Norfolk Safeguarding Adults Board

Safeguarding Adult Review:

Case E

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NORFOLK SAFEGUARDING ADULTS BOARD
SAFEGUARDING ADULTS REVIEW: Ms E

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1. INTRODUCTION

1.1. Brief overview of the circumstances that led to this review

1.1.1. Ms E (who was born in 1921) died aged 95 in Norfolk & Norwich University Hospital in November 2016, having been admitted by ambulance earlier the same day in a severely hypothermic state. The pathology report showed that hypothermia contributed to her death; however, she also had bronchial pneumonia, which can lead to hypothermia. The Coroner's verdict was that she died of bronchopneumonia and hypothermia. The coroner noted that she had not received antibiotics prescribed by her GP the previous day, and that the care home's boilers were broken, resulting in the use of portable heaters. The Coroner concluded that *"The evidence does not reveal which developed first or to what extent these two issues contributed to her death*."

1.1.2. Ms E had lived in the care home since 20th April 2011, having entered as a self-funding resident following a hospital admission. She had previously lived in a self-contained facility at her daughter's home in the same town, and had had one short period of respite at the care home in 2010. She had multiple co-morbidities, including osteoporosis, osteoarthritis, cerebrovascular disease, chronic kidney disease, hiatus hernia and cataracts. She occasionally experienced falls, and needed support with her personal care. She had been registered with her GP since October 2008.

1.1.3. In the months and weeks prior to her death, Ms E had been treated by her GP surgery and by community nurses from the Community Health & Care NHS Trust, and was also known to the East of England Ambulance Trust (as a result of call outs and an admission to hospital) and to Norfolk County Council Adult Social Care Department (due to a safeguarding incident involving an altercation with another resident at the care home).

1.1.4. The care home was an old poorly-insulated building with high ceilings and large rooms. Its heating and hot water ran on two boilers dating back to the 1960s, which were run alternately for short periods in order to produce the full load of the output required for the building. One boiler failed in the early summer of 2016, leaving the home reliant on the second, which itself failed in October 2016, and, as a result, the home lacked hot water and heating for a number of weeks. Both boilers had been the subject of condemnation notices issued in 2013. Temporary measures (involving portable heaters, hot water conveyed in jugs, and temporary water heaters) were in place at the time of Ms E's death, and were being monitored by the Care Quality Commission and the Quality Assurance team of Norfolk County Council's Adult Social Care Department.

1.1.5. Ms E's admission to hospital resulted in a safeguarding enquiry jointly led by Norfolk Constabulary and Norfolk Adult Social Care. Norfolk Constabulary investigated Ms E's death to determine whether criminal offences had taken place. Concerns about the safety of other residents at the care home triggered immediate review by Ambulance personnel, and

on-going review of their health and social care needs by Norfolk Adult Social Care and the Community Health & Care Trust. The Care Quality Commission, Quality Assurance and Environmental Health continued to monitor and manage on-going health and safety concerns in the care home.

1.1.6. In the context of concerns about whether neglect had contributed to Ms E's death, on 17th November 2016 the Adult Abuse Investigation Unit of Norfolk Constabulary requested that a Safeguarding Adult Review take place to explore concerns about how the agencies involved had worked together to manage the risks evident in the care home's situation.

1.1.7. Prior to the start of this review, the owner of the care home took the decision to close the home at the end of May 2017. All residents were re-located. No criminal proceedings were taken by Norfolk Constabulary against any party.

1.2. Statutory duty to conduct a Safeguarding Adult Review

1.2.1. The Norfolk Safeguarding Adults Board (NSAB) has a statutory duty[1] to arrange a Safeguarding Adults Review (SAR) where:

(a) An adult with care and support needs has died and the SAB knows or suspects that the death resulted from abuse or neglect, or an adult is still alive and the SAB knows or suspects that they have experienced serious abuse or neglect, and

(b) There is reasonable cause for concern about how the Board, its members or others worked together to safeguard the adult.

1.2.2. Board members must co-operate in and contribute to the review with a view to identifying the lessons to be learnt and applying those lessons in the future[2]. The purpose is not to allocate blame or responsibility, but to identify ways of improving how agencies work, singly and together, to help and protect adults with care and support needs who are at risk of abuse and neglect, including self-neglect, and are unable to protect themselves.

1.3. NSAB's decision to conduct a review

1.3.1. The NSAB's SAR subgroup, at its meeting on 6th December 2016, found that the case met the criteria for undertaking a SAR, and appointed a SAR Panel to undertake the review.

1.3.2. The membership of the SAR Panel was as follows:

- Independent chair of the panel: Norwich City Council
- Independent lead reviewer and overview report writer: Suzy Braye, Independent Consultant

[1] Sections 44(1)-(3), Care Act 2014
[2] Section 44(5), Care Act 2014

- Care Quality Commission
- East of England Ambulance NHS Trust
- GP Surgery
- Norfolk Community Health & Care NHS Trust
- Norfolk Constabulary
- Norfolk County Council Adult Social Care Department
- Norfolk & Norwich University Hospitals NHS Foundation Trust
- Norfolk Safeguarding Adults Board: Manager/Business Lead
- A Norfolk Clinical Commissioning Group
- A Norfolk District Council Environmental Health Department

1.3.3. The NSAB Coordinator provided administrative support to the Panel.

1.4. Terms of reference for the review

1.4.1. The terms of reference set out the focus of the review:

(a) To examine the care and treatment Ms E was receiving during the period under review (and whether correct processes, protocols and procedures were followed and required standards met);

(b) To consider whether Ms E's physical and mental health needs were given due care and attention (and whether key policies, practices, actions and resources were appropriate);

(c) To explore whether the different agencies involved worked effectively together to safeguard Ms E, including:
- Information-sharing
- Interagency communications
- Roles and responsibilities
- Processes for discussion, challenge and resolution of disagreements.

(d) To consider whether supervision, oversight and training had an impact and whether monitoring was at a sufficient level;

(e) To consider whether the recommendations of any relevant previous reviews were complied with;

(f) To make recommendations for improvements to policies and practices.

1.4.2. The period under review was originally set as the six-month period prior to Ms E's death. At its first meeting, the SAR Panel amended this to the two years prior to Ms E's death.

1.5. Other investigations

1.5.1. Norfolk County Council has conducted risk assessments with regard to all residents within the care home, covering environmental and care issues, as a result of a safeguarding referral received from Norfolk & Norwich University Hospital following Ms E's death on 9th November 2016. As part of this process operational staff have undertaken individual reviews of all residents. The minutes of a series of strategy discussions and meetings taking place between 9th November 2016 and 8th May 2017 have been made available to the SAR panel.

1.5.2. Norfolk Constabulary conducted a criminal investigation into the circumstances surrounding Ms E's death between the 9th November 2016 and 8th March 2017, the outcome of which was a decision by the Complex Case Unit of the Crown Prosecution Service to take no further action.

1.5.3. Norfolk County Council Quality Adult Social Care Quality Assurance Team has indicated that it is undertaking a review of commissioning and a review of current quality assurance and contract management arrangements. These reviews are, however, quite separate from the SAR. The reviews are expected to be completed by March 2018, with a likely recommendation that the QA team be strengthened.

2. THE REVIEW METHODOLOGY

2.1. The review model

The approach chosen was a review model that involved:

- Appointment of (a) an independent senior manager from an agency not involved in the case to chair the SAR Panel and (b) an independent lead reviewer and author to provide, in consultation with the SAR Panel, a report containing analysis, lessons learnt and recommendations;

- Submission of chronologies of involvement and Internal Management Reviews (IMRs) from all agencies who were involved in either providing services to Ms E prior to her death or responding to the risks arising from the boiler failure at the care home. The purpose of the IMRs was to enable each agency to reflect on and to evaluate their own involvement with Ms E and to identify recommendations for changes to their own or interagency practice;

- Invitation to Ms E's daughter to contribute to the review. This was declined;

- Interview with the registered manager employed by the care home at the time of the events in question;

- Written request to the care home owner for attendance at a meeting with the panel chair, NSAB manager and lead reviewer, to provide responses to a detailed and targeted list of questions;

- A series of SAR Panel meetings for discussion and analysis of the learning themes emerging from the material submitted by the agencies and information derived from interviews;

- A learning event held with practitioners and operational managers from the services in question. The purpose was to seek clarification and views about the themes emerging, and to ensure that the SAR Panel's analysis and recommendations were informed by those most closely involved in the case;

- Formal reporting to the NSAB to inform its action planning and monitoring of implementation across the partnership.

2.2. Agencies providing information to the review

2.2.1. The panel received chronologies and IMRs from the following:

See below

Care Quality Commission (CQC)	CQC is the independent regulator of health and adult social care in England. The organisation registers, monitors, inspects and rates providers of services, setting out and enforcing care standards. The care home in which Ms E resided was registered with CQC and had last been inspected in January 2015, when it was rated as 'Requires Improvement'. During the last 6 months of the period under review, CQC worked with NCC Quality Assurance, Environmental Health and NCC Adult Social Care to manage the risks arising from the failure of the care home's boilers, and other concerns about care standards. From 1st April 2015 a Memorandum of Understanding (MoU) between the CQC, the Health & Safety Executive (HSE) and the Local Government Association (LGA) established that the CQC is the lead inspection and enforcement body under the Health & Social Care Act 2008 for safety and quality of treatment and care matters involving patients and service users in receipt of a health or adult social care service from a provider registered with CQC. It is this version of the Memorandum that was in force at the time of the events that are the subject of this review. The Memorandum was revised and reissued in December 2017 as an agreement between HSE and CQC, with the support of the LGA[3].
East of England Ambulance NHS Trust (EEAST)	EEAST provides urgent and emergency medical care to people who call 999. It covers six counties: Bedfordshire, Cambridgeshire, Essex, Hertfordshire, Norfolk and Suffolk. EEAST attended Ms E at the care home three times during the period under review, conveying her to hospital on two of those occasions.
General practitioner (GP)	The GP practice provided primary care to the residents of the care home, all of whom were registered with the practice. It made a weekly visit to the home during which any resident could be seen, as well as visits in response to individual requests at other times. It has a number of GP partners, several of whom visited Ms E, who was seen on 9 occasions during the period under review. She was also under regular review by the practice nurse as part of the surgery's Admission Avoidance Scheme.
Norfolk Community Health & Care	Ms E received visits from community health practitioners who provided continence management advice, seasonal influenza vaccination and ear syringing. Following Ms E's death, the community matron participated in

[3] An overview of the regulatory powers of the agencies involved during the time period covered by this review may be found at Appendix 2. The original Memorandum may be found at Appendix 4 and the revised version at Appendix 5.

NHS Trust (NCH&C)	safeguarding strategy discussions relating to the health of other residents, and took place in reviews of their health and care needs.
Norfolk Constabulary	Within the Norfolk Adults Multi Agency Safeguarding Hub (MASH), Norfolk Constabulary is responsible for assessing reports of abuse and neglect to identify whether any criminal offences have taken place, and for participating in multi-agency strategic discussion. Between 9th November 2016 and 8th March 2017, staff from the Adult Abuse Investigation Unit undertook an investigation into the circumstances of Ms E's death and on the basis of advice from the Crown Prosecution Service concluded that no prosecution would be pursued.
Norfolk County Council Adult Social Care Department (ASC)	ASC has statutory lead responsibility for adult safeguarding. In addition to investigating the safeguarding concerns relating to Ms E, the Council has led risk assessments related to environmental and care issues within the care home, and operational social work teams have reviewed all residents as part of this process. NCC had had historical involvement with Ms E prior to her admission to the care home in 2011, but there had been no recent involvement with her individually, and as a self-funding resident she was not subject to annual reviews. The care home was registered as a provider with NCC.
Norfolk County Council Public Health Department (PH)	PH has responsibility for the prevention and control of infection. Arising from the care home's boiler failure affecting both heating and hot water, PH were asked to review and advise on infection control measures in the care home. They undertook an inspection on 29th November 2016 and a further review visit on 8th February.
Norfolk County Council Quality Assurance & Market Development Team (QA)	QA is part of the Council's Commissioning Section, and is responsible for ensuring that adult social care providers consistently provide good quality care in accordance with the Care Act 2014 and related regulatory requirements. They do so through a mix of proactive and reactive interventions ranging from information and advice to deep dive audits and close monitoring.
Norfolk & Norwich University Hospitals NHS Foundation Trust (NNUH)	Ms E was admitted to NNUH with severe hypothermia early in the morning of 9th November 2016. The Emergency Department raised a safeguarding alert and Ms E received treatment during the day, but died late in the afternoon. She had previously been treated at the hospital in June 2016 for a lower respiratory tract infection.

A Norfolk District Council Environmental Health Department (DC)	Officers from the Public Protection Team of the district council worked with the CQC, Quality Assurance and the care home to attempt to resolve the lack of heating and hot water following failure of the home's boilers and to manage the risks arising. The service had previously been involved with the care home managing risk arising from concerns about legionella[4].

2.2.2. The panel did not receive any response to its requests, made under s.45, Care Act 2014, that the care home owner provide information to the review. The owner's non-engagement with the review process remains a matter of serious concern.

2.3. Participation by Ms E's family

The NSAB has provided background information about SARs to Ms E's daughter, inviting her to take part in the review relating to her mother. She has not responded to the invitation. When the review is complete the lead reviewer and panel chair will offer a meeting to discuss its findings.

3. Ms E: THE PERSON

3.1. In the absence of information from Ms E's daughter, we have relied upon information from staff who knew her in the care home.

3.2. Ms E had been known to care home staff for some time. While still living with her daughter she would come to the home for respite and would sometimes come to garden parties. They knew that she had been a walker in the past, and loved animals, having dogs at home. Prior to her admission in April 2011 she had had a number of falls at home. As a resident since April 2011, she was (despite her multiple health challenges) relatively independent; she could wash herself, and use the toilet in her room, needing a hand with dressing. She had a raised hospital bed and used a wheelchair to move around into the lounge and dining room, and was able to transfer herself independently. She did occasionally experience falls.

3.3. She had a good appetite, choosing her own food from the menu; sometimes needing it to be liquidised to make it easier to eat. She was sociable, taking part in communal activities, and had one close friend. She enjoyed TV, and liked animal programmes in particular. Her room was close to the office, and she would often wheel herself in to talk to the manager. She knew how she liked things to be, and would let staff know her preferences in relation to her care. She remained in close contact with her family, who visited twice a week.

[4] Legionella bacteria are found in water systems. If conditions are favourable, they may grow, increasing the risks of Legionnaires' disease, a potentially fatal form of pneumonia, and other conditions. Appropriate measures must therefore be taken to control and monitor risks. (http://www.hse.gov.uk/legionnaires/)

4. CASE CHRONOLOGY OVERVIEW

4.1. Introduction

The full chronology of agencies' involvement with Ms E may be found at Appendix 3, and contains the detailed evidence upon which the analysis in this report is based, cross-referenced to the sources of that evidence in the documentation submitted to the panel. Here, a short overview of key episodes is provided.

4.2. Signficant events prior to the review period

4.2.1. Safeguarding activity: The Norfolk Constabulary IMR reports 15 safeguarding referrals relating to the care home between 2005 and 2015. The majority relate to concerns expressed by relatives, visiting professionals, the care home manager and in one case a former care worker about compromised standards of care within the home. It is notable that eight of the incidents fall within a single year (2013). None of the alerts related to Ms E.

4.2.2. Health and safety concerns: The same year, CQC notified a number of health and safety concerns to the district council Environmental Health Department. Inspection revealed a range of non-compliance on matters such as safety policy, risk management, slips and trips, falls, manual handling, asbestos control, electrics, gas safety, water systems, lifting equipment and stair-gates. Requirements were imposed, including a formal Improvement Notice relating to control of legionnaires' disease risk.

4.3. Between June 2014 and Ms E's death in November 2016

4.3.1. During this period, Ms E received regular medical attention. She was registered on the GP's Admission Avoidance Scheme, which provided enhanced monitoring, and she received seasonal influenza vaccine and continence management from community nursing. She had occasional falls: on one occasion, the ambulance service was called to help her (29th June 2014); the GP in follow up found her to be chesty and weak, with bradycardia, although an ECG did not indicate any need for action. After another fall (19th January 2015) the GP arranged an x-ray, which found she had a toe fracture.

4.3.2. CQC inspected the care home in January 2015, rating it as 'Requires Improvement'.

4.3.3. During the same period, Environmental Health note that a legionella risk assessment by an external specialist water hygiene company (November 2014) had resulted in a number of recommendations to the care home. During March 2015, when legionella was found in 3 rooms, Environmental Health emphasised the importance of implementing the recommendations. New hot water storage tanks were installed, and temperatures were found to be within the legionella control range (June 2015). However, the

subsequent legionella risk assessment due in November 2015 did not take place[5]. Environmental Health understand that this was not due to any failing on the part of the contractor, but that the care home did not arrange the review.

4.3.4. CQC postponed its inspection due in April 2016 due to prioritisation of work on higher risk situations elsewhere.

4.3.5. Ms E experienced further medical interventions. The ambulance service attended on 4th April 2016; she had been given the wrong medication by the care home and felt nauseous. Admission to hospital was not necessary, and checks the following day by her GP indicated the incident was unlikely to have caused her any harm. The ambulance attended again when Ms E fell (12th June 2016). After intervention to reduce her temperature she was admitted to hospital, where she was treated for lower respiratory tract infection and discharged the following day. A chest x-ray arranged by the GP later in the month showed hiatus hernia. In August she was treated for blocked ears, with a community nurse visiting to carry out syringing.

4.3.6. On 11th October, Ms E was slapped by another resident during an altercation, receiving bruising above her eye. A safeguarding referral resulted in a decision that the police would lead an investigation with a social worker present to support the resident. The investigation had not concluded before Ms E's death on 9th November.

4.3.7. At around this time, in mid-October, the care home's boilers failed[6], with concern first being raised with CQC by a family member on Friday 28th October. On Monday 31st October both Norfolk County Council's adult social care enquiry desk and the District Council's Environmental Health Department heard from a relative that the home lacked heating and had had no hot water for 2 weeks. Environmental Health advised CQC (in the light of the national Memorandum of Understanding setting out respective roles and responsibilities relating to health and safety in registered provision)[7]. CQC liaised with the home by phone on Monday 31st October, identifying that temporary portable heaters were in place and that staff were carrying

[5] District Council IMR: It is for care homes to ensure that their Legionella management controls are effective and that they are up to date. They should have systems in place to ensure that all safety critical systems, including the inspection of lifting equipment, thermostatic devices, pressure systems and Legionella controls are undertaken on a set frequency.

[6] The care home's boilers had been the subject of a condemnation notice issued by the servicing company in 2013. Such notices indicate that an appliance is not compliant with regulations and cannot be made compliant, but would not prevent lawful ongoing use.

[7] The Memorandum of Understanding between CQC, the Health & Safety Executive and the Local Government Association came into effect on 1st April 2015 and was operational during the period under review. It may be found at Appendix 4. Under the agreement, CQC is the lead inspection and enforcement body under the Health and Social Care Act 2008 for safety and quality of treatment and care matters involving patients and service users in receipt of a health or adult social care service from a provider registered with CQC. The Memorandum was revised and reissued in December 2017 as an agreement between HSE and CQC, with the support of the LGA. The new version may be found at Appendix 5 and at this URL: http://www.hse.gov.uk/aboutus/howwework/framework/mou/mou-cqc-hse-la.pdf

hot water from the kitchen and an upstairs hot water boiler to points of use. On Thursday 3rd November, Environmental Health expressed concern to CQC about the temporary arrangements. The same day CQC alerted the Adult MASH, asking what help NCC could offer and conveying Environmental Heath's concerns. In response, NCC's Quality Assurance Team, who had been alerted on Tuesday 1st November by the NCC enquiry desk, visited the care home on Friday 4th November. Both boilers required replacement, but the temporary arrangements were deemed manageable, without immediate risk to residents. Heaters were said to be being left on overnight, and staff were said to be checking the temperature in residents' rooms regularly.

