Bexley Safeguarding Adults Board

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Serious Adult Review (SAR) – Mrs A
Executive Summary and Findings Publication
15 June 2018

Reviewed by: Gina Tomlin, Safeguarding Adult Lead, Dartford Gravesham NHS Trust
Review completion date: February 2018
Accepted and owned by BSAB date: March 2018

Introduction:

1.1 Bexley Safeguarding Adults Board (BSAB) initiated this Safeguarding Adult Review (SAR) in 2016, following the notification of death of a 43 year old woman, for the purposes of this report will be known as Mrs A. The review panel are aware that this may be upsetting to people who knew her but they are also concerned about the family's right to confidentiality and privacy. Mrs A was found in her flat by a housing officer on the 9th June 2015 having died from a self-inflicted stab wound in the chest from a carving knife.

Why was this case reviewed?

1.2 As a result of Mrs A's death, BSAB were required to consider if a SAR should be conducted. A SAR is a multi-agency review process which seeks to determine which relevant agencies and individuals were involved and if anything could have been done differently that could have prevented harm or death from taking place. The purpose of a SAR is not to apportion blame but capture positive learning to improve systems and professional practice for the future.

1.3 In making a decision to initiate a SAR, BSAB complied with the Care Act 2014, the main provisions of which came into force in April 2015. Under the Care Act, Safeguarding Adults Boards must initiate a SAR when an adult in its area with needs for care and support dies or suffers significant negative impact as a result of serious abuse or neglect (known or suspected), and where there is a concern that the partners agencies could have worked more effectively to protect the adult (The Care Act 2014, section 44)

1.4 Mrs A had been identified as having care and support needs with a number of professionals and agencies involved that go back a number of years.

1.5 This case was therefore chosen to be reviewed in that the death met the legal criteria. An independent reviewer was appointed by BSAB to facilitate the review.

Review Period Time Frame:

1.6 It was agreed that the period would focus on the period from 2013 to the date of Mrs A's death on 9th June 2015. A small amount of background detail prior to 2013 has been added to give some context to the review. The review period was divided into three phases: Pre-arrest, Arrest and Care Treatment Order Period and the three months to end of life.

1.7 It is within this timeframe that particular attention has been paid to understanding Mrs A's needs, and the services and systems around her.

SAR Methodology:

1.8 There is no prescriptive methodology for a SAR, though it is now widely accepted that for multi-agency reviews, a system based approach and methodology is desirable.

1.9 This SAR is using the IMR format; Individual Management Review style and the SAR is owned by the BSAB in its entirety. The SAR sub group from a partner agency nominated the Lead Reviewer; they had no involvement in the care of Mrs A. There were several meetings with the Lead Reviewer and the involved agencies to Mrs A. care and support across.

The Findings:

2.1 This section contains 13 findings that have emerged from the review. Each finding provides evidence identified by the Review Team that indicates that these are not unique to the case.

2.2 The findings are therefore a reflection of the systems at the time but also indicate that the issues raised are not 'one off events'. Changes to some systems have been implemented prior to the SAR completion.

2.3 SAR's should provide a 'sound analysis of what happened, why and what action needs to be taken to prevent recurrence'. The Care Act also requires that findings should be 'of practical value to organisations and professionals'

2.4 This case raises some fundamental issues facing professionals when working with complex individuals with mental health needs. It also identifies the additional complexities of someone going through the Criminal Justice System with bail conditions specifically around accommodation.

13 Findings (in phases below):

PHASE 1: PRE-ARREST PERIOD -

1. Lack of compliance with policies / procedures in particular with regards to review within The Care Programme Approach (CPA), Zoning and Risk Assessment.

2. CPA meetings should have an integrated and holistic engagement with professionals across sectors in order to make safeguarding personal.

PHASE 2: ARREST AND CTO PERIOD -

3. Acute lack of understanding regarding professional language used across the sectors, especially for professionals outside the court, police and probation services requiring improved access for information and terminology.

4. Professionals should gather, share and access information in a robust and timely way.

5. In order for services to understand what the concerns are a more formal system of escalation needs to be in place in organisations.

6. Agencies need clear policies / procedures regarding court and probation pathways and the criminal justice system; to include notification when naming of agencies within this.

7. When someone is identified as high risk The Care Programme Approach (CPA) must be followed in a dynamic way ensuring all services not just mental health are involved.

8. All agencies need to understand the importance of their statutory requirements under the Care Act 2014 and to ensure this is managed locally at a senior level and through the Board representative.

9. Lack of out-of-hours (Fri-Mon) provision services for crisis management.

PHASE 3: 3 MONTHS TO END OF LIFE –

10. Agencies to consider when Court Bail Condition state ‘not to return to a specific address’ that thorough checks are made with Housing Services for verification of current address.

11. Agencies should consider all options of communication with patients and understand ‘writing to’ as least beneficial method of communication.

12. Agencies should identify adult community and support services earlier in the ‘at risk’ assessment stage.

OTHER FINDINGS -

13. The community mental health teams in the trust where undergoing a restructure at the time of death.

Involvement and Engagement with Family:

3.1 The parents of Mrs A contributed to the Serious Incident Review conducted by the Mental Health Trust at the time of Mrs A's death. At the time of this report's conclusion, the family has not made contact with the Lead Reviewer nor the BSAB directly with respect to Mrs A and the care and support she received even though attempts were pursued. The Lead Reviewer has taken this in mind to ensure strictest anonymity have been made to respect the deceased and any surviving relatives particularly the young children she left behind.

