this was not effective.

3.495 At 11.30pm, Colin's repeat blood pressure was found to be low (75/55, MAP 47). The transfusion service was called, who said the cross match for the blood transfusion would be a further 40 minutes. Two units of blood were requested from the flying squad.

3.496 At 1.04am, Colin was reviewed by the surgical team after bouts of hypotension (BP before review was 87/57). On review, Colin's BP was 103/68. The plan included stat IV fluids, bloods to be tested, and for the nursing team to contact the on-call team if they had any further concerns or there were signs of bleeding.

3.497 At 1.23am on 28 July, the CT scan results confirmed "*a large anterior abdominal wall right rectus abdominis and subcutaneous haematoma with central acute haemorrhage. I suspect this is originating from the muscular branch of the right inferior epigastric artery. Consider triple phase CT abdomen and pelvis to assess the accurate source of haemorrhage depending on assessment requirements of the local vascular surgeon/interventional radiologist. Right anterior pelvic wall hernia at the lateral margin of the right rectus abdominis muscle containing loop of small bowel with apparent mural thickening. Strangulation of the herniated loop of small bowel cannot be excluded.*"

3.498 The surgeons (names not specified) were informed of the results. On review, they advised that they would contact IR for embolisation of Colin's right inferior epigastric artery.

3.499 At 1.42am, the on-call interventional radiologist (who was at home) was informed by Consultant Surgeon 1 about the bleed. The CT scan was shared and a WhatsApp conversation between the consultant surgeon and the on-call interventional radiologist documented a discussion about where the bleed was coming from, the need for embolisation (which was considered a difficult procedure if coming from a side branch) and the potential of a '*pressure corset'* to tamponade the bleed if not from a major vessel. It was clear at this point that IR was considered preferable to surgery although surgery would be an option if the bleed was from a major vessel.

3.500 At 2.25am, however, it is documented via the WhatsApp messages that Colin was still in the resuscitation bay and hypotensive, '*not really responding to fluids'*. Due to his cardiac history the surgeons confirmed that they were seeking a transfer to ITU.

3.501 At 2.27am, the interventional radiologist agreed that the team should come in to see Colin as soon as possible. We were told that the IR nurses arrived in the emergency department at around 3am, the radiographer arrived at around 3:30am and the interventional radiologist arrived by 3:35am.

3.502 Colin was seen by IR seven hours after the bleed had been suspected, four hours after it had been verbally confirmed, and one and a half hours after the formal report. On review it was noted that Colin would not be a candidate for IR unless the procedure could be done under general anaesthetic as he had become aggressive (the nursing records state he punched and kicked the IR staff, with attempts to bite and security were called). The IR team were not aware that Colin had been an inpatient at the time of his injury. A dose of 1mg midazolam was administered to help calm Colin. An anaesthetist who was present then advised administration of 2mg midazolam. A conversation took place about the need for IR without general anaesthetic or surgery with. A decision was reached by the IR and surgical team to "*watch and wait*".

3.503 By this time, Colin had been in the emergency department for 11 hours, with no indication of how long his stay there would continue. The surgical team had described Colin as 'stable' at 1.23am (BP 86/52, MAP 69, HR 89 bpm and oxygen saturations 98 per cent), and his BP was recorded as 98/56 at 2.45am with a pulse rate of 91 (again 'stable'), but he had an active bleed and was requiring supplementary intravenous fluids; nursing staff described "*worsening swelling to stomach*" and

continued haemorrhaging may have resulted in hypovolemic shock[135] with a risk of death, particularly as Colin had been in receipt of anticoagulant therapy, which has been reported to be a risk factor of increased mortality.

3.504 Colin was clerked for admission by a core trainee doctor in the resuscitation bay (records indicate the clerking had commenced at 2.48am). The records include that Colin had "*an increasing abdominal haematoma likely coming from branch of inferior epigastric. Unable to thrombolise with IR – IR Consultant has said patient too agitated. Patient not currently for surgery as unlikely to be able to stop bleeding vessel. Plan: not for surgery or IR at current time, abdominal binder, regular tranexamic acid, repeat bloods and coag[ulation] at 6am, ITU are coming to review*."

3.505 Colin was reviewed by the ITU registrar on-call (time unstated) who noted that Colin was calm post midazolam. They suggested that the IR procedure should be undertaken and to give haloperidol to keep Colin calm. They contacted the IR Consultant who wanted to know when the procedure could be done, and referred the patient to the anaesthetic team so that they could liaise with IR to undertake the procedure.

3.506 Colin was reviewed by the anaesthetist on-call at 4.50am who noted Colin's history and clinical presentation. They documented that Colin was clinically and haemodynamically stable and that the surgical plan was application of an abdominal binder and observations. The anaesthetist suggested giving tranexamic acid and taking arterial blood gases.

3.507 Following a series of communications between the surgical, ITU and IR teams (which are not documented in the clinical records), the emergency department staff who were concerned about Colin's treatment plan prompted a further joint review at 5am when there was a decision that Colin would be for IR management. The rationale for this change was not documented. The IR nurses had, however, been informed by the interventional radiologist that they could not intervene without general anaesthetic and had gone home just before 5am. At 5.08am the nurses received a message from the interventional radiologist asking them not to leave but they had already done so.

3.508 It was documented (in retrospect at 7am) that while the anaesthetist on-call had been preparing the drugs for Colin's general anaesthetic, the on-call interventional radiologist phoned the anaesthetist and said the team could not proceed with the embolisation as the case was lengthy and delicate and the team lived far away; instead, they suggested the day team should do the procedure. Consultant Surgeon 1 had not been made aware of this delay or the reasons that were given for it.

3.509 At 5.35am, the Emergency Department nursing staff bleeped the surgical registrar to review Colin as '*according to IR, the [embolisation] procedure was not due to be done until 1pm'*.

3.510 Colin was reviewed by an ITU registrar at 6.15am. They contacted ITU Consultant 1 who said that Colin was not for ITU currently although no rationale for this was documented.

3.511 At 9.25am on 28 July, Consultant Surgeon 1, discussed Colin's abdominal swelling with ML. They said that they had liaised with IR for embolisation but, unfortunately, this had not been done overnight as Colin had not been sedated. The plan was to contact the anaesthetist to sedate Colin and attempt the procedure at 1pm. They described that the haematoma would then gradually be absorbed over the next few weeks and that Colin was to be moved to HDU post procedure.

3.512 At 11.20am, a phone call was received from IR asking about the allocation of a bed for Colin post procedure (as they are unable to proceed with their interventions until a bed has been allocated). It is documented that the plan had been for Colin to go to ITU (although the surgeon had said HDU), but IR said that ITU had not accepted him. IR were told that he would be assessed after the procedure to determine bed allocation, but they replied that the procedure could not take place without a prior allocation. The clinical site manager and surgical consultant were informed and were

[135] Hypovolemic shock is an emergency condition in which severe blood or other fluid loss makes the heart unable to pump enough blood to the body. This type of shock can cause many organs to stop working.

to discuss this with ITU, but there is no record of the decision-making in the clinical records or why HDU was not an option, and Colin was transferred to Bulphan Ward after the procedure.

3.513 In relation to the embolisation, at 3am there had been a decision to observe Colin as IR decided he was too agitated for the procedure without general anaesthetic. However, by 5am, when it was agreed that the procedure would go ahead, the IR nurses had gone home and the interventional radiologist and anaesthetist decided that it would be safer for the procedure (which was delicate) to be undertaken by the day team as he was deemed clinically stable at that point. A new bed was also required (as the bed on Florence Nightingale that he been in would now not be appropriate) but had not been allocated. As the IR team were required to attend the vascular MDT meeting that morning, there was a subsequent agreement (by 5.35am) for the embolisation to be undertaken at 1pm. This meant that the embolisation was carried out nearly 12 hours after the bleed had been confirmed, 10 hours after IR's initial review, and eight hours after the decision to proceed. Colin was reviewed at regular intervals by the surgical team, anaesthetists and ITU staff with fluid resuscitation and anticoagulation corrected, however, Colin remained in the emergency department with an active bleed during this time, with concerns raised by the nursing staff about his continued agitation and abdominal pain. There was a lack of collective and assertive decision-making and ownership of Colin by the IR, ITU, anaesthetic and surgical teams despite him having come to significant harm while in the care of the Trust.

3.514 The embolisation should have been instigated much earlier, but as an absolute minimum, Colin should have been transferred to a high dependency unit (HDU) or close monitoring bay to allow further assessment and stabilisation to occur when the decision to "*watch and wait*" was made or when it was agreed that the procedure would take place at 1pm. Given Colin's presentation, the harm that had been sustained while in the care of the hospital and administration of the general anaesthetic, a monitoring bed would have been more appropriate post procedure (rather than transfer to Bulphan Ward), even if only for 12-24 hours, to ensure that he remained stable.

3.515 The IR procedure was undertaken at 1pm on 28 July. Many sections of the IR integrated care documentation pack were left blank, including the 'procedure on patient arriving in imaging' checklist and the pre-procedure part of the WHO Surgical Safety Check List; however, it was recorded that the embolisation was successful. The discharge instructions section of the form was also left blank, although the post-procedure instructions for ward staff included that the puncture site would need observing for signs of bleeding. Beyond this checklist, we can see no evidence of a written handover to the theatre recovery or Bulphan Ward staff regarding the ongoing care and observations that Colin would require. This is relevant because the next day (29 July) the reviewing surgeon noted that, if stable, Colin could be triaged to the psychiatric team for their care; this was despite some indications that Colin was deteriorating.

3.516 In relation to other aspects of physical health monitoring, blood testing was undertaken at 5.15pm on 27 July. Venous blood gases were also recorded at 8.15pm and at 12.04am and 7.50am on 28 July. These latter samples indicated deranged blood gas and oximetry values; however, repeat testing was not undertaken until the early hours of the following day (29 July), despite being requested to be taken at 6am on 28 July by the doctor who reviewed Colin at 2.25am. The results on 29 July showed significant changes including increased WCC and CRP (see Appendix D). Colin should have been closely observed in a monitored bed, but instead he was transferred to a surgical bed on Bulphan Ward where instructions for close monitoring were not included in the handover that was given. Earlier blood testing would have allowed a more timely response to Colin's deteriorating condition (see commentary in next section).

3.517 While the trauma and emergency department staff were responsive to Colin's care needs and presentation, there were multiple delays by the surgical and IR teams during this episode of care, with a lack of decisive interventions and ownership, despite Colin having an active abdominal bleed. Delays were excessive and would have contributed to Colin's distress, discomfort, size of the haematoma and haemodynamic instability. Observations (preferably in a high dependency bay) were required for at least 24 hours post-procedure to ensure the embolisation was maintained, but a further period of observation would also have been required within the acute setting to ensure that

there were no other effects from such a significant fall from height; however, instructions for onward monitoring were absent, with delays noted in subsequent responses to Colin's deteriorating condition.

3.518 Notably, these unacceptable delays and 'handoffs' were similarly recognised by the emergency department staff, who documented their concerns in an incident report (3025). This included:

"*Under surgical care for abdominal wound/bleeding. Surgical team not happy to take over care as previously under medics. After multiple consultations they agreed to take him under their care after repeated CT abdomen. Patient became hypotensive and escalated to surgical team. Decision made to give Beriplex and blood transfusion to optimise surgery. Patient became aggressive and agitated. Surgical team decided not to perform surgery but to refer to IR due to multiple previous surgeries. IR not happy to take care of patient as unsafe to do so being too agitated. Called surgical team again due to IR saying he needed surgery, Surgical team then escalated to ITU as unsafe to keep patient on ward due to agitation – midazolam given with no effect.*"

3.519 "*ITU refused to admit patient and stated patient needed urgent IR. Surgical team contacted again. Nursing team organised ITU, IR and surgical meeting to make a collaborative decision. The output was for patient to go to IR under general anaesthetic. IR stated unable to do procedure until 8am. Patient has been in the Emergency Department for 15 hours, not clerked by surgical team for 10 hours, delays in making decision from surgical team, delays in reply to escalation from surgical team, lack of leadership and management in the whole process resulting in patient being uncomfortable and agitated.*"

3.520 The emergency department incident form (3025) concluded that the outcome was "*no harm*" and a "*near miss*". It is our understanding that this is an initial grading and the delays, increased agitation, pain and distress that were noted for Colin will be taken into account once the Niche investigation has been completed as it is linked to the incident form that was submitted for the fall (2977). The final grading of the incident is yet to be determined but Colin developed a haematoma which increased in size after his fall, his abdomen became infected and by 5 August a fistula[136] had formed; in our view, this was serious harm.

Medications

3.521 On arrival to the emergency department and to facilitate the CT scanning, 5mg IV morphine and 5mg midazolam (in three doses) were administered to Colin. These were appropriate medications given his presentation and the need for diagnostic imaging. An emergency department doctor informed ML and Colin's daughter that Colin had been given sedation for his and others' safety.

3.522 A dose of 1mg midazolam was also given at 2.50am on 28 July when Colin became agitated, trying to punch and kick staff. Security were called, but it is not documented whether any physical restraint was required to give this drug. The Trust's Policy for the Management of Incidents and Serious Incidents (2019) requires all incidents of violence and aggression to be reported. The Trust's Managing Challenging Behaviours of Adults and the Use of Restrictive Intervention Policy also requires an incident to be reported if a restrictive intervention is used, whether planned or unplanned. An incident form (3025) was submitted for delays in treatment, and included reference to chemical restraint; however, an incident form should also have been submitted for the violence and aggression, with confirmation of any restrictive interventions (such as administration of rapid tranquillisation or physical restraint) that might have been required.

3.523 Stat doses of IV fluids, Beriplex and RPC were also given in response to Colin becoming hypotensive later that day. Although there was some delay in commencing the blood transfusion, these were appropriate interventions which helped to stabilise Colin until the IR embolisation could be undertaken.

[136] A gastrointestinal fistula is an abnormal opening in the stomach or intestines that allows the contents to leak to another part of the body.

3.524 Regular or as required analgesia were not prescribed even though Colin had fallen from height. Morphine had been administered on arrival to the emergency department and 1mg of IV paracetamol was given to Colin seven hours later at 11.08pm, although it is not recorded why. After this, we can see no record of pain relief being given until midday on 28 July when a repeat dose of IV paracetamol was given. This was despite reports of significant abdominal pain and requests from the nursing staff for analgesia to be prescribed from 5.35am that day. The surgical registrar (name not specified) had been contacted but declined to prescribe analgesia for Colin and said the post-take ward round team should be contacted instead, but no contact information was given. This meant that Colin was in unnecessary pain and distress for approximately seven hours (if not longer, as some of his agitation, including when reviewed by IR at 3am, may have been due to pain).

3.525 At 6.45am the drug chart indicated that Colin was given 5mg IM haloperidol, but the reason for this, or the rationale for the choice of medication, is not documented in the clinical records and the prescription does not include instruction for when this should be given. The incident report that was submitted about the delays/failure to treat (3025, above) described, however, that Colin became aggressive and put himself and staff at risk by pulling his catheter and cannulas out and hitting staff. The form included that staff were unable to record his physiological observations or get close to him: "*unable to maintain standard of care*". Haloperidol was given with the help of security staff but was not separately incident reported despite these being chemical and physical restraints. As mentioned before, it is possible that this agitation was due in part to uncontrolled pain. Also, although referenced as an option on the Trust's Rapid Tranquillisation Policy (2021), caution is required when prescribing haloperidol in patients with severe heart failure, cardiac arrhythmias, cardiomyopathy, and medications that prolong QT-interval. Haloperidol should not, therefore, have been the first choice of sedation given Colin's cardiac history.

3.526 The IR embolisation was undertaken at 1pm and Colin was extubated at 5.45pm. He started to wake up, tried to get off the bed and began to hit out at staff. He was given IM haloperidol and IV lorazepam and by 6.20pm had started to calm down. There was no incident report regarding this chemical restraint, and please also note the comments about haloperidol above.

3.527 IR records include that Colin was allergic to penicillin. We can see no record of known drug allergies being recorded in Colin's other previous hospital or GP medical records but his allergy status should have been checked after this time and the rationale for prescribing penicillin documented in the medical records going forward.

Care planning and risk assessment

3.528 Covered above.

Behaviour and presentation – MCA and safeguarding

3.529 Covered above.

Bulphan Ward 28 July – 4 August 2021

3.530 Colin was transferred to Bulphan Ward on 28 July 2021 following the IR procedure. Bulphan Ward was a high-acuity general surgical ward with 25 beds.

3.531 On 29 July at 1.04am, Colin was reviewed by a doctor at the request of nursing staff, as he had an elevated National Early Warning Score (NEWS) of 5.

3.532 At 1.54pm, Colin was reviewed by the MHLT and his medications were reviewed.

3.533 At 2.15pm, Colin was reviewed by a consultant general surgeon who had been contacted by ML. They advised the ward to repeat bloods, start oral antibiotics, stop apixaban, continue tranexamic acid, and if Hb was stable, then Colin would be ready for discharge tomorrow. This plan was agreed with the ward consultant.

3.534 On 30 July, at 8.50am, Colin was reviewed by the specialist registrar (SpR). The plan was documented as medically safe for discharge (MSFD), continue tranexamic acid for five days, oral antibiotics, discharge letter, EPUT Mental Health Liaison Team (MHLT) will review.

3.535 At 11.22am, Colin was reviewed by the MHLT. They confirmed that a Mental Health Act (MHA) assessment could not be requested as his blood results were deranged.

3.536 At 11.30am, Colin became agitated and aggressive. He headbutted a member of staff, began throwing objects and tried to abscond.

3.537 At 1.30pm, the SpR surgery contacted the psychiatrist on-call to come and assess Colin for transfer, as he was surgically fit to go. The MHLT called later that afternoon to say Colin could not go to a mental health ward as his bloods were deranged and he was not medically fit for transfer.

3.538 On 31 July, Colin was reviewed again by the MHLT, who confirmed that he was not fit for discharge.

3.539 That night, Colin became very restless and agitated. Security were called on two occasions.

3.540 On 1 August, at 2.14pm, Colin became very aggressive. Colin's case was discussed with an intensive therapy unit (ITU) consultant, and they documented that Colin should not be for chemical sedation from the ITU team, instead he needed sectioning by the mental health team.

3.541 On 2 August, Colin was reviewed on the ward round. His abdomen was swollen on the right side, and he appeared in pain. The plan was for urgent ultrasound, blood testing and for laxatives.

3.542 At 4pm, Colin was reviewed by a perioperative medicine consultant who queried delirium.

3.543 At 7.15pm, the MHLT assessed Colin and noted that he was not medically fit for a MHA assessment.

3.544 At 9.44pm, Colin was reviewed by the vascular SpR. Antibiotics were reviewed.

3.545 On 3 August, at 9.10am, Colin was reviewed by the medical SpR. They noted that his inflammatory markers and haematoma were increasing. The plan was for antibiotics to be changed. A microbiology referral was sent, and a query recorded that he might need urgent drainage.