4.3.8. Environmental Health raised further concerns with CQC on Monday 7th November about the adequacy of the current arrangements; they had concerns about maintaining the home at 18°C and about residents' capacity to complain about cold, about bed baths, falling temperatures, hot water being carried around the home in jugs, the length of time for a resolution, the cumulative effect of exposure, temporary heating, and infection control.

4.3.9. During this period, the owner was out of the country; it was the care home manager who attempted to progress the temporary arrangements but it was unclear what authority she had to commit expenditure. Temporary hot water immersion heaters were in action by Tuesday 8th November, but the boilers remained out of commission.

4.3.10. On Tuesday 8th November, the GP visited Ms E at the request of care home staff, who felt she was too unwell to await the routine weekly GP visit two days later. She had been unwell for 3 days, had a cough, and her behaviour had become more confused. The GP diagnosed a chest infection and provided a handwritten prescription for antibiotics; it is not known what Ms E's temperature was at that point, as the GP did not take a reading during the visit, and her heart rate was not recorded in the notes. Despite having called the doctor to an urgent visit, and the doctor's expectation that the medication would be obtained as a matter of urgency, the care home did not ensure that the prescription was dispensed, so Ms E did not receive the antibiotics. After Ms E's admission to hospital, the care home manager learnt that staff on duty the previous day had faxed the prescription to the wrong chemist, and did not query with the correct chemist why the medication had not been delivered[8].

4.3.11. At 05.35 on the morning of Wednesday 9th November, the ambulance service responded to a 999 call from the home. They found Ms E severely hypothermic at 27.5 degrees with an absolute bradycardia heart rate of 37bpm and conveyed her to hospital. Having sampled other residents' temperatures and found them also to be hypothermic, the ambulance crew, before leaving, requested further assistance for the other residents from

[8] The chemist receiving the prescription has informed this review that they did alert the home to the error. It appears, however, that the home did not then correct their mistake by faxing the prescription to the correct chemist.

Ambulance Control. Clinicians from a second ambulance subsequently undertook welfare checks of the remaining residents, with none requiring treatment or onward transportation. On admission to NNUH Ms E was found to have pneumonia, and died later that afternoon.

4.3.12. The ambulance service raised a safeguarding referral with the Adult MASH, and the hospital advised the police and the hospital safeguarding and social work teams. A joint safeguarding investigation, led by the police and adult social care, was initiated and an unannounced visit to the care home took place the same day. This resulted in concerns that other residents may be at risk of harm, arising from the failure to provide adequate heating and hot water, poor recording of care interventions, apparent failures to act upon a resident's ill health, and evidence that the home's physical environment was not being adequately maintained. The police also initiated a criminal investigation.

4.4. The period following Ms E's death

4.4.1. While review of involvement with Ms E ends with her death on 9th November 2016, the SAR Panel has also been given information about the six-month period following this. Ms E's death brought heightened awareness of a number of shortcomings at the care home, and focused the attention of relevant agencies on the need to assess and manage risks to other residents and to enforce appropriate standards in the care home. The panel is of the view that valuable learning emerges from this on-going period, and that the chronology and analysis should therefore be continued to include it.

4.4.2. Following Ms E's death, the safeguarding and criminal investigations continued. While a temporary boiler became operational for heating on 11th November, and for hot water on 1st December, a wide range of health and safety concerns remained:

- CQC inspections on 10th and 15th November 2016 found shortcomings across all areas of the home, with significant concerns regarding medication, care records, risk assessments, infection control, care needs and the fabric of the building. On 22nd November, CQC issued a Notice of Decision[9] to immediately restrict any admissions to the care home, including readmissions (for example where residents had been admitted to hospital) without prior agreement. The home was rated 'Inadequate' and placed into special measures, under which it was expected to take significant steps to improve the quality of provision. On 16th January 2017, CQC issued a Notice of Proposal setting out its intention to cancel registration of the home (against which the owner made representation).

[9] Under s.31, Health & Social Care Act 2008: CQC can impose conditions on a regulated activity urgently if people are at risk of harm.

- Environmental Health assessed the home's legionella control on 17th November 2016. During this visit it became apparent that the information previously supplied by the care home regarding the availability of hot water to the kitchen was not accurate. On this basis, the following day the department issued a Food Hygiene Improvement Notice requiring a constant supply of hot water to the kitchen. On 22nd November an Improvement Notice requiring the home owner to take measures to control legionella in the system was served. In addition, the home was required to connect drinking water to the mains supply. (It had emerged that drinking water was tank-fed rather than mains-fed, thus exposing it to risk of bacterial infection, and that a substance not approved for use in drinking water had been added to the tanks for legionella control.)

- At the request of Environmental Health, the Fire Service conducted an investigation of fire safety procedures, resulting in recommendations and follow up of staff training and evacuation planning.

- Public Health were asked to review of infection control measures in the home. It carried out an inspection on 29th November 2016, resulting in a range of improvement actions being required. A follow up inspection on 8th February identified some actions completed while others remained outstanding.

4.4.3. The police criminal investigation continued, with both the care home owner and the care home manager interviewed under suspicion of manslaughter by gross neglect; witness statements were taken. A file was subsequently submitted to the Crown Prosecution Service, resulting in a decision that no prosecution would take place.

4.4.4. As a result of the above concerns, Adult Social Care during November and December undertook a review of each individual resident's care needs, assisted by the community matron. This exercise did not result in any residents needing or requesting to be moved. The majority of residents had a family or friend to accompany them and had capacity. In the case of nine others, relatives or attorneys were unable to attend but wished the review to go ahead and shared their views either by phone or at a later date. In one case where the individual lacked capacity, an IMCA was involved and in the other the individual had support from her husband who also lived at the home.

4.4.5. The Ambulance Service was called to the home a further 14 times, a mixture of GP transport requests and emergency calls. These involved a range of different residents and the volume was not exceptional. Crews raised no further safeguarding alerts.

4.4.6. Planning concerns arose in relation to new units being constructed by the home owner on an adjacent site. The owner had originally intended that care support to the residents of those units would be resourced from the

care home, but the CQC condition to restrict new admissions made this impossible. He therefore merely rented the units out, sourcing the care and emergency cover from a third party provider. This arrangement contravened his planning permission.

4.4.7. The efforts of the agencies involved were coordinated through a series of safeguarding strategy meetings, held between 9th November 2016 and 8th May 2017, attended by representatives of Norfolk Constabulary, Norfolk County Council's Quality Assurance, Adult Social Care and Safeguarding teams, the CCG, CQC, Norfolk Community Health & Care Trust, the District Council Environmental Health Department and NNUH[10]. In the absence of evidence of immediate risk to life, concerns nonetheless remained about risks to residents from poor care standards and from environmental hazards such as legionella infection, poor window closures, and inadequate safety in the home's lift. There were differences of opinion between agencies on the extent to which enforcement action should be taken, with NNUH expressing grave concern that residents were allowed to remain there, and Environmental Health expressing frustration that more assertive action to prohibit occupation of the home was not considered.

4.4.8. On four occasions, by agreement of all agencies, a smaller group met with the care home owner and manager to review progress on the improvement actions required by the agencies. Confidence in the home's ability to manage the situation was low, due to poor engagement by the home owner and a lack of proactive response to the agencies' requirements, requiring repeatedly renewed deadlines for action plans. While progress on some matters was made, concerns remained about legionella control, lift safety, care standards and the support arrangements for residents of the new-build units. The CQC condition to restrict new admissions was twice breached[11].

4.4.9. Following a further CQC inspection on 28th March, resulting in a further rating of 'Inadequate', CQC refused the owner's application to remove the imposed condition on new admissions, and in April the owner took the decision to close the home; he had indicated his intention to do this should the fall in the number of residents cause the home to become financially unviable. NCC Adult Social Care staff supported residents and families through the closure process and the last resident moved out on 31st May 2017.

4.4.10. On 23rd May 2017, CQC, having heard and not upheld the owner's representation against the Notice of Proposal to cancel registration issued in January, served a Notice of Decision to cancel registration, against which the owner did not appeal, and the home was de-registered.

[10] In error, NNUH was not invited to the first meeting, but was involved thereafter.
[11] Once when a resident was readmitted following a hospital stay, and once when a day care attender spent two weeks in residential respite.

4.4.11. Following the closure of the home, Environmental Health did not further pursue the breach of its management notice in relation to legionella control, it not being the public interest to do so. Potential concerns about care standards in the new-build units did not materialise, as tenants were not in receipt of care services.

4.4.12. CQC were granted access to the police investigation files, and the case remains under consideration by CQC with a view to possible criminal prosecution under Regulation12, Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

5. THEMED ANALYSIS

5.1. Introduction

The following section reports on findings that emerge from the combined chronology of events, from evidence provided to the panel in the agencies' IMRs and from discussions held at the learning event. The analysis considers both single and joint agency actions, with an emphasis on how the various agencies worked together.

5.2. Attention to Ms E's needs

5.2.1. It appears that both routine and acute health needs experienced by Ms E in the months prior to her death were appropriately responded to by the GP, community nursing, the ambulance service and NNUH. Her listing on the surgery's Admissions Avoidance Scheme meant that she received proactive monitoring and review of her needs. She had received annual influenza vaccine, continence management, ear syringing, ECG, x-ray and follow up medical attention on the few occasions on which she experienced falls. The ambulance service had attended on 3 occasions, providing appropriate attention to her emergency needs, including on one occasion (5 months prior to her death) appropriate admission in NNUH where she received necessary treatment for a respiratory infection. EEAST records show that while target response times on two calls were not met[12], the delay did not affect outcomes. On each occasion ambulance clinicians completed a systematic patient assessment, which includes a functional enquiry, physical assessment and a decision on how to support the patient in their wellbeing, and the outcome on each occasion was justified.

5.2.2. Since mid-2016, in addition to responding to calls for urgent visits, the surgery had provided a regular weekly visit to the care home from a doctor who could see anyone the staff felt needed attention, or who had requested themselves to be seen. Since September 2016 the same doctor had carried out these visits, in order to provide continuity and an improved service for the residents.

[12] On 4th April 2016, the response time was 1hr, 36 minutes against a target of 30. On 12th June 2016, the response time was 16 minutes against a target of 8.

5.2.3. There is no suggestion that Ms E lacked capacity in relation to any decisions that she was required to make. Where mention of capacity is made (for example by ambulance personnel in April and June 2016) it is to confirm that she could be deemed to have capacity in relation to conveyance to hospital and treatment. Similarly, the safeguarding strategy discussion minutes from the morning of 9th November 2016, recording the decision to investigate circumstances in the home while Ms E was being treated in hospital, noted that on the basis of information available there was no need for a capacity assessment.

5.2.4. On none of the 9 occasions that GPs saw Ms E were any concerns about her care highlighted. She had been seen by a GP on 8th November, the day before she died, at the request of care home staff, and was clearly unwell at this stage as staff felt she could not await the routine GP visit two days later. The GP prescribed medication for a chest infection, but did not notice that the ambient temperature was low or that Ms E seemed to be cold. Her temperature was not taken. The care home failed to obtain the medication. They faxed the prescription to the wrong chemist, and although the chemist say they alerted the home to the error, the care home staff did not the approach the correct chemist, or question the non-arrival of the medication.

5.2.5. The GP IMR also reports that surgery records relating to all visits to the home for all residents in the 2 weeks prior to Ms E's death were searched – again no concerns about the care of residents arose (although it is mentioned in another agency's IMR that a doctor had been unable to take a blood sample on one occasion due to the resident being too cold, and having had to warm the resident before the intervention could be carried out).

5.2.6. The practice had discussed a few low level concerns about the care of the residents, but had not felt they reached the level of safeguarding concern or that they needed to be reported elsewhere. For example, the surgery reports that there had been incidents in the past where staff had delayed getting prescriptions dispensed; the doctors would express their concerns to the staff, but did not report it to anyone else as they did not feel it reached the level of neglect to be a safeguarding issue and it was not clear to whom such concerns should be addressed. Thus it appears the care home's failure to secure the antibiotics the GP had prescribed for Ms E on 8th November 2016, having diagnosed a chest infection, was part of a pattern of failing to attend speedily to residents' health needs.

5.2.7. It appears Ms E deteriorated very quickly overnight, her condition possibly exacerbated by the absence of medication. During this period temporary halogen and electric heaters were in use in residents' rooms and were said not to be being switched off at night. The home had assured the Quality Assurance team, at its visit on 4th November, that risk assessments had been done and that extra staff had been brought in to check heating systems, ensure residents were appropriately dressed, and provide extra bedding. Staff were said to be undertaking regular

checks every 15 minutes. QA, accepted the temporary arrangements, and informed CQC that they were sufficient. No review of the care home's logs of the temperature checks was carried out, however, and during the investigation into Ms E's death no evidence was found that she was seen at all overnight between 19.30 on 8th November and 05.35 on 9th November, when an ambulance was called.

5.2.8. Ms E's immediate health needs at that point received appropriate attention from the ambulance crew and she was urgently admitted to NNUH for treatment. While the ambulance response time missed its target (27 minutes against a target of 20), this did not affect outcomes; the ambulance personnel recognised the time-critical nature of her condition and provided an appropriate response.

5.2.9. Following arrival at the NNUH Emergency Department, Ms E was admitted to the Acute Medical Unit. She was too drowsy to communicate.

5.3. Agencies' responses to concerns about health & safety and care standards in the care home

Historical involvement

5.3.1. Historical concerns had been expressed about standards at the care home. This is evident from safeguarding records: Norfolk Constabulary list fifteen safeguarding referrals at the care home between 2005 and 2014, prior to the start of the review period, including 8 in 2013 alone. All related to concerns expressed by relatives, visiting professionals, the care home manager and in one case a former care worker about compromised standards of care within the home. Strategy discussions were held in relation to each referral, resulting where necessary in follow up by adult social care and/or the Quality Assurance team. CQC are mentioned in relation to five of the referrals, either as originating the referral following contact from members of the public, or as having been provided with information about the safeguarding issue.

5.3.2. The panel has considered whether the volume of safeguarding referrals was unduly high. The Police Abuse Investigation Unit did not consider that it was. Information from the QA team indicates that the average number of safeguarding referrals relating to care homes is 2.32 per home per year (2016 figures). Thus the referral rate between 2005 and 2014 was below the 2016 market average but 8 referrals in 2013 was significantly above.

5.3.3. The frequency of referral, particularly in the 2013 period, does raise a question about how cumulative alerts are monitored over time (how many ambers does it take to make a red?). Equally it leads to questioning whether CQC are routinely involved and/or informed about care standards concerns that are raised through safeguarding, and conversely what

threshold criteria are used to identify whether a care standards concern constitutes a safeguarding issue[13].

5.3.4. The year 2013 was not only notable for the number of safeguarding alerts. Care standards and health and safety matters were also the subject of concern. In January 2013 CQC had become aware, as a result of an anonymous report from a member of staff, of safety concerns about the home's boiler. When it learnt in February that a boiler safety check had deemed the boiler unsafe to use and capped the gas supply, CQC passed this and other safety concerns to district council health and safety officers. Inspection by the Environmental Health Department revealed a range of non-compliance on matters such as safety policy, risk management, slips and trips, falls, manual handling, asbestos control, electrics, gas safety, water systems, lifting equipment and stair-gates. Requirements were imposed, including a formal Improvement Notice relating to control of legionnaires' disease risk. The home was slow to comply, necessitating extensions to deadlines, and it appears that the legionella risk was not adequately addressed, surfacing again in 2016.

5.3.5. CQC were also aware during 2013 that the home had had no registered manager since 1st October 2010 and was therefore in breach of its conditions of registration[14]. Following an application process, a manager was subsequently appointed and registered by CQC and remained as the registered manager in post at the time of Ms E's death.

5.3.6. It is thus clear that the shortcomings in the care home's compliance with standards observed later following the crisis triggered by Ms E's death had a long history, raising questions about the extent to which agencies had been able to communicate and work together during that earlier significant 2013 period.

Responses to the boiler failure in October 2016

5.3.7. Relatives' concerns about the breakdown of the boilers in the home came to agencies' attention on 28th October (to CQC), and on 31st October (to the NCC enquiry desk and the district council). There were initial delays in investigating the situation, and a lack of proactive response by some of the agencies who held key responsibilities.

5.3.8. CQC held responsibility for health and safety matters relating to residents in registered provision, but CQC did not contact the care home (or anyone else) for 3 days, doing so only on 31st October, having received

[13] NHS Eastern Regional Safeguarding Adults Forum (2017) *Adult Safeguarding Best Practice Guidance for Providers of Healthcare in East Anglia and Essex*.

[14] Under the Health & Social Care Act 2008 (implemented 1st October 2010), appointment of a registered manager is a condition of registration imposed by CQC where certain regulated activities (including the provision of accommodation with personal or nursing care) are being carried out. The provider was therefore in breach of the registration condition (a breach of section 33 of the Health & Social Care Act 2008), for which CQC could prosecute or take civil action such as cancellation of registration.

a call from the district council, who themselves had spoken to the home immediately upon receipt of a relative's complaint to them that day. It was another 3 days before CQC on 3rd November contacted the Adult MASH and the NCC QA team, and there is no evidence that CQC had by this stage instigated its own risk assessment procedure. It was not until 8th November that CQC concluded, in the absence of sufficient progress with a replacement boiler, that it should conduct an urgent inspection visit.

5.3.9. The NCC enquiry desk had learnt of the problem from a relative on 31st October, but did not raise this as a safeguarding concern, merely emailing QA the following day to ascertain whether they were aware. QA thus learnt of the problem on1st November, when advised by the NCC enquiry desk, but did not initially take any action. In consultation with CQC and Adult Social Care during the interagency discussions of 3rd November, QA then took the lead, visiting the care home on Friday 4th November and keeping CQC and Adult Social Care informed about the temporary measures in place. The QA team, in reviewing their involvement, have reflected that they could instead have taken immediate action on 1st November, and also that they could have visited over the weekend of 5th/6th November to verify that the actions they were told were being taken were indeed in place. Equally, not having visited over the weekend, they conclude they should have conducted a follow up visit on Monday 7th, rather than chasing progress by phone. While describing their approach as timely, proportionate and effective at the time, they recognise that more proactive involvement would have been appropriate given the seriousness of the situation.

5.3.10. The district council, having learnt of the problems on 31st October and, after an initial phone call to the home, passed concerns to and liaised with CQC. It did not visit the care home until 17th November to conduct legionella checks, and has reflected that an earlier visit to pursue its own professional curiosity, rather than relying on other agencies, would have been appropriate.

5.3.11. It is clear that a number of agencies held a range of powers and duties in relation to the concerns that had arisen. A short summary of these is provided at Appendix 2.

5.3.12. After a slow start, from 3rd November there appear to have been regular communications between QA, Adult Social Care and CQC, and a measure of agreement between them that the temporary measures, implemented by the care home, while not ideal, did not pose immediate risk to residents' safety. The district council, however, did not agree with this evaluation, which it learnt and expressed concern about in communications with CQC. The agency believed that the temporary solutions approved by CQC and QA created further risk to residents and staff, and investigated whether they could use other legislation, which was not covered by the MOU, to require the owner to repair or replace the boiler. They escalated their concerns to QA on 8th November, but without receiving a response. Thus

they were missing from the interagency patterns of communication in the early stages of agencies' response.