Summary of Key Action Points:

Finding	Recommended Action(s)	By Whom	Due for Review By BSAB Sub Group	What does Completed Look Like
Finding 1	Ensure compliance with relevant Trust policies and procedures, with particular regard to Care Programme Approach (CPA), use of Zoning and Risk Assessment tools.	Oxleas NHS Foundation Trust	Finding 1	Ensure compliance with relevant Trust policies and procedures, with particular regard to Care Programme Approach (CPA), use of Zoning and Risk Assessment tools.
Findings 2 and 7	Incorporate pathways into the BSAB's Safeguarding Adult Toolkit. Make sure that the Care Coordinators are involving and engaging all professionals/stakeholders are aware of the process and contribute throughout. Making sure the CPA process is being	BSAB By supervisors and oversight by team managers Oxleas NHS FT		BSAB to share toolkit with all staff Making sure the professionals involved are compliant with the process and that they adopt a holistic approach to the CPA and that the agreed CPA is shared with relevant members of the MDT – CPA is recorded on electronic patient record available to all MDT members; printed copy given to patient & any other relevant people with patient's

	appropriately applied. Meetings between Mental Health Locality and Team Managers and Housing Colleagues to talk through specific issues.	Oxleas NHS FT Locality Manager Head of Social Care		consent. Ensuring that all professionals are involved, share and gather all relevant information and engage with key partners. Ensure robust multi-agency meetings, training and learning events across all services and articulate pathways across the services. Hold joint-short team briefings and more collaboration across Housing and Oxleas and other partners. Update CPA check list to ensure safeguarding included and other agencies are invited – to be incorporated into updated Team Standards for Care Co-ordinators. Housing and Mental Health liaison meetings to continue and already talk through specific issues and implement joint protocol.
Finding 3	Incorporate Glossary of terminology used across sectors including Courts, Probation, Housing and other health and social care services; this is not limited to terms but also processes	BSAB	30 April 2018	Glossary will be located on the BSAB website for reference across partners and public.

Finding 4	Make sure that all agencies are recording all professionals involved and where a care plan is in place we are sharing that plan with others involved.	Oxleas NHS FT (Locality & Team Managers)	31 May 2018 30 April 2018	Patient Experience Questionnaire completed Week 3 of each month & also given to Bexley Locality's (Oxleas MH) patients on discharge. Sample audit of care co-ordinators use of Professional Contacts section of RiO.
Finding 5	BSAB to emphasise and agree an Escalation Process to follow with regards to care and support needs and risks to safeguarding. Ensure that all agencies have an Escalation and Resolution Policy.	BSAB Partners	February 2018 February 2018	Take to Chairs Meeting for agreement. All Mental Health front line staff to escalate concerns via their manager and to have a clear structure chart of housing managers. BSAB Audit to have evidence provided against partner's policies/procedures – BSAB will need to agree with partner agencies what is being measured.
Finding 6	Make recommendations to the Courts that when someone is banned from premises the owner of the property should be notified.	BSAB	June 2018	Include in published SAR Report and to escalate to National SAB and HRC
Finding 7	See Finding 2 as linked		May 2018	
Finding 8	BSAB Toolkit updates and cascading Care Act training for mental health staff	BSAB Head of Social Care	May 2018 June 2018	Toolkit will be circulated and on the BSAB website. Joint training to be planned by Head of Social Care, Complex Care & AMH Locality Manager for AMH staff.

Finding 9	BSAB to collect all out-of-hours services and pathways and circulate throughout the partnership.	BSAB	March 2018	Will be added to the Toolkit and kept on the website. All parties will be responsible to keep Board updated on any changes/amendments.
Finding 10	Agencies to consider appropriate communication and what mitigation can be put in place where potential or likelihood of harm is identified. Create generic inboxes for teams across the agencies.	Partners	March 2018	Evidenced by communication between agencies. Including, meetings and joint visits where appropriate. For Mental Health and Housing – Care Coordinators to be informed in advance of potentially sensitive correspondence. Locality inbox already set up for communication in relation to open cases & internal referrals. Referrals inbox already in existence for external referrals.
Finding 11	When any of an agency's systems change or restructure take place, there must be consideration of potential disruption to services and steps to mitigate this put in place. All agencies to ensure that when changes occur to processes and structures that they are alert to the risks to adults risk.	Bexley Care	July 2018	Noted and to ensure service user safety and risk addressed in Bexley Care re-design.

Finding 12	See Finding 6 as linked. When any of an agency's systems or changes take place, there must be consideration and compensate for disruption on services. All agencies to ensure that when changes occur to processes and structures that they are alert to the risks to adults risk.		May 2018	

This concludes the Executive Summary and Findings publication. The BSAB Independent Chair along with the Board made the decision not to publish the full report due to living young children still residing in the area. For more information regarding the Bexley Safeguarding Adults Board please visit – www.safeguardingadultsinbexley.com

If you have a concern or are worried about an adult, please contact the Screeners Team on: 0208 303 777 or secure email to screeners@bexley.gov.uk