3.546 Colin was reviewed by the on-call surgical consultant at 9.20am. Colin's NEWS had increased, and he was found to have extensive bruising on the left side of his abdomen.

3.547 Colin was also reviewed by the perioperative medicine consultant at 10.20am. The plan was to treat the infection, drain the haematoma, bowel management, to keep hydrated, and pain relief.

3.548 At 11am, the MHLT made a request to the surgical team to consider ITU sedation for Colin if maximum doses of psychotropics[137] did not work.

3.549 At 12.30pm, the IR consultant was consulted in relation to the haematoma. They stated they would not be able to perform an IR drain of the haematoma as it was solid.

3.550 At 4.30pm, Colin was reviewed by a surgical consultant. They queried haemolysis[138] and documented a plan for a liver ultrasound scan (USS) depending on the results of liver function blood tests.

3.551 On 4 August, at 7.40am, Colin started to "*tear up*" his surgical wound site, which began to bleed. He was agitated and attempted to hit staff. Analgesia was given for pain.

3.552 At 11.25am Colin became increasingly agitated, was verbally aggressive and attempted to headbutt and punch security staff.

[137] Psychotropic medications are used to treat mental health disorders.

[138] Haemolysis is the medical term used to describe the destruction of red blood cells. Red blood cell destruction is a normal, healthy process, but sometimes, red blood cells get destroyed too soon, causing too few red blood cells. This results in a condition called haemolytic anaemia.

3.553 It was noted on the ward round (untimed) that Colin's abdomen was widely bruised, that his belly button had perforated, and his haematoma was externalising.

3.554 At 2.45pm, Colin was reviewed by the surgical consultant, who noted that security staff were no longer willing to restrain him. The haematoma was leaking via the umbilicus, and it was documented that this needed evacuation and to be discussed with ITU, as this would require Colin to be intubated.

3.555 Colin was reviewed by the ITU consultant, who requested that Colin go to theatre before admission to ITU; however, the surgical consultant explained that the haematoma was already draining so there was no need for theatre. ITU accepted Colin for transfer.

3.556 A Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)[139] form was completed by the surgical consultant after a discussion with ML and the ITU consultant.

3.557 Colin was transferred to ITU at 6.15pm.

Commentary on this care episode and points for learning

Physical health

3.558 Colin was transferred to Bulphan Ward on 28 July after embolisation of the right inferior epigastric artery. Although this was a general surgical ward, it is our view that a high dependency monitoring bed may have been more appropriate at this time (see comments above).

3.559 His physiological observations were monitored at 11.40pm and his NEWS found to be elevated at 5. He was hypotensive (BP 87/57), his HR was 110 bpm, and his temperature was 37.7°C. Nursing staff appropriately escalated these results to the on-call doctor. Colin was reviewed by an FY1 and his NEWS was 4 when seen. Venous blood gases were taken after discussion with the surgical SpR. These showed Hb 107. The documented plan was for stat IV fluids, blood tests, and to contact the on-call doctor if there were any concerns or signs of bleeding. Colin was allowed to settle, and his NEWS reduced to 2 when next recorded at 6.26am, but at the point when Colin was reviewed, he was already showing signs of a potential bleed or a deterioration in his physical condition which required more intensive monitoring and attention.

3.560 At 9am on 29 July, Colin was reviewed on the ward round by a specialist grade doctor and the plan was for "*on-call psychiatrist, eating and drinking, continue holding apixaban, review tomorrow*". There was no reference to the blood results (samples had been sent at 12.50am) which showed a rise in Colin's CRP (147) and WCC (11.8), with a drop in Hb (105), and we can see no evidence of these being reviewed until that afternoon when Colin was seen by the Consultant Surgeon 2 following an email received from ML. The notes do not indicate that Colin was examined, but Consultant Surgeon 2 recorded that he reviewed Colin's results and observations, although he did not specify which or what they were. He advised the ward to sedate Colin "*as per RAID"* (rapid assessment interface and discharge), to stop apixaban, continue tranexamic acid; and he suggested commencing oral antibiotics, but did not state why. The consultant surgeon documented that "*if Hb stable, fit for discharge tomorrow … needs sedating and triage to psych*".

3.561 The plan was agreed with Consultant Surgeon 1. Although Colin did not have an elevated temperature at that point, there were several possible sources of infection including the indwelling catheter (for previous urinary retention), multiple wound sites (one to his abdomen caused by scissors and several to his scalp caused by glass/debris from the coffee table that he fell on) and embolisation. Colin was also confused and increasingly agitated. Wound swabs were not requested and should have been, given that there were indicators of infection and Colin had stabbed himself with scissors that may not have been clean.

[139] DNACPR means that if a person has a cardiac arrest or dies suddenly, there will be guidance on what action should or should not be taken by a healthcare professional, including not performing CPR on the person.

3.562 Colin was reviewed by the surgical SpR on the ward round the following morning (30 July). His NEWS was 0 and he was noted to be feeling well, with no expanding haematoma, no bleeding, and a stable Hb. The plan included "*discharge letter*" and that Colin was MSFD. However, it is not documented whether Colin's abdomen was examined or how the size of the haematoma was assessed, and although listed on the ward round form, there were no comments on the adverse blood results from the day before. The blood results from the samples that had been collected at 12.05am that morning were not included (CRP 284 (raised), WCC 15.5 (raised), Hb 105 (reducing)) and we can see no evidence of these being reviewed until the following day (31 July). This was commented on by the MHLT who were asked to review him. At 11.22am on 30 July the MHLT documented that repeat blood tests showed that his Hb was now 95 (lower still), his CRP was on an upward trend and his WCC high. The plan was for him to remain in Bulphan Ward over the weekend and with a nurse on '*1:1'*. He was started on risperidone and was to continue on regular lorazepam. It was documented that the MHLT nurses would review Colin until 2 August (Monday), and then the MHLT medic would review on 2 August to consider the request for the MHA assessment. The plan was also to involve ML when this was being done as she did not feel he needed to stay in a mental health ward, but a care home, on discharge. We note that ML would have to have been involved as nearest relative under the MHA – this was not optional.

3.563 During these two days, there were multiple comments about Colin having no acute surgical problem and that his elevated CRP was due to tissue damage, "*however, he is also on antibiotics*". Colin had fallen from height, had a haematoma with extensive abdominal bruising and had undergone an embolisation of his epigastric artery, complications of which are known to be bleeding or infection. He had a significantly elevated and rising CRP and WCC. The absence of clinical stability was evident, including to the MHLT, who were asked again to assess Colin for a MHA assessment. It would appear that the focus was on Colin's behaviours and confusion rather than his underlying and deteriorating physical condition. He became increasingly agitated, and his physiological parameters varied significantly with episodes of hypotension, tachycardia[140] and pyrexia; however, delirium was not documented as being considered by the surgical team despite his presentation and the behaviours displayed.[141]

3.564 There was also no reference to the possibility of sepsis despite Colin having three risk factors (he was over 75, had had a recent trauma/invasive procedure with broken skin, and indwelling lines). He also had multiple sources of potential infection and over this period, he had occasions when his NEWS was 4 and 5, with a single parameter having a score of 3, including a systolic BP less than 90 and HR greater than 130 bpm. Sepsis screening should have been initiated and bloods reviewed on a more frequent basis. A psychiatric or older adults consultant opinion may have been appropriate for advice and support in the management of Colin's behaviour and aggression, but recommending a move to psychiatry was wholly inappropriate at this time.

3.565 On 31 July at 7.45am, ML had commented to staff that Colin was sweating, was in pain and looked unwell. Nursing records indicated that his HR was found to be 140 – 160 bpm, and his temperature was 37.5°C, although these readings were not included on his observation chart. He was seen by the medical registrar at the request of the surgical registrar, and his abdomen was examined after blood tests had been requested. There was a comment which said, "*CRP 284 yesterday, on oral co-amoxiclav for his wound injury*" and it was documented that Colin was "*constipated, some abdominal pains*". On examination, Colin was found to have generalised tenderness of his abdomen with extensive bruising. The nursing records say his wound was cleaned and redressed, but with no description of the wound itself either in the medical or nursing records, nor whether there were any signs of inflammation or infection. The SpR documented that Colin could have stat bisoprolol if his HR increased to, or above, 100 bpm. Additional laxatives and as required oramorph[142] were also

[140] Tachycardia is the medical term for a heart rate over 100 beats a minute.

[141] Symptoms of delirium often fluctuate over the course of the day. Healthcare professionals divide delirium into three types based on the other symptoms that someone has. These three types are hyperactive, hypoactive and mixed delirium. A person with hyperactive delirium may seem restless, be agitated (for example, with more walking about or pacing), resist personal care or respond aggressively to it and can easily get very distressed due to not understanding where they are or losing track of time.

[142] Oramorph is a liquid form of morphine, a drug often used as a pain killer.

prescribed for Colin; however, sepsis screening was not undertaken, despite the elevated heart rate, CRP and WCC, with multiple potential sources of infection, all of which are indicators which should have been acted on.

3.566 On the night of 31 July, Colin became very restless and agitated. Security were called on two occasions, and they escorted him back to his bed. Colin refused his medication, but ML helped him to take his tablets (other than ramipril). Midazolam was given for aggression, and he settled down. He appeared to have difficulty opening his bowels. This constipation may have added to his acute confusional state/delirium.

3.567 On 1 August, at 2.15pm, Colin became very aggressive and began to throw things around his room. Security were called and a medical emergency team (MET)[143] call was also put out. Colin's case was discussed by the ward medical team with ITU Consultant 1 who was part of the critical care outreach team which responded to the call. ITU Consultant 1 documented that Colin should not be for chemical sedation from the ITU team; instead, he needed sectioning by the mental health team. While Colin may not have reached the criteria for their sedation, the reference to a requirement for sectioning was inappropriate. Colin's bloods were not tested on 1 August despite the increasing inflammatory markers and agitation, and no reference was made by the doctors who reviewed him to the possibility of delirium (with an underlying physical cause) and pain potentially contributing to Colin's agitation. Colin was given 3mg IM midazolam, and the psychiatric team were contacted. Colin's room was cleared of all items that could be potential weapons and an incident form was completed (3581) in line with hospital policy. Colin's daughter was in attendance during this episode.

3.568 On 2 August, Colin was reviewed on the ward round by the specialist grade doctor. His abdomen was swollen on the right side, and he appeared in pain. It was noted by the doctor that he was having trouble opening his bowels since the weekend: "*small type 2 stool*[144] *31 July 2021*". The plan was for urgent ultrasound, to monitor bowels, chase regular bloods, and for laxatives.

3.569 Colin was then reviewed by a FY2 doctor and Consultant Surgeon 3 who was on-call as Colin was severely agitated. It was documented that there was no need for the ultrasound scan, that Colin's CRP was increasing, but his haematoma was resolving. The surgical team did not document how this was assessed or the reason for the cancellation of the USS. The plan was for co-amoxiclav antibiotics and to take Colin over to psychiatry, but again, this was an unrealistic plan that focussed on his behaviours rather than his clinical instability and deteriorating condition.

3.570 The surgical team asked for an opinion from a perioperative medicine[145] consultant who reviewed Colin that afternoon. Colin was found to be "*very very agitated* [largely illegible] – *raised CRP and WCC could be trauma or infection. Delirium superimposed also likely. Therefore, sedation then re-attempt cannulation. If bloods okay and CT shows no visible causes should be considered for admission to* [illegible*]/section 2/3 for further assessment and treatment.*" This was the first reference to delirium despite the many indicators that there was an underlying physical health cause for Colin's confusion and agitation.

3.571 Analysis of a repeat CT scan of Colin's abdomen conducted that afternoon concluded that the anterior abdominal wall haematoma had in fact slightly increased in size and had undergone changes in appearance from the previous scan, as there were now extensive pockets of gas seen. The reporting radiographer noted, "*I wonder if this has become infected? This could be the source of the infection. Clinical correlation is recommended*."

3.572 Repeat blood samples were sent for testing at 4pm, more than two days (55 hours) since the last testing. Given Colin's physical condition, agitation and previously deranged blood results, this

[143] A MET call is a hospital-based system, designed for staff to alert and call other staff for help when a patient's vital signs have fallen outside set criteria.

[144] Type 2 stools are "lumpy, hard, sausage-shaped". Types 1 and 2 describe stools that are hard to pass and may point to constipation. Stools of these types may be darker in colour than normal stools.

[145] Perioperative medicine aims to improve post-operative outcomes and optimise a patient's experience of their surgery.

should have been at least daily. Results included that Colin's CRP was 282 (from 298) and WCC 14.8 (from 17.6). We note that the bloods taken during this period of care did not reflect that he was clinically dehydrated at any point with his urea[146] and electrolyte readings were all within normal ranges.

3.573 At 7.15pm, a psychiatric consultant attended to undertake a MHA assessment for Colin as he was still having behavioural and psychological symptoms of dementia and "*assaulting staff*". The medical team were looking for a psychiatric bed. The psychiatric consultant noted that there had been no improvement in Colin's overall behaviour but that he was not medically fit for an MHA assessment at that time.

3.574 Colin was also reviewed by a vascular SpR at the request of Consultant Surgeon 3. Colin was sleeping and there was no current concerns from the nurses. Colin's CRP was 289 (previously 297) and his WCC 14.7 (previously 17.1). The CT of Colin's abdomen showed pockets of gas in the haematoma, which had slightly increased in size. A stat dose of IV antibiotics (gentamicin) was given that evening, but without blood cultures being requested, and it is not documented that advice had been sought from microbiology to assist with this prescribing. Colin's NEWS was 1 (not requiring medical intervention) at this time but he had signs of intra-abdominal pathology, with potential bowel perforation indicated on the CT scan that should have been responded to; for example, through active consideration of a laparotomy[147].

3.575 At 9.10am on 3 August, Colin was reviewed on the ward round. The surgical SpR noted the expanding haematoma and possible cellulitis. IV antibiotics (tazocin) were prescribed, a referral sent to microbiology (although we can see no evidence of a response to this before Colin's transfer to ITU the following day) and a note made about potential urgent drainage of the haematoma. A definitive plan was to be discussed with Consultant Surgeon 2.

3.576 At 9.20am, Colin was reviewed by Consultant Surgeon 4. Colin's NEWS was 8; his temperature 37.7°C, his respiratory rate 26, systolic BP 82, HR 118 bpm. On examination, he was found to have extensive ecchymoses[148] (bruising) on the left side of his abdomen. The plan was for close monitoring, nil by mouth during the day (stop at 6pm and review at 8am), and for psychiatric review. His apixaban was to be put on hold and blood cultures sent if his temperature increased. Pressure was to be applied to the abscess, and a plan made to consent if theatre was required, and for IV fluids and antibiotics, enema, daily bloods, close observations and monitoring, to discuss with medical team how to manage agitation, and possible intubation. This management plan was unclear and at odds with Colin's clearly deteriorating condition; his temperature was already elevated, he was hypotensive and tachycardic, his inflammatory markers were significantly deranged, he had an expanding haematoma and the criteria for theatre being required was not stated.

3.577 A discussion between the FY2 doctor and Consultant Surgeon 4 is documented as taking place at 10am. This included that the consultant wanted to reduce the sedation, as confusion was worsening, and that this would be discussed with the medical team. It was also discussed that if Colin deteriorated, he would need surgery or IR drainage of the haematoma. As before, the plan was unclear; Colin's condition had significantly deteriorated and the criteria for further deterioration was not specified.

3.578 Colin was then reviewed by the perioperative medicine consultant at 10.20am. They spoke with ML and advised her that hospital admissions would worsen dementia. They added that in some instances, in order to deliver medical care, rapid tranquillisation might need to be used. It is documented that ML believed Colin should be in ITU, but the doctor confirmed that there was no requirement for organ support (a criteria for ITU). They informed ML that admission to ITU carried a risk of ITU psychosis that needed to be avoided if possible. Bloods from 2 August were recorded,

[146] Urea is one of the principal products of the breakdown of body proteins and is excreted by the kidneys into the urine.

[147] A laparotomy is open abdominal surgery. It can help your surgeon both diagnose and treat issues.

[148] Ecchymosis can appear similar to a bruise but is caused by bleeding underneath the skin.

including albumin[149] 31 (normal range 35 – 50), Hb 105 (previously 143), WCC 14.8 (previously 17.6), CRP 282 (previously 298). The plan was to treat the infection, drain the haematoma, bowel management, to keep Colin hydrated, and pain relief.

3.579 An ECG was recorded and showed atrial fibrillation, with a recommendation from the perioperative medicine consultant to give a stat dose of digoxin.[150]

3.580 At 11am, the MHLT made a request to the surgical team to consider ITU sedation for Colin if maximum doses of psychotropics did not work: "*behaviour is unlikely to resolve until physical issues resolve*". They documented that they had tried to make multiple arrangements for two registered mental health nurses to support '*2:1'* care, but this had not yet been approved. They added that admission to a psychiatric ward would only be considered once all medical and surgical issues were resolved. The side effects and risks of psychotropics were explained to the surgical team and ML was advised that Colin had delirium secondary to physical health, complicated by dementia.

3.581 At 12.30pm, the IR consultant was consulted in relation to the haematoma. They stated they would not be able to perform an IR drain of the haematoma as it was too solid.

3.582 At 1.30pm Colin was then seen by Consultant Surgeon 2 who noted the slightly improved blood results and agreed with current plan including IV tazocin and sedation. They documented that, "*if becomes unwell/increased temperature/not settling, plan for theatre for evacuation of haematoma*". This was at a point when Colin was already significantly unwell, was frequently agitated and unsettled, his temperature had been elevated that morning (although within normal ranges at the time of the medical review) and the presentation of his abdomen was deteriorating. Decisive intervention was required, but not given.

3.583 That evening (untimed) an FY1 doctor was asked to review Colin due to bleeding from his wound site. Venous blood gases were recorded with Hb 114 and lactate[151] 2.2 (normal lactate levels typically range from 0.5 to 2.2). The plan was for IV fluids, the day team to review Colin's wound, and to chase repeat bloods.

3.584 On 4 August, Colin became agitated and "*tore up*" his surgical wound, which began to bleed. It is unclear which wound this was (namely, the old stab wound, or the haematoma IR wound site), as notes from 9.30am describe two dressings to Colin's abdomen (right upper quadrant mildly soiled, midline dressing blood soiled). Colin agreed to have the midline dressing changed, and a circular abdominal wound was seen with a large thick clot. He refused to have the other dressing changed. During the day multiple dressing renewals were required, with Colin pulling each off after application. It was documented that the midline wound was bleeding, and the doctors on the ward round (untimed) noted that his belly button had perforated, and that the haematoma was externalising. This is the first description of the wound since admission to the ward (including within the nursing records and body maps which occasionally described "*wounds*" but with type and grade omitted).