5.3.13. CQC and QA, while clear about the advice given to the care home to manage the risks associated with the temporary arrangements, did not explicitly seek evidence of the care home's adherence to aspects of that advice. Neither agency inspected the care home's logs of temperature checks in residents's rooms carried out by staff each night, as required in line with the advice they had given. The absence of evidence that checks had been undertaken in Ms E's room during the night before she died calls into question the home's degree of compliance with the advice given, and the level of oversight given to the temporary arrangements.

5.3.14. It was the circumstances of Ms E's admission to hospital on the morning of 9th November that triggered a fuller and more coordinated interagency response to the care home's situation. The safeguarding procedures provided a clear framework for determining strategy in respect of the concurrent strands of a criminal investigation into Ms E's subsequent death and the management of on-going risks to other residents from conditions in the care home. By the time of strategy meeting on 22nd November, all agencies were engaged and remained so until the closure of the home in May 2017.

5.3.15. On the morning of 9th November, the ambulance personnel who attended Ms E in response to the 999 call found the home's environment extremely cold. They acted quickly, sampling residents' temperatures and, on finding signs of hypothermia, called for back up in the light of the time-critical nature of Ms E's need for hospital admission. The service responded with due recognition of the urgency, providing a second ambulance that attended to undertake the necessary welfare checks. The EEAST IMR writer notes: "*This is a situation that is rare within the ambulance service but one that is trained for and the crew should be commended for taking the correct steps even though they were managing a time critical patient in challenging situations*".

5.3.16. The QA visits on 4th, 11th and 12th November, the inspections carried out by CQC on 10th and 15th November, and the assessment visit by Environmental Health on 17th November all identified a wide range of matters requiring attention, relating both to care standards and to material conditions in the home. Adult Social Care provided staffing to review the needs of all residents, assisted by the community matron. But on other matters, the care home's progress on achieving the required improvements to care standards and the fabric of the building was slow. While the emergency replacement boiler became fully operational by 1st December, the concerns about legionella risk management, infection control, windows and lift remained. On 12th December, NNUH expressed grave concern to NCC about residents remaining in the premises.

5.3.17. Both CQC and Environmental Health continued to use their available powers. CQC imposed a condition to restrict new admissions (22nd

November 2016) and issued a notice of proposal to cancel the care home's registration (16th January 2017), against which the care home appealed. Environmental Health issued improvement notices in relation to the kitchen hot water supply and legionella risk management and was proactive in monitoring progress throughout the months that followed, although deadlines were repeatedly missed and renegotiated. Few of the required improvements had been implemented by the time the owner in April took the decision to close the home, and the agencies stopped short of taking such action themselves.

5.3.18. While the contractual arrangements between NCC and providers allow for performance notices to be issued in relation to more serious breaches of contract by a provider, QA took the view (in the evidence from its visit on 4 November) that adequate (whilst not ideal) arrangements were in place regarding heating of the home. The quality of care was undoubtedly affected by the situation in terms of the general environment in the home this was not considered a major breach that would have warranted a performance notice being issued. Ongoing monitoring of the situation was believed to be an appropriate and proportionate response.

5.3.19. All the agencies were hampered in their efforts by the attitude and responses of the care home owner. These included lack of clarity about the delegated power of the care home manager and her authority to commit expenditure in the absence of the owner, misinformation (for example assurance that the kitchen had an independent supply of hot water supply and a connection to the mains, when had neither), procrastination on required actions, financial constraint, and an apparent failure to appreciate the serious nature of the concerns and the risks. His disengagement remained a serious impediment to effective management of the ongoing concerns.

5.3.20. Equally, risk management in this context had to balance two competing imperatives: the need to enforce the home's compliance with health & safety standards on the one hand, and on the other the potential risks of enforcement action that, pursued to its conclusion of closing the home, would have resulted in the need for frail and elderly residents to move to other accommodation, an action that in itself would have posed risks.

5.3.21. It is of course impossible to know whether a more proactive response when the problems first came to light would have made any difference to the outcome for Ms E. Arguably, work with the care home to secure a solution could have started earlier, but given Ms E's medical condition, which itself could have contributed to her hypothermia alongside the temperatures in the care home, no firm conclusions can be drawn. What is clear, however, is that after her death there were delays and unresolved disagreements in the agencies' single and collective responses to the on-going risks, and that the care home was able to take considerable leeway in whether and when it met deadlines for improvement.

5.4. Use of safeguarding processes

5.4.1. Norfolk Constabulary, in providing information about safeguarding referrals about care standards in the care home historically, have confirmed that the outcomes listed appear appropriate. Equally, in relation to the two previous referrals relating to Ms E (2011 and 2016), the safeguarding response has been deemed appropriate and proportionate. A delay noted in progressing the 2016 assault allegation can be attributed to the enquiries being made to determine whether the resident in question was fit to be interviewed; although the enquiry was unresolved at the time of Ms E's death, it had no impact on the circumstances that resulted in her death.

5.4.2. Norfolk Constabulary has reviewed its involvement in the safeguarding incidents against operational standards[15] and found standards and expectations to have been met in all cases. However, in a number of the referrals deemed suitable for investigation by a single agency approach, other than the police, the Constabulary found it placed reliance on those agencies to report back if they had any further concerns, following their own visits. They view this as potentially problematic, in that other agencies would not be familiar with national crime recording standards, and therefore might not identify a crime that required recording.

5.4.3. In relation to conditions in the care home resulting from the boiler failure, CQC did not categorise this as a safeguarding matter or raise a safeguarding concern with the local authority when they learnt about the home's heating and hot water problems on 28th October 2016 or following their subsequent discussions with the care home manager on 31st October. They did contact the Adult MASH on 3rd November, but did not subsequently forward to NCC an email from the district council on 7th Nov expressing concern about the temporary arrangements. QA, having learnt of the boiler failure on 1st November and visited the home on 4th November, did not make a safeguarding referral as they believed there was no evidence of harm to an individual.

5.4.4. Safeguarding does appear, however, to have been an effective vehicle for driving multiagency communication and collaboration in relation to the multiple strands of enquiry. Both EEAST and NNUH raised appropriate safeguarding referrals on 9th November, following Ms E's admission to hospital, receipt of which led to a Red BRAG rating and immediate strategy discussion within the Adult MASH. A joint, unannounced investigation visit to the care home took placed directly afterwards, followed over the ensuing 6 months by a series of meetings of a multiagency safeguarding strategy group, in which all key agencies with powers and duties relating to care standards were involved. The benefits to interagency communication and collaboration are considered in a later section.

[15] Norfolk Multi-Agency Safeguarding Adults Procedures; Norfolk Multi-Agency Safeguarding Hub Standard Operating Procedures; National Crime Recording Standards; Home Office Counting Rules

5.4.5. The safeguarding strategy group also reviewed the care home's use of safeguarding, finding that it could not have confidence in the staff's understanding and compliance with safeguarding expectations. During the investigation subsequent to Ms E's death, it came to light that the care home had failed to report a safeguarding incident between two residents in August, because the care worker had recorded it on a behavioural chart but not in the daily care notes.

5.5. Escalation and management oversight

5.5.1. There are some good examples of effective escalation and/or management oversight.

5.5.2. In the case of EEAST, ambulance crew took appropriate advice on two of the call-outs to Ms E. On 4th April 2016 they took advice from senior clinicians when called to an incident in which care home staff had given Ms E incorrect medication. On 9th November 2016, the coding of the 999 call from the care home (GREEN 1) has been audited for compliance against Medical Priority Despatch System standards by a registered auditor and awarded 'total compliance'. Appropriate escalation by the crew who attended in response to that call produced an effective emergency response to the situation in the home. The crew attending Ms E appropriately communicated their concerns about the remaining 37 residents to the Control Centre, who escalated the concerns to the Incident Control Desk, where a decision was made to mobilise the Hazardous Area Response Team. Further appropriate escalation to the Local Duty Locality Officer resulted in the mobilisation of a second ambulance, which could reach the home more quickly.

5.5.3. On receipt of the safeguarding referral from EEAST and NNUH on 9th November 2016, consultation involving the Safeguarding Practice Consultant took place within the Adult MASH.

5.5.4. Norfolk Constabulary confirm that their criminal investigation, undertaken by officers with specific knowledge of the workings of care homes, had the required level of supervisory oversight by both a Detective Inspector within the Adult Abuse Investigation Unit and the Major Investigation Team. A review of the investigation was also conducted by a Detective Inspector from the Norfolk & Suffolk Major Investigation Team, prior to advice being sought from the Complex Case Unit of the Crown Prosecution Service. The subsequent decision not to proceed with criminal prosecution, on the basis of CPS early advice, was also reviewed by the Major Investigation Team. In previous safeguarding incidents relating to Ms E, police representatives with significant experience in adult abuse were involved in strategy discussions.

5.5.5. Escalation was, however, sometimes absent. GPs had discussed among themselves a number of 'low-level concerns' about care standards in the home, including delay in getting prescriptions dispensed, but did not escalate these to any other agency, believing they did not reach the level

of neglect to become a safeguarding issue, and feeling unsure about to whom their concerns should be addressed.

5.5.6. Following concerns about heating and hot water in the care home being communicated to CQC (on 28th October 2016), the first documented evidence of management involvement from within CQC appears on 8th November, when the inspector who had been liaising with the home notified the Inspection Manager of the need to do an urgent inspection. The inspector recalls previously advising the Manager about the concerns on 3rd November, but this conversation is not documented; no management review record was generated either then or in response to the email on the 8th, and it appears the inspectors who undertook the early contacts with the care home were unclear about applying the CQC's risk assessment process introduced earlier in the year. The IMR writer comments that the management review process would have provided the opportunity to assess whether a regulatory response (such as an earlier inspection) was required. It was not until Ms E's admission to hospital on the 9th November that the inspector was asked to halt other work they were engaged on in order to start an urgent inspection on 10th November. The first CQC management review was held on 11th November.

5.5.7. CQC did hold a management review meeting following its inspection on 15th November, determining that had the care home not provided assurances about the new boiler it would have been necessary to remove its registration.

5.5.8. A further issue related to management oversight is that of time pressures for staff.

5.5.8.1. CQC note that the inspector dealing with the reports about the care home's boiler at the end of October/early November had considerable workload due to concerns about risk in another service. A decision was eventually taken within CQC to prioritise an urgent inspection of the care home in the present case, but it is clear that the service was under pressure at this time, raising questions about the level of resourcing available to manage critical incidents.

5.5.8.2. QA have noted that while in theory they are able to enforce compliance with its contracts for care, in reality they have very limited capacity for doing so. The team is almost entirely focused on dealing with problems that have already occurred, with minimal capacity for proactive compliance activity.

5.6. Interagency communication and collaboration

5.6.1. As outlined above, it took some time to get everyone talking together about the implications of the care home's boiler failure, which first became known (to CQC) on 28th October 2016, and the absence of appropriate

communications at that point meant a slow start to identifying and managing the risks. The GP surgery has commented that they did not feel it their role to check what was happening regarding the heating; having raised it with the staff they took it on trust that the care home would resolve it. While one resident of several seen earlier in the boiler failure episode had seemed cold, needing to be wrapped in a blanket as they were too cold to give a blood sample, this had been an isolated case, with other residents appearing comfortable. CQC did not communicate with NCC for 6 days (including a weekend) after learning of the boiler failure. NCC's enquiry desk did not communicate with safeguarding on 31st October, querying only the following day whether QA were aware. QA did not communicate internally within NCC to ascertain whether a safeguarding response was required. EH communicated with CQC, believing them to be the lead agency under the Memorandum of Understanding, but not initially with NCC. Once the Adult MASH was alerted on 3rd November by CQC, the initial enquiries were routed not through safeguarding but through QA.

5.6.2. QA have reflected that they could have responded in a more timely way on learning of the concerns on 1st November, and could have explored the use of contractual levers to secure the care home's compliance about the boiler failure, but raise the question of whether clarity was lacking over the respective roles of CQC and NCC during the initial period. CQC have stated that it appeared agencies were looking to them to take a lead in dealing with the circumstances in the care home, when the lead statutory agency on safeguarding was NCC. In the absence of any structure or forum for discussing and coordinating responses during this early period, there was little opportunity for mutual understandings of roles to be clarified in a way that facilitated a shared strategy.

5.6.3. Clearly a key failing of communication here also was on the part of the care home manager and owner, who were legally obliged to notify CQC of the boiler breakdown and failed to do so. Nor did they inform NCC.

5.6.4. Conversely, in relation to Ms E, communications between agencies on 9th November were highly effective, with all relevant parties communicating appropriately with others and ensuring a rapid response both to Ms E's situation and to the risks evident in the care home.

5.6.5. In relation to management of the on-going risks, from mid-November onwards communications between the agencies involved in reviewing and seeking improvement in standards were frequent and effective, and able to respond to changes in circumstances in the situation.

The interagency safeguarding strategy group set up to steer the multiple strands of enquiry after Ms E's death met 7 times between 22nd November 2016 and 8th May 2017, and a subgroup also met 4 times with the care home provider. Adult Social Care comment that procedures were followed correctly and within timescales, and frequent meetings enabled a consistent group to remain focused on the issues throughout the ensuing

period. Other agencies have commented on a good level of interagency discussion, a shared sense of ownership within the group, and a strong commitment by each agency to achieving actions attributed to them between meetings. There was also significant learning between agencies about their respective roles and responsibilities, and the technical elements of some of the risks. NNUH, however, was in error not invited to the first meeting of the group, and has expressed concern that the minutes do not reflect the concerns that the hospital raised; for example it would appear that a letter from the Director of Nursing to the Director of Service (Safeguarding)[16] expressing grave concern about residents remaining in the care home was not discussed in the strategy group.

5.6.6. The agencies involved also individually communicated frequently with the care home manager and owner by phone and visit on the specific matters within their remit.

5.6.7. However, it is also clear that the agencies took different positions on the dilemmas posed by the competing imperatives in the care home's situation: the need to weigh the risks to the on-going health and safety of residents remaining in the care home alongside the risks of moving the entire care home population to alternative accommodation. The district council and NNUH in particular sought a more assertive approach to the care home's failure to comply with the requirements imposed upon it by CQC, NCC and QA. There thus remained unresolved differences of opinion about the degree to which the care home's compliance should be enforced. While the safeguarding structure appears to have provided a means for agencies to communicate together about their respective responsibilities and actions, what it did not seem to provide was a forum for resolution of differences. The letter from NNUH referred to in 5.6.4 above does not appear to have been considered in the multiagency forum. In addition, CQC were not present at all meetings[17], so while they provided information on their own activities and received the minutes they did not always witness the discussions of others' concerns.

5.6.8. The district council remained dissatisfied with the way in which the shortcomings in the care home were addressed. They expressed concern that as a result of the national Memorandum of Understanding they no longer had powers in certain areas, and that powers transferred elsewhere were not being utilised. The MoU that was operational at the time split the health and safety powers relating to the care home between Environmental Health and CQC. While Environmental Health could and

[16] Letter dated 7th December 2016, sent on 12th December 2016 to the NCC Head of Service - Safeguarding

[17] CQC have indicated to the review that they do not routinely attend safeguarding strategy meetings and that it would be unrealistic for them to do so, given the number that occur. This is in line with guidance in their inspectors' safeguarding handbook, which leaves attendance to individual inspectors' discretion, and indicates that unless CQC is planning to take some action there should not be a need to attend, although there should be a conversation with the local authority about level of involvement: http://www.cqc.org.uk/sites/default/files/20180223%20CQC%20Inspector%20Handbook%20Safeguarding.pdf

did pursue legionella concerns, and risks to safe preparation of food arising from water temperature, they could not pursue other health and safety matters. They were concerned that the temporary measures approved by QA and CQC in response to the boiler failure presented further risks to residents, yet could not themselves use improvement notices and prohibition notices to enforce the home's compliance with an adequate and safe supply of hot water and heating. The agency states:

> "*An MOU which constrains any regulator can only have the effect of increasing the risks to vulnerable populations*".

In such circumstances, joined up decision-making would be crucial to effective implementation.

5.6.9. It may be that the differences of opinion in this case were irresolvable, and clearly finely balanced judgements needed to be exercised, given there were no risk-free options, but the use of safeguarding processes may have masked the absence of a strategic forum specifically dedicated to *joint* decision-making (as opposed to communication about and coordination of individual agencies' *own* decisions). While it is clear that no one agency has the power to determine how another agency uses its power, this set of circumstances was one in which resolution of conflicting perspectives was important to achieve. Norfolk Constabulary have suggested that the accumulating deterioration in living conditions at the home in the context of the deteriorating weather situation reached the point at which some form of 'critical incident' should have been raised to allow all agencies to be aware of the situation and to formulate a *shared* response, whether involving enforced improvements, removal of persons at risk or operating restrictions on the home.

6. CONCLUSIONS

6.1. Scope of the review

6.1.1. The focal points of this review have been (a) the care provided to Ms E prior to her death, and (b) the agencies' responses to health and safety risks and to breaches of care standards at the care home. The conclusions below are overtly linked to the terms of reference set for the review.

6.1.2. The detailed evidence on which the SAR Panel's conclusions are based is set out in section 5 of this report above. Here the intention is to avoid repetition, and to provide concise statements of the key points.

6.2. Care and treatment of Ms E

6.2.1. While Ms E's routine and acute medical needs had been met historically, as a resident in a care home that failed to meet health and safety standards Ms E's care is likely to have been significantly compromised by the absence of adequate heating and hot water for a period of three weeks between mid-October 2016 and her death on 9th November. The care home did not make timely and adequate arrangements for her and other residents' comfort and

safety during that period, and the temporary arrangements in place in themselves posed risks to health and safety. Despite having been sufficiently concerned to call the doctor when she had been unwell for 3 days, the care home then failed to secure medication that was prescribed for her by the GP. During the night of 8th November, despite the assurance that regular checks on residents' temperatures were being made through the night, no record of such checks was found, casting doubt on whether they were conducted at all. Alongside the absence of temperature check by the GP during the 8th November consultation, this makes it impossible to know when and how quickly Ms E's condition deteriorated, or whether her deterioration might have been prevented.

6.2.2. But the roots of the acute problem lie far deeper. The care home had a history of care standards deemed by CQC to require improvement. During 2013 a pattern of concerns about health and safety, care standards and management had unfolded; and by 2015 the home still required improvement. A series of safeguarding referrals and complaints from 2012 onwards provides further evidence of compromised care standards. GPs had concerns about delays in the care home securing prescribed medication. The deteriorated state of the care home environment, which only fully came to light in inspections after Ms E's death, showed evidence of chronic under-investment in the fabric of the building. Equally, care practices in the home were inconsistent: records, care plans and risk assessments were found to be inadequate. The manager was observed to struggle to manage some aspects of the home's operation, and lacked support from the owner. The home was understood to be in financial difficulties, and had a history of late payments to local services and contractors, resulting in their subsequent reluctance to carry out work. It did not regularly supply evidence of attention to legionella control, and did not take part in QA's self-audit of contract compliance. It did not alert CQC or NCC to its boiler failure in the summer of 2016 or in a timely way to the boiler failure in October 2016.