3.585 At 2.45pm, Colin was reviewed by Consultant Surgeon 2 who noted that Colin's inflammatory markers were increasing (CRP 382 (previously 282) WCC 16 (previously 13)) despite him being on IV tazocin. The haematoma was leaking via the umbilicus, and it was documented that this needed evacuation and to be discussed with the ITU, as this would require Colin to be intubated. This decision was also discussed and agreed with Consultant Surgeon 5.

3.586 ITU consultant 2 reviewed Colin and requested that he go to theatre prior to admission to their unit. The procedure was, however, cancelled as Consultant Surgeon 5 reported that the haematoma was

[149] Albumin is a protein in the blood plasma. It keeps fluid from leaking out of blood vessels, nourishes tissues and carries hormones, vitamins and ions like calcium throughout the body. The concentration of albumin in the blood drops when the liver or kidneys are damaged, if a person experiences severe inflammation in the body, or with shock. It can also indicate malnutrition.

[150] Digoxin is a cardiac glycoside used to treat atrial fibrillation.

[151] Lactate, also known as lactic acid, is a substance produced in the body during intense physical activity or when oxygen levels are low. Lactate levels can be measured in the blood to assess various medical conditions including sepsis.

already draining (through the perforation). This was two days after the scan had shown a deterioration in the haematoma and a day after the decision that intervention and drainage was required. During this time Colin was clearly distressed and agitated and would undoubtedly have been in pain (see comments in medications section below). The absence of a clear and decisive plan allowed the haematoma to expand, and caused significant internal and external harm, culminating in a fistula being confirmed the following day.

3.587 Prior to transfer, ITU Consultant 2 and Consultant Surgeon 5 discussed the admission to ITU with ML and explained the risks associated with this. There was an agreement that Colin would not be for cardiopulmonary resuscitation[152] (CPR) and the DNACPR form was signed. This practice was in line with the Trust's Do Not Attempt Cardiopulmonary Resuscitation Policy (2021), which states that if a patient lacks capacity and has an attorney for health and welfare, it will be necessary to discuss matters relating to CPR with them; however, we note that a capacity test was not undertaken for Colin, and this section of the form was left blank.

3.588 A TEP was also completed by Consultant Surgeon 5. This indicated that Colin was not for CPR and that ITU was for sedation only. All treatment options were to be given other than "*haem/dia/filtration, non-invasive ventilation and optiflow*".

Medications

3.589 There were no changes to Colin's core medication regime on transfer to Bulphan Ward. He remained on a range of medications for his cardiac failure, hypertension, enlarged prostate, constipation and dementia. Although these were given to Colin on most days, there were also omissions on 29 July due to the medications being unavailable or 'other' (mostly due to refusal). As has been highlighted before, omissions due to medications being unavailable were unnecessary and clinically unsafe.

3.590 A broad-spectrum oral antibiotic (co-amoxiclav) was commenced on 29 July, although the rationale for commencement was not stated in the clinical records, and we can see no evidence of sensitivities being sought (either through urine testing or wound swabs) prior to these being given. The additional information on the drug chart was that Colin had a large haematoma with a raised WCC and CRP, but Colin had multiple sources of potential infection and there should have been a more considered approach to the antibiotic regime at this time.

3.591 Inflammatory markers continued to rise, and a stat dose of antibiotics (gentamycin) was prescribed on 2 August in response to the CT scan of his abdomen showing pockets of gas in the haematoma, which had slightly increased in size. Again, wound samples were not sent for testing and microbiology advice was not sought at this time and should have been.

3.592 On 3 August, different IV antibiotics (tazocin) were commenced with reference to a referral being made to microbiology, although we can see no evidence of advice being received before this additional medication was commenced.

3.593 Colin was also noted to be potentially constipated on 31 July (a Saturday), with concerns about this raised by ML (Colin was on a stool chart and his last recorded bowel movements were on 30 July at 4.15am and 6.14am). Colin was already on senna 7.5mg at night, but an additional laxative (Fybogel) was prescribed. This was, however, unavailable on the ward. Rather than requesting a different laxative, the medication was omitted over the next two days, during which time Colin did not have a recorded bowel movement, and it was documented by nursing staff that Colin had abdominal pain with difficulty opening his bowels. Colin had a phosphate enema on the morning of 2 August, and it was noted by the perioperative medicine consultant that Colin had his bowels open that day (large type 6[153]) with their plan of care indicating a requirement for bowel management (type 6 loose stools and diarrhoea can be a sign of constipation). Colin was found to have a soft, distended abdomen when examined on 3 August, and a phosphate enema was prescribed again,

[152] Cardiopulmonary resuscitation (CPR) is an emergency lifesaving technique used when someone's breathing or heartbeat has stopped.

[153] On the Bristol Stool Chart, types 5 and 6 are loose stools that are easier to pass but may mean mild diarrhoea.

although not signed as being given. Monitoring and responding to concerns about bowel habits is essential for all patients and was particularly important for Colin, as constipation can result in delirium and agitation (and bowel obstruction). Colin was displaying signs of delirium and had suffered a significant abdominal injury, so preventing faecal impaction was essential for his recovery.

3.594 Research has also highlighted that people with dementia are at higher risk of experiencing unmanaged pain (Alzheimer's Society, 2019). During this period of care, there were several references to Colin complaining of pain but with no reference to this being regularly and proactively assessed. Paracetamol was prescribed and given four times daily, with 10mg as required oramorph administered once on 30 July, three times on 31 July, once on 1 August, twice on 2 August, and three times on 3 August. The perioperative medicine consultant indicated on 3 August that pain relief was required, and 2.5 to 5mg as required oxycodone[154] was prescribed with 5mg given at 3.20pm that day, and four times on 4 August. Colin had fallen from height, had wounds to his head, had a wound from the scissors he stabbed into his abdomen, and an expanding abdominal haematoma. His increasing agitation was likely to have been contributed to by uncontrolled pain, but we can see no evidence of how this was assessed, with no pain charts being completed for Colin during this period of care.

3.595 In relation to his mental health, the MHLT reviewed Colin every day between 29 July and 4 August. On transfer to Bulphan Ward, Colin had been on 10mg memantine and as required clonazepam. On 29 July the MHLT recommended discontinuing the clonazepam and commencing regular lorazepam, with 1mg also to be given as required (route not stated). On 30 July, following incidents of violence and aggression, they added 0.5mg risperidone to be given at night. The risperidone was increased the following day to 0.5mg twice daily, with memantine also increased to a daily dose of 15mg. This was in line with NICE prescribing recommendations.[155]

3.596 On 29 July, midazolam 2 – 3mg IV/IM ("*for surgeons"*) and haloperidol 5mg IM were also prescribed by the ward doctor, but there is no record of why or what was meant by "*for surgeons*". We are unable to determine who made the entry, as only one prescriber completed the signature record on the chart. This should not have been prescribed without clear instruction included on the chart. Also, although in line with the Rapid Tranquillisation Policy (2021), haloperidol is known to trigger extrapyramidal symptoms[156] and many other adverse effects such as QT-interval prolongation leading to cardiac arrythmias, and can itself cause agitation or restlessness, often during the first few days of initiation. It should have been avoided given Colin's cardiac history unless other methods of sedation had failed.

3.597 On 31 July, when Colin was reviewed by the MHLT, their plan included to "*continue IM prn medication as per char*t" but did not specify whether this referred to the lorazepam that they had recommended to be given on 29 July, or if this also included the haloperidol and midazolam that had been prescribed and administered on three occasions. Incomplete prescriptions appear to have been consistent themes throughout Colin's stay.

3.598 When reviewed on 2 August by the perioperative medicine consultant, Colin had been very agitated and was described as "*still combative*" despite administration of IM lorazepam and haloperidol. The consultant advised the ward to give IM promethazine, haloperidol and lorazepam. They noted the risperidone and indicated that Colin should also receive regular promethazine, although we can see no evidence of this being prescribed.

3.599 On 3 August, the MHLT recommended commencing 1mg four times daily (qds) oral haloperidol, as required lorazepam (up to 4mg daily) for severe agitation, and as required haloperidol (up to 10mg

[154] Oxycodone belongs to a class of drugs known as opioid analgesics and is used to help relieve moderate to severe pain.

[155] https://cks.nice.org.uk/topics/dementia/prescribing-information/antipsychotics/#:~:text=The%20optimum%20dose%20is%200.5,persistent%20aggression%20in%20Alzheimer's%20dementia.

[156] Extrapyramidal symptoms include movement dysfunction such as dystonia (continuous spasms and muscle contractions), akathisia (may manifest as restlessness), parkinsonism characteristic symptoms such as rigidity, bradykinesia (slowness of movement), tremor, and tardive dyskinesia (irregular, jerky movements).

daily). They documented that antipsychotics and as required medications had been optimised. They added that it was important to note that Colin's confusion and behaviour was driven by his underlying physical health pathology and was complicated by dementia, "*It is not advisable to increase his psychotropics any more as it increases his risks of side effects"*. They also noted that if these medications did not work, Colin would require ITU admission and sedation. The haloperidol included an instruction that it was for agitation and to monitor Colin's QT-interval. While the instruction to monitor Colin's cardiac function was in line with good practice (as haloperidol is known to have adverse effects on the cardiovascular system – see above), the frequency of monitoring was not specified. Colin did not receive any oral haloperidol on the day that it was prescribed due to it being clinically contraindicated, with the nursing staff documenting that he was too drowsy to take oral medication. Although it was appropriate for lorazepam to be used as the IM option if required, the haloperidol and midazolam should not have been prescribed as these medications can in themselves worsen delirium.

3.600 During this episode of care, variations of rapid tranquillisation were administered by the ward staff in response to Colin's increasing episodes of violence and aggression with some advice also given by the MHLT and the perioperative medicine consultant. IM sedation that was administered is shown in the table below:

Date	Time	Medication	Initiation
29 July	10.20am	1mg IM lorazepam	Prescribed by ward on 29/07/21
	3pm	5mg IM haloperidol	Prescribed by ward on 29/07/21
	11pm	1mg IM lorazepam	Prescribed by ward on 29/07/21, endorsed by MHLT
30 July	11.52am	5mg IM haloperidol	Prescribed by ward on 29/07/21
	1.25pm	2mg IM midazolam	Prescribed by ward on 29/07/21
	6.50pm	2mg IM midazolam	Prescribed by ward on 29/07/21
31 July	4.59am	5mg IM haloperidol	Prescribed by ward on 29/07/21
1 August	2.05pm	3mg IM midazolam IR 3581	Prescribed by ward on 29/07/21
	2.20pm	5mg IM haloperidol	Prescribed by ward on 29/07/21
	9.10pm	3mg IM midazolam	Prescribed by ward on 29/07/21
2 August	11.15am	3mg IM midazolam	Prescribed by ward on 29/07/21
	11.20am	1mg IM lorazepam	Prescribed by ward on 29/07/21, endorsed by MHLT
	12.15pm	5mg IM haloperidol	Prescribed by ward on 29/07/21
	1.39pm	5mg IM haloperidol	Prescribed by ward on 29/07/21
	2.40pm	1mg IM lorazepam IR 3707	Prescribed by ward on 29/07/21, endorsed by MHLT
	6pm	0.5mg IM lorazepam	Recommended by perioperative medicine consultant
	6pm	2.5mg IM haloperidol	Recommended by perioperative medicine consultant
	6pm	0.5mg IM promethazine	Recommended by perioperative medicine consultant
	11.30pm	2.5mg IM haloperidol	Recommended by perioperative medicine consultant
	11.30pm	0.5mg IM lorazepam	Recommended by perioperative medicine consultant
3 August	12.30pm	5mg IM haloperidol	Prescribed by ward on 29/07/21
	3.00pm	1mg IM lorazepam	Prescribed by ward on 29/07/21
	3.15pm	1mg IM lorazepam	Recommended by MHLT on 03/08/21
4 August	12.21am	1mg IM lorazepam	Recommended by MHLT on 03/08/21
	5.43am	5mg IM haloperidol	Recommended by MHLT on 03/08/21
	11.45am	1mg IM lorazepam	Recommended by MHLT on 03/08/21
	1.10pm	5mg IM haloperidol	Recommended by MHLT on 03/08/21

3.601 This prescribing and administration of medications did not appear to be joined up across the teams and was not in line with good practice guidelines, and other causes of agitation such as pain and infection were not addressed sufficiently.

3.602 There were also occasions when this prescribing exceeded the limits of various Trust policies, including in the Initial Pharmacological Management of Agitated Behaviour Symptoms Arising from an Underlying Delirium in Adults guidance (2021), which says that no more than 2mg lorazepam should be given in a 24-hour period for adults over 65 and no more than 3 to 5mg haloperidol. Also, the Emergency Control of the Acutely Behavioural Disturbed/excited Delirium Patient: Rapid Tranquillisation Policy (2021) which states that a maximum of 4mg lorazepam can be given daily or 12mg haloperidol.

3.603 A recording has been shared with us, and this includes a doctor telling a nurse to *'give sedation and painkillers freely as this is the only way to keep him calm'.* This statement would appear to be consistent with the administration of medications seen in the table above.

3.604 Staff that we spoke with referenced a lack of understanding by many nursing staff about the use of rapid tranquillisation and chemical restraints. The drugs were not prescribed as rapid tranquillisation and should have been. Other than on one occasion, these were not incident reported (either as restraints or potential safeguarding incidents), and we can see no evidence of physiological observations being increased after these events, both of which are requirements of the Rapid Tranquillisation Policy. We note that on 30 July, at 11.47am, Colin's HR was 90 bpm. He was administered IM haloperidol at 11.52am and midazolam at 1.25pm. His next physiological measurements were recorded at 5.21pm and his HR was 140 bpm. He remained tachycardic until 11.30am on 31 July, during which time he was also administered 2mg IM midazolam (at 6pm on 30 July) and 5mg IM haloperidol (at 4.59am on 1 August). He became tachycardic again on 2 August and was prescribed a stat dose of digoxin for this.

<u>Care planning and risk assessment</u>

3.605 On Colin's arrival on the ward, we can see no evidence of the inpatient nursing assessment document being updated and many sections of this document were left blank for the duration of Colin's hospital stay (see comments in the care planning and risk assessment section of the AMU episode of care).

3.606 In relation to other nursing assessments:

- Colin's Waterlow (tissue viability) score was updated after transfer to the ward in line with expected practice. However, he was marked as having no pain but without completion of the pain chart and despite Colin having fallen from height and sustaining extensive bruising and wounds to his abdomen.
- The moving and handling assessment was not updated.
- A body map was not completed until three days later (31 July). The nursing records say his wounds were cleaned and redressed but with no descriptions of these either in the medical or nursing records, including on the repositioning chart body map, which just says wounds re-dressed). Commentary did not include the size of the wounds or whether there were any signs of inflammation or infection, which meant that the nursing and medical staff were unable to determine if Colin was improving or deteriorating. There was no management plan for Colin's wounds.
- We can see no evidence of a Malnutrition Universal Screening Tool (MUST) nutritional assessment being completed on this ward (there is a requirement for the screening tool to be repeated at least weekly) including when nil by mouth status was commenced on 3 August. Colin had been in hospital for seven days without being weighed at the time of his transfer. Although it was noted that he was eating and drinking, optimal nutrition was an essential part of Colin's recovery, especially in the healing of his traumatic injuries and surgical wound.

- We have also been told by ML that on one occasion she found Colin in bed, with the bed rails up, restrained by the bed being tilted in such a way that he could not get out. We have been unable to corroborate this finding, although we are aware that bed rails were used during this period of care (and have seen photographs of the same) but without an appropriate bed safety rail risk assessment being undertaken.

3.607 It was documented by the nursing staff that Colin would have had enhanced supervision with one-to-one nursing due to his history, and this was also recommended by the MHLT who reviewed Colin the day after his transfer to the ward. An Increased Nursing Supervision Trigger Tool chart was commenced but the assessment criteria were only partially completed, and the risk reduction strategy section left blank. We can see no evidence of this being reviewed despite being a requirement every 48 hours if nursing supervision is agreed. We can also see no evidence in the nursing records of the levels of supervision that Colin was meant to be having at any one time or by which grade of staff. Other than occasional progress notes, and some entries on activity charts, the records also do not include the numbers and grades of staff that were allocated to Colin or whether they were substantively employed by the Trust, by EPUT who were helping to support his enhanced nursing supervision needs, or agency/bank. We have seen no rota or register that would allow us to identify the staff that were booked to look after Colin. There are some entries by some registered mental health nurses (RMNs) but not for every shift. Where there were comments (in the clinical notes) about changes to the levels of supervision, these were without time restrictions being given. For example, in the late afternoon of 30 July, after an incident of violence and aggression, it was documented that Colin was to be nursed by three staff (two registered nurses and one healthcare assistant, preferably male staff) with a note that a family member could stay 24/7 to support this staffing. The activity chart does not indicate that this was achieved, with one-to-one nursing documented that night. There were also occasions when one-to-one nursing could not be supported by the ward; the majority of additional shifts went unfilled and there were insufficient ward staff to cover this level of supervision (for example, on the night of 2 August, when a healthcare assistant helped, when the ward were unable to provide one-to-one nursing because they were short staffed and providing one-to-nine care across the ward, with the healthcare assistant included in those numbers).

3.608 During this period there was a heavy reliance on bank and agency staff, with many substantive staff having time owing from having to work extra hours throughout the pandemic. There were also no substantive Band 6 senior staff nurses, as all three posts were vacant at that time and filled with Band 5 staff who were acting up into these positions. These shortfalls were not incident reported, and should have been, because without this reporting there was limited information available to senior managers about the impact of this on the ward. There were comments by ML that some of the agency staff were not fluent in English and were difficult to understand on some occasions and that this would have been frustrating for Colin.

3.609 On 3 August, it was documented that the MHLT had made multiple attempts to arrange for two RMNs to support the ward, and in order to ensure two-to-one observations and supervision of Colin, but that these arrangements had not yet been approved.

3.610 Having been assured that Colin would receive one-to-one nursing care, ML became distrustful of staff, as there were occasions when she visited when the required staffing was not provided (often due to short staffing on the ward and an inability to fill shifts). ML was often in attendance to support Colin, and she stayed through the day and night several times and was able to escalate Colin's care needs to staff (including in relation to his bowels, pain and other potential causes for agitation), but this was challenging for staff, as ML became frustrated at their inability to provide appropriately trained staff who would be able to respond to Colin's needs. She was noted to have apologised to staff on some occasions but had been concerned and was "*panicking*" about him. Staff felt that there were occasions when Colin was settled but ML would disturb him, and he would become agitated. On 3 August ML was restricted back to normal visiting hours for her own wellbeing but also because staff were finding her "*obstructive and unsettling for Colin*".

3.611 Notably, the activity charts that were maintained on the ward were different to those employed on Florence Nightingale Ward and included sections for activity (trigger), behaviour and consequence. These have no stated frequency for completion but were mostly filled in every hour, although in a few cases every two to three hours. They included a more detailed description of Colin's activity but with no reference to any distraction techniques that might have helped to calm him other than noting that he was settled when visited by friends or family; this was contrary to the comments about ML "*disturbing*" Colin. Under 'consequence' there was often a statement to say "*closely monitored*", including, for example, when Colin was "*aggressive and pulling on catheter*" but also when he was asleep. This indicates a serious lack of understanding about the purpose of these charts; the content was largely a tick box exercise given that the outputs were not reviewed by any member of the ward team, the MHLT or the RMNs who were supervising Colin.

3.612 The Care of Patients With Dementia Policy (2020) includes that it is essential to have individualised care plans for confused patients, yet there were no plans of care that would have supported staff to understand Colin's care needs and what might have helped to prevent or reduce Colin's agitation should it occur, and the entries on the enhanced supervision charts would not have supported staff to understand what these might be. Colin was on enhanced supervision throughout this episode of care, and many shifts were filled by temporary bank and agency (mental health and security) staff ("*we never had a familiar face*"), but there was no detail about how staff could ensure that Colin's care needs were met, what staff should observe for, what staff needed to be aware of, how specific situations may be managed, or how the observations that were recorded on the activity charts were to be reviewed. Handovers were verbal, and there was no expectation for the staff looking after Colin to write in his notes. It became clear to staff when reflecting on Colin's episode of care that Colin tended to become agitated when he wanted to leave, or after his family visited him as he wanted to go with them; however, this was not recognised or acknowledged while he was on the ward in a way that was helpful in terms of staff being able to agree some strategies for diversion.

3.613 At the point of transfer to Bulphan Ward, Colin had a history of violence and aggression, and had become violent and aggressive on multiple occasions within the hospital. As with Florence Nightingale Ward, it was, therefore, reasonable to expect that episodes of this nature would reoccur. However, we can see no evidence of risk assessments or care plans being initiated for Colin on admission to the ward or in response to his further episodes of violence, aggression and absconsion. We can also see no evidence of a MDT discussion (supported by senior managers, senior security staff, the dementia nurse, the MHLT, LPA and family) to assist the ward staff in agreeing an approach to managing Colin's behaviour. This meant that Colin, other patients and staff were again exposed to risk and harm that could potentially have been avoided through more appropriate interventions and management strategies.

<u>Behaviour and presentation – MCA and safeguarding</u>

3.614 A standard authorisation for Deprivation of Liberty Safeguards (DoLS) had been requested on 24 July when Colin was admitted to the Florence Nightingale Ward, with an urgent application authorised by the safeguarding team for seven days. An extension for a further seven days was requested on 30 July.

3.615 On 30 July, Colin was reviewed by Adult Safeguarding Lead 2 who documented that he had "*DoLS and MCA in place… DoLS dated for 14 days, after this <u>there is no need</u> for further DoLS – Trust responsibility is met*". *Local authority aware of DoLS.*" There was, however, no evidence of the request having been authorised by the local authority. If DoLS was not available (after the two 7-day urgent authorisations had been completed) then the hospital should have re-done their capacity assessment; if a deprivation was still proportionate and necessary, the Trust should have held a best interests meeting (preferably before the DoLS ran out) and (again if necessary) sought court authorisation for the deprivation or (if appropriate) considered use of the MHA.

3.616 We have been told that during this period there was a backlog of DoLS requests at the local authority, with DoLS authorisations rarely being met. The Trust had defaulted to a position where requests were not repeated after urgent authorisations had been made.

3.617 At 11.30am on 30 July, Colin became agitated and aggressive. He headbutted a member of staff, began throwing objects and tried to abscond. Security were called on two occasions and the medical matrons also attended the ward. Colin was moved into side room 13 and was to be assigned two registered nurses and one healthcare assistant ("*preferably male staff*"). ML and Colin's family were also given permission for one person to be present 24/7 until safe staffing levels were attained but subject to change depending on staffing levels. While we recognise the benefits of family being able to support patients while in hospital, using them to achieve safe staffing levels was unacceptable, particularly given the violence and aggression being displayed by Colin. Safety concerns should have been incident reported and a meeting held with senior medical and nursing staff to discuss the options available to the ward.

3.618 On 31 July, the on-call manager was asked to see ML who remained concerned about the care Colin was receiving. Her concerns were about staffing, an ECG being performed inappropriately, observations not being taken, sepsis/infection, plans for mental health, sedation, physiological monitoring after "*rapid sedation*", and wound review. ML was advised that staff could not update her on a permanent basis and that video and recording of Colin and conversations with staff were not permitted. ML was told that bloods were being regularly reviewed and that Colin was on a broad-spectrum antibiotic. She was also told that sepsis pathway triggers were in place and the abdominal wound had been reviewed by the team, with no signs of infection. An agreement was made to have touch points for updates, although the frequency of these were not specified and we can see no evidence of proactive meetings being held with ML after this time. These responses were not accurate; serious concerns had been raised by ML, many of which had foundation, yet a safeguarding concern was not raised. Colin continued to deteriorate, and further harm was caused to him and to other staff.

3.619 Colin continued to be agitated throughout this episode of care and there were several episodes of violence and aggression, as indicated in the medication section above. Chemical sedation was invariably given after physical restraints had occurred, with physical restraint also being required for administration. As with the chemical restraints, many of these physical restraints were not incident reported and should have been. Documenting the type, duration and involvement of staff for each restraint was essential as there are notes which state that on some occasions three and four staff were required to restrain Colin, with some injuries caused to him, including a skin tear on his arm. Also, on 3 August, it was noted that Colin's haematoma had externalised and was bleeding. ML described his abdominal wound bursting during a restraint when "*three security guards forced him onto his bed after biting their colleague*". There were no documented body checks after the restraints and, without accurate record keeping and incident reporting from the security and nursing staff, it is impossible to know how much harm was inflicted on Colin during these restraints. At the time of his transfer to ITU, Colin had extensive bruising and an open wound on his abdomen but also a skin tear and bruising to his arms, legs and penis.

3.620 Staff (and ML) were also injured during these episodes of violence and aggression, with reference made to them being headbutted, punched and bitten. The absence of incident reporting meant that the Trust was unable to assess the level and frequency of violence that was occurring, and whether the staff involved had the required PMVA or other relevant training to allow them to undertake these interventions, or received briefings and support after these difficult and upsetting interventions. On 4 August, four security staff were required to be present with Colin; he made several attempts to headbutt, bite and punch them, and by the afternoon the team confirmed that they were no longer willing to restrain him. The ward should have made a safeguarding referral, not only for Colin but for other patients, given the concerns about physical injuries, the levels of aggression and restraints. The safeguarding team could then have looked at the use of medications, the levels of restraint, appropriateness and training levels of staff doing the restraints, and any impact on other patients.

3.621 In relation to support for the ward staff and Colin, the MHLT were responsive to the requests for review. On 30 July they were contacted by ward staff, as Colin was becoming aggressive towards them. The MHLT advised regular and prn lorazepam, one-to-one monitoring and confirmed that they would review him on the ward. The team reviewed Colin that day at 1.54pm. They noted that

he was confused and disorientated, believing he was on a cruise, "*has MCA and DoLS in place*". They spoke on the phone with ML, who agreed Colin could be medicated to prevent further absconsion and to allow bed rest. She was also reported to be happy for a MHA assessment when Colin was MSFD. The team documented that lorazepam could be increased to 0.5mg three times daily if needed and to discontinue clonazepam. They would call the ward every day and would review Colin if there were any changes prior to the MHA assessment.

3.622 Members of the MHLT visited the ward each day and they liaised with ML and advised on the medication regime for Colin; however, we can see no evidence of other support strategies being offered to ward staff, who struggled to safely manage his behaviours.

3.623 Similarly, it was recorded that various managers, including the on-call manager, matrons and the associate director of nursing attended the ward during and after some episodes of violence and aggression. They fielded some of the concerns that were raised by ML, and stipulated visiting times and points of contact, but not on a consistent and proactive basis and did little to effectively or practically support Colin, other patients or staff.

3.624 We note that when Colin was reviewed by the perioperative medicine consultant on 2 August, they spoke with ML and described that the management plan was to treat the infection, drain the haematoma, bowel management, to keep him hydrated and use pain relief "*with no choice but to deploy MCA/DoLS and the rapid tranquillisation protocol. If PoA wants us to stop sedation, we will need to make an application to the Court of Protection to continue treating in best interests. Personally, treating the collection/haematoma remains the last option for continued survival and treating the delirium*."

3.625 The episodes of violence and aggression reached such a level that Colin's sink had to be removed from his room (on 2 August the door to his side room was shut and he had thrown his dinner plate, pulled the radiator cover off which was already loose and also the panel from below the sink – the sink had been assessed as potentially harmful if broken) and two days later, the security staff refused to restrain him.

3.626 An early best interests meeting with all professionals (including the MHLT, surgeons, nursing, security staff), ML, Colin's children and an IMCA should have been convened given the risks of harm to Colin and others. This was also essential because ML was strongly opposed to the administration of certain forms of sedation (for example, haloperidol), with staff being regularly challenged about these prescriptions. This meeting would have allowed a management plan to be agreed within an appropriate legal framework. It would equally have allowed ML's disagreements with medication to be discussed and, if necessary, resolved through advocacy, mediation or referral to the Court of Protection. Ultimately, if the care team had believed ML was not acting in Colin's best interests, then they should have made a referral to the Office of the Public Guardian.

3.627 An incident report was completed by Adult Safeguarding Lead 2 about this episode of care on 6 August under the category 'safeguarding adults' and sub-category 'alleged abuse by staff: neglect'. This included concerns raised by ML about repeated restraints used on Colin by security staff ("*with no medical training*"), "*chemical coshing*", Colin being in "*immense pain*", and insufficient staffing to supervise him. She concluded by saying that Colin was "*unsafe … urgent action must be taken … the paper trail of these requests is ridiculous … when will social care actually do something to help*". The form included that the Trust had reported incidents in relation to the admission and that Colin was under DoLS to support any restrictive practices in place. We have seen no evidence of this being escalated to the local authority through a safeguarding alert. The local authority should have been notified of the concerns so that they could meet with Colin, speak with staff and family (the referrer especially) and if appropriate could have carried out a full Section 42[157] safeguarding enquiry under the Care Act 2014. Given that a standard authorisation had been completed, the local authority would have been aware of this case and could have used the DoLS/MCA, MHA and Care

[157] A formal adult safeguarding Enquiry (Care Act, Section 42) is the range of actions undertaken or instigated by the local authority in response to an abuse or neglect concern in relation to an adult with care and support needs who is unable to protect themselves from the abuse or neglect or the risk of it.

Act frameworks to develop a safety plan. They could also have supported an application to the courts if necessary and/or instructed an approved mental health professional (AMHP) to review Colin. These concerns may also have met the criteria for a CQC statutory notification[158] (for physical abuse – safeguarding) but we are unaware of a notification being made.

3.628 In relation to ML recording conversations and taking photographs of Colin, it is recognised that patients or their carers may see filming as a way to protect themselves, particularly where there are concerns that standards of care are not being met. People receiving health and care services have the same right to privacy and dignity as everyone else. Recording equipment should only be used with the consent of the person whose care someone is concerned about. If the person does not have the capacity to give their consent it is important that the relative/carer feels sure they are acting in their best interests. Healthcare staff should be informed if conversations are going to be recorded; however, it is not illegal to do so without their permission unless there is found to be misuse of any such filming or recordings.

3.629 There were many references to ML recording conversations without consent and the staff response was to incident report, tell her it was not allowed or, in some cases, conversations were stopped. This created further ongoing tensions and mistrust between ML and staff. At the point where staff realised that this was happening, a (senior) member of staff should have:

- Listened to ML's reasons for why she wanted to film or record conversations and worked with her to find the best solution for capturing what staff said. It should have been explained that asking for permission was a matter of courtesy and respect and was more likely to lead to a positive and trusting relationship.
- Made sure that any ongoing or immediate concerns that ML had about Colin's care were understood and addressed – including safeguarding concerns.
- Made a note in Colin's records that video/sound recording had been discussed and could take place.
- Informed ML that appropriate civil or legal action would be taken if it was believed that the recordings were going to be (or had been) misused.
- Ensured that staff were aware of what was or was not permissible with reference to the Trust policy.

Intensive Therapy Unit 4 August – 3 September 2021

3.630 On admission to the intensive therapy unit (ITU), Colin was reviewed by ITU Consultant 2. A treatment plan was documented.

3.631 At 7pm, one litre of blood clots was expressed from Colin's haematoma by the consultant surgeon.

3.632 On 5 August, at 8.25am, Colin was reviewed by a doctor who noted bile-stained fluid in the stoma bag. The on-call consultant surgeon reviewed Colin and queried an enterocutaneous fistula.[159]

3.633 At 12:35pm, ITU Consultant 2 also reviewed Colin. The plan was for a central venous catheter (CVC)[160] line insertion (for IV fluids and blood transfusions that might be required), a possible CT scan of abdomen, surgical discussion, to be nil by mouth (NBM), and to continue IV antibiotics.

3.634 Colin was reviewed by Consultant Surgeon 2 who documented that the fistula was to be treated conservatively.

[158] https://www.cqc.org.uk/guidance-regulation/providers/notifications

[159] An enterocutaneous fistula is an abnormal connection that develops between the intestinal tract or stomach and the skin. As a result, contents of the stomach or intestines leak through to the skin.

[160] A CVC is a long, flexible tube which is inserted into a patient's neck, chest, arm or groin to help them receive drugs, fluids or blood for emergency or long-term treatment.

3.635 On 6 August at 9:15am, Colin was reviewed by a colorectal surgeon who advised continuing management with the stoma bag.

3.636 At 10.50am, there was a review by the surgical team. They documented the need for nutrition team input and noted Colin's bloods results were improving.

3.637 The discussed Colin's specimens results with microbiology and were advised to continue antibiotics and await sensitivities.

3.638 Colin was also reviewed by the nutritional team, who noted that there was a refeeding[161] risk.

3.639 On 7 August at 11.20am, Colin's oxygen saturations dropped. Endotracheal intubation[162] was commenced and a nasogastric tube was inserted.

3.640 A doctor was asked to review Colin (untimed) as faecal matter was "*pouring out of the abdominal wall*". It was noted by the nursing staff that Colin had blood in his faecal matter when his bowels were opened. This was escalated to the medical staff.

3.641 Nasogastric feeding was commenced on 9 August at 6am.

3.642 On 10 August, there were attempts to reduce Colin's sedation for extubation, but he became agitated, and a decision was made by the ITU team to defer this to another time.

3.643 On 12 August at 1.20pm, Colin was reviewed by the vascular SpR who examined his abdomen and found a small amount of pus from one wound [right quadrant], and bowel content from the other.

3.644 On 16 August, Colin was extubated at 1.15pm.

3.645 On 17 August, Colin was reviewed by Consultant Surgeon 2 at the request of the ITU team. He noted that Colin's WCC and CRP were increasing.

3.646 On 18 August at 9.20am, Consultant Surgeon 1 noted the CT scan results which indicated some internal improvement in the abdominal wall haematoma. An opinion was sought from the psychiatrist, who felt the current state was due to delirium.

3.647 At 2.45pm Colin was noted to be deteriorating and a decision was made to re-intubate him.

3.648 On 20 August, Dementia Nurse 1 introduced herself to ML and arranged to meet with her on 24 August.

3.649 On 24 August, the EPUT Mental Health Liaison Team (MHLT) documented that the surgeons were considering nasogastric feeding – to replace the total parenteral nutrition[163] (TPN), and that Colin now had a permanent fistula (the plan was still to manage this conservatively).

3.650 A trial of extubation was aborted that day due to Colin becoming clinically unstable.

3.651 On 28 August at 5.45pm, Colin was extubated.

3.652 At the Critical Care multidisciplinary team (MDT) meeting on 1 September, there was reference to no new changes on a CT head scan that had been undertaken, and that Colin's decline was likely due to ITU admission and sepsis. A DNACPR form was completed due to "*poor physiological reserve, chronic cardiac failure, and underlying dementia*". A TEP was completed which included that Colin was for ward-based care.

3.653 On 2 September, a referral was made to the palliative care team.

[161] Refeeding syndrome appears when food is introduced too quickly after a period of malnourishment.

[162] Endotracheal intubation is a medical procedure in which a tube is placed into the windpipe (trachea) through the mouth or nose to support people who are unconscious or who cannot breathe on their own.

[163] Total parenteral nutrition (TPN) is when the IV administered nutrition is the only source of nutrition the patient is receiving.

3.654 On 3 September there was a meeting involving senior managers and the legal team to discuss Colin's move back to the ward. It was agreed that Colin would be transferred by 11am that day.

3.655 Colin was transferred to side room 7 on Bulphan Ward at 11.25am.

Commentary on this care episode and points for learning

Physical health

3.656 During this episode of care Colin was reviewed by ITU clinicians each day. He was also regularly reviewed by the surgeons and a range of other specialists for opinions on the care and treatment that was being received. Seeking these opinions was in line with good medical practice and included colorectal, vascular, gastroenterology and ear, nose and throat.

3.657 Colin was transferred to the ITU on 4 August at 6.15pm under the care of Consultant Surgeon 1. Prior to transfer, ITU Consultant 2 and the Deputy Director of Nursing met with ML. It was confirmed that support would be for antibiotics, to clean the haematoma and control Colin's agitation, with a review in 48 hours. They also told ML that it was possible that Colin might end up on a ventilator, which would have risks of complications, and these were described in full.

3.658 Colin was clerked on arrival and commenced on a propofol[164] infusion. He was reviewed by ITU Consultant 2, and his diagnosis recorded as "*extreme agitation secondary to possible dementia, possible delirium, abdominal trauma, possible infection*". The plan was to keep him sedated (with propofol), monitor BP, receive antibiotics and IV fluids, to send bloods, to stop apixaban, and to receive deep vein thrombosis[165] prophylaxis.

3.659 Colin was reviewed by Consultant Surgeon 5 the same evening. The wound from the haematoma was explored and approximately one litre of blood clots expressed. A specimen was sent for culture and sensitivity with "*indication sepsis*" marked on the request form and a stoma bag was placed over the midline wound. Specimen results were chased the following day. These indicated the presence of coliforms,[166] and antibiotics were amended in conjunction with ongoing microbiology advice. This was the first reference to sepsis by the surgeons and was a course of action that should have been taken while Colin was on Bulphan Ward when his CRP and WCC became elevated (see comments in physical health section of Bulphan Ward).