6.2.3. It appears that none of the agencies routinely involved in the care home pieced all of this together to build a holistic picture of the risks involved in its mode of operation. A CQC inspection in 2015 found the care home 'Required improvement', but the follow up inspection a year later did not take place. The cumulative picture of safeguarding concerns does not appear to have emerged or been questioned. GPs treated individual residents but perhaps did not see the bigger picture relating to the home overall; believing their concerns did not reach a safeguarding threshold, they were unsure of where to address them and therefore did not. The home was under no duty to inform Environmental Health about routine legionella risk assessments and therefore their absence was not noticed. While in the days before Ms E's death one resident had needed to be wrapped in a blanket to warm them before a GP could take a blood sample, this was seen as an isolated case and the implications for others not questioned. Such omissions can be seen as arising from a lack of professional curiosity that allowed the home to remain under the radar in terms of the need for any proactive risk management. They also raise questions about what data

might be available to agencies that could be lent to the purpose of exercising greater vigilance in relation to patterns of events.

6.2.4. In contrast, once Ms E's needs came to the notice of the ambulance service on the morning of 9th November, the response was proactive, both in recognising and responding to the risks of her condition, and in identifying and securing appropriate management of the risks to other residents.

6.3. How the different agencies involved worked effectively together including information-sharing, interagency communications, roles and responsibilities, processes for discussion, challenge and resolution of disagreements.

6.3.1. The days that followed the first reports of the care home's boiler failure (i.e. the period between the initial complaint to CQC on 28th October 2016 and Mr E's death on 9th November) were a critical point at which interagency communication, information sharing and coordination were required. Instead, this period was characterised by delay and lack of clarity about who could and should be taking what action, and who could and should be coordinating the efforts of the agencies involved. No action was routed through safeguarding until Ms E's death. There were delays too in individual agencies (CQC, Environmental Health, QA) taking action to investigate within their own acknowledged remit. The pattern of communication did not include all key players until 22nd November, when the first safeguarding strategy meeting was called, almost 4 weeks after the boiler failure came to light.

6.3.2. Contributing to the lack of clarity was the national Memorandum of Understanding, delineating the responsibilities of CQC and Environmental Health in relation to heath and safety in care homes (Appendix 4). In implementation in this case, it appears not to have provided clarity on the responsibility for leadership on investigation and enforcement action during this early period. Environmental Health understood this to lie with CQC; CQC understood NCC to have the key role in relation to safeguarding residents; QA took some leadership in the early investigation, but only held powers relating to the provider's contract compliance. Thus it appears that an owner who, through complacency or reluctance, failed to respond to the requirements, was able to slip through the enforcement net, and the Memorandum of Understanding's dispersal of powers contributed to this.

6.3.3. As the agencies' various investigations and inspections took place during November 2016, a much wider picture of risks in the care home emerged, awareness of which gave rise to divergence of opinion within the interagency network about how those risks should be managed. Essentially at issue was the extent to which CQC could and should exercise its powers to enforce compliance, to the point of debating whether and when to cancel the care home's registration – with immediate effect (requiring immediate relocation of all residents) or through a lengthier process of an appealable Notice of Proposal.

Its decision to pursue the latter route, which it judged to be a proportionate response to the risks, also generated frustration from some agencies who felt a more assertive approach was warranted. The same principle of proportionality was applied in relation to the possible use of contractual levers by NCC in relation to residents whose care it was funding.

6.3.4. While the series of safeguarding strategy meetings that took place between November 2016 and May 2017 became a generally positively viewed forum for communication and information-sharing about the actions each agency was taking, it was not in a position to establish a consensus on a shared strategy or to require agencies to operate in a specific way. Nor did it act as a dispute resolution route in relation to the fundamental differences of opinion about intervention.

6.3.5. The panel notes that going forward the agencies' exercise of regulatory responsibilities will be governed by a revised version of the Memorandum of Understanding, issued in December 2017 (Appendix 5). The panel has considered whether the revised version would prevent similar difficulties arising in a different case, and has concluded that it would not.
The revised memorandum, at Annex B, recognises that in certain circumstances discussion between those holding regulatory powers will be necessary to determine whether CQC or the HSE/Local Authority should take the lead in any necessary action, or whether joint/coordinated investigations should take place. While the annex lists examples of such circumstances it does not provide an exhaustive list, and it is clear that discretion about leadership will need to be exercised in individual cases[18].
Equally it recognises that there will be cases in which there is uncertainty about jurisdiction and advises liaison between those holding regulatory powers to determine which regulator will take primacy and whether joint or parallel regulatory action will be conducted. It is the view of the panel that, given this potential for uncertainty, robust communications between those with regulatory powers are essential, and recommendations to facilitate this are given in section 7 below.

[18] The memorandum clearly states that it does not create any legally binding or enforceable obligations on the HSE, CQC or local authorities.

6.4. Whether supervision, oversight and training had an impact and whether monitoring was at a sufficient level

6.4.1. There were some positive examples of escalation, and it is clear that appropriate management scrutiny took place within the Ambulance Service and Norfolk Constabulary in terms of how those agencies exercised their responsibilities.

6.4.2. Escalation elsewhere was less evident. The GP surgery lacked clarity on where low-level concerns judged not to reach a safeguarding threshold should be addressed. CQC inspectors involved in the early notifications and discussions of the care home's boiler failure did not escalate the matter for management review in a timely way.

6.5. Whether the recommendations of any relevant previous reviews were complied with

6.5.1. The SAR panel was tasked with identifying any strands of learning from this review that resonate with themes emerging from earlier NSAB's SARs. The panel has therefore scrutinised the recommendations and action plans from SARs relating to AA, BB, and one further unpublished SAR. While in AA's case information sharing also emerged as needing attention, this related specifically to mental health services, which were not implicated in the present review. Similarly in BB's case there was learning about how agencies dealt with cumulative risk, and with information sharing and escalation about risk, but this related specifically to dementia services, which again were not implicated in the present review. Both of these matters (information sharing and cumulative risk management), however, are themes within SARs in other areas[19], and run across a range of services; they are therefore worthy of particular attention by the NSAB. The remainder of the learning from the present review, while new within the context of NSAB SARs, is of specific value both locally and nationally, given the number of providers in the field and the high number of SARs in which care homes feature[20].

[19] See for example Braye, S. and Preston-Shoot, M. (2017) Learning from SARs. London: ADASS. http://londonadass.org.uk/wp-content/uploads/2014/12/London-SARs-Report-Final-Version.pdf
[20] See the same report as noted in footnote 14.

7. RECOMMENDATIONS

7.1. Changes already implemented by agencies

During the course of its work, the SAR Panel learnt of changes implemented by agencies in response to their experience in this case:

7.1.1. The GP surgery now keeps a separate file for each care home with which it works, so assist in drawing together clinicians' perspectives and reviewing the cumulative impact of any concerns;

7.1.2. EEAST: EEAST's new supervision policy that will ensure supervision is provided to front-line ambulance crews; supervision will be offered on an ad-hoc basis as detailed within the policy.

7.1.3. District Council: Officers will establish procedures to ensure that early assessment takes place where there is a potential significant risk to food hygiene where it involves vulnerable groups.

7.1.4. QA: QA will be using a new quality assurance system from January 2018, which will enable a range of audits to be carried out by providers and enable QA to see evidence that the audits have been carried out. As part of this initiative, a self audit that covers infrastructure in care homes including plumbing and heating will be used.

7.1.5. CQC: CQC updated its risk management processes in April 2017. It has provided learning opportunities and workshops on the expectations of hub working to offer support for inspectors and inspection managers. It has introduced a portfolio-weighting tool to enable inspection managers to identify inequalities in portfolio size and better manage varying workloads. The importance of following the management review meeting process to assess risk will continue to be highlighted to all staff. New guidance is being drafted for GPs on their legal duty and responsibility to notify CQC of incidents that are occurring in other regulated services that they are working with.

7.2. Urgent actions taken during the course of the review

7.2.1. During the review the panel considered whether any urgent action needed to be taken in the light of the emergent learning:

7.2.1.1. It was agreed that NCC Quality Assurance team would include in its forthcoming newsletter for care homes reminders of the need for attention to boiler efficiency and safety during the approaching cold weather;

7.2.1.2. The CCGs' Autumn newsletter for GPs featured a spotlight on hypothermia, reminding GPs of the importance of being vigilant about temperatures when visiting patients in care homes and private premises, and of reporting any concerns.

7.2.1.3. During the review the SAR panel learnt of a notification to all CCGs from a pharmacy in receipt of a Prevention of Future Deaths Notice issued by Nottingham Coroner. The notification states: "*the EPS system does not allow urgent prescriptions to be highlighted to the receiving pharmacy when sent from GP system. For urgent prescriptions a phone call is required to alert the pharmacy team to the patient need. NHS Digital are currently reviewing the options available to support the identification of clinically urgent prescriptions*". The advice has been shared by the CCG with all GP surgeries.

7.3. Recommendations to the NSAB arising from this review

The recommendations from this review have, as requested by the NSAB, been cross-referenced with the Thematic Learning from SARs framework, which sets out four domains of learning: Professional curiosity; Fora for discussion and information sharing; Collaborative working and decision-making; Ownership, accountability and management grip. Each recommendation below is categorised according to this thematic framework (TF).

It is recommended that the NSAB takes measures to strengthen preventive and QA systems in relation to care standards or health & safety in care homes:

7.3.1. Issue guidance on communications between the Police, Adult Social Care, CCGs, NCC QA, district councils, GPs and CQC when concerns that are raised by third parties with any of these agencies about care standards or health & safety in care homes; (TF category: Discussion and information-sharing)

7.3.2. Ensure that all IT systems used in the Adult MASH (Liquidlogic, Athena, SystmOne) are able to log concerns about care standards or health & safety in care homes where these are not related to a named individual; (TF category: Ownership, accountability and management grip)

7.3.3. Ensure that the Adult MASH IT systems are able to link and cumulatively monitor lower level concerns about care standards, health & safety or safeguarding in care homes that do not individually meet safeguarding thresholds, in order to identify locations in which clusters of events or cumulative events should be subject to further scrutiny; (TF category: Ownership, accountability and management grip)

7.3.4. Liaise with EEAST and NCC to identify how EEAST's high user address monitoring can contribute to the identification of property-based risk in care homes; (TF category: Discussion and information-sharing)

7.3.5. Adopt formal triggers for scrutiny of property-based risk in care homes, and issue guidance and staff briefings on the potential significance of such risk for the safeguarding of residents; (TF category: Ownership, accountability and management grip)

7.3.6. ASC and the Police within the Adult MASH to ensure that the National Crime Reporting Standards are met where single agency safeguarding investigations are carried out by an agency other than the Police; (TF category: Ownership, accountability and management grip)

7.3.7. Norfolk CCGs to formulate and roll out a system-based approach to GP practices to enable their clinicians to collate and see any emerging picture of concerns based around any particular care or nursing home; (TF category: Ownership, accountability and management grip)

7.3.8. NCC, as part of its work to support contingency planning by care homes (to cover significant interruptions in the supply or quality of care through predictable interruption risks such as fire, flood, power outage, disease outbreak and environmental problems such as boiler breakdown), to ensure that care homes provide evidence of such contingency plans and that those plans are periodically sampled for review; (TF category: Ownership, accountability and management grip)

7.3.9. NCC to consider setting a threshold for the number of safeguarding referrals relating to a care home that would trigger review of that home; (TF category: Ownership, accountability and management grip)

7.3.10. NCC and Norfolk CCGs to review their contracts with care homes to specify that supervision is provided to care home managers, and to monitor compliance; (TF category: Ownership, accountability and management grip)

7.3.11. NCC to communicate with care homes about the importance of efficient and timely arrangements for securing residents' medication, and appropriate guidance for care home staff; (TF category: Ownership, accountability and management grip)

7.3.12. In their inspections of care homes' compliance with care homes regulations[21], CQC to include explicit monitoring of:

- Arrangements for obtaining residents' medication (regulation 17)
- Essential facilities maintenance contracts (regulation 17)
- Provision of supervision to care home managers (regulation 18)

(TF category: Ownership, accountability and management grip)

[21] Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

7.3.13. The Department of Health to be requested to review regulation 18[22] to ensure that it includes specific mention of supervision and support for care home managers; (TF category: Ownership, accountability and management grip)

7.3.14. CQC and NCC to ensure robust communications between them about any concerns relating to business continuity, staff supervision, essential facilities and financial viability of a care home, with a clear plan about which agency is supporting and monitoring progress in cases where improvements are required; (TF category: Discussion and information-sharing)

7.3.15. CQC to review its guidance for inspectors on factors to take into account when determining whether to attend safeguarding strategy meetings, in order to ensure the robust exercise of discretion about attendance (TF category: Discussion and information-sharing)

7.3.16. NCC to consider the flow of information from its quarterly meetings with CQC, CCGs and Healthwatch, specifically whether information can be shared with others, such as GPs and health providers, to ensure higher levels of awareness about improvements to care standards or health & safety that are being sought; (TF category: Discussion and information-sharing)

7.3.17. NSAB to clarify in guidance how agencies can raise lower level concerns that do not (in the agency's view) warrant a safeguarding referral but where nonetheless information should be shared. Possible mechanisms include:

- Adult social care engagement in early help hubs
- Involvement of adult health workers in the Adult MASH

(TF category: Discussion and information-sharing)

It is recommended that the NSAB takes measures to strengthen interagency responses to failures of care standards or health & safety in care homes:

7.3.18. Develop guidance setting out the respective roles and responsibilities of key partners in relation to concerns about care providers and whole home risk. This should include clarity on the responsibilities of both county and district authorities, as well as those of the CQC; (TF categories: Discussion and information-sharing; Collaborative working and decision-making)

7.3.19. Develop a clear protocol on information-sharing and communication pathways. This should include a requirement that all cases involving

[22] Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

breaches of health and safety in registered provision within Norfolk are subject to notification between the agencies with regulatory powers, with provision for discussion (should any agency consider it necessary) about actions to be taken and lead responsibility for those actions. The purpose is to enable full consideration of all potential powers held by all regulators; (TF categories: Discussion and information-sharing; Collaborative working and decision-making)

7.3.20. Ensure agencies likely to receive complaints/concerns about care homes (QA, CQC, Adult MASH) to strengthen triage and risk assessment processes by providing guidance and where necessary training to staff on onward routes and timescales for referral; (TF category: Professional curiosity)

7.3.21. Develop a major safeguarding incident response plan involving a 'risk summit' early in the process to ensure:

- Early communications between agencies at point of initial concerns
- Critical incident pathway, with a lead investigator/coordinator
- Clarity on role and enforcement options
- Clarity on how and by whom risk management measures are monitored and evaluated
  (TF category: Collaborative working and decision-making)

7.3.22. Escalate this review's findings on implementation of the national Memorandum of Understanding to the Health & Safety Executive, the Local Government Association and the CQC. The circumstances of this case demonstrate that the MoU may not be providing a clear and effective pathway for collaborative responses to matters that affect both care standards and health & safety, and the revised version does not fully address the potential difficulties of implementation. The NSAB should request that:

- Broader and systematic evidence on implementation of the Memorandum is sought by the HSE to inform future review of its operation[23];
- Explicit avenues are created for local authority perspectives to inform such review[24];
- Consideration is given to whether CQC powers are sufficient to enable improvement notices with financial penalties to be issued and for work to be carried out in default, and to the circumstances in

[23] The Memorandum contains provision for annual review.
[24] The panel notes that the revised Memorandum is between the HSE and the CQC "with the support of the LGA", whereas the LGA was previously a full party.

which responsibilities for enforcement should revert to the local authority.

(TF categories: Collaborative working and decision-making; Ownership, accountability and management grip)

It is recommended that NSAB takes measures to strengthen safeguarding adults review processes

7.3.23. NSAB to review the measures available to it for seeking compliance with section 45, Care Act 2014, where an individual or organisation fails to fulful their statutory duty to provide information, and to consider requesting that the Department of Health strengthen national guidance on this matter.

END.

APPENDIX 1
ACRONYMS USED IN THIS REPORT

ASC	Norfolk County Council Adult Social Care Department
BRAG rating	Black, Red, Amber, Green rating
CPS	Crown Prosecution Service
CQC	Care Quality Commission
ECG	Electrocardiogram
EEAST	East of England Ambulance NHS Trust
EH	District Council Environmental Health Department
GP	General practitioner
IMCA	Independent Mental Capacity Advocate
IMR	Internal Management Review
MASH	Norfolk Multiagency Safeguarding Hub
MOU	Memorandum of Agreement
NCC	Norfolk County Council
NCH&C	Community Health & Care NHS Trust
DC	District Council
NNUH	Norfolk & Norwich University Hospitals NHS Foundation Trust
NSAB	Norfolk Safeguarding Adults Board
PH	Norfolk County Council Public Health Department
QA	Norfolk County Council Norfolk County Council Quality Assurance & Market Development Team
SAB	Safeguarding Adults Board
SAR	Safeguarding Adults Review

APPENDIX 2:
AGENCIES' POWERS RELATING TO HEALTH, SAFETY AND CARE STANDARDS IN RESIDENTIAL CARE HOMES DURING THE TIME PERIOD COVERED BY THIS REVIEW

This appendix contains information that assisted the SAR panel to understand the diverse roles and responsibilities for health, safety and care standards in residential care homes. It is provided here as background to the analysis in the main body of the report. Local authorities safeguarding duties in respect of *individuals* are set out in section 42 of the Care Act 2014, and in chapter 14 of the Department of Health's Statutory Guidance[25].

Introduction

Historically, Environmental Health Departments dealt with all concerns relating to the health, safety and welfare of residents in residential care homes using powers provided under the Health and Safety at Work etc Act 1974 and associated regulations. The powers available to Environmental Health officers included:

- Service of Improvement Notices which require certain works to be undertaken by a set date (with a minimum compliance period of 21 days);
- Service of Prohibition Notices, which stop an activity with immediate effect;
- Prosecution.

This position changed on 1st April 2015 when the Memorandum of Understanding (MOU) between the CQC, the Health and Safety Executive and Local Authorities in England came into force. The MOU states that under the Health and Social Care Act 2008 CQC is the lead inspection and enforcement body for safety and quality of treatment and care matters involving patients and service users in receipt of a health or adult social care service from a provider registered with CQC.

The MoU does not cover powers under legionella regulations, food safety, and the health and safety of employees, which remain with the Environmental Health Department.

CQC

The following information supplied by CQC is extracted from the Work-Related Deaths Protocol, agreed with the Police, Health & Safety Executive and Local Authorities[26].

CQC is the independent regulator of health and social care in England. It is also the lead inspection and enforcement body under the Health and Social Care Act 2008

[25] https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

[26] This document is available at: www.hse.gov.uk/pubns/wrdp.pdf © *Crown copyright.*

(HSCA 2008) for the safety and quality of health and social care services provided to patients and other service users by providers registered with CQC.

CQC's regulatory remit includes:

- Care and nursing homes;
- Private and public hospitals;
- Health and social care in secure settings including prisons, youth offender institutions and secure hospitals;
- Domiciliary care;
- GP and dental practices; and,
- Mental health services.

CQC's main objective is to protect and promote the health, safety and welfare of people who use health and social care services, as set out in the HSCA 2008, and its associated regulations, the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (RAR 2014) and the Care Quality Commission (Registration) Regulations 2009 (RR 2009).

CQC will pursue civil and, where appropriate, criminal enforcement action against registered persons who provide health and social care services for breaches of health and social care law under HSCA 2008 and RAR 2014.

From 1 April 2015 CQC has a power to prosecute for failures to provide safe care and treatment resulting in avoidable harm or a significant risk of exposure to avoidable harm (Regulation 12(1) RAR 2014). This power does not apply to failures before 1 April 2015. Prosecutions can be brought against registered providers, individual registered managers and directors of corporate providers.