3.660 At 8.30am on 5 August, bile-stained fluid was noted in the stoma bag. On review, Consultant Surgeon 5 queried an enterocutaneous fistula with 300ml having drained that day. After consulting with his colleagues, Colin was reviewed by Consultant Surgeon 2 and a decision was made for conservative management (namely, no surgical intervention), although the rationale for this was not stated. Colin was to have TPN, IV antibiotics and a stoma bag. He recorded that a ceiling of care[167] (namely, through a TEP) should be agreed with the family and that an independent mental capacity advocate (IMCA) may need to be appointed. Discussing the ceiling of care was good medical practice. So too was the recommendation for advocacy which was in line with the requirements of the Mental Capacity Act (MCA), but this should have been much earlier in Colin's care journey. As before, we can see no evidence of a referral for advocacy being actioned.

3.661 A colorectal surgical opinion was requested. This was expected practice given the complexity of Colin's presentation. They noted that 800ml of mixed faecal fluid had drained via the stoma bag and indicated that, if it drained more than one litre in one day, Colin would need fluids with IV nutrition.

[164] Propofol is an intravenous anaesthetic used for procedural sedation, during monitored anaesthesia care, or as an induction agent for general anaesthesia.

[165] Deep vein thrombosis is a blood clot in a vein, usually in the leg.

[166] Coliforms are a type of bacteria found naturally in the intestines of humans and animals, and some are even found naturally in soil and water. Therefore, a positive coliform test does not necessarily indicate faecal contamination.

[167] The ceiling of care refers to the maximum level of care which a patient is set to receive. This is often a complex and sensitive decision reached between the patient (where possible), their family and the healthcare team responsible for the patient.

3.662 At 1.10pm, ML and Colin's son were informed in a planned meeting with Consultant Surgeon 5, ITU Consultant 2, MHLT team members and the Deputy Director of Nursing about the plan of care for Colin. The family were told that the haematoma had been evacuated the day before, but that there was now evidence of gastric contents, which suggested a fistula. The plan was to rest the bowel, and for nutrition and fluids to be provided via the vein, and sedation to be reviewed daily. They stated that it was unclear how long it would take for the fistula to heal (and whether it would heal) and that it could be a source of infection. Visiting was discussed and it was agreed that an ITU consultant would update ML each day at 2pm. Arranging defined contacts at a specified time was a helpful strategy which ML accepted. It would also have been beneficial to staff, with fewer interruptions to their working day. Daily and sometimes lengthy conversations were recorded with ML after this point either in person or via telephone calls including with the ITU team, surgeons and MHLT.

3.663 On 7 August, a doctor was asked to review Colin (untimed) as faecal matter was "*pouring out of the abdominal wall*" (abdominal diagrams indicate that this was on the right quadrant of Colin's abdomen). A stoma bag was placed over this wound entry, which was separate to the fistula that had already formed. At 3.30pm, results were received from microbiology for blood culture samples that had been sent on 5 August. These indicated that Colin had klebsiella[168] infection and he was to continue receiving tazocin.

3.664 From this point there were some confused entries about the two wounds on Colin's abdomen, with ward round sheets depicting different positions and descriptions. There was no commentary about the source of the second wound site and we have been unable to ascertain whether this was the original stab site. On 4 August, nurses referred to two dressings, one midline, which was blood soiled, and one right upper quadrant that was mildly soiled. On 9 August, nursing staff documentation included "*two puncture wounds collecting into stoma bags draining a lot*", but when reviewed by the vascular SpR, the notes indicate that the right quadrant wound had drained 250ml, and the midline fistula "negligible". By 12 August, the right quadrant was draining a small amount of pus, while the midline fistula was draining bowel content. The MHLT reviewed Colin that day and documented that no-one was able to clarify what both bags were for.

3.665 On 13 August, both stoma bags were draining faeces. Daily ward round notes from 13 to 16 August did not include wound markings, but on 17 August only one (midline) wound was depicted, and it is unclear what happened to the second right quadrant opening. Consultant Surgeon 2 noted on his review on the same day (but without a diagram) that the right-sided enterocutaneous fistula was draining some small bowel contents; we believe the fistula had been midline. A CT and second opinion on the management of the fistula was sought in line with good medical practice. On 20 August a different surgical SpR (illegible name) indicated that two wounds remained – the drain was empty midline, but the right quadrant wound still had a stoma bag (content description illegible). On 21 August the ITU team described "*two abdominal fistulas*".

3.666 The conventional therapy for an enterocutaneous fistula in the initial phase is always conservative. Immediate surgical therapy on presentation is contraindicated because the majority of these fistulas spontaneously close as a result of conservative therapy. Surgical intervention in the presence of sepsis and poor general condition is hazardous for the patient; however, patients who have adverse factors including a high-output fistula, may require early surgical intervention. Although the management of Colin's abdominal wounds were likely to have been unchanged, as outputs after 5 August reduced, there should have been clearer descriptions and allocation of wound type to the skin openings on Colin's abdomen. This was particularly important given that different doctors reviewed him on different days. It would have been difficult for a new doctor to determine the

[168] Klebsiella species are a gram-negative rod-shaped bacteria. They are commonly found in the environment and in the human intestinal tract (where they do not normally cause disease). These species can cause a range of healthcare-associated infections, including pneumonia, bloodstream infections, wound or surgical site infections. Acquired endogenously (from the patient's own gut flora) or exogenously from the healthcare environment.

progress of each wound given the very many descriptions that were documented on charts and in the clinical notes.

3.667 Colin's physiological observations, fluid balance and Glasgow Coma Scale (GCS) were monitored at least hourly from admission to the unit. This was essential given the sedation that was being administered. Medical staff were notified if there were any adverse readings including, for example, on 5 August, when Colin's GCS was low (5/15); this was escalated to the ITU medical team and noted to be acceptable as long as his airways were not compromised. In our view, the GCS was too low for conscious sedation, as Colin was unlikely to have been able to protect his airways with this level of consciousness and he should have been intubated at this point or his sedation reduced. On 7 August, Colin's oxygen saturations dropped to 24 per cent ('normal' range 95 – 100 per cent) and endotracheal intubation was commenced. This was an emergency procedure and consent from ML was therefore not required; however, she has said that she was not informed of the intervention until she visited the unit later that day.

3.668 Patients in the critical care setting are at high risk of malnutrition.[169] Colin's nutritional status was considered and managed in line with expected practice. A nasogastric tube[170] was inserted due to Colin being sedated, placement was confirmed on X-ray and the emergency feeding protocol commenced the next day. This was appropriately discontinued when the fistula was noted. TPN was commenced on 6 August following a review by the nutrition team. Blood results at that time included albumin 25 (normal ranges are 35-50), CRP 221, WCC 14.5, Hb 102. Body mass index was 29.4 with an estimated weight of 89kg. Regular advice and ongoing support was given by the nutrition support team. There were trials of nasogastric feeding during his stay; however, this had driven fistula outputs, so Colin had remained on TPN throughout his ITU admission.

3.669 Colin's sedation continued to be controlled, with plans for extubation discussed in the MDT to ensure this was done at an appropriate time but also with adequate medication and nursing support to manage any adverse behaviours. On 9 August, when reviewed on the ITU ward round, concerns were raised about the potential for agitation if ventilation were to be removed, but also that long-term sedation may adversely impact Colin and could potentially lead to a respiratory tract infection. It was agreed to increase his dose of haloperidol to three times daily and add chlorpromazine[171] 50mg three times daily with suggestions made for additional medications if required. It was noted that there was negligible output from Colin's stoma but that 250ml bowel contents had drained from the wound site on the right side of Colin's abdomen.

3.670 There was then an attempt to extubate him on 10 August; however, he became increasingly agitated, and a decision was made to defer this procedure to another time. Colin was extubated successfully on 16 August (a medical review at 8.54pm recorded his GCS as 13/15), but he deteriorated two days later, became distressed, with a respiration rate of over 40, and had to be intubated again. Physiotherapy was appropriately requested when concerns were raised about his airways and mucous collecting in his chest.

3.671 Colin's arterial and venous bloods were also tested at regular intervals, with microbiology advice sought when samples from the evacuation of the haematoma were sent on 4 August. His blood results were included on daily ITU ward round charts, and IV infusions adjusted according to the results received. On 17 August, Colin's Hb was noted to have reduced to 87, so a review by Consultant Surgeon 2 was requested. The consultant attended the unit and noted there was also an increased WCC (16) and CRP (231). They requested a microbiology review, repeat chest X-ray, and CT scan of the abdomen and pelvis. This was an appropriate response given the deterioration in his clinical presentation. They also asked for a second surgical opinion for management of the fistula and a second psychiatric opinion following a request from ML.

[169] https://doi.org/10.1016/j.clnu.2018.08.037

[170] A nasogastric tube (NG tube or NGT) is a special tube that carries food and medicine to the stomach through the nose.

[171] Chlorpromazine is a typical antipsychotic medication primarily used to treat psychiatric disorders such as schizophrenia, but it has other indications for use including for acute agitation.

3.672 On 18 August at 9.20am, Consultant Surgeon 1 noted the CT scan results, which indicated some internal improvement in the abdominal wall haematoma. They agreed with the management plan (conservative management of the fistula/drainage, to continue antibiotics and TPN, that physiotherapy was required).

3.673 On 19 August Colin's Hb dropped slightly (to 80) and his urea and creatinine[172] increased. A positive fluid balance[173] was noted by the ITU team and a diuretic (furosemide[174]) commenced with the aim to reach a 0 – 300ml negative fluid balance to reduce the fluid overload. An echocardiogram was requested. This was undertaken on 20 August and confirmed severe left ventricular dysfunction with an ejection fraction of 20 per cent (on 26 May this had been 25 per cent). The ITU team continued to monitor Colin's fluid balance, which improved over the next few days, with a negative balance achieved through to 29 August when a Hartmann's[175] infusion was commenced in response to a review of his blood results. Colin's creatinine levels returned to normal ranges; his urea slightly reduced but stabilised and remained elevated (between 9.5 and 11.7) during the rest of his stay.

3.674 At 10.46pm, the FY2 doctor confirmed that the CT had been undertaken and results reviewed, with no action required currently. It was also confirmed that Colin was on amiodarone[176] due to fast atrial fibrillation, that his DNACPR had been removed as advised by the ITU consultant and that Colin was for full escalation.

3.675 Another trial of extubation had to be aborted on 24 August due to Colin's HR elevating to 140 bpm, BP 170/100 and respirations 40; his propofol was discontinued at this time. Three days later Colin had not woken properly, and a CT head scan was ordered in order to establish whether there was any underlying cause for this. The results did not indicate any changes from previous scans, and it was concluded by the ITU team that his decline was likely due to the ITU admission and sepsis. The risks of this had been fully explained to ML on Colin's transfer to the unit.

3.676 On 26 August, Colin was reviewed by Consultant Surgeon 6. They documented that Colin had not had his bowels open despite an enema the previous day. The output from the fistula was 350ml in the last 24 hours. Colin was noted to be tolerating the nasogastric feed.

3.677 Colin was reviewed on 27 August by Consultant Surgeon 7 who indicated that Colin had a high-output fistula, and advised to stop his nasogastric feeding as this may be contributing to the high output.

3.678 Colin was extubated on 28 August and did not require further sedation prior to his transfer to Bulphan Ward on 3 September 2021. Colin was reviewed by the physiotherapist, who documented that his GCS was 11/15 but that he was unable to follow commands as he was drowsy. A cough was triggered on yankauer[177] suctioning and his chest noted to be clear.

3.679 On 31 August at 4.30pm, Colin was reviewed by the physiotherapist, who documented audible upper airway secretions and that Colin was currently saturating on air, but that his respiration rate was increasing. The plan was to continue nebulisers. ML was, however, concerned about Colin's chest and whether he was receiving any antibiotics. She was informed by ITU staff that he had no increased inflammatory or infection markers, that they were giving him nebulisers and using other means to clear his secretions. ML also asked when diazepam had been given but was told they

[172] Creatinine is a waste product produced by the muscles which gets filtered out by the kidneys. A raised creatinine level in the blood can be a sign of impaired kidney function.

[173] A positive fluid balance occurs when intake is greater than output.

[174] Furosemide is a loop diuretic medication used to treat oedema (a build-up of fluid in the body) due to heart failure or kidney disease.

[175] Hartmann's (compound sodium lactate) is used to replace body fluid and mineral salts that may be lost for a variety of medical reasons. It is especially suitable when the losses result in too much acid being present in the blood.

[176] Amiodarone is an anti-arrhythmic drug used to restore normal heart rhythm and maintain a regular, steady heartbeat.

[177] A yankauer tool is used to suction oropharyngeal secretions in order to prevent aspiration.

were not giving sedatives at this time and diazepam had not been given for many days (since 17 August).

3.680 In the critical care MDT meeting on 1 September, the ITU staff agreed that it was not in Colin's best interests to escalate treatment and the TEP and resuscitation status would need to be reviewed. They had an extensive conversation with ML the following day about Colin's deteriorating condition (see comments in MCA and safeguarding section below). The DNACPR form was completed after this meeting and also a TEP in line with the Trust's Do Not Attempt Cardiopulmonary Resuscitation Policy (2021); treatment options included ward-based care, CVC, enteral/parenteral nutrition and IV antibiotics/fluids.

3.681 Colin was then referred to the palliative care team. Given Colin's presentation, the referral to this team was in line with good practice, as palliative care is specialised medical care for people living with a serious illness and is focussed on providing relief from the symptoms and stress of the illness. The goal is to improve quality of life for both the patient and the family and is based on the needs of the patient, not on the patient's prognosis. It is appropriate at any age and at any stage in a serious illness and can be provided along with curative treatment.

3.682 When the palliative care nurse reviewed him, Colin was unresponsive; the palliative care specialist nurse noted that Colin looked comfortable with no signs of distress. It was not felt to be in Colin's best interests to continue IV fluids/TPN due to excess secretions. They advised prescribing anticipatory drugs in order to optimise any symptoms and to maintain Colin's comfort. However, the palliative care specialist nurse did not speak directly with ML, and on review two days later, the medication regime had not been prescribed as Colin was for ward-based care and not "*end of life*". This reflects a lack of understanding by the medical staff because although anticipatory medicines are often given towards the end of life, these are medicines which can also be used for symptom management and can be given at any point in someone's illness if they need them.

3.683 The general surgery SpR documented on the same day that if the fistula output was more than 500ml, Colin would need to be NBM and for IV fluids and assessment by the nutrition team. They documented that surgery for an enterocutaneous fistula was not normally done for at least six months and that no surgical input was required currently. Options were then confirmed by Consultant Surgeon 1.

3.684 The palliative care specialist nurse reviewed Colin the following day at 9.40am (3 September). Colin appeared agitated, "*raising arms*", but the nurse said they could see no signs of pain, discomfort and nil audible secretions were heard. They noted again that the anticipatory drugs that they had advised on the previous day had not been prescribed. They also noted the conversation about hospice care and documented that Colin met the criteria for the end-of-life care integrated care plan (ICP)[178], but that withdrawal of medical treatments would have to be discussed with the family before this could commence. They recommended prescribing as required anticipatory medications as these would optimise any symptoms of pain, terminal agitation, shortness of breath and respiratory secretions.

3.685 At 10.30am, there was a meeting with ITU clinicians, managers, the legal team and the adult safeguarding lead about moving Colin to Bulphan Ward and the options and interventions that might be required if ML became aggressive about the proposed plan of transfer. It was agreed that Colin would transfer at around 11am. ML phoned the ITU at 11am asking about discharge and was told that Colin was being transferred. She became aggressive on the phone, so the nurse referred her to the matron, who ended the call. An incident form was submitted for this interaction (7574).

3.686 It is well known that patients and their families often become anxious about transfer from an intensive care setting to a ward, as they feel the patient will receive less medical and nursing intervention in a ward area. ML had significant (and in our view justified) concerns about Colin's safety on the wards given his experience on Florence Nightingale and Bulphan Ward) and

[178] An end of life integrated care plan includes practical procedural guidelines for limiting inappropriate therapeutic medical interventions and improving the quality of care of the dying within an ethical framework and through a professional and family/patient consensus process.

alternative care options should have been explored more fully with ML given her request for him to stay on the unit.

Medications

3.687 Colin was sedated with propofol, midazolam and noradrenaline infusions when he was transferred to the ITU. On 6 August, the MHLT advised continuation of the 2.5mg twice daily IV haloperidol and to look at any other additional support depending on his presentation when weaning (from sedation) was planned.

3.688 Colin also remained on a range of core medications on transfer to the ITU, although his memantine was discontinued with an instruction to review once medically fit for discharge. Tamsulosin and bisoprolol were omitted due to Colin having an indwelling urinary catheter and there were some omissions of his core medications during the transfer to ITU, but he was continuously monitored to ensure no adverse effects from this. Medications were reviewed on the daily ward round, with some other medications appropriately omitted due to clinical contradictions (such as bleeding). The midazolam and propofol sedation were titrated according to his presentation and GCS.

3.689 IV medications such as omeprazole[179] and Pabrinex[180] were also prescribed; however, Colin still required some oral medications. These were administered through the nasogastric tube that was inserted on the evening of 4 August.

3.690 During Colin's stay he received IV fluid infusions; these varied according to his clinical condition. Some of these required use of a pressure infusion bag to hold and increase the rate of delivery of the fluids; however, there is evidence to support use of a device that was significantly past its expiry date of 2019. The manufacturer has said that using expired pressure infusion bags is highly discouraged due to potential equipment failure, patient safety risks and legal implications such as:

- Material degradation, malfunction and safety risks - the bag's material may weaken over time, increasing the risk of leaks, ruptures, or failure under pressure.
- Regulatory and legal issues - using expired medical devices violates hospital policies and regulatory guidelines.

3.691 We were unable to identify any incidents or harm that occurred as a result of the pressure infusion bag being out of date but the Trust Medical Devices Policy that was in place at that time requires all users to check that service labels on medical devices are within date and to withdraw from use and report wherever possible; this did not occur on this occasion.

3.692 As described in the physical health section above, Colin was prescribed daily IV furosemide on 19 August, as he was noted to be in fluid retention. A stat 10mg dose had also been given IV at 7pm on 15 August. We can see no evidence of the rationale for this being included in the records, but in our view, this was appropriate therapy for Colin's presentation and was administered from 19 to 24 August, when it was discontinued. Colin's bisoprolol was increased on 24 August and amlodipine 5mg daily commenced in response to Colin's raised blood pressure and heart rate.

3.693 Colin continued to be reviewed by the MHLT on the ITU, who advised continuation of haloperidol for Colin's agitation and episodes of violence and aggression. This was initially administered as a 2.5mg IV dose but was increased to three times daily in preparation for the first extubation, with 1mg IM lorazepam also given to help with this process.