CQC cannot investigate or prosecute murder, manslaughter, health and safety at work act offences, wilful-neglect or ill-treatment.

CQC also has a power to prosecute unregistered providers of health and social care services for an offence of carrying on a regulated activity when unregistered to do so.

It should also be noted that CQC has civil powers that it can use to take enforcement action. It did use those powers in November 2016 both urgently to prevent new admissions to the home and again when it cancelled the provider[1]s registration in 2017.

Environmental Health

Since implementation of the Memorandum of Agreement transferring certain responsibilities for health, safety and welfare of care home residents to CQC (see Introduction above), Environmental Health retain the enforcement of health and safety standards as they relate to Asbestos (using the Control of Asbestos Regulations 2012), Gas (using the Gas Safety (Installation and Use) Regulations 1998), Legionella (using the Health and Safety at Work etc. Act 1974) and Lifting Equipment (using the Lifting Operations Lifting Equipment Regulations 1998).

Environmental Health also retain the health and safety enforcement responsibility for health and safety matters affecting members of staff or visitors to a care home.

Care homes are not under any obligation to routinely notify Environmental Health of the findings of a Legionella risk assessment unless specifically requested to do so by an Environmental Health Officer. When Environmental Health become aware that a business does not have a risk assessment or that the risk assessment is out of date then the action taken would be dependent upon a number of factors including the perceived risk and the attitude of the duty holder. Where risks are low and the duty holder is keen to work with Environmental Health to make the necessary adjustments than informal advice is given. Where that is not the case then formal action, ordinarily in the form of the service of an Improvement Notice, would be taken.

NCC QA

The NCC QA team have no enforcement powers under the Care Act 2014 or any other legislation. They have no powers in relation to health and safety legislation and CQC is the sole regulatory body with legal powers to secure compliance with the fundamental standards of care and related statutes and statutory instruments.

The council has a duty to promote the effective and efficient operation of the care market including securing good quality care services.

Where the council is funding the care it has a range of contractual levers available to it. In the case of health and safety, the care provider's contract requires compliance with all the relevant legislation. The council carried out a self audit exercise in 2013 but the care home did not take part. The council carried out another self audit in 2017 by which time the home had closed. Such audits are followed up but capacity to do so is very limited.

The council has a small health and safety unit that supports the council in its own compliance and compliance on the part of contractors. Again capacity is very limited.

In summary the council is able to enforce compliance with its contracts for care but in reality has very limited capacity for doing so. The QA team is almost entirely consumed with dealing with problems that have already occurred with minimal capacity for proactive compliance activity.

So far as funding is concerned, generic requirements in the council's contracts such as compliance with health & safety legislation would apply to the home as a whole as long as there was at least one council funded resident.

APPENDIX 3
Ms E SAR: FULL CHRONOLOGY

1. The Police chronology lists 16 safeguarding referrals relating to the care home[27] prior to those that fall within the review period. NCC have provided further information in relation to some of these incidents[28].

1.1. On **8th February 2005**, a former care worker at the care home made a safeguarding referral, having resigned due to concern about the poor level of care the home provided as a result of inadequate staffing and poor management. He had also written to the MP and social care inspectors. One resident, who was very ill, had died, and the former care worker felt that with better care and medical attention he may well have 'lived longer and better'. Drugs were also missing from the home and believed this had been reported to Police. On 11th February, a safeguarding conference was held but no criminal issues or complaints were identified; CSCI and Adult Social Care would monitor.

1.2. On **13th August 2009**, a health professional made a safeguarding referral, the referrer stating that when attending the care home to check on a resident she was taken aside by a care worker who stated there were neglect issues at the home and alleged: service users have been left in their wheelchairs overnight; staff ignored buzzers, particularly if a double person response was required, due to staffing levels; equipment was poor - slings for hoists were beginning to fray. The case was discussed with a social worker, agreeing single agency follow up of poor practices, with no criminal offences.

1.3. On **23rd December 2009**, a member of the public expressed concerns about the standard of care at the care home: particles of mould floating on the surface of water, reported to staff but still present several hours later; a resident with pressure sore was refused medical attention and had died. It was agreed a social worker would visit the premises with a Quality Assurance Officer to assess, and to contact the Police if any issues were identified.

1.4. On **10th March 2011**, the Occupational Therapy Department of NNUH made a safeguarding referral about a number of falls Ms E had sustained at home (she was then living with her daughter in a separate annexe) and the alleged reluctance of her daughter to accept care and support for her mother. It was agreed there were no criminal issues requiring police involvement and that Adult Social Care would be exploring options with the family.

1.5. On **19th June 2012**, CQC received and reported to safeguarding an anonymous call about an incident at the care home: a resident went missing and was eventually found outside on the floor with a cut to her head and

[27] Police chronology
[28] NCC chronology

dried blood suggesting she had been there for some time. She was taken inside and given a cup of tea but remained cold and shaking and had not been the same since. It was agreed a social worker would visit and assess care needs, and report back any concerns to the Police if appropriate; there was no indication of criminal issues. On investigation, the social worker concluded that the care home had not been negligent.

1.6. On 2nd **October 2012**, NCC received a safeguarding referral from a relative who had collected her parents from a week's respite at the care home. The mother smelt of an unwashed odour, and her father stated she had not been washed or had clothes changed for a week; privately provided continence pads had not been used. The home had been asked not to launder any clothes for the week, yet there were no dirty items of clothing to collect. The daughter believed staff lied about levels of care: they stated her mother had got herself up, washed and dressed but this could not have happened as her mother needed assistance to dress. She also noted issues with administration of medication. NCC held a strategy discussion with the Police the following day, agreeing that Adult Social Care and Quality Assurance would visit to assess. Discussion with the care home manager resulted in an apology, which was accepted by the family. The care home's policy and procedures were to be reviewed, and extra training given to staff on dementia care. QA and CQC would monitor during future visits.

1.7. On **18th January 2013**, a community nurse raised a safeguarding referral about the quality of care provided to a resident, and the on-going care of grade 3 pressure sore. The resident was unable to bear weight and was cared for in a profile bed. A soiled continence pad had been left on the mattress and the bed was soaked in urine that smelt stale. The nurse pressed the call bell pressed for assistance but none came and the bell had been silenced from elsewhere in the building. The nurse removed the wet bed linen and placed the resident on a towel, reporting this to staff before treating other residents. The nurse returned to the resident's room an hour later and found the resident to be in same condition as previously reported to staff. The incident was raised with the care home by QA (see below).

1.8. On **21st January 2013**, a community nurse raised concerns about the care given to resident who was an insulin-dependent diabetic. A social worker undertook a joint visit with the community nurse. There was inappropriate food and drink in his room; he had previously been given orange juice for breakfast. Staffing levels raise doubt as to whether he got food within 30 minutes of his insulin. He had been found drowsy on occasion, still in bed late in the morning. He stated he wanted another placement and was not happy with the care at the care home; staff were rough with him, and he did not receive support to go to bed at an earlier time. The home was also regularly short staffed. The staff were not sufficiently knowledgeable about diabetes management and care needs, and about pressure sore/skin integrity interventions. A strategy meeting with the Police the following day concluded that the social worker and QA would raise the concerns with the care home and QA would monitor care quality at the home until satisfied

about standards; the resident would move to another home. QA's discussion with the home included concerns about out-dated care plans, limited recording of daily activities and lack of staffing related to this and the incident reported on 18th January. QA followed up with a visit to carry out checks on 13th February.

1.9. On **22nd February 2013**, CQC received anonymous concerns about residents' welfare. Two inspections were made and while staff were meeting basic needs, the concerns merited a safeguarding referral. At a strategy discussion held the same day, nothing of a criminal nature was alleged; it was believed a daughter had made the anonymous complaint and had complained many times before. Her relative was then in hospital and would not be discharged back to the care home without safeguarding checks. QA also aware and were dealing with the care standards issues.

1.10. On **13th March 2013**, the care home manager had reported that a senior night carer went to administer a resident's medication; the medication had not been administered but the care worker signed to say it had been. Another resident's medication had been removed but not signed. The carer had been suspended pending investigation. A strategy discussion held the same day agreed that this was an internal disciplinary matter. It was later confirmed that the care home had followed correct procedures to safeguard residents.

1.11. On **10th May 2013**[29], CQC received and passed to safeguarding an allegation of neglect observed on 1st May by an agency care worker. A resident had blisters to inner thighs and stomach, probably caused by poor hygiene; they were in a soaking wet pad and were not washed when the pad was changed. Staff applied simple dressing to the thigh only when prompted by the person raising the alert; no cream or night pads were available or used. No senior care worker was on duty for advice or to support staff to administer medication. The referrer had concerns about the care provided during night shifts and the competence of some night staff in relation to manual handling and care provision. A social worker visited the care home, met with the resident, reviewed his care plan, and discussed with the manager the need for moving and handling training in relation to staff on duty. No further investigation was required but QA and CQC would monitor.

1.12. On **12th August 2013**, senior care staff noticed significant bruising on a resident's head, both hands and leg. Investigation/interviews by the manager with three members of duty staff failed to establish how or when the injuries occurred. The resident had dementia and was hoisted for all care, and was also recorded at high risk of falling due to a number of recent falls; details of sensor pad and alarm/buzzer activations were recorded. A strategy discussion held the same day determined no account would be possible as the resident lacked capacity, so it was not possible to establish

[29] NCC chronology

whether a crime had been committed. The 3 carers on duty would be making written records and forwarding to Adult Social Care.

1.13. On **25th October 2013**, the manager reported that a carer had put 50ml of descaler in a resident's urine bottle; she stated this was because the bottle didn't smell nice. The resident lacked capacity. He stated he had put some of the liquid in his Horlicks as his cup was not full enough and drank the whole cup despite it not tasting very nice. The resident was admitted to hospital as a precaution and returned to the care home 2 hours later. A strategy discussion held the same day concluded that the manager would carry out internal investigation; the staff member had been suspended and the incident reported to CQC. Environmental Health learnt of the incident (notification required by RIDDOR[30]). The need for additional staff training was discussed with the home and monitoring of COSHH[31] training and risk assessments took place through the subsequent weeks. The carer received a final written warning following the care home's disciplinary procedure.

1.14. On **3rd December 2013**, a safeguarding referral was made about an incident two days previously involving a resident who normally pressed her buzzer throughout the night. On this occasion a female staff member responded and found a male staff member had already responded; he was observed shouting and swearing at the resident, standing over her with a pillow, then throwing the pillow at her head. He was also heard to say 'fucking be quiet, you too noisy'. The resident has complex health needs and has a history of falls. The male member of staff had previously been suspended with two other staff members when another resident presented with facial bruises. A strategy meeting determined that a social worker would follow up with the Quality Assurance Team and the home. The staff member was suspended and later left the care home's employment of his own volition rather than return with the restrictions proposed. The care home was reminded of its duty to to refer to the Disclosure and Barring Service.

1.15. On **26th March 2014**[32], a safeguarding referral was made when a resident correctly entered the number into the care home door keypad, the number being on a sticker by the door. He was found fallen on the road and had sustained bruises, and was taken to the Emergency Department before being returned to the care home. At a strategy discussion the following day no criminal offences were disclosed; the CQC and the care home manager stated that code had since been changed.

1.16. On **11th April 2014**[33], a safeguarding referral indicated that a man in respite care had told his wife, who was visiting him, that a male member of staff had slapped him around the face. When Police and Adult Social Care spoke to him, his account of the incident varied. A strategy discussion held the

[30] Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995
[31] Control of Substances Hazardous to Health
[32] Police chronology
[33] Police chronology

same day agreed the police would lead an investigation into common assault. The staff member was suspended. No subsequent action was taken - the victim was happy for an internal investigation to take place.

2. **On 28th January 2013**[34], CQC contacted the care home having received (on 24th January) anonymous information about an unsafe boiler and requesting a copy of a letter the informant claimed to have seen in the care home office. The care home denied there was such a letter, indicating they were merely awaiting a repair to the boiler. On 20th February CQC followed up with a request for more information about the boiler, at which point it emerged that the gas contractor had visited on 29th January. The company's notice dated the same day indicates that the boiler had been deemed unsafe to use and the gas capped, necessitating immediate action to resolve the deficit before the boiler could be reconnected.

3. On **20th February 2013**[35], CQC notified Environmental Health about the boiler and a number of other health and safety concerns, and on 25th February EH visited the care home to undertake a health and safety inspection, finding that the immediate boiler issue was resolved. The outcome of the inspection was notified to the care home on 5th March, listing a number of improvements required to safety policy, risk management, slips and trips, falls, manual handling, asbestos control, electrics, gas safety, water systems, lifting equipment and stair-gates, some matters having immediate deadlines, others required within 3 months. The outcome was notified to CQC on 6th March 2013.

4. Environmental Health followed up the care home's implementation of the requirements in July 2013, setting new deadlines for those that had not been completed. On 8th October 2013 an Improvement Notice was issued, following a visit the previous day, requiring the home to implement measures to control risk of legionnaires' disease. The deadline for completion was later extended to 2nd February 2014 due to difficulties experienced from the presence of bats in the loft areas of the home. The care home requested a further extension for the same reason on 14th February 2014, and it appears that no further follow up on this issue by EH took place until the events following Ms E's death in November 2016.

5. In **June 2014**, the home appointed the registered manager who remained the manager in post at the time of the events that are subject to the present review.

6. On **29th June 2014**[36], the Ambulance Service responded to a request to assist Ms E, who had fallen. The crew helped her from the floor.

7. On **30th June 2014**[37], a GP carried out a visit at the care home as Ms E was chesty and felt weak. She was noted to have bradycardia, which required ECG at the surgery.

[34] Correspondence and information supplied by EH and CQC
[35] Correspondence and information supplied by EH and CQC
[36] GP chronology
[37] GP chronology

8. On **7th July 2014**, her ECG result was borderline, but required no immediate action. Blood samples were taken, which showed only minor abnormalities requiring no action.

9. On **23rd September 2014**[38], the GP gave Ms E an admission avoidance care plan, as part of the surgery's enhanced service.

10. On **23rd October 2014**[39], Ms E received seasonal influenza vaccine

11. On **1st November 2014**[40], Environmental Health note that a specialist water hygiene company carried out a legionella risk assessmentat the home and made a number of recommendations.

12. On **8th December 2014**[41], a continence nurse visited Ms E at the care home to discuss on-going continence management. Advice was given and Ms E was discharged from the care of the service.

13. On **15th/16th January 2015**[42], CQC inspected the care home and rated it as 'Requires Improvement'.

14. On **19th January 2015**[43], Ms E sustained a fall and the GP visited, asking the care home to take her for an X-ray. Three days later the care home rang to say they were expecting an ambulance as they could not convey her in a car; she had had another fall the previous evening. The GP questioned why it had taken 3 days to notify of the difficulty with transport. Later the care home called to say they had organised transport. On x-ray the following day Ms E was found to have a toe fracture.

15. On **2nd February 2015**[44], the practice nurse reviewed the admission avoidance care plan.

16. On **16th February 2015**[45], the GP visited Ms E, who had a swollen and red eye with a slight discharge.

17. On **20th February 2015**[46], Environmental Health visited the care home as part of its care home project, noting concerns in respect of legionella.

18. On **1st March 2015**[47], the specialist water hygiene company visited and took water samples. Legionella was found in three of the rooms.

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[38] GP chronology
[39] GP chronology
[40] DC chronology
[41] NCH&C chronology
[42] CQC IMR
[43] GP chronology
[44] GP chronology: review of the care plan by the practice nurse is standard practice for all patients on the admission avoidance scheme if they have been seen in hospital.
[45] GP surgery chronology
[46] DC chronology
[47] DC chronology

19. On **9th March 2015**[48], Environmental health visited the care home to meet with the owner, expressing concern and explaining that the water hygiene company's legionella report must be actioned.

20. On **12th March 2015**[49], the practice nurse visited and reviewed Ms E as part of the surgery's admission avoidance scheme. Test requests relating to Ms E's chronic kidney disease were sent.

21. On **10th April 2015**[50], Environmental Health noted that the care home stopped adding Supersil to water tanks[51].

22. On **22nd April 2015**[52], a GP visited Ms E, who had a rash on her forearms.

23. On **7th May 2015**[53], a GP visited Ms E and reviewed the admission avoidance care plan.

24. On **1st June 2015**[54], the specialist water hygiene company sampled the water and found legionella in the kitchen and in two rooms.

25. On **8th June 2015**[55], Environmental Health's senior commercial officer visited, noting that new hot water storage tanks had been installed and temperatures were now in the legionella control range.

26. On **30th September 2015**[56], a GP visited and reviewed the admission avoidance care plan. It was noted that Ms E required a blood pressure check.

27. On **19th October 2015**[57], a nurse visited the care home and administered flu vaccine.

28. On **1st November 2015**[58], the specialist water hygiene company were due to review the legionella risk assessment; Environmental Health note that this was not done.

29. On **23rd November 2015**[59], the GP surgery noted that Ms E had received seasonal influenza vaccine.

[48] DC chronology
[49] GP surgery chronology
[50] DC chronology
[51] Supersil is a Hydrogen Peroxide based sanitiser.
[52] GP surgery chronology
[53] GP surgery chronology
[54] DC chronology
[55] DC chronology
[56] GP surgery chronology
[57] NCH&C chronology
[58] DC chronology
[59] GP surgery chronology

30. On **3rd March 2016**[60], the practice nurse visited Ms E and reviewed the admission avoidance care plan. No problems were noted.

31. On **1st April 2016**[61], CQC postponed a routine inspection of the care home due to prioritisation of higher risk activity.

32. On **4th April 2016** (23.50)[62], the Ambulance Service responded to a 999 call from the care home relating to a possible overdose: Ms E had been given an incorrect tablet (Donezepil) in error at 20.00. Staff had called NHS111, who advised it would be ok, but when the patient felt nauseous and clammy staff called 999. Ambulance crew advised that the symptoms could be side effects from medicine; after taking senior clinical advice they did not convey her to hospital and she remained in the care of care home staff.

33. On **5th April 2016**[63], the GP received notification that Ms E had been given one tablet of donepezil in error; staff had called the out of hours service for advice; it was noted that there were no interactions with her own medication and the incident was unlikely to have caused harm.

34. On **7th April 2016**[64], a GP visited and reassured Ms E, who remained nauseous since receiving medication in error.

35. On **12th June 2016** (14.35)[65], the Ambulance Service responded to a 999 call from the care home relating to Ms E, who had fallen. Ms E was not alert and was unable to explain the fall. Ambulance crew noted some sepsis markers and removed 3 layers of outer clothing to reduce her temperature, which improved the markers. Ms E was conveyed to NNUH.

36. The same day[66] the GP surgery received notification that Ms E had been admitted to hospital, having been seen in the Emergency Department after a collapse secondary to low blood pressure.

37. The hospital records her admission[67] with possible sepsis, the ambulance crew having assessed her to be tachycardic, tachypneic and hypoxic on air. She underwent radiology examination (chest x-ray) and was admitted for antibiotic therapy for a lower respiratory tract infection. On 13th June 2016 she was deemed medically fit for discharge[68], and the GP surgery received a discharge summary[69] indicating a lower respiratory tract infection.

[60] GP surgery chronology
[61] CQC chronology
[62] EEAST chronology
[63] GP surgery chronology
[64] GP surgery chronology
[65] EEAST chronology
[66] GP surgery chronology
[67] NNUH chronology
[68] NNUH chronology
[69] GP surgery chronology

38. On **22nd June 2016**[70], a GP undertook a desk review of medication, following the discharge summary.

39. On **9th July 2016**[71], Police attended the unexpected death of an 87-year old male resident at the care home. His health was said to have declined leading up to his death. There were no concerns raised and a standard report was submitted to the coroner.