3.694 On 13 August at 3pm, the MDT noted that Colin was still intubated and sedated, and "*trying to build up anti-delirium drugs for when we stop sedation to extubate him*". It was recorded that ML had some concerns about the medication, which were addressed by the team. The plan was for

[179] Omeprazole reduces the amount of acid in the stomach and is used to treat indigestion, heartburn and acid reflux or to prevent and treat stomach ulcers.

[180] Pabrinex is a high-dose combination of several B vitamins and vitamin C. It is indicated for rapid therapy of severe depletion or malabsorption of the water-soluble vitamins B and C.

haloperidol to be increased to 2.5mg IV four times a day given the agitation that occurred during the first (failed) attempt, and with three times daily chlorpromazine and as required lorazepam.

3.695 Colin also received IM lorazepam on 15 August at 12pm and 6pm, and 2.5mg IV diazepam at 1pm on 16 August. We can see no record of the rationale for these medications being given in the clinical notes although it was documented that Colin's sedation was being stopped "*to wake the patient up*". Three doses of 2.5mg IV diazepam and one dose of IV haloperidol were also administered over a seven-hour period on 17 August, as Colin was off his sedation but attempting to get off the bed and pull out his tubes.

3.696 Although this prescribing was in line with the Trust's Rapid Tranquillisation Policy (2021), and also the Initial Pharmacological Management of Agitated Behaviour Symptoms Arising from an Underlying Delirium in Adults guidance (2021), cautions are required when prescribing haloperidol in patients with severe HF, cardiac arrhythmias, cardiomyopathy, and medications that prolong QT-interval. Haloperidol should not, therefore, have been the first choice of sedation given Colin's cardiac history without a clear rationale and consideration of the risks and benefits being documented in the clinical records. As mentioned previously, haloperidol can, in itself, worsen delirium. We can see no evidence of incident forms being completed for these chemical restraints. Propofol had last been given at 4am on 16 August and was recommenced at 2.30pm on 18 August.

3.697 On 18 August at 10.40am, the MHLT noted that Colin was "*fidgety in the bed but no severe episodes of agitation observed*". A chest infection was suspected and being treated. They suggested switching the haloperidol to risperidone 0.5mg at night, to be administered through the nasogastric tube. This was appropriate given that haloperidol can in itself cause restlessness.

3.698 At 2.45pm Colin was noted to be deteriorating. His respiration rate was over 40, oxygen saturations 92 per cent, PO2[181] 8.4. A decision was made to re-intubate him.

3.699 On 19 August, the MHLT documented that the risperidone had not been given, as the medical team were not using the nasogastric tube due to Colin's deteriorating presentation. A discussion with the ITU consultant confirmed that Colin appeared more settled and that ITU were of the view that the antipsychotics could be discontinued but that the team would continue to assess the requirement for re-starting. Recognising the caution that is required with antipsychotics, changing the medication regime when Colin appeared to be settled may not have been prudent at that time.

3.700 Colin was also on a wide range of IV antibiotics during this episode of care, initially for "*intra-abdominal gas and ongoing chest sepsis*". These were amended in consultation with the microbiology department which is in line with expected practice.

<u>Care planning and risk assessment</u>

3.701 A range of nursing assessments were undertaken on the ITU; however, there were some notable omissions:

- The MUST nutritional assessment should have been completed on admission, but this task was not undertaken until 8 August, four days later. Colin was, however, given supported nutrition through nasogastric feeding and TPN due to the sedation he was receiving.
- Colin's Waterlow score should also have been assessed on admission but was similarly not completed until 8 August. Colin's skin integrity was then assessed on a daily basis; this was good practice given Colin's high-risk score and sedation. Scores initially included, however, that Colin had no pain, but we can see no evidence of how this was assessed. IV paracetamol was being administered but with no pain charts being completed for Colin during this episode of care.
- A body map was completed on 4 August as part of the Waterlow assessment and this depicted a surgical incision on Colin's abdomen and also a self-imploded puncture wound with additional generalised bruising, abrasions and scars on various aspects of Colin's body. The body map

[181] PO2 (partial pressure of oxygen) reflects the amount of oxygen gas dissolved in the blood, with normal ranges 11.0 – 14.4.

was updated on 8 August, but we can see no evidence of nursing updates after this time despite Waterlow scores being updated daily and green pus being noted on Colin's penis.

3.702 Care plans, with goals to be achieved, were included on the ITU observation sheets and these were completed each day of Colin's stay. On 17 August, a critical care rehabilitation care plan was initiated for airway clearance. On 18 August a delirium care plan was also commenced in response to the MHLT indicating that Colin's presentation was due to delirium (this type of care plan should have been initiated on Bulphan Ward or admission to the ITU); and on 24 August a mobilising assessment care plan was also added. These plans included actions to be taken and evaluation date/comments. These were the first individualised care plans that we have seen for Colin during his stay at Basildon Hospital. A plan for delirium was appropriate but should have been initiated on Bulphan.

3.703 Dementia Nurse 1 was invited to the ITU MDT meeting on 18 August in preparation for withdrawal of Colin's sedation and him "*waking up*". On 20 August she introduced herself to ML and arranged to meet with her on 24 August. The hospital ITU environment, and the impact that it might have on Colin, was discussed as was the plan to help settle and distract him. The dementia nurse told ML she would look at the use of a baby RITA[182] and bring one to the unit for Colin, and a 'person-centred care plan' was initiated for Colin on 26 August. This was in line with the requirements of the Care of Patients With Dementia Policy (2020), which includes that it is essential to have individualised care plans for patients with dementia. The plans identified actions that could be taken in relation to communicating with Colin (for example, thinking about what he might be trying to communicate, arranging supportive access for his family, sensory and music stimulation) and improving the environment (for example, through personalised playlists, background music, closing the curtains around him and dimming the lights). The plan also included completion of the 'This is Me' booklet. These were helpful strategies in helping to support Colin being taken off his sedation and to aid his settling on the unit and the ward when discharged; however, these actions were never evaluated (either by nursing staff or the dementia nurse) and were a month too late. The dementia nurse should have been made aware of Colin on his admission to Basildon Hospital and should have been involved in helping staff to manage his care after the first incident of violence and aggression had occurred.

3.704 During his stay on ITU, Colin was occasionally fidgety and agitated but there were no episodes of violence and aggression noted. Colin was receiving intensive care with one-to-one nursing supervision and did not require additional support from mental health staff during his period of sedation; however, on 19 August a MHLT nurse discussed staffing with the nurse in charge of the unit and agreed that the MHLT would continue to provide a healthcare assistant (HCA) but with consideration of two-to-one nursing provision when Colin was due to be extubated.

3.705 On 24 August there was a trial of extubation which had been planned to take place with two registered mental health nurses (RMNs) present although only one was present at that time. This had to be aborted, but sedation was not recommenced. The notes indicate that two RMNs were present from that time until 31 August, although this is not confirmed on any activity charts or other nursing documentation. ML has said many of the mental health nursing staff members who did attend were health care assistants or student nurses working as health care assistants. On 31 July, there was a discussion between the MHLT and ITU staff about only one RMN being sufficient at that time. This was then discussed with ML, who agreed with this view but on the basis that staffing would increase if needed.

<u>Behaviour and presentation – MCA and safeguarding</u>

3.706 On 4 August, prior to Colin's transfer, ITU Consultant 2 and Consultant Surgeon 5 agreed with ML that Colin would not be for resuscitation and a TEP was completed by the surgical team in line with the Trust's Treatment Escalation Plan Policy. This indicated that Colin was not for CPR and that ITU

[182] Reminiscence/Rehabilitation & Interactive Therapy Activities (RITA) is an all-in-one touch screen solution which offers digital reminiscence therapy.

was for sedation only. All treatment options were to be given other than "*haem/dia/filtration*", non-invasive ventilation and optiflow (see physical health section above).

3.707 On 5 August, the MDT (including from surgery, the ITU, MHLT and the deputy director of nursing) discussed Colin's care and treatment with ML and that the issuing of the DNACPR would not mean that there would be no interventions if he were to deteriorate. At 8.46pm, a letter was sent by ML to the MDT. It included that she had reflected on the DNACPR and had discussed this with Colin's family, and as attorney under LPA she wanted to "*categorically and for the record retract her agreement*". She requested Colin to have full treatment and resuscitation, because she believed this was in his best interests and reflected what he would have wanted.

3.708 We can see no evidence of the DNACPR being revoked at this time, or of a best interests decision being formally recorded from the meeting, or another meeting being convened to discuss ML's letter. While the TEP was amended on 6 August by ITU Consultant 2 to reflect ML's request to include non-invasive ventilation and optiflow as treatment options, the decision not to immediately revoke or discuss the DNACPR was not in line with the MCA, which requires life-sustaining treatment disagreements with LPA in place (and no living will/advance statement) to have gone before the Court of Protection if resolution could not be reached.

3.709 At 3.45pm on 9 August, an ITU consultant (name illegible) had a meeting with ML with another member of staff present. They explained the process of extubation but confirmed that repeated cycles of intubating, extubating and sedating would not be in Colin's best interests. ML was told that DNACPR was a medical decision, and due to Colin's expected quality of life post-resuscitation, this would not be revoked. As stated previously, this was not in line with the MCA. A best interests decision cannot be made without involving the family/LPA and there should have been a referral to the Court of Protection at this point if the team disagreed with ML's request.

3.710 On 13 August, at 7.22pm, the ITU consultant had a call from a team manager from Essex Council. They said that ML had raised a safeguarding concern, as she felt her views were not taken into account for the DNACPR decision. She wanted a second opinion. ML had also raised a concern to the police.

3.711 On 18 August, Consultant Surgeon 1 sought an opinion from the MHLT, who felt that Colin's presentation was due to delirium. This was five days after the request for a second opinion had been made by ML and should have been actioned earlier. The DNACPR was revoked as a result of this observation and a new TEP completed by the FY2 doctor and countersigned by the consultant on 20 August. This indicated that Colin was now for resuscitation. The DNACPR form that had been completed on 4 August was removed from Colin's records.

3.712 Records written by ambulance staff on admission to Broomfield Hospital included that Colin did not want a DNACPR placed on him, and ML was very clear as his attorney under LPA about wanting his wishes to be complied with. The ITU staff had, however, confirmed on Colin's transfer that although he would be receiving full treatment, resuscitation would not be in his best interests given his underlying comorbidities and current presentation. The DNACPR was not revoked until the safeguarding concern had been raised and a second opinion requested by ML. Although decisions about resuscitation can be guided by doctors, they are not just a 'medical decision', and this is reflected in the Trust's Do Not Attempt Cardiopulmonary Resuscitation Policy (2021), which states that "*decisions about CPR should be reviewed at appropriately frequent intervals and especially whenever changes occur in a person's condition or in their expressed wishes. This applies to a decision that CPR is appropriate as well as to a DNACPR decision*". ML was Colin's attorney under LPA, and her wishes should have been taken into account or a best interests meeting convened, with legal advice sought by the Trust about referring the case to the Court of Protection if the hospital team disagreed with ML's request.

3.713 On 30 August, following a deterioration in Colin's condition, the ITU staff agreed that it was not in Colin's best interest to escalate treatment and that the TEP and resuscitation status would need to be reviewed. Discharge planning was to commence and there would need to be a discussion with

ML about the poor prognosis to involve the surgeons and psychiatry. The ITU staff had an extensive conversation with ML about this the following day. ML was informed that all ITU consultants, the surgical team and the MHLT opined that escalating Colin for ITU support would prolong his dying and that a DNACPR was being made. A remote case review had been undertaken by a ITU consultant from Southend and they agreed with this plan of care. The conversation with ML was in line with expected practice given her status as attorney under LPA, as was seeking a second opinion to support the decisions that were being made. ML confirmed that if Colin was dying, she would want him to go home but that she also needed to go home that evening to think about everything that had been said. The DNACPR form was completed after this meeting and also a TEP; treatment options included ward-based care, CVC, enteral/parenteral nutrition and IV antibiotics/fluids.

3.714 On 2 September, the ITU team (names not specified) met with ML and Colin's two children. They explained that it was not now in Colin's best interests to remain in ITU, as their support was no longer required. Instead, Colin would benefit from transfer to a side room on a ward where there would be less noise and stimulation. ML objected to this saying that he needed to stay on ITU "*where he is safe*" and that a hospice or home would be preferrable. Colin's daughter additionally advised that they would like to ensure that things happened in the most dignified way in her father's final days. The ITU consultant concluded that it would be in Colin's best interests to move him from ITU, but that hospice services may be a possibility and would need to be explored. While it was good practice to have a family meeting to inform them of plans for Colin, presenting the family with decisions that had already been made was not in line with the MCA.

3.715 In relation to the restrictions that had been placed on Colin during his stay in ITU, a standard DoLS authorisation request had been made on 24 July while Colin had been on Florence Nightingale Ward. An urgent seven-day request was extended for a further seven and the adult safeguarding lead had documented that "a*fter this there is no need for further DoLS – Trust responsibility is met. Local authority aware of DoLS*." On 5 August, however, the safeguarding lead recorded that although Colin had a DoLS to outline restrictions when he was not in ITU, it would be advisable for a new request to be made for his care now. This was in line with national guidance. A standard authorisation had been requested on 24 July with two urgent authorisations to cover 14 days. The standard authorisation would have covered Colin if restrictions remained the same, but a new one was required if conditions changed, which they did when he transferred to ITU.

3.716 Separate DoLS application forms were subsequently completed for urgent seven-day authorisations on 9 and 17 August so that mittens[183] could be used for Colin due to him becoming agitated, with [peripheral] lines and his stoma bags being at risk of being pulled out (by Colin).

3.717 However, we can see no capacity assessment being undertaken for use of the mittens, and on both occasions, the forms included that Colin "lacks capacity" but did not specify the decision for which he lacked capacity or when/how this was assessed. Equally, the request for DoLS was to put in preventative measures, but these were not described and "*is the person subject to some aspect of the Mental Health Act 1983*" was marked as yes ("*lacks capacity – existing dementia diagnosis*"). Colin was not detained under the MHA and this comment demonstrates a lack of understanding of the MCA and the MHA. "*The person is being accommodated here for the purpose of being given care or treatment*" was left blank, despite this being a requirement for Colin given his physical health problems at this time. The DoLS authorisation request form on 9 August indicated that ML had been informed of this request but not on 17 August.

3.718 Another urgent DoLS authorisation request was submitted on 24 August. This request should not have been made as there can only be one seven-day extension to an urgent authorisation (a total of 14 days cover). Instead, a standard authorisation request should have been made on 9 August and this would have covered the following 28-day period. The request was for one day for weaning and trial of extubation but did not detail the proposed restrictions other than "*two mental health nurses*

[183] Mittens are designed to restrict the movement of one or both hands and are used with patients who have removed essential lines or tubes on more than one occasion or have the potential to remove these.

are around". It also did not include that ML had been informed of the request, and all sections about the conditions of the authorisation already being met were left blank. As with previous forms, "*is the person subject to some aspect of the Mental Health Act 1983*" was marked as yes (*lacks capacity – existing Alzheimer's*), which demonstrates a lack of understanding of the MCA and MHA. This repeated request was only for one day.

3.719 On 19 August, Adult Safeguarding Lead 2 visited the unit in response to safeguarding concerns that had been reported to the local authority by ML on 13 August. They noted that Colin had been reintubated and asked the unit to contact him if there were any further safeguarding concerns. Concerns had, however, already been raised and the safeguarding lead should, as a minimum, have referred the matter for a Section 42 enquiry, asked the Trust's legal team to give their view of the concerns raised, chased the standard authorisation to ensure that Colin was placed correctly under a DoLS, and sought advice from an AMHP regarding the use of MCA versus the MHA. We can see no evidence of any of these actions being undertaken in order to safeguard Colin.

3.720 On 20 August, ML was asked if she would like any psychological support, but she told staff she was "*okay for now*". The Trust should have offered this after the incident on 27 July rather than nearly three weeks later.

3.721 As was the case with previous wards Colin had been admitted to, ML was noted to be recording conversations with staff without their consent and was found to be videoing Colin on one occasion. Staff tried to contact the safeguarding lead without success on 24 August (safeguarding records indicate that this was at 10pm; the safeguarding lead worked Monday to Friday 9-5pm), and on 27 August an incident form was completed (6598) under the category of consent after ML was found to be taking pictures of Colin, who was ventilated at that time. Staff were concerned that other patients might also be (inadvertently) photographed without their consent. As mentioned in the Bulphan Ward episode of care above, at the point where staff realised that this was happening, a (senior) member of staff should have:

- Listened to ML's reasons for why she wanted to film or record conversations and worked with her to find the best solution for capturing what staff said. It should have been explained that asking for permission was a matter of courtesy and respect and was more likely to lead to a positive and trusting relationship.
- Made sure that any ongoing or immediate concerns that ML had about Colin's care were understood and addressed – including safeguarding concerns.
- Made a note in Colin's records that video/sound recording had been discussed and could take place.
- Informed ML that appropriate civil or legal action would be taken if it was believed that the recordings were going to be (or had been) misused.
- Ensured that staff were aware of what was or was not permissible with reference to the Trust policy.

Bulphan Ward 3 – 6 September 2021

3.722 Colin was transferred to Bulphan Ward from ITU on 3 September 2021.

3.723 At 3.30pm, Colin was reviewed by the MHLT. It was documented that Colin did not warrant further input from their service at this time.

3.724 At 5pm, Consultant Surgeon 1, MHLT consultant, Matron 1 and the nurse in charge met with ML to discuss Colin's care. It was agreed that ML would decide overnight about his ongoing treatment and palliative care.

3.725 On 4 September at 8.40am, the surgical SpR had a discussion with ML, who said the decision about stopping Colin's treatment was still not decided. She wanted treatment to continue and to take Colin home.

3.726 At 9am a lengthy entry included detail about a discussion between Matron 1 and ML, who wanted a fast-track discharge for Colin.

3.727 At 11.15am, Colin was reviewed by the palliative care team with ML in attendance. Their plan included anticipatory medications, that in the event of excessive secretions to stop IV fluids and TPN. The remaining part of the plan was illegible.

3.728 At 3pm Colin was reviewed by the complex care management team. They informed ML that the hospice-at-home team currently had no capacity. The team were to review Colin on 6 September.

3.729 During the night, it was documented that Colin pulled his CVC line out (untimed) at about 2am. He was not wearing mittens at this time.

3.730 On 5 September, Colin was reviewed by a palliative care nurse, who noted that he was now unresponsive and met the criteria for end-of-life care.

3.731 At 4.40pm, a medical review confirmed that Colin's GCS was 6/15, pupils not reacting. The nasogastric feeding tube was noted to be out.

3.732 On 6 September, a DNACPR form was completed.

3.733 At 1.30pm, there was a meeting with ML, the medical team and the palliative care nurse. It was agreed that Colin would receive palliative care with a second opinion to confirm this approach.

3.734 At 2.45pm, a respiratory consultant second opinion doctor reviewed Colin and agreed that they did not feel that replacement of the CVC would be in Colin's best interests and that he should be for symptom management and palliative care.

3.735 Colin was discharged via ambulance. ML had been made aware that Colin may not survive the journey, but he arrived home safely at about 9.30pm.

Commentary on this care episode and points for learning

Physical health

3.736 Colin was transferred to Bulphan Ward from ITU on 3 September 2021. He was for ward-based care with TPN/NG feeding. He was noted to be settled at 11.45am.

3.737 At 4.34pm, Matron and the nurse in charge of the ward contacted Consultant Surgeon 8, requesting a plan of care/ICP for Colin. Being unable to contact Consultant Surgeon 1 (who was the named surgeon for Colin), the consultant surgeon contacted Consultant Surgeon 5 who was on-call. They suggested that the plan of care should be decided by the primary consultant (namely, Consultant Surgeon 1) or Consultant Surgeon 2. Consultant Surgeon 2 advised that he was not aware of the current status of the patient, and that he had spoken with the Consultant Surgeon 1 who had agreed to review Colin that day.

3.738 Consultant Surgeon 2 had reviewed Colin as recently as 29 August and had been involved in his care throughout the ITU stay. He knew the difficulties that the wards and ITU had encountered and should, as a minimum, have offered to support the decisions that were to be made.

3.739 At 5pm, there was a meeting involving the Consultant Surgeons 1 and 8, EPUT Consultant Psychiatrist 2, Matron 1 and the nurse in charge of the ward, and then a follow-up meeting with ML about options of care. Colin's GCS was noted to be 5/15. They explained to ML why the "*huge proximal enterocutaneous fistula*" was unlikely to heal, why Colin's nutritional status was poor, and that the palliative care team had confirmed that he was terminally ill. ML was noted to agree with these explanations and wanted him to be made comfortable. The meeting concluded with a decision to withdraw active treatment, but also with an agreement that ML would return in the morning with a

decision and that TPN would continue until then. Notes include that the management plan "*if ML wants palliative care for transfer:*

- *stop all non-essential medication including antibiotics, low molecular weight heparin, stop IV fluids*
- *keep only IV fluids going including one litre normal saline with 40mmol potassium*
- *write up anticipatory medications*"

3.740 This management plan was confusing. The note about "*if ML wants palliative care*" was not clearly written and could easily have been missed, and the first bullet point said stop IV fluids, while the second said to keep IV fluids going. At 7.20pm, the nurse who was looking after Colin indicated that they were still waiting for a clear plan of care.

3.741 Observations were recorded overnight and the TPN was still in progress. IV fluids were not, however, prescribed or continued. When ML asked about this, the on-call doctor told her that the plan said to stop IV fluids but had conflicting information. This lack of clarity in the management plan caused considerable anxiety for ML, who felt that her views were not heard and that Colin's care was being compromised. The staff on duty were put in a very difficult position which could have been avoided if the documentation had more clearly identified the treatment that was to be provided at that time.

3.742 On 4 September at 8.40am, the surgical SpR had a discussion with ML who said the decision about stopping Colin's treatment was still not decided. She wanted treatment to continue and to take Colin home. It was explained to her that although it had previously been written to stop Colin's treatment, they would continue IV fluids and TPN, inform the palliative care and outreach teams and send Colin home under their care.

3.743 A lengthy entry at 9am included details about a discussion between Matron 1 and ML, who wanted a fast-track discharge for Colin. She was informed that if she wanted palliative care, treatment would be withdrawn other than IV fluids. It was agreed, however, that IV fluids and potentially the TPN would be left running right up to the point of discharge even if for palliative care. This was appropriate as a strategy and aligns with the concept of palliative rather than end-of-life care. From reading the medical and nursing records, we have been unable to identify, however, if this distinction was ever made to ML. Better clarity may have helped her to understand the purpose of the palliation (namely, to ensure Colin was kept comfortable and given appropriate psychological care, with support to the family) and that it did not mean that a decision on end-of-life care had been made.

3.744 Colin was reviewed by the palliative care team at 11.15am, with ML in attendance. They documented that Colin did not appear agitated or in pain. Their plan included a review by the complex care management team to facilitate discharge, to prescribe anticipatory medications, and in the event of burden of secretions, to stop IV fluids and TPN. The remaining part of the plan was illegible.

3.745 At 3pm Colin was reviewed by the complex care management team, who found Colin to be alert and trying to communicate with ML. They informed ML that the hospice-at-home team currently had no capacity. ML stated that she felt the decision regarding palliative care had already been made, despite her saying she would think about it. Colin was now awake for the first time in 29 days, so she wanted to wait to see what happened before making a decision. The MHLT were to review Colin on 6 September.

3.746 These were timely responses from the palliative care and complex care management team and their involvement was good practice in order to support Colin but also ML at a time where difficult decisions were being made about his ongoing care, treatment and discharge.

3.747 During the night, at about 2am, it was documented that Colin pulled his CVC out. He was not wearing mittens at this time (see commentary in the behaviour and presentation section below). An

incident report was submitted by the nursing staff (7682), and this included that it was explained to ML that the medical staff had said it would not be possible or ethical to replace the line as Colin was "*too poorly and potentially for ICP soon*". ML does not, however, believe that Colin pulled his line out as in her view he was too drowsy, the line was retained in place with a dressing and stitched into the skin. She said that she witnessed four members of the nursing staff removing it in the dark; however, we cannot substantiate that claim.

3.748 On 5 September at 10.12am, Colin was reviewed by the palliative care nurse (illegible name), who noted that although Colin had been more aware the day before, he was now unresponsive. They recorded a high respiration rate (32) and that he had been given three doses of morphine (the last dose at 1.50am). The nurse documented that Colin met the criteria for end-of-life care but would need a senior medical review to determine whether this would be an appropriate approach.

3.749 At 10.40am, the ward nurse aspirated Colin's nasogastric tube prior to use[184] but the pH[185] was 9.5, which indicated that it was not correctly positioned. The tube was removed in consultation with the medical team.

3.750 At 4.40pm, a medical review by the surgical SpR confirmed that Colin's GCS was 6, pupils not reacting. It was explained to ML that Colin was in a coma state, and this was end of life, but she thought it was because of the last doses of morphine and shared videos of Colin with the doctor. It was agreed that Consultant Surgeon 5 would review Colin and discuss his care with the family. Consultant Surgeon 5 documented later that day that decisions had already been made about DNACPR and Colin should now be considered for the integrated care pathway if the family would accept it. Managing this situation was difficult for the team as conversations with ML remained challenging, with her changing her mind after some decisions had been made. Consultant Surgeon 1 documented at 1.30pm on 6 September that ML was refusing to overtly say that Colin was for palliative care but wanted him home, "*kept comfortable and to die at home*", thus implying palliative care. Anticipatory medications had been prescribed for palliation and the MDT agreed Colin should be for palliative care, but without ensuring that ML (as attorney under LPA) agreed with this plan of care.

3.751 On 6 September, there was another meeting with ML, Consultant Surgeon 1 and the palliative care nursing team. On discussing Colin's future care needs, ML had a panic attack and had to leave the room. A decision was made in her absence for Colin to receive palliative care and for arrangements to be made to send him home. A second opinion was to be gained in order to ascertain if they agreed with this decision which was in line with good practice.

3.752 At 2.45pm, a respiratory consultant second opinion doctor reviewed Colin and agreed that they did not feel that replacement of the CVC would be in Colin's best interests and that he should be for symptom management and palliative care.

3.753 The complex care management team reviewed Colin at 6.20pm to arrange terminal discharge planning. It was noted that the hospice had no capacity to deliver care, so arrangements were made to send him home. A DNACPR form was completed for the discharge, but the TEP was not revised. Reasons for DNACPR included poor physiology, hypoxic brain damage, dementia, chronic heart failure. Colin was discharged home by private ambulance at 8pm.

<u>Medications</u>

3.754 On transfer to Bulphan Ward, Colin remained on some of his core medication regime, with oral medication such as bisoprolol given via the nasogastric tube. These were unable to be administered after removal of the tube on 4 September and we can see no evidence of them being discontinued on the chart or of alternatives being given (for example, intravenously). We can see no record of this

[184] A small amount of fluid needs to be taken from a nasogastric tube before use to test it for acid content. If the tube is placed correctly in the stomach, the aspirated fluid should have stomach acid in it, which will give it a lower pH. If pH strip testing indicates a reading of more than 5.5, the tube should not be used.

[185] pH is a measure of how acidic a fluid is. The range goes from 0 to 14, with 7 being neutral and pHs of less than 7 indicating acidity.

being discussed, although we note the conversations on 3 September about withdrawing active treatment and stopping non-essential medication. However, as described in the physical health section above, this was only to be enacted following a decision being made by ML about palliative care, and bisoprolol may have been classed as essential given the ongoing hypertension. Medications should have been reviewed by the team with a clear rationale documented for continuing or discontinuing each item listed in the medical records to ensure correct information and to avoid confusion in administration.

3.755 Colin was prescribed 2.5 – 5mg subcutaneous morphine sulphate as part of the anticipatory medication regime. A 2.5mg dose was administered at 5.40pm on 4 September. Although described by Matron 1 who visited the ward as "*a little more awake … and restless*", there is no reference in the nursing notes to this medication being administered or the rationale for it. Doses of 5mg were administered at 12.30am and 1.50am for restlessness. On 5 September at 10.12am, Colin was reviewed by the palliative care nurse (illegible name) who noted that Colin was now unresponsive. They recorded a high respiration rate (32) and that he had been given three doses of morphine (the last dose at 1.50am). On further discussion with ML, she described that Colin had received a "*chemical cosh*" overnight. Additional doses of morphine sulphate were given at 6pm and 7.25pm on 5 September for agitation, and also at 7.20am and 2.33pm on 6 September, but the reasons for this are not documented in the nursing records. The morphine sulphate had been prescribed for pain relief and shortness of breath, with midazolam prescribed for terminal agitation (although ML had requested for it not to be given). The prescriptions for morphine sulphate and midazolam were in line with palliative care prescribing guidelines for pain and symptom control (although the maximum daily doses were omitted from both prescriptions and there was no maximum daily dose included for the midazolam) but as with previous episodes of care, we can see no evidence of Colin's pain levels being assessed. The instructions should have been followed by the nursing staff who administered these medications, with a clear record in the nursing notes about the reasons for giving these drugs.

3.756 We also note that ML observed the nurses giving Colin his morphine (and midazolam) injections on their own despite the Controlled Drugs Policy requiring the administering registrant to enlist a second authorised registrant to witness the whole procedure. We have reviewed the drug charts and can see that two nurses signed for these medications being given on all but one occasion. When asked, the (then) Head of Nursing for Basildon Hospital confirmed that during the COVID-19 pandemic (as was the case at this time) the Trust did have an acceptance that two nurses would check out a controlled drug but could administer on their own. We have not seen a policy document to formalise these arrangements; however, we understand that the original practice of two nurses being present throughout the whole procedure has now been resumed.

<u>Care planning and risk assessment</u>

3.757 The nursing documentation that was completed for Colin on transfer to Bulphan Ward was limited.

3.758 24-hour repositioning charts were commenced but were incomplete:

- On 3 September the form was left blank other than "*repositioned*" added once at 11pm.
- On 4 September hourly checks were documented more frequently during the day but left blank for the night shift.
- On 5 September, Colin was repositioned several times in the morning and during the night shift, but with no entries between 3 and 8pm in the afternoon or from 1am to discharge home on the evening of 6 September.

3.759 Colin's Waterlow score on the ITU had been assessed as 36 prior to transfer and on 4 and 5 September his scores remained at 33. These scores indicated a very high risk of Colin's skin integrity being compromised. Recognising that there was a requirement to maintain his comfort, there should have been a plan of care which described the frequency of repositioning and skin checks that had been agreed for his risk category.

3.760 We are aware that bed rails were used for Colin, but without an appropriate bed safety rail risk assessment being undertaken.

3.761 For this episode of care there was an absence of individualised care planning which, if in place, would have provided a person-centred approach to Colin. Its absence meant that staff were unable to fully understand and manage Colin's behaviour or care needs, what staff should observe for, what staff needed to be aware of, or how specific situations were to be managed. The absence of these care plans will have impacted the consistency of care that Colin received.

Behaviour and presentation – MCA and safeguarding

3.762 Following his transfer to Bulphan Ward on 3 September, Matron 1 committed to reducing the mental health supervision from two staff to one at the request of ML. We have not seen any activity charts or a list of mental health staff who observed Colin at this time to confirm which grades or numbers of staff were present at any one time.

3.763 Colin was reviewed by EPUT Consultant Psychiatrist 2 and his team. They noted that in the last three to four weeks there had been no objective evidence of behavioural disturbances, needs were increasingly physical, and Colin was now bed bound. Sedation had been stopped two weeks ago, and he had not recovered consciousness. It was documented that Colin did not warrant further input from MHLT at this time. The team met with ML, and it was agreed that one-to-one nursing would continue over the weekend but that this would be reviewed the following week.

3.764 On 4 September, when discussing Colin's care with Matron 1, ML asked for the second RMN to be reinstated as Colin was "*coming to life*". The matron observed Colin and found him to be awake; the nasogastric feeding tube appeared to be bothering him but was needed for medication. It was explained to ML that the RMN had been removed at her request and, for this to be re-instated, Colin would need another mental health review. The matron then asked two members of the MHLT who were visiting another patient to assess Colin, which they did. They confirmed that the mental health support worker was struggling with Colin and had been asking for extra help from that morning. The MHLT advised that they would try to arrange a second team member to support Colin.

3.765 At 5.25pm, ML told Matron 1 she was concerned about the care that Colin had delivered overnight and asked about mittens for him. It was agreed that this was a sensible suggestion, and it was documented that the senior sister was to "*complete the MCA/DoLS and place mittens*". It was good practice to make this recommendation, but we can see no evidence of an assessment being undertaken for use of these. The matron instructed a senior member of the ward team to complete these tasks but should also have ensured that mittens were applied at that time if there was a risk that Colin might pull out essential peripheral lines, rather than leaving it to the ward staff. There is no evidence of checks to see if the shifts had been covered by extra staff, which was important to consider given the challenges that had been faced by the members of staff that day. This was an example of staff not being practically supported to care for Colin (see comments in previous sections).

3.766 This is relevant as, during the night, Colin had one nurse present and ML stayed due to a second nurse not being available. Colin was noted to be restless, and it was documented that he pulled his CVC line out (untimed) at about 2am. He was not wearing mittens despite the instruction from Matron 1. An incident report was submitted by the nursing staff (7682), as Colin was being supervised on a one-to-one basis and they felt that he should not have been able to remove his line. There was commentary in some of the nursing records about a DoLS not being in place and this being the reason for no mittens, yet we have seen a DoLS form that was dated 3 September (untimed) which requested authorisation. This was a more comprehensive urgent seven-day authorisation request than some of the others that had been submitted, although the form was untimed and did not include if ML had been informed. Preventative measures that were listed on the form included antipsychotic medication to manage agitation/aggression, mittens to support lines being kept in that were essential to care and treatment, and one-to-one support from RMNs. The form correctly indicated that Colin was not subject to elements of the MHA. It included that he

lacked capacity, but we can see no evidence of an assessment to support this assertion. We are unable to ascertain who submitted this request or how its submission had been communicated to staff on the ward, but this would have covered use of the mittens for Colin at the point where he became restless. We note that another DoLS request form was submitted on 4 September at 8pm, again, before the CVC line came out.

3.767 A mental capacity assessment was completed on 5 September, as the doctor had been told that this was needed for the DoLS authorisation request. This was in line with the requirements of authorisation. The doctor included that Colin was unconscious but did not specify what the decision specific to the mental capacity assessment was.

3.768 During this episode of care there were meetings with the ward team and other professionals to discuss the approach to Colin's care and treatment needs with conversations about palliation and end of life. These discussions were good practice but, as mentioned previously, ML was increasingly anxious and distrustful of the nursing and medical staff as issues arose. Conflicting instructions were given, for example, on the night of 3 September when fluids were discontinued despite ML being told that they would continue until she had made a decision about palliative care for Colin. She also raised concerns about Colin waking up and needing greater supervision. These were validated when Colin was noted to have pulled out his CVC *(*ML says that Colin did not pull this out and she witnessed four members of the nursing staff removing it in the dark; however, we cannot substantiate that claim*)*. Matron 1 took a lead on some of the communications and met with ML to discuss care issues on the ward and also discharge for Colin. This was a helpful strategy as it allowed a single point of contact for ML while also freeing up time for the ward staff to care for the patients on the ward, although more positive action in response to the concerns that were being raised by ML was required at times. This approach should have been adopted much earlier in Colin's care journey.

3.769 As with other episodes of care, ML was found to be recording staff covertly, and we note one occasion when Consultant Surgeon 5 told her that he would not be prepared to talk to her while she had her phone on her and that she would need to leave the ward if she was being difficult. Strategies for resolution should have been adopted by the Trust when ML was first found to be recoding conversations with staff. As mentioned in previous sections of this report, at the point where staff realised that this was happening, a (senior) member of staff should have:

- Listened to ML's reasons for why she wanted to film or record conversations and worked with her to find the best solution for capturing what staff said. It should have been explained that asking for permission was a matter of courtesy and respect and was more likely to lead to a positive and trusting relationship.
- Made sure that any ongoing or immediate concerns that ML had about Colin's care were understood and addressed – including safeguarding concerns.
- Note in Colin's records that video/sound recording had been discussed and could take place.
- Informed ML that appropriate civil or legal action would be taken if it was believed that the recordings were going to be (or had been) misused.
- Ensured that staff were aware of what was or was not permissible with reference to the Trust policy.

Appendix A – Terms of Reference

Terms of reference for independent investigations in accordance with Appendix 1 of NHS England's Serious Incident Framework 2015

The terms of reference were developed in collaboration with the investigative supplier and the affected family**.**

Purpose of the Review

To undertake a comprehensive review of the nature and extent of involvement of all agencies, private and NHS, that Colin had contact with dating back to the first contact with services in respect of his symptoms of dementia/delirium/possible infection. Establish the facts, roles and responses of all agencies involved and any agencies who should have been involved, in the care and management of Colin.

To include an understanding of his past medical history (particularly from January 2021) and the management of his physical conditions with regard to any potential impact on his symptoms of dementia/mental health management.

To independently assess the quality of the care and treatment provided to Colin against best practices, national guidance and organisation policies.

To bring forward a set of recommendations based on an analysis of the systemwide insight to enable learning and development that may be applicable on a local, regional or national basis.

These Terms of Reference should be read in conjunction with specific questions raised by ML and family. The investigating company will work with both and their representative(s) to set out the detail of the specific questions.