40. On **23rd June 2016**[72], a GP visited Ms E. She had had a cough for many years, but a chest x-ray showed hiatus hernia. The following day a GP undertook a desk review of her admission avoidance care plan.

41. On **18th August 20**16[73], a GP visited Ms E, who had blocked ears. The GP made a referral for ear syringing. The referral is recorded by the community health trust[74].

42. On **6th September 2016**[75], a nurse visited and syringed Ms E's ears. Ms E's daughter is noted as indicating that her mother's hearing had diminished.

43. On **30th September 2016**[76], a GP undertook a desk review of the admission avoidance care plan.

44. On **11th October 2016**[77], Adult Social Care[78] submitted a safeguarding referral relating to an incident at the care home. A male resident had become distressed and was turning over furniture; Ms E had kicked him on the shin and in response, he had slapped her on the face, resulting in a red mark. Ms E, who was understood to have mental capacity in relation to the incident, wanted the matter reported. Care home staff were present at the incident and were monitoring to prevent further occurrence. The referral was rated BRAG Green (adult at risk of abuse, immediate risk managed) and of medium complexity. A safeguarding adults referral was completed and sent to the police.

45. The same day[79], the Police note the incident. A fellow resident had asked Ms E to be quiet; when she said no, he had shouted at her and thrown a table, stating he would slap her if she wasn't quiet. Ms E had kicked him and he then had slapped her across the face. Ms E had been shaken; a cold compress had been put on her face and she had received bruising above her left eye. Care home staff had de-fused the situation and taken the other resident to his room.

[70] GP surgery chronology
[71] Police chronology
[72] GP surgery chronology
[73] GP surgery chronology
[74] NCH&C chronology.
[75] NCH&C chronology
[76] GP surgery chronology
[77] NCC chronology
[78] NCC chronology
[79] Police chronology and IMR

46. A strategy discussion was held on 12th October[80]. There were no concerns about Ms E's capacity; she understood what had happened to her, and she wanted to take the matter further. The assault was recorded as a crime of common assault, and it was agreed that the Police would lead the investigation, with a social worker present[81]. They would visit the care home[82] to discuss the incident with both residents, and would advise whether any further safeguarding action was required.

47. **Sometime in mid-October 2016**[83], the care home's boilers started to fail.

48. On **26th October 2016**[84], the community health trust received a referral for annual flu vaccination[85].

49. On **27th October 2016**[86], a member of care home staff called the Police, stating they were having difficulty restraining a resident who wanted the carers out of the building; the 4 members of staff had shut themselves away in a treatment room, leaving the resident alone in the corridor. The male calmed down and returned to his room. The attending officers did not identify any offences.

50. **On 28th October 2016**[87/88], a family member raised a concern with CQC about the breakdown of the boiler at the care home.

51. On **31st October 2016**[89], a family member raised concerns with the NCC Customer Service Centre about faulty boilers at the care home, resulting in lack of heating and hot water.

52. Also on **31st October 2016**[90], Environmental Health received a complaint from a relative that the care home had had no hot water for two weeks and residents could not have baths or showers. The Senior Public Protection Officer discussed the home's previous history and the restrictions now imposed by the MOU with the Public Protection Team Manager, who advised the matter be referred to the commercial team. The Commercial Team Manager contacted the care home manager, who advised that the kitchen was on a separate supply and not affected. Environmental Health advised CQC of the situation, as required under the Memorandum of Understanding relating to safety and care quality matters in services run by registered providers.

53. Also on **31st October 2016**[91], CQC note receipt of the call from Environmental Health. A CQC inspector rang the care home manager, who advised that the

[80] Police chronology and IMR
[81] The Police chronology notes that Ms E died before the investigation was completed.
[82] NCC chronology
[83] DC chronology
[84] NCH&C chronology
[85] This due to be administered on 10th November 2016, but Ms E was by then deceased.
[86] Police chronology
[87] NCC supporting documentation: strategy meeting minutes 22nd November 2016
[88] CQC chronology
[89] NCC chronology
[90] DC chronology
[91] CQC chronology

owner was abroad, but was aware of the plumbing issues before he left. One boiler had ceased working two weeks ago and the other, after a period during which it had required re-starting every few hours, had broken down completely the previous day. Plumbers were on site attempting to re-start it. A new boiler was needed but the manager did not have funds to buy this outright and would need to pay by instalments; she could not go elsewhere due to the owner's poor reputation for paying contractors. In the meantime, hot water from the kitchen was being transported round the home; electric fan heaters and oil-based portable radiators were being used for heating. The inspector advised that a risk assessment would be required.

54. On **1st November 2016**[92], the care home stopped recording hot water temperatures. Review of the legionella risk assessment by the specialist water hygiene company became due, but this was not done.

55. Also on 1st November[93], QA received an email from SCCE[94] in relation to the failure of the boiler and hot water system at the care home, about which relatives had expressed concern.

56. The same day, CQC[95] recorded receipt of information about the boiler breakdown from NCC safeguarding team.

57. On **2nd November 2016**[96], email exchanges took place between Environmental Health and CQC, Environmental Health pointing out that the weather was deteriorating and that the situation had been on-going for 2 weeks. The same day[97] a family member raised concerns with QA.

58. Also on **2nd November 2016**[98], the CQC inspector rang the care home manager for an update. The old boiler had been temporarily repaired but was now broken again.

59. On **3rd November 2016**[99] Environmental Health expressed concerns to CQC about relatives bringing in heaters to the home. CQC advised that both boilers were beyond repair and that hot water tanks (later known to be immersion heaters) were to be fitted at weekend. The care home had provided halogen heaters for rooms.

60. The same day[100], the CQC inspector rang the care home manager, who reported that neither boiler was working but two electric hot water boilers were to be installed. Staff had access to hot water in the kitchen, and upstairs in an electric tureen; staff were carrying the hot water in jugs to the point of use. Halogen and

[92] DC chronology
[93] QA chronology
[94] SCCE (Social Care Centre of Excellence) is NCC's initial enquiry point for adult social care.
[95] CQC chronology
[96] DC chronology
[97] NCC supporting documentation: strategy meeting minutes 22nd November 2016
[98] CQC chronology
[99] DC chronology
[100] NCC chronology

convector heaters were being used in rooms, following individual risk assessments, and monitoring checks were in place. A quote was awaited for the replacement boiler.

61. CQC contacted the MASH[101] with concerns about the boiler, questioning what help NCC could offer, which the MASH safeguarding practice consultant forwarded to the NCC locality Head of Integrated Care, and to NCC locality team managers. The home manager had stated they had a quote to replace the boiler and were looking for ways to pay for this; the home owner was said to be out of the country.

62. CQC advised QA of the district council's concerns[102]. QA contacted the manager[103] to confirm the issues raised in the email from CQC. The SAPC and the locality Head of Integrated Care liaised by email about whether QA had ascertained whether the home had sufficient temporary heating and whether the temperature was adequate. The same day, QA notified the NCC locality Head of Integrated Care of an intended visit to the care home the following day.

63. On **4th November 2016**[104], QA visited the care home and updated CQC and the locality Head of Integrated Care on the situation following the visit. There were[105] 2 boilers, one considerably older than the other. The newer boiler had broken in the summer and the home had tried, unsuccessfully, to repair it. The older boiler then broke and was deemed irreparable. There was no hot water or heating through normal systems. The home had purchased temporary halogen fan convector heaters for resident's rooms and communal areas. Risk assessments had been done and extra staff brought in to check heating systems, ensure residents were appropriately dressed, provide extra bedding and keep residents in the communal areas. QA expressed the view[106] that while not ideal, the situation could hold and would be followed up after the weekend.

64. The same day[107], the CQC note the email from QA, which gave reassurance that residents were not at immediate risk. Staff were carrying hot water on each floor, but not up/down stairs, and the home manager had put in place a risk assessment. Residents with heaters in their rooms either have capacity to understand any risks they pose, or require staff to mobilise; risk assessments and checks were in place, with a checklist for staff to complete. All communal areas in use have a staff presence, and risk assessments in place. Staff are monitoring that residents have adequate clothing. Extra staffing is in place. Families have been advised and are supportive. The QA view was reported as being that while not ideal the situation would hold over the weekend, after which hot water would be available.

[101] NCC chronology
[102] QA chronology
[103] NCC chronology
[104] NCC chronology
[105] NCC supporting documentation: strategy meeting minutes 22nd November 2016
[106] QA chronology
[107] CQC chronology

65. On **6th November 2016**[108], Environmental Health note that QA had visited the home and considered the home had done "all they could to reasonably ensure people's safety". New hot water boilers (now known to be immersion heaters) were to be fitted over the weekend. Care staff were undertaking bed baths, carrying hot water around in jugs. Heaters had been provided to rooms and all residents had capacity to understand the associated risks.

66. On **7th November 2016**[109], Environmental Health raised to CQC concerns they had arising from QA's feedback: concerns about maintaining the home at 18°C and about residents' capacity to complain about cold; concerns about bed baths, falling temperatures, hot water being carried around the home in jugs, the length of time for a resolution, the cumulative effect of exposure, temporary heating, and infection control. The following day Environmental Health forwarded the email to QA, and requested updates from CQC, raising concerns about the temperature having fallen to below freezing the previous night. QA did not respond. CQC advised by phone that the home had had water heaters fitted to each floor[110], and Adult Social Care had told the home they needed an emergency boiler. CQC was of the view that if a solution was not in place by 11th November, the home may have to close; discussion took place as to what health and safety powers were available.

67. Also on 7th November[111], QA spoke to the home to check progress. There had been an issue with the 2 new thermostatically controlled hot water heaters, which had delayed the hot water over the weekend, so hot water had not been back in place. They had looked to source other heating and had found industrial heating but these were not suitable. They were awaiting a quote for the boiler. The manager had changed some of the routines that had been put in place and they were no longer switching the heaters off at night. Staff[112] were checking temperatures regularly.

68. The same day[113], CQC received a further concern from a relative about the broken boiler. CQC also received an email from the district council advising that concerns about risk were escalating.

69. On **8th November 2016**[114], the duty Practice Consultant Occupational Therapy had a follow up phone discussion with the social worker about the safeguarding referral.

70. The same day[115], the GP visited Ms E at the care home in the late morning, at the request of staff, who felt she was too unwell to await a the doctor's visit to the home two days later. She had had a cough for 3 days, but her behaviour had become more confused. She had previously been on trimethoprim for UTI

[108] DC chronology
[109] DC chronology
[110] Environmental Health question whether this could make sense.
[111] NCC supporting documentation: strategy meeting minutes 22nd November 2016
[112] QA chronology
[113] CQC chronology
[114] NCC chronology
[115] GP surgery chronology

prevention, but this had stopped in July. The GP diagnosed a chest infection and provided a handwritten prescription for antibiotics. It later emerged that the care home faxed the prescription to the wrong chemist, and did not follow up with the correct chemist when the expected medication did not arrive. The chemist to whom the prescription was faxed have said (in the course of the present review) that they contacted the home to alert them to the error. If this is the case, it is clear that the care home did not take any timely remedial action.

71. Also on 8th November 2016[116], the home manager advised CQC that immersion tanks were now installed and hot water was available. An emergency boiler for heating was still being sought. Later that day, in the absence of progress, CQC advised the home of actions that could be taken if the situation was not resolved. CQC concluded that an urgent inspection visit was required.

72. **On 9th November 2016**, (05.35)[117], the Ambulance Service responded to a 999 call from the care home relating to Ms E, who had experienced possible stroke/CVA. Ms E was not alert, and was hypothermic at 27 degrees. The care home had had no heating for 3 days. Ambulance crew conveyed her to hospital, and the hospital informed the police due to possible criminal negligence. The Ambulance Service entered a Datix and made a safeguarding referral to Adult Social Care.

73. Having sampled other residents' temperatures and found them also to be hypothermic, the ambulance crew had escalated a request for the Hazardous Area Response Team to be mobilised. In the event, a second ambulance was able to provide a faster response, and crew undertook welfare checks of the remaining residents, with none requiring treatment or onward transportation[118].

74. The hospital records Ms E's admission[119] to the Emergency Department with severe hypothermia (her temperature was 28ºC) and too drowsy to communicate. Ms E was admitted to an acute care ward. The hospital notified her daughter of her poor medical condition. The hospital also received the Datix, and made a safeguarding alert to the hospital safeguarding team and the NNUH social work team, notifying that the paramedics had reported the care home as cold and without heating or hot water for 3 weeks. The hospital also contacted the Hazardous Area Response Team, the Special Operational Response Team and the Police.

75. Also on 9th November 2016[120], the MASH received notification from the Ambulance Service that Ms E had been taken to hospital, with a reduced level of consciousness, confusion, and life-threatening hypothermia (temperature of 27.5C, with absolute bradycardia heart rate of 37 bpm). Care home staff had explained that the heating system for the property had been broken for the past 3 days. The building had felt very cold and all staff were wearing outdoor coats.

[116] CQC chronology
[117] EEAST chronology
[118] EEAST IMR
[119] NNUH chronology
[120] NCC chronology

While at the home, ambulance crew had taken temperatures from 5 other patients who were also found to be hypothermic with an average temperature of between 35C and 35.5C. They had phoned the manager, advising her of how severe the situation was and that urgent steps were required. They reported suspected organisational/institutional abuse by employees of the care home. The hospital had informed the police with a view to criminal negligence. The situation was rated BRAG Red and the referral sent to the Police Adult Abuse Investigation Unit for discussion and to the locality team.

76. The locality team manager advised the locality Head of Integrated Care of the safeguarding referral, offering to seek residential vacancies if necessary.

77. The Police[121] record a call received from NNUH, informing that Ms E had been taken to the Emergency Department with a body temperature of 27ºC, from a care home that had been without heating for 28 days. She was not expected to survive. A police officer liaised further with the hospital and with QA, who advised that the care home had informed them that Ms E had not been well for 2 days, and had received a GP visit the previous day with antibiotics prescribed, but that she had continued to deteriorate.

78. The same day[122], the GP surgery received notification from the hospital that Ms E had been seen in the Emergency Department and had hypothermia. A police officer also advised the surgery that Ms E had been admitted to hospital with pneumonia and seemed unlikely to survive. The care home's heating system was broken and the police and adult social care had safeguarding concerns. Ms E had not received her antibiotics the previous day. The police officer wanted to know whether, if Ms E did pass away, Dr F would issue a certificate (expected death) or whether this would go to post-mortem and possible further action against the care home.

79. SAPC JM received a forwarded email[123] containing the details that the hospital had passed to the police, raising concerns about the care home as a result of the admission of Ms E. It was stated that medical professionals had checked on the temperatures of other residents and heating was being arranged for each room. Ms E was unlikely to survive – it could not be confirmed as yet whether the heating situation was a contributory factor.

80. The police and SAPC JM discussed the details of the safeguarding referral[124], and an urgent unannounced joint visit was agreed – a police led investigation with SAPC JM attending; details would be shared with CQC, CCG, QA and NCC locality management team. The MASH advised QA[125] of the referral and that the joint social services/police investigation was to take place

[121] Police chronology
[122] GP surgery chronology
[123] NCC chronology
[124] NCC chronology
[125] QA chronology

81. The joint visit to the care home took place immediately after the strategy meeting[126]. On the visit, the heating still not operational; the manager said a boiler was coming later that day, however it was not operational until 2 days later. There were concerns around other features, such as broken window catches appearing to have been broken for some time. In relation to Ms E, there were inconsistencies in recording and in the management of her health. Staff had been supporting her with extra bedding and a fan heater, but as she was no longer there these had been removed from the room. Her notes were ambiguous and timings were not noted; detail was lacking on what had been done and some notes appeared to have been altered - one member of staff saying he realised it wasn't right and amended it. It was unclear when exactly Ms E had became unwell; it was said she became unwell on the 7th and the GP came on the 8th, however there was also a reference to her having been unwell for 3 days. The manager had recorded this but said it had been a mistake. The GP had visited around 13.40 on the 8th and prescribed antibiotics for what was thought to be a chest infection or UTI but these were not obtained; staff appeared confused as to who was responsible for doing this. There was no evidence that Ms E had been seen overnight between 19.30 and 06.30, despite the manager having requested checks every 15 minutes; night staff were not on site to be questioned. The manager called an emergency staff meeting to pass on QA's advice about checking on residents.

82. The NNUH duty social worker[127] liaised with the hospital safeguarding lead nurse and with the locality duty desk, sharing information about the police investigation that was in hand. The NNUH social work team would track Ms E through her admission. The safeguarding lead nurse advised her temperature remained very low and she had severe pneumonia. The police were updated.

83. SAPC JM entered a record[128] to indicate that in the joint visit to the care home with the police numerous issues were noted that raised concern that other service users may be at risk of harm, arising from the alleged failure to provide adequate heating and hot water, poor recording of care interventions, apparent failures to act upon resident's ill health, and evidence that the home's physical environment was not being adequately maintained. The situation was rated BRAG Amber (adults at risk of abuse, interventions in place to attempt to minimise risks) and of high complexity (evidence of impact upon multiple service users). A safeguarding adults assessment was to be completed by the locality SAPC. CQC were informed of the detailed plan for resident care while the heating and hot water system were fixed.

84. QA received feedback on the outcome of the visit[129], and further telephoned the home for an update on the hot water and heating. Hot water was functioning correctly and a temporary boiler was expected the following day. QA received assurance that residents' temperatures would be checked through 24 hours.

[126] NCC supporting documentation: strategy meeting minutes 22nd November 2016
[127] NCC chronology
[128] NCC chronology
[129] QA chronology

85. Also on 9th November 2016[130], the care home manager advised CQC that Ms E had been taken to hospital, that paramedics had checked other residents' temperatures and that the police were involved. CQC received a further complaint from a relative raising concerns about the boiler. The district council[131] received notification from CQC that the police and the safeguarding team were involved in the case.

86. Ms E died at 17.32[132]. Her daughter attended a meeting with the ward consultant, stating the Police had already contacted her in relation to allegations about the care home.

87. **On 10th November 2016**[133], the NNUH safeguarding team contacted the MASH to inform them of Ms E's death. MASH indicated that a full investigation was in progress.

88. Also on 10th November 2016[134], the GP surgery made an administrative note indicating that ambulance crew had seen Ms E the previous day, and that there were concerns about possible neglect of residents. The same day[135] CQC advised Environmental Health that a resident had been admitted with hypothermia, and the following day Environmental Health learnt that she had died.

89. CQC visited the care home[136], noting temperatures in every bedroom and bathroom that had a thermometer, and identifying draughty windows. When they first arrived the reading in the dining area was 17°; this increased throughout the day but was not above 19°. The small lounge was 22°. Some bedrooms were 22° or higher and some were 20/21°. There were no thermometers in the corridors, which were cold, as were the bathrooms and toilets. They talked to a number of residents, who seemed to rally round. Comments were mixed; some said they were cold and were moved to a warmer area. Some complained about the lack of hot water, one saying he was unable to shave or have a bath. The maintenance man said the tanks would not be able to heat the water to the temperature required.

90. CQC also had concerns regarding infection control. Four rooms smelled badly of urine; water was leaking into the bathrooms and shower room grouting was dirty. They requested to see the list for the GP who was due to visit and found 2 residents who had said they were unwell that were not on the list. When CQC spoke to the GP he said that 2 weeks earlier he had been unable to take blood from a resident as they were too cold. They had had to wrap the resident in blankets to warm them up.