Compile a comprehensive chronology of events leading up to 27 July 2021 including a timeline of contact and involvement of all health services, social care, voluntary services, and private providers involvement with Colin.

Compile a comprehensive chronology of events following the incident on 27 July 2021 up to his death on 7 September including the timeliness and management of the injuries sustained and any palliative, end of life care management and medicine management.

Review the care, treatment and services provided by the NHS, the local authority, suitability of the Care Home placement, and other relevant agencies from Colin's first contact with services in 2021 until 7 September 2021.

Review and comment on the roles of the organisations involved, joint working practices, and the management of risk and suitability of placements and services in the overall response to Colin.

Review the adequacy of risk assessments and risk management, availability of suitable placements and services including the availability of an Older Persons Pathway. Identify any factors that hindered any assessment and management processes and what plans were put in place to mitigate those risks.

Review the use of Deprivation of Liberty Safeguard, Do Not Resuscitate orders, use of restraint whilst an inpatient and examine if any breaches of Colin's human rights occurred.

Consider and comment on the key 'touch points' in the system over the period under review identifying any weaknesses in systems or processes within organisations or across system working and the extent to which these factors may have influenced the responses to Colin.

Review and assess compliance with local policies, national guidance and relevant statutory obligations

Examine the effectiveness of the care given to Colin, including the involvement of Colin and his partner and family and the response to any concerns raised by them.

Determine whether there were any missed opportunities to engage other services and/or agencies to support Colin his partner and family.

Review the appropriateness of the treatment of Colin in the light of any identified health and social care needs, identifying both areas of good practice and areas of concern

Involve ML and family in understanding their concerns, key questions and keep them up to date with the progress of the investigation, in liaison with NHS England and other identified support organisations.

Provide a written report to NHS England that includes sustainable recommendations that have been co-produced with the organisations involved.

Create a learning bulletin with the key points for sharing and wider dissemination

Produce a written report that may be made public.

Undertake a follow up review 6 months after the report has been published, to assess whether the report's recommendations have been fully implemented. Produce a short report that may be made public.

Appendix B – Questions from ML

Questions		Comments
1	Please provide a list of agencies, (private and NHS) that are under review.	Please see approach to the investigation on page 23
2	Identify whether any aspects of care should have been delivered differently and if any lessons could be learned, including improvements and services which would help prevent similar incidents occurring as a highlight of good practise.	Areas for learning and references to good practice guidance have been highlighted throughout the report with key themes identified in the summary.
3	How effectively were the transitions between services, care settings, care providers and localities managed and coordinated. How were these transitions coordinated and communicated across providers? How were these arrangements recorded, reviewed and evaluated?	We have included commentary, and learning where appropriate, on transfers and handovers between wards and other services for each care episode. A key theme has been identified in relation to handovers, with narrative around delayed or absent handovers and inappropriate ward moves in the summary of the report.
5	How effective were health assessments in identifying and understanding the holistic assessment of needs for Colin? How well did trust staff understand the specific needs of Colin and how well did non-trust staff understand the specific needs of Colin while he was detained under the Mental Health Act or DOLS?	We have included commentary, and learning where appropriate, on nursing assessments and care planning for each care episode. A key theme has been identified in relation to these aspects of care, with narrative around incomplete assessments and a lack of person centred care planning in the summary of the report.
6	Were Risk triggers and relapse indicators for Colin assessed adequately and to policy?	We have included commentary, and learning where appropriate, on the identification of risks and triggers in each care episode (also linked to care planning as above).
7	Of all the agencies involved, including the Police, was information collaborated from other sources?	We have included commentary, and learning where appropriate, on handovers and information sharing between wards and other services for each care episode. A key theme has been identified in relation to handovers, with narrative around delayed or absent handovers/information sharing in the summary of the report.
8	Was there adequate response from the local authority to any safeguarding raised and did anyone escalate concerns through the trust safeguarding? If safeguardings were raised to the trust what action was taken? In particularly what safeguarding	We were unable to meet with the social worker involved in Colin's care. However, we have included commentary, and learning where appropriate, on several aspects of safeguarding for each care episode. A key theme has been identified in relation to this in the summary of the report.

	measures (if any) were put in place to make sure this does not happen again and what safeguarding measures (if any) were put in place to protect Colin?	
9	Was the equipment used by the provider for providing care or treatment to Colin safe for such use and used in a safe way?	Due to the passage of time, it has not been possible to assess the safety of equipment used for Colin although we have commented on the safety of the stairs that Colin fell from on page 88.
10a	Were security guards (both Broomfield and Basildon sites) trained in restraint?	Incidents that were reported did not include the names or the training that security officers had received. Some incidents were not reported so we have been unable to identify the staff involved. However, as indicated within the report, the Trust was reliant on the training that security staff had received through their Security Industry Authority (SIA) license which includes components of physical interventions but not in a healthcare setting. The training of security staff has since been improved and the Prevention and Management of Violence and Aggression (PMVA) level 2 training was introduced as a standard approach in March 2022 to replace the reliance on the SIA license.
10b	Review use of restraint and restrictive practices within the different placements. Paying particular attention to the recording or non-recording of vital signs during/after restraint.	We have included commentary, and learning where appropriate, on the use of restrictive practices and the monitoring of physiological observations after restraints in each care episode (under medications and also behaviour and presentation). A key theme has been identified in relation to this in the summary of the report.
10c	Review the responsibility for the recording of vital signs during/after restrictive restraint specified in local procedures or embedded in mandatory training.	As above.
11	Review the use of rapid tranquillisation within the different placements. Paying particular attention to the recording or non-recording of vital signs.	As above.
12	Review what support was in place for staff in managing challenging situations with regard to aggression and what staff training had had in these situations.	We have included commentary, and learning where appropriate, on the support offered to staff in relation to the management of patients who present with challenging behaviours. Also see 10a above regarding training.
13	Review the quality of clinical record keeping, care planning and associated risk assessment documentation. Review records written in retrospect and why this was allowed to happen. (Paying particular attention to records from Bulphan Ward, Basildon Hospital).	We have included commentary, and learning where appropriate, on record keeping, care planning and risk assessments in each care episode. A key theme has been identified in relation to this in the summary of the report. We noted a number of medical/nursing entries that had been made in retrospect but are of the view that these were added shortly rather than days after (possibly due to staff being too busy to write up their notes at the time of events happening). While record keeping could have been improved by adding a rationale for the late notes, it was

		good practice to add that entries had been made retrospectively.
14	Was it reasonable to have expected those who cared for Colin to have taken more proactive steps to manage the risk presented by him and to him?	We have included commentary, and learning where appropriate, on care planning and risk assessments in each care episode. A key theme has been identified in relation to this in the summary of the report.
15	Review the assessment of risk of Colin harming himself/or taking his own life or harming others during the period between first admission and the date of the death.	We have included commentary, and learning where appropriate, on safeguarding for Colin and other patients and staff in each care episode. A key theme has been identified in relation to this (under restrictive practices, the Mental Health Act, care planning and risk assessment) in the summary of the report.
16	Is there evidence the risks to the health and safety of Colin were assessed. If assessed what was done to mitigate any such risks? What evidence is there that timely care planning took place to ensure the health, safety and welfare of Colin where responsibility for his care and treatment was shared with or transferred to other appropriate persons.	We have included commentary, and learning where appropriate, on physical health and safeguarding for Colin, other patients and staff in each care episode. A key theme has been identified in relation to this (under restrictive practices, the Mental Health Act, safeguarding, care planning and risk assessment) in the summary of the report.
18	Were the premises used by Colin safe to use for their intended purpose and used in a safe way?	We have included commentary on the cardiothoracic centre stairs where Colin fell on page 88. We have also included a key theme in the summary in relation to the acute hospital environment.
19a	Was there any evidence of assessing the risk of, and preventing, detecting and controlling the spread of infection and /or hospital acquired infection.	We have commented on some aspects of infection prevention and control throughout this report.
19b	Did staff take reasonable steps to manage known risks? Review the speed and effectiveness of coming to any assessments.	Please see above comments in relation to care planning and risk assessments.
19c	Did clinical assessments and behavioural monitoring processes adequately access risk, and was escalating risk effectively identified and acted upon?	We have included commentary, and learning where appropriate, on screening for delirium, care planning and risk assessments in each care episode. A key theme has been identified in relation to this in the summary of the report.
20	Consider whether steps could have been taken to prevent the incident occurring and whether this could have been predictable or preventable.	We do not comment on predictability or preventability within our reports, although in this case we have said that some of Colin's behaviours were predictable when he was admitted to AMU at Basildon Hospital. Appropriate management strategies should have been adopted to better mitigate the risks of harm to Colin and staff.
21	Review all reported safety incidents within Mid Essex hospital trust in previous five years and action taken.	We have reviewed all incidents involving a fall from height but can see very few similarities with this case or actions which may have prevented a recurrence of the fall from the cardiothoracic centre stairs.

		We have not been able to review all incidents reported within the last five years. However, in the summary we have commented on poor incident reporting processes and the impact this has in relation to understanding and improving restrictive practices and the management of patients who present with challenging behaviours.
22	Review and assess compliance with trust-wide clinical observation, risk assessment.	See comments in relation to care planning and risk assessment above.
23	Extremely important that the investigation should also review any internal serious incident investigations reference Colin. ➢ Organisational response to the serious incidents. ➢ Was the SI reported? ➢ Was a 72hr initial investigation report completed. ➢ Were any SI investigations in line with recommendations of NHS serious incident framework and was SIF followed correctly? ➢ Did the lead investigator have the required skills and knowledge needed to complete the investigations. ➢ Were the family involved in the terms of reference for any SI investigations? ➢ Did the SI investigations TORS identify the scope of the investigations sufficiently? ➢ Did the investigators have access to all the records to complete the investigations? ➢ Were the timescales for notification and completion of serious incidents met.	We have commented on the incidents that were reported within the relevant sections of each care episode and have incorporated our findings into the summary of the report. We have also commented on the initial management review that was submitted for the fall in the cardiothoracic centre on page 87. An investigation was not undertaken by the Trust as there was a deferral to the Niche independent investigation.
24	Staffing, to consider: - levels, capacity, skill mix and performance. Did the staff providing care or treatment to Colin have the qualifications, competence, skills and experience to do so safely.	We have been unable to comment on all aspects of staffing; however, where able, we have referenced any staffing shortfalls and experience within each care episode.
25	Search procedure for DoLS/MHA patients – was this followed.	We have commented on the search procedure under the Bardfield Ward care planning and risk assessment section.
26	What aspects of the investigation are going to highlight serious	We have commented on there being no cctv coverage of the stairs within the cardiothoracic centre on page 87. We

	failures in the process, such as who is accountable for failing to secure available objective evidence, such as CCTV- an apology for such failing is clearly insufficient! There is a distasteful possibility - as highlighted through Winterborne's view and other investigations, that these actions are not always accidents if they have the potential to inform accountability.	understand that cameras do not cover this area rather than footage having been erased.
27	Review to understand health and social care act regulations and ECHR articles in relation to events.	Where possible, we have commented on compliance with the Care Act. We have also referenced breaches of human rights in relation to Deprivation of Liberty Safeguards.
28a	Review medicines management. In particular consider whether the medication administered to Colin was suitable for his needs.	We have included commentary, and learning where appropriate, on medicines management in each care episode. A key theme has been identified in relation to this in the summary of the report.
28b	Where medication was prescribed. Were there sufficient quantities of prescribed medicines to ensure the safety of Colin and to meet his needs?	We have also commented on medication administration (and any omissions) in each care episode. A key theme has been identified in relation to this in the summary of the report.
28c	Where medication was administered was a review done of the effects of such medication on Colin.	We have included commentary on the monitoring (or otherwise) of side effects from medications in care episodes where this was appropriate.
28d	Was medication checked against known allergies before being administered.	It has not been possible to determine whether medications were checked against known allergies before administration. In the medications section of the emergency department episode of care on 27 July 2021 we have, however, stated that '*interventional radiology records include that Colin was allergic to penicillin; however, we can see no record of known drug allergies being recorded in Colin's other hospital or GP medical records'*.
28e	Was there evidence of the proper and safe management of medicines.?	See above regarding medication management. All care episodes include comments on medication prescribing and also administration. A key theme has been identified in relation to this in the summary of the report.
28f	Was medication correctly administered to Colin.	As above.
28g	Consider evidence of use of out-of-date stock.	Other than the photograph supplied, we have been unable to determine whether any out-of-date stock was used given the passage of time.
28h	Were delivery of end-of-life drugs subject to regular review of Colin's response to such treatment.	Please see comments in the medication section of the second Bulphan Ward episode of care.
29	Review management of physical health treatment and care.	We have included commentary, and learning where appropriate, on physical health management in each care episode. A key theme has been identified in relation to this in the summary of the report.

30	Was Colin was given sufficient fluids and nutrition throughout his care period.	We have included commentary on these areas in each care episode where relevant.
31	Review management of self harm and suicide.	We have included commentary on this aspect of care on where relevant in each episode of care.
32	Establish what lessons are to be learned from the trusts response to the incidents, taking into account early learning themes, regarding the way in which professionals work individually and together.	We have identified key themes for learning across all care episodes and have made several recommendations in response to these.
33	Based on overall investigative findings, constructively review any gaps in professional working and identify opportunities for improvement.	Where possible, we have identified gaps and opportunities for improvement in relation to the care pathway.
34	Identify any issues in relation to, culture, leadership, capacity or resources that impacted on the Trust's ability to provide safe services, identify any actions that could have led to a different outcome for Colin.	We have provided commentary throughout the report on key issues that have been identified and have included these as themes in the summary of the report. Where relevant we have identified actions that should have been taken to keep Colin safe.

Appendix C – Healthcare providers

Tiptree Road Medical Centre General Practice			
Mid and South Essex NHS Foundation Trust	Broomfield Hospital (Emergency Department and three wards)	25 May - 9 June	16 days
Essex Partnership University NHS Foundation Trust	Mental Health Liaison Team	31 May - 9 June	10 days
North East London NHS Foundation Trust	Goodmayes Hospital	9 - 17 June	8 days
Essex Partnership University NHS Foundation Trust	Dementia Intensive Support Service (at home)	17 June - 21 June	4 days
Highwood Surgery General Practice			
Barchester Care	Woodland View Care Home	21 June - 7 July	17 days
Essex Partnership University NHS Foundation Trust	Dementia Intensive Support Team	21 June - 7 July	17 days
Hallmark Care Homes	Anisha Grange Care Home	7 July - 21 July	15 days
North East London NHS Foundation Trust	Dementia Crisis Support Team	7 July - 21 July	15 days
Mid and South Essex NHS Foundation Trust	Basildon Hospital (Emergency Department and six moves)	21 July - 6 September	45 days
Essex Partnership University NHS Foundation Trust	Mental Health Liaison Team	26 July - 6 September	40 days

Appendix D – Blood results 21 July – 10 August

Key blood results 21 July – 10 August 2021

Investigation / Test	21/07/2021 23:30	23/07/2021 10:52	27/07/2021	29/07/2021 00:50	30/07/2021 00:05	31/07/2021 08:45	02/08/2021 16:00	05/08/2021 09:36	06/08/2021 07:02	07/08/2021 07:02	08/08/2021 08:26	09/08/2021 06:30	10/08/2021 07:17
Sodium (133 - 146) mmol/L	137	136	133	137	138	**129 L**	134	136	141	142	141	138	139
Potassium (3.5 - 5.3) mmol'L	4.1	4.5	4.3	3.9	3.6	3.6	3.9	4.1	4.8	4.6	4.7	4.7	4.5
Urea (2.5 - 7.8) mmol'L	7.2	6.8	6.1	5.4	3.6	4.4	4.4	5.6	3.7	3.1	4.3	4.8	4.9
Creatinine (59-104) umol/L	93	94	90	86	80	82	68	68	68	55	58	62	62
Total bilirubin (0 - 21) umol/L	17	16	14	**35 H**	**29 H**	**31 H**	**47 H**	**29 H**	20	14	12	10	9
Corr Calcium (2.20-2.55mmol/L)								**1.92 L**	2.26	2.25	2.21	**2.17 L**	**2.1 L**
Creactive protein (<5) mg/L	2	2	1	**147 H**	**284 H**	**298 H**	**282 H**	**308 H**	**221 H**	**175 H**	**121 H**	**89 H**	**71 H**
Troponin T (<14) ng/L	**22 H**	**21 H**	-	-	-	-	-						
HAEMOGLOBIN (115-165) g/L	135	149	143	**105 L**	**105 L**	**95 L**	**105 L**	91	102	104	104	106	98
WHITE CELL COUNT (4.0-11.0) 10*9/L	7.4	8.1	8.3	**11.8 H**	**15.5 H**	**17.6 H**	**14.8 H**	**12.6 H**	**14.5 H**	10.08	8.4	10	8
INR (0.8- 1.2) INR	1	-	1.1	1.1	-	1.1	-	1.1	1.1	1.2	1.1	1	1.1

Appendix E – Glossary

ACS	Acute coronary syndrome
AMHP	Approved mental health practitioner
AMTS	Abbreviated mental test score
AMU	Acute medical unit
BPSD	Behavioural and psychological symptoms of dementia
CCMT	Complex case management team
CEO	Chief executive officer
CPN	Community psychiatric nurse
CQC	Care Quality Commission
CRP	C-reactive protein
CT	Computerised tomography
CVC	Central venous catheter
CXR	Chest X-ray
DCST	Dementia Crisis Support Team
DISS	Dementia Intensive Support Service
DIST	Dementia Intensive Support Team
DNACPR	Do Not Attempt Cardiopulmonary Resuscitation
DoLS	Deprivation of Liberty Safeguards
EPUT	Essex Partnership University NHS Foundation Trust
FY	Foundation Year
GCS	Glasgow Coma Scale
HCA	Healthcare assistant
HDU	High dependency unit
ICP	Integrated care plan
ICU	Intensive care unit
IMCA	Independent mental capacity advocate
IMHA	Independent mental health advocate
IR	Interventional radiology

ITU	Intensive therapy unit
LPA	Lasting power of attorney
MCA	Mental Capacity Act
MDT	Multidisciplinary team
MET	Medical emergency team
MHA	Mental Health Act
MHLT	Mental Health Liaison Team
MSFD	Medically safe for discharge
MUST	Malnutrition Universal Screening Tool
NBM	Nil by mouth
NELFT	North East London NHS Foundation Trust
NEWS	National Early Warning Score
PMVA	Prevention and management of violence and aggression
RAID	Rapid assessment interface and discharge
RMN	Registered mental health nurses
SHO	Senior house officer
SpR	Specialist registrar
SQiD	Single question to identify delirium
TEP	Treatment escalation plan
TPN	Total parenteral nutrition
WCC	White cell count

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