[130] CQC chronology
[131] DC chronology
[132] NNUH chronology
[133] NNUH chronology
[134] GP surgery chronology
[135] DC chronology
[136] NCC supporting documentation: strategy meeting minutes 22nd November 2016

91. The CQC inspection lasted from 10th to 15th November 2016[137]. Following the visit CQC had a management review meeting and would have looked to remove registration had assurances not been given that the new boiler would be up and running by the Friday[138]. The care home was rated 'Inadequate' and automatically placed into special measures[139].

92. Also on 10th November[140], QA and the home were in email contact, the home advising that Ms E had died, and QA confirming that CQC had not raised immediate concerns following their visit.

93. On **11th November 2016**[141], QA visited the home again and received assurance that legionella checks would be arranged as a matter of urgency, and that stays were being fitted to all broken windows. The GP had visited and seen residents who were unwell. Confirmation was received from the home[142] that the boiler was in place and the heating back on.

94. The same day[143], two police officers and a crime scene investigator visited the care home; they seized bedding and a heater from Ms E's room, obtained invoices relating to the plumber who had been called, and photographed Ms E's room, including a faulty window.

95. Also on 11th November[144], the GP surgery was advised by the hospital that Ms E had died on 9th November at 17.32.

96. On **12th November 2016**[145], the QA team visited and recorded temperatures of 24-27ºC. A further resident had been admitted to hospital, unresponsive and with a low temperature and pulse.

97. On **14th November 2016**[146], the GP surgery de-registered Ms E and sent her record to the health authority. The same day, the Police closed the investigation into common assault against Ms E (raised as a safeguarding alert on 11th October). A social worker had spoken several times to the male resident, who had no recall of the incident.

98. On **15th November 2016**[147], CQC undertook a general inspection, finding towel rails that were scalding hot, poor infection control, and wet patches and stains on chairs. No deep cleans could be identified. The premises were shabby with 12 windows that didn't close properly, which maintenance had been aware of since April. Asked how the owner ensured good quality, he said he walked around the

[137] CQC chronology
[138] NCC supporting documentation: strategy meeting minutes 22nd November 2016
[139] CQC IMR
[140] QA chronology
[141] NCC supporting documentation: strategy meeting minutes 22nd November 2016
[142] QA chronology
[143] Police chronology
[144] GP surgery chronology
[145] NCC supporting documentation: strategy meeting minutes 22nd November 2016
[146] GP surgery chronology
[147] NCC supporting documentation: strategy meeting minutes 22nd November 2016

home to check the maintenance, but he hadn't noticed any of the issues that were pointed out to him. He gave the manager no formal supervision. CQC had widespread concerns across all areas of the home, with significant concerns regarding medication, care records, risk assessments and care needs.

99. On **16th November 2016**[148], a police officer made a log entry stating that a family member of a resident has complained numerous times to the manager of the care home about the lack of heating/hot water.

100. On **17th November 2016**[149], a senior public protection officer visited to assess legionella control and took water samples for analysis. The home advised they had received a quote for a new boiler.

101. A further resident[150] was admitted to hospital with pneumonia. CQC advised the GP of the legionella concern.

102. On **18th November 2016**, Environmental Health's commercial team manager and senior commercial officer visited to inspect the care home's kitchens and served an improvement notice requiring a constant supply of hot water to kitchens to be in place within 14 days. Breach of this requirement would result in prosecution, with immediate closure if risks were not appropriately managed in the meantime.

103. The same day[151], Environmental Health's commercial team manager received a call from CQC requesting to use information that Environmental Health had supplied, in an attempt to pressure action from the County Council. AD expressed surprise that CQC had not already acted to close the home, drawing attention to the powers listed on the CQC website.

104. On **19th November 2016**[152], Police interviewed the care home manager as a voluntary attender, under suspicion of manslaughter by gross neglect. She was not arrested, and left the police station pending further enquiries.

105. On **21st November 2016**[153], the care home owner was interviewed as a voluntary attender, on suspicion of manslaughter by gross neglect. He was not arrested, and left the police station pending further enquiries.

106. The same day[154], CQC met with the owner, who had been back in the country a week before he visited the care home. He stated that the manager had everything in hand, and appeared not to appreciate the significance of the situation. CQC intended to restrict placements, including readmission without prior agreement, and had informed the owner that they were considering de-registration.

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148 Police chronology
149 DC chronology
150 NCC supporting documentation: strategy meeting minutes 22nd November 2016
151 DC chronology
152 Police chronology
153 Police chronology
154 NCC supporting documentation: strategy meeting minutes 22nd November 2016

107. Also on 21st November 2016[155], the senior public protection officer contacted the specialist water hygiene company requesting copies of all recent legionella paperwork relating to the care home. The officer also requested more information from CQC on the death of the resident, highlighting a recent case elsewhere that had occurred prior to the national Memorandum of Understanding: https://www.theguardian.com/uk-news/2016/sep/28/care-home-maria-mallaband-care-fined-allowing-woman-freeze-death The officer also raised concerns with the Fire Service that when the fire alarm had sounded during his recent visit (most probably as a result of dust disturbed during his legionella sampling), one resident and all members of staff with the exception of the maintenance man left the building, leaving the other residents and the officer inside.

108. On **22nd November 2016**[156], a safeguarding strategy meeting was held to review actions since the previous discussion on 9th November. The strategy group was concerned that the home were still not engaging and being proactive with what needed to be done. The emergency boiler was in place but hot water was still an issue. The owner had stated that he wanted keep running the emergency system until the New Year in order to get alternative quotes for a new one. It was agreed that Social Care and Health would undertake reviews of all the residents in the home, with clear communications to families to keep them fully informed. QA was to be the main point of contact for the care home manager and to speak to her daily to offer support and direction. The meeting concluded that there was no evidence of immediate risk to life, although confidence in the home's ability to manage the situation was low.

109. The same day[157], CQC issued a Notice of Decision[158] to immediately restrict admissions (including readmissions) to the care home.

110. The same day[159], the senior public protection officer served an improvement notice on the care home owner requiring the company to take measures to control legionella in the system. If the result of further tests was positive, it might be necessary to serve a prohibition notice that would close down the water supply.

111. On **24th November 2016**[160], Environmental Health received notification from the specialist water hygiene company that the care home's kitchen was tank-fed not mains-fed as claimed by home.

112. On **28th November 2016**, CQC sent Environmental Health copies of two boiler condemnation notices issued for the home by Gasway during their servicing of the boilers in 2013. The same day Environmental Health received legionella test results: low levels of legionella (10cfu) were found in the treatment room sample; the other eight samples were clear.

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[155] DC chronology
[156] NCC supporting documentation: strategy meeting minutes 22nd November 2016
[157] CQC IMR
[158] Under s.31, Health & Social Care Act 2008: CQC can impose conditions on a regulated activity urgently if people are at risk of harm.
[159] DC chronology
[160] DC chronology

113. Between **28th and 30th November 2016**[161], a community matron participated with a social worker in a review of the care needs of the remaining residents at the care home

114. On **29th November 2016**[162], Public Health conducted an inspection visit of infection control measures at the care home, identifying a number of required actions, most of which were for immediate completion.

115. On **1st December 2016**[163], Environmental Health received confirmation that a plumber had now connected the hot water supply to the emergency boiler (until this point the emergency boiler had only been providing heating).

116. On **5th December 2016**[164], a further safeguarding strategy meeting took place, with multiagency attendance.

- Environmental Health reported 'satisfactory' legionella test results. While the water temperatures were low from the legionella perspective, they should allow effective washing and bathing for residents.

- It had emerged that all drinking water was tank-fed rather than mains-fed and the home has added a substance not approved for use in drinking water supplies to the tanks as part of legionella control. They are to be asked to investigate the use of mains water for drinking.

- A fire officer has found procedures at the home satisfactory but recommended staff training, which the manager is organising. QA will raise further queries about resident safety with the fire officer.

- The home owner has responded to CQC's requirements in a satisfactory way (but lacking detail and timelines). CQC had questioned whether the second director of the company was aware of what was happening, and were assured that they were in agreement with all that was being done.

- The Police were continuing with key witness statements; the pathologist's report will not be available for some time.

- QA and CQC had notified Public Health of the issues at the home, following which they had undertaken an audit of infection control and left recommendations with the manager.

- Reviews of residents have begun. Residents were generally well and eating well, with positive comment about care from relatives. Care plans had been found to be 'messy' with loose pages. Not all had been updated monthly; bowel charts were missing and there were no MCA assessments. The biggest complaint from families was property maintenance.

[161] NCH&C IMR
[162] Information provided by NCC Public Health
[163] DC chronology
[164] NCC supporting documentation: strategy meeting minutes 5th December 2016

- The GP was concerned about delays in residents getting prescribed medication.

- Windows had still not been fixed since the CQC visit – catches need replacing, but windows are generally ill-fitting and single-glazed. Concerns were voiced that the home was not dealing with the maintenance issues in a timely way. The home remains under close review by CQC, with some worrying aspects of care.

117. On **12th December 2016**, the NNUH Director of Nursing emailed a letter dated 7th December to the NCC Head of Service – Safeguarding, expressing grave concern that vulnerable residents had been allowed to remain in the home and were at significant risk of harm. The Head of Service responded on 13th December recognising the serious nature of the concerns and outlining the measures already taken and being further pursued to reduce risks.

118. On **19th December 2016**[165], a further safeguarding strategy meeting took place.

- Environmental Health updated on the legionella risk assessment outcomes, which require a lot of work; the home has asked for an extension to the improvement notice and a short extension has been given, along with priority targets. The home has achieved compliance regarding hot water in the kitchen.

    - Public Health's report, when it is available, will express significant concerns about infection control.

    - The fire officer will witness a fire drill on his next visit.

    - It was thought the manager was prioritising quick fixes in order to make progress on things within her control while awaiting the owner's action.

    - CQC does not impose time deadlines on work needed, but has restricted new admissions, as have Adult Social Care. Their report will indicate that the home is inadequate/special measures required, and at that point the home will be required to produce an action plan with timeframes.

    - It was noted that the powers of agencies are set out in law.

    - All resident reviews have taken place, with most concerns arising about the state of the building, and absence of staffing to assist residents especially at meal times. No residents have asked to be moved.

    - The Police will be discussing their investigation with CPS in the new year.

[165] NCC supporting documentation: strategy meeting minutes 19th December 2016

- While recognising that residents remained safe, there remained significant concerns about the home. The group would request a meeting with the owner to seek a response to all the concerns.

119. On **3rd January 2017**[166], the senior public protection officer visited the care home, finding little progress; there was still only water hot enough to have an effective bath/shower in one location in the home.

120. On **9th January 2017**[167], a further safeguarding strategy meeting took place.

- A resident had been admitted to hospital with broken ribs (having been patted on the back due to choking).

- Environmental Health are chasing a response on outstanding issues and will enforcement action if this is not forthcoming.

- There is no indication that any expenditure has taken place on the fabric of the building.

- Reassurance was required from the owner that he understood the severity of the situation.

121. The same day[168], members of the strategy group met with the home owner and the manager. No plan of action on Environmental Health, Public Health and CQC requirements was forthcoming, and responsibilities between the owner and the manager did not appear to be clearly delineated, with responsibility for all actions falling to the manager. The group expressed concern about he owner's lack of engagement and set renewed deadlines for action plans.

122. On **16th January 2017**[169], CQC issued a Notice of Proposal to cancel the provider's registration, against which the care home owner made representation.

123. On **31st January 2017**[170], a further safeguarding strategy meeting took place.

- Environmental Health confirmed there was now a timetable in place for the legionella work, including the home moving to a mains water supply. The lift has been examined and recommendations made. The home owner does still not engage, and the manager has to be chased for responses.

- Window repairs were starting this week.

- Updated information on residents was shared. The attorney for one resident has complained about non-notification of the review, and

[166] DC chronology
[167] NCC supporting documentation: strategy meeting minutes 9th January 2017
[168] NCC supporting documentation: strategy meeting with provider minutes 9th January 2017
[169] CQC IMR
[170] NCC supporting documentation: strategy meeting minutes 31st January 2017

instructed an independent social worker to assess the individual, raising a number of points relating to care standards.

- Discussions have been held with the manager on implementation of the CQC report requirements; she will require support and guidance, as the home owner is not providing supervision of managerial support.

- CQC issued a Notice of Proposal on 16th January, with no representation yet received from the home. After 14th February CQC will move to a Notice of Decision, which will be followed by a 28-day appeal period.

- The Police file was with CPS.

- The planning department has confirmed that new units being built on the site are tied to the home, and if they will not be linked to the home then new planning permission would be required.

- Staff fire training has been held, and individual evaluation plans are to be made for all residents.

- Concerns remain about the quality of care. The SAPC will visit to prompt and support progress.

124. On **8th February 2017**[171], Public Health carried out a follow up inspection of infection control measures at the care home, noting completion of some required actions, with a range of further matters either in progress or awaiting attention.

125. On **20th February 2017**[172], members of the strategy group had a further meeting with the home owner and the manager.

- The manager and home owner provided updates on progress with environmental changes to the home and on staff training that has been provided. Senior staff are reviewing residents' care plans, with the manager ensuring content is appropriate.

- Appeal has been lodged against the CQC Notice of Proposal. The home owner indicted that if the case goes to Tribunal he will close the home, as it could not survive financially with reduced numbers.

- The strategy group again emphasised the importance of the home owner supervising and supporting the manager with the work being undertaken.

- The home owner clarified that when the new units were operational, the care would not be provided by the care home's care team. He was asked to liaise with the planning department as this represented a change from the basis on which planning permission had been granted.

[171] Information provided by NCC Public Health
[172] NCC supporting documentation: strategy meeting with provider minutes 9th January 2017

126. On **27th February 2017**[173], Environmental health further extended the Improvement Notice for legionnaires disease controls to 24th March 2017.

127. On **10th March 2017**[174], the GP surgery scanned a document Adult safeguarding concern 2 (16-Feb-2017).

128. On **24th April 2017**[175], Environmental health served a further improvement notice relating to legionella management, indicating that the company was now considered to have breached the initial improvement notice.

129. On **23rd March 2017**[176], a further safeguarding strategy meeting was held.

- It was confirmed that no safeguarding referral was required about the circumstances in which staff had accompanied a resident to a theatre performance.

- There was some evidence of a more person-centred approach being used, although much remained that was routinised. Positive feedback had been received from a resident on the care being provided to them.
- Two safeguarding referrals had been received on 2nd March about incidents on 26th and 27th February; the importance of timely reporting had been emphasised. One was deemed not a safeguarding issue, and the other required follow up through a risk assessment. Gaps had been found in assessments and care plans.

- The CPS decision following the Police investigation meant that neither the care home owner nor the manager would face criminal charges. The pathology report on Ms E had shown that hypothermia contributed to her death; however, she also had bronchial pneumonia, which can lead to hypothermia. The manager would be submitting a report to the Coroner.

- CQC was requesting the Police investigation files in order to consider prosecution under Reg.12 HSCA 2008.

- Given the CQC block on admitting residents to the new units with their care linked to the home, the home owner was renting the units, with residents arranging their own care from a third party. This contravened the planning permission, but Trading Standards cannot intervene until the Planning Department issues a notice.

- Difficulties remained with the quality of care plans.

[173] DC chronology
[174] GP surgery chronology
[175] DC chronology
[176] NCC supporting documentation: strategy meeting minutes 31st January 2017

- With regard to legionella management, the improvement notice had been extended to 24th March. With regard to the lift, Environmental Health have set a deadline for the work required to the lift.

130. On **28th March 2017**[177], CQC inspected and again rated the care home 'Inadequate'.

131. On **3rd April 2017**[178], members of the strategy group had a further meeting with the home owner and the manager.

- The home owner and manager updated on progress with the work in hand and ongoing matters such as infection control.

- Environmental Health emphasised that further work is still required on legionella management; the improvement notice was to be extended to 19th April.

- The home owner did not wish to proceed with work on the lift due to financial constraints, but the strategy group emphasised it should be completed before the end of April.

- CQC had raised further concerns about standards on a visit the previous week.
- A resident had been admitted to hospital and returned to the home with CQC consultation, and a day care user had spent two weeks as a resident without CQC authorisation, both in breach of the CQC requirements currently imposed.

- The strategy group reviewed the home's financial position and queried the arrangements for the new units, the home owner indicating that he would refer the Planning Department's communications to his solicitor. He reiterated that he would not keep the home open if the residents fell below 20 in number He had requested that CQC lift the restrictions on admissions.

132. On **8th May 2017**[179], there was a further meeting of the safeguarding strategy group.

- CQC reported that they had undertaken an inspection on 28th March and sent the owner the draft report. He had requested the admissions restrictions be lifted, but this had been rejected; he had subsequently taken the decision to close the home.

- CQC would be continuing with its review of the owner's appeal against the CQC's Notice of Proposal to close the home.

[177] CQC IMR
[178] NCC supporting documentation: strategy meeting with provider minutes 3rd April 2017
[179] NCC supporting documentation: strategy meeting minutes 8th May 2017

- A residents' meeting had been held on 27th April, where all residents were given a NCC letter regarding the closure process. Adult Social Care staff have been contacting families.

- Environmental Health still had unresolved concerns about legionella management (with two sites of high readings) and more general concerns about health and safety during the home closure period. Environmental Health could continue to pursue the breach of the improvement notice, irrespective of the home closure.

- There are concerns about residents of the new units, and the on-going availability of support for them.

133. Also on **8th May 2017**, [180]members of the strategy group had a further meeting with the home owner and the manager.

- The meeting focused on the closure of the home; residents and their families had all been informed in writing. The manager provided updates on the status of each resident.

- The owner had not read Environmental Health's communications of 24th April[181] and indicated that no further measures were being taken for legionella management or in relation to the lift[182]. The home would be shut for at least 2 years. Environmental Health emphasised the need for risk control measures to continue to be taken during the home closure period, and proposed action that could control the risk of legionella spread.

- Only one of the new units was occupied, and arrangements had been made with the third party care provider to respond to call bells. The fire alarms would also be linked to the provider.

- The manager was informed that in relation to a recent safeguarding alert involving a registered nurse member of staff, she would need to inform the NMC

134. On **18th May 2017[183]**, the home owner failed to attend a PACE interview with Environmental Health, and sent no notification of his non-attendance[184]. In the light of the care home's subsequent closure, Environmental Health did not further pursue any prosecution.

[180] NCC supporting documentation: strategy meeting with provider minutes 8th May 2017
[181] DC chronology
[182] NCC supporting documentation: strategy meeting with provider minutes 8th May 2017
[183] DC chronology
[184] Interviews under the Police & Criminal Evidence Act 1984 are voluntary in this context; they provide an individual with the opportunity to state their side of a situation as part of an investigation which may result in a prosecution. If they later in court introduce defences that the Council had no knowledge of when bringing the prosecution, their failure to attend a PACE interview can be taken into account in considering those defenses.

135. On **14th June 2017**[185], the GP surgery made an administrative note - Letter from outside agency 2, Letter to Coroner

136. On **23rd May 2017**[186], having heard and not upheld the care home owner's representation against the Notice of Proposal to cancel registration, CQC issued a Notice of Decision to cancel the provider's registration.

137. On **31st May 2017**, the last resident left the care home, which then closed.

138. On **21st June 2017**[187] the appeal deadline following the issuing of the Notice of Decision to cancel registration concluded. No appeal was made by the provider. Therefore the CQC enforcement action, commenced following the service of the proposal to cancel registration on 16 January 2017 to de-register the provider, took effect. The service provider was removed from the register.

[185] GP surgery chronology
[186] CQC IMR
[187] Further information provided by CQC.

APPENDIX 4

2015 MEMORANDUM

Memorandum of Understanding between the Care Quality Commission, the Health and Safety Executive and Local Authorities in England

Introduction

1. This Memorandum of Understanding (MoU) applies to both health and adult social care in England. It comes into effect on 1 April 2015, to reflect the new enforcement powers granted to the Care Quality Commission (CQC) by the Regulated Activities Regulations 2014. It replaces the 2012 Liaison Agreement between CQC and the Health and Safety Executive (HSE) that applied solely to healthcare.

2. The purpose of this MoU is to help ensure that there is effective, co-ordinated and comprehensive regulation of health and safety for patients, service users, workers and members of the public visiting these premises. It is one of the measures taken by Government to close the 'regulatory gap[1]' identified by the Francis Report into failings at the Mid Staffordshire NHS Foundation Trust.

3. It outlines the respective responsibilities of CQC, HSE and Local Authorities (LAs) when dealing with health and safety incidents in the health and adult social care sectors, and the principles that will be applied where specific exceptions to these general arrangements may be justified. It also describes the principles for effective liaison and for sharing information more generally.

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4. Other organisations also have roles or responsibilities for investigation, prosecution and/or oversight in relation to offences in health and adult social care settings – such as ill-treatment or wilful neglect. Appropriate liaison with other prosecutors/regulators/oversight bodies, such as the police, Crown Prosecution Service (CPS) and Safeguarding Adults Boards is essential. Some of these may be signatories to the Work-related Deaths Protocol (WRDP). CQC, HSE and LAs will notify relevant bodies of incidents and agree the coordination of activity or work with them as appropriate to protect patients, service users, workers and the public from risk of harm.

[1] The regulatory gap was due to the restrictiveness of HSE's health and social care investigation policy and CQC lacking the necessary powers to secure justice at that time.

Respective responsibilities for dealing with health and safety incidents

5. CQC is the lead inspection and enforcement body under the Health and Social Care Act 2008 for safety and quality of treatment and care matters involving patients and service users in receipt of a health or adult social care service from a provider registered with CQC.

6. HSE/LAs[2] are the lead inspection and enforcement bodies for health and safety matters involving patients and service users who are in receipt of a health or care service from providers not registered with CQC.

7. HSE/LAs are the lead inspection and enforcement bodies for health and safety matters involving workers, visitors and contractors, irrespective of registration.

8. Annex A contains examples of incidents typically falling to CQC and HSE/LAs respectively to illustrate the responsibilities outlined above. The response from the lead body will be in line with their regulatory approaches, and their decisions on whether to investigate or take further action will be subject to their guidance and published policies.

Incidents where specific circumstances may apply

9. In a small number of cases, more specific criteria may be applied to ensure that the most appropriate body takes charge of the investigation and/or any related action. These criteria are set out in Annex B. Any such cases will be considered individually on their merits, taking these criteria into account.

Liaison in relation to individual incidents

10. Where there is uncertainty about jurisdiction or where Paragraph 9 applies, the relevant bodies will:

    - determine who should have primacy for any regulatory action and whether joint or parallel regulatory action will be conducted;
    - keep a record of this decision and agree criteria for review, if appropriate;

[2] HSE is responsible for enforcing health and safety at all healthcare premises as well as care homes with nursing, and public social care providers, whilst LAs are responsible for other residential care homes.

- designate appropriate contacts within each organisation to establish and maintain any necessary dialogue throughout the course of the regulatory action; and
- keep duty-holders / providers, injured parties and relatives (where appropriate) informed.

Incident notifications and general information sharing arrangements

11. The existing statutory requirements for the notification of incidents will continue for the time being (e.g. RIDDOR and CQC's notification requirements).

12. Each party to this MoU will work collaboratively by:
    - notifying the other parties as appropriate as soon as possible about information they receive on incidents in the jurisdiction of that body; and
    - sharing relevant intelligence and enforcement data (see Annex C).

13. This MoU will be regularly reviewed – at least on an annual basis.

Annex A: Illustrative examples of incidents that fall to CQC and HSE/LAs respectively

Examples of the types of incidents falling to CQC to consider and decide the action to be taken (if the premises are registered with CQC). These examples are not exhaustive and do not take account of the police / CPS potential involvement:

- a patient/service user falling from a window;
- a severe scalding of a patient/service user in a bath/shower;
- a patient/service user with a need for assistance with eating being given inappropriate food and being seriously harmed or dying from choking;
- a patient/service user who did not receive treatment in line with their care plan who died or was severely harmed as a result;
- a patient/service user being seriously injured or dying after being physically restrained by staff; and
- ill-treatment or wilful neglect of a patient/service user.

Incidents falling to HSE/LAs:

- circumstances where the commissioner of the service, rather than the provider, seems to have been primarily at fault;
- circumstances where the provider is not required to be registered with CQC;
- employees developing dermatitis related to glove use;
- a manual handling injury to an employee from moving ill-maintained trolleys; and
- a contractor's tower scaffold collapses into a care home car park.

Annex B: Incidents where more specific and exceptional criteria may apply

In a small number of cases, more specific criteria may be applied to ensure that the most appropriate regulator takes charge of the investigation and/or any related action. This may be because of more applicable legislation or because of an absence of applicable legislation (CQC does not have enforcement powers, equivalent to Section 7 of the Health and Safety at Work etc. Act 1974 (HSW), in relation to individuals, for instance). In such cases the circumstances will be considered on their individual merits, and a mutually agreed decision reached, in line with our published policies. These examples are not exhaustive and do not take account of the police / CPS potential involvement.

Factors tending towards HSE/LA taking the lead include incidents:

- involving maintenance contractors (e.g. scaffolding or asbestos);
- involving installed plant for the use of anyone (e.g. lifts or escalators);
- where specific HSW legislation can most adequately deal with the cause of the harm (e.g. related to the statutory examination of plant, or the Legionella Approved Code of practice).

Factors tending towards CQC taking the lead include incidents:

- which may have exposed staff to harm, but the principal concern is the greater risk of harm to patients / service users.

Factors tending towards joint or co-ordinated investigations include incidents where:

- both commissioners and registered providers appear to be significantly at fault;
- employers not required to be registered with CQC, as well as CQC registered providers, appear to be significantly at fault, and
- providers should be registered with CQC, but are not. (In such cases CQC would consider the failure to register, and HSE/LAs the specific non-compliance issues.)

Annex C: Arrangements for sharing of intelligence to support the MoU

The obtaining, handling, use and disclosure of such information is principally governed by the Data Protection Act 1998 and the common law duty of confidence, respectively.

This annex sets out the mechanism for sharing information with the other parties where it is clearly in the interest of the workers or patients and service users.

The following has been agreed as the operational means of information sharing over and above the normal working level arrangements described in paragraph 12 of this MoU:

- HSE/LAs will request intelligence from CQC, or share concerns, on a case by case basis by contacting their National Customer Service Centre.
- CQC will share concerns with HSE via the Public Services Account.
- CQC will request intelligence from, or share information with, LAs on a case by case basis by contacting the relevant local authority.
- HSE will share the outcomes of its health and social care RIDDOR and concerns investigations (including enforcement notices and prosecutions), in England, with CQC on a quarterly basis.
- CQC will share intelligence with the police and/or CPS by contacting the relevant local service.

APPENDIX 5

2017 REVISED MEMORANDUM

Memorandum of Understanding (MoU) between the Care Quality Commission (CQC) and the Health and Safety Executive (HSE)

December 2017

Introduction

1. This MoU has been agreed between the Care Quality Commission (CQC) and the Health and Safety Executive (HSE) with the support of the Local Government Association (LGA). It applies to both health and adult social care in England. The purpose of this MoU is to help ensure that there is effective, co-ordinated and comprehensive regulation of health and safety for patients, service users, workers and members of the public.

2. It outlines the respective responsibilities of CQC, HSE and local authorities (LAs) in England when dealing with health and safety incidents in the health and adult social care sectors, and the principles that will be applied where specific exceptions to these general arrangements may be justified. The MoU applies to all activities; therefore it describes the principles for effective liaison and for sharing information more generally.

3. HSE, LAs and CQC will co-operate effectively to enable and assist each other to carry out their responsibilities and functions, and to maintain effective working arrangements for that purpose.

4. Other organisations also have roles or responsibilities for investigation, prosecution and/or oversight in relation to offences in health and adult social care settings – such as ill-treatment or wilful neglect. Appropriate liaison with other prosecutors/regulators/oversight bodies, such as the police, Crown Prosecution Service (CPS) and Safeguarding Adults Boards is essential. Some of these may be signatories to the Work-related Deaths Protocol (WRDP). CQC, HSE and LAs will notify relevant bodies of incidents and agree the coordination of activity or work with them as appropriate to protect patients, service users, workers and the public from risk of harm.

Respective responsibilities for dealing with health and safety incidents

5. CQC is the lead inspection and enforcement body under the Health and Social Care Act 2008 for safety and quality of treatment and care matters involving patients and service users in receipt of a health or adult social care service from a provider registered with CQC.

6. HSE/LAs[1] are the lead inspection and enforcement bodies for health and safety matters involving patients and service users who are in receipt of a health or care service from providers not registered with CQC.

7. HSE/LAs are the lead inspection and enforcement bodies for health and safety matters involving workers, visitors and contractors, irrespective of registration.

8. Annex A contains examples of incidents typically falling to CQC and HSE/LAs respectively to illustrate the responsibilities outlined above. The response from the lead body will be in line with their regulatory policies. Their decisions on whether to investigate or take further action will be subject to their guidance and published policies.

General considerations for enforcement responsibilities

9. When considering the circumstances of a specific incident the primary consideration is whether the injured person is a patient/service user and whether the service provider is registered with the CQC. If that is the case the responsible authority will normally be the CQC unless the police have primacy.

10. An enquiry will generally commence with the CQC because a patient/ service user is injured. During the course of the enquiry information may emerge that the service provider is not registered or there may not be a regulated activity taking place or that CQC does not have applicable legislation or sufficient powers to take action. In such circumstances CQC should liaise with HSE/LA regarding why a particular case may revert to the HSE/LA or CQC to jointly investigate with HSE/LA.

11. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 are broad in their concept of the duty to provide care and treatment in a safe way. This duty includes ensuring that the premises used by the service provider are safe to use for their intended purpose and ensuring that the premises and equipment are suitable, properly used and properly maintained. The definition of ‘premises’ is very broad and includes any building or other structure or machinery physically affixed to the building, any surrounding grounds or a vehicle.

[1] HSE is responsible for enforcing health and safety at all healthcare premises as well as care homes with nursing, and public social care providers, whilst LAs are responsible for other residential care homes.

12. Regulation12 (1) of the Regulated Activities Regulations which relates to the need to provide safe care and treatment includes a duty to ensure that the premises used by the service provider are safe to use for their intended purpose.

13. Although specific health and safety at work (HSW) legislation may exist, such as Lifting Operations and Lifting Equipment Regulations 1998 (LOLER), it should generally be the case that CQC can adequately enforce using their legislation, without needing recourse to specific legislation. In a limited number of cases CQC may exhaust its enforcement powers and may look to HSE/LA for support.

Incidents where specific circumstances may apply

14. In a small number of cases, more specific criteria may be applied to ensure that the most appropriate body takes charge of the investigation and/or any related action. These criteria and some examples are set out in Annex B. Any such cases will be considered individually on their merits, taking these criteria into account.

Liaison in relation to individual incidents

15. Where there is uncertainty about jurisdiction or where paragraph 14 applies, the relevant bodies will:

- determine who should have primacy for any regulatory action and whether joint or parallel regulatory action will be conducted;
- keep a record of this decision and agree criteria for review, if appropriate;
- designate appropriate contacts within each organisation to establish and maintain any necessary dialogue throughout the course of the regulatory action; and
- keep duty-holders / providers, injured parties and relatives (where appropriate) informed.

See also Annex D.

Incident notifications and general information sharing arrangements

16. The existing statutory requirements for the notification of incidents will continue for the time being (e.g. RIDDOR and CQC's notification requirements).

17. Each party to this MoU will work collaboratively by:

- notifying the other parties as appropriate as soon as possible about information they receive on incidents in the jurisdiction of

that body, and

- sharing relevant intelligence and enforcement data (see Annex C).

18. The effectiveness of these arrangements will be subject to an annual review carried out at Director level for HSE and Deputy Chief Inspector at the CQC.

Dr Richard Judge
Chief Executive
Health and Safety Executive

Sir David Behan
Chief Executive
Care Quality Commission

Annex A

Illustrative examples of incidents that fall to CQC and HSE/LAs respectively

Incidents where CQC take the lead (if the provider is registered with CQC)

These examples are not exhaustive and do not take account of police / CPS potential involvement. Where appropriate, comments have been added to aid understanding

- a patient/service user falling from a window; (*premises issue directly relevant to care of vulnerable patients/service users)*
- severe scalding of a patient/service user in a bath/shower
- a patient/service user develops legionnaires' disease when a regulated activity is being carried out *(staff also at risk but greatest risk is to patients/service users)*
- a complaint received that the hot and cold water system in a residential care home is not being properly maintained and there is risk of Legionella proliferation. *(staff also at risk but greatest risk is to patient/service users)*
- a patient/service user with a need for assistance with eating being given inappropriate food and being seriously harmed or dying from choking
- a patient/service user being seriously injured or dying after being physically restrained by staff
- a patient/service user travelling in an ambulance is injured because their wheelchair is not properly secured (*transport services provided in a vehicle designed and used mainly for carrying a person who requires treatment is a regulated activity)*
- a patient/service user injured in their own home whilst receiving care from a regulated domiciliary care agency *(regulated activity in the course of being provided)*
- a patient/service user injured during a supervised outing where the carer is employed by a registered service provider *(definition of regulated activity also includes an activity that is ancillary to, or carried on wholly or mainly in relation to a regulated activity when the ancillary activity is in line with the patient/service users care plan)*

- a patient/service user is injured when leaving their appointment due to a pothole in the clinic car park *(injury is to the patient because of the lack of safety of the premises);* and

- ill-treatment or wilful neglect of a patient/service user.

Incidents where HSE/LAs take the lead:

- circumstances where the commissioner of the service, rather than the provider, seems to have been primarily at fault; *(CQC have no remit over third parties not registered with them but they can prosecute those carrying out a regulated activity without registering)*

- circumstances where the provider is not required to be registered with CQC

- employees developing dermatitis related to glove use

- a manual handling injury to an employee from moving poorly maintained trolleys

- a patient/service user is injured where construction work is being carried out by a construction/maintenance contractor that has created a risk (e.g. breach in security allowing patient/service user to exit premises and be injured or an unsecured door falls causing injury *(CQC has no vires over construction company, appropriate to use HSW legislation)*

- a staff member develops legionnaires' disease

- cooling tower implicated in a legionnaires' disease outbreak or general concerns over management of same *(societal health risks introduced)*

Annex B

Incidents where more specific and exceptional criteria may apply

CQC should generally have appropriate and sufficient powers under their own legislation to take action. However in a small number of cases, more specific criteria may need to be applied to ensure that the most appropriate regulator takes charge of the investigation and/or any related action. This may be because of more applicable legislation e.g. Control of Asbestos at Work Regulations or because of an absence of applicable legislation e.g. CQC does not have enforcement powers, equivalent to section 7 of the Health and Safety at Work etc. Act 1974 (HSW), in relation to individuals. In such cases the circumstances will be considered on their individual merits, and a mutually agreed decision reached, in line with the published policies of CQC and HSE/LAs and following the guidance in paragraph 15. These examples are not exhaustive and do not take account of police / CPS potential involvement.

Factors tending towards CQC taking the lead include incidents:

- which may have exposed staff to harm, but the principal concern is the greater risk of harm to patients / service users (e.g. unsecure storage of cleaning chemicals may be an issue under the Control of Substances Hazardous to Health Regulations but the greater risk of harm may be to vulnerable patients/service users)

Factors tending towards HSE/LA taking the lead include incidents:

- involving any maintenance contractors (*e.g. failings in management of hot and cold water systems and creation of risks of Legionella are due at least in part to failings by a water treatment company*. *CQC have no vires over such contractors)*

- involving an activity that is not a regulated activity and is not being managed/supervised by a registered provider (*e.g. patient/service user injured while being escorted in a taxi because wheelchair not properly secured, travel in a taxi is not a regulated activity and taxi company not a registered provider, therefore CQC has no vires)*

- where specific HSW legislation can most adequately deal with the cause of the harm *(e.g. the thorough examination and test requirements of lifting equipment under LOLER, or duty to manage asbestos under Regulation 4 of the Control of Asbestos Regulations*)

- some premises issues *(e.g. patient/service user injured by faulty automatic entrance door to health centre where the door was under a maintenance contract and CQC were satisfied that the GP had done what he/she needed to by contracting a maintenance firm)*

Factors tending towards joint or co-ordinated investigations include incidents:

- where both commissioners and registered providers appear to be significantly at fault

- where employers not required to be registered with CQC, as well as CQC registered providers, appear to be significantly at fault, and

- where providers should be registered with CQC, but are not (*in such cases CQC would consider the failure to register, and HSE/LAs the specific non-compliance issues*).

Annex C

Arrangements for sharing intelligence to support the MoU

The obtaining, handling, use and disclosure of such information is principally governed by the Data Protection Act 1998 and the common law duty of confidence, respectively. In sharing information under the MoU CQC, HSE and LAs will at all times comply with respective obligations under the Data Protection Act 1998.

This annex sets out the mechanism for sharing information with the other parties where it is clearly in the interest of the workers or patients and service users.

The following has been agreed as the operational means of information sharing over and above the normal working level arrangements described in paragraph 17 of this MoU:

- HSE/LAs will request intelligence from CQC, or share concerns, on a case by case basis by contacting their National Customer Service Centre.
- CQC will share concerns with HSE via the Public Services Sector Account.
- CQC will request intelligence from, or share information with, LAs on a case by case basis by contacting the relevant local authority
- HSE will share the outcomes of its health and social care RIDDOR and concerns investigations (including enforcement notices and prosecutions), in England, with CQC on a quarterly basis; and
- CQC will share intelligence with the police and/or CPS by contacting the relevant local service.

Annex D

Operational working arrangements

The purpose of the MoU is to help ensure that there is effective, co-ordinated and comprehensive regulation of health and safety for patients, service users, workers and members of the public. To this end there needs to be effective operational working arrangements brought about by effective collaborative working.

This MoU is a statement of intent. Nothing in it shall create any legally binding or enforceable obligations on the HSE, LAs or CQC.

Effective collaborative working will be achieved through:

- a common understanding of each other's roles and responsibilities and good regulatory practice
- regular sharing of knowledge in areas of mutual interest; and
- close co-operation on respective regulatory and other activities.

The main body of this MoU sets out the principles to consider when establishing the lead enforcement body for the site or activity in question. Where the need for effective collaborative working arises, e.g. for a transfer of enforcement responsibility or joint working, in the first instance the inspector responsible for the site in question should liaise with their operational counterpart in HSE, the LA or CQC.

CQC inspectors can be contacted via the National Customer Service Centre (03000 616161) asking for the relationship owner for the service. Issues not resolved through this liaison should be referred to the relevant sector specific enforcement leads.

HSE inspectors can be contacted via the Public Services Sector account.

Local Authority inspectors can be contacted via the contact details for the relevant LA.

In the event of agreement not being reached, the matter should be escalated through the operational management chain. Advice may be sought at any stage from HSE's Health and Social Care Services operational policy and strategy team via the Public Services Sector account.