SAFEGUARDING ADULT REVIEW REPORT

“Jolaade”

2024

BEXLEY SAFEGUARDING ADULTS BOARD

Independent Reviewer: Mick Haggar
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1. Introduction

This report covers the findings and recommendations of the Safeguarding Adult Review, undertaken on behalf of Bexley Safeguarding Adults Board (BSAB), relating to the care of an adult (referred to as Jolaade throughout this report to preserve her anonymity). The Safeguarding Adult Review (SAR) is not intended to attribute blame, but to learn lessons from this case and make recommendations for change that will help to improve the future safeguarding and wellbeing of adults at risk in Bexley in the future.

The review was conducted in the light of the following legislation: Section 44, Care Act 2014 Safeguarding Adult Reviews. The purpose of a Safeguarding Adult Review is described very clearly in the statutory guidance as to 'promote effective learning and improvement action to prevent future deaths or serious harm occurring again'.

The Department of Health care and support Statutory Guidance – published to support the operation of the Care Act 2014, (14.168).

"SARs should seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again. Its purpose is not to hold any individual or organisation to account"[1].

1.1. Why was this case chosen to be reviewed?

Jolaade was referred to the BSAB for consideration of a SAR by the Lead nurse for Adult Safeguarding at Lewisham and Greenwich NHS Trust in July 2023. The grounds for the SAR are mandatory, under S44.1 and S44.2 of The Care Act 2014[2]. Jolaade died from natural causes while in hospital, having previously been detained under S2 MHA 83, for assessment and treatment of a mental disorder. There were grounds for concern about how agencies worked together in the days preceding her death and whether Jolaade's physical health had been neglected during her admission. Jolaade had care and support needs arising from her mental health condition and she was the mother of 3 children, her eldest son also being known to mental health services. The SAR was commissioned in December 2023, with the independent author appointed to undertake the review and chair the SAR Panel, which first convened in April 2024. The Terms of Reference for the SAR were agreed by the Panel in April 2024(see 1.3).

[1] [1]https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1

[2] https://www.legislation.gov.uk/ukpga/2014/23/section/44

1.2. Brief Summary of the case

Jolaade was 50 years old when she died after experiencing a cardiac arrest on 18th May 2023, while an inpatient in a mental health ward in Bexley, she was transferred to the Princess Royal University Hospital and died on 20th May 2023.

The Cause of death was as follows;
1a Multi-Organ Failure
b Prolonged Cardiac Arrest
c Multi-segmental Pulmonary Embolism

Jolaade was born in Nigeria and worked as a teacher, she was married and had 3 children, a son and two daughters. The family all moved to the UK in 2015 and became known to Bexley Housing Services, who accepted the family as homeless, and they were housed in Temporary accommodation from this time. Jolaade worked as a support worker up to commencing her nursing degree course in 2021. She began to experience mental health symptoms of a paranoid nature in May 2021 and had some brief contact with services via the MH Liaison Team at Queen Elizabeth hospital, then subsequently by Greenwich Home Treatment Team. She did not engage with services and was re-referred in 2022 to the Bexley Home Treatment Team (BHTT) after moving into the borough and then subsequently to the Bexley Early Intervention in Psychosis Team (BEIP). She was prescribed medication and allocated a Care Coordinator. In September 2022 Jolaade was detained under S2 MHA'83 and discharged from hospital after a month. She once more disengaged as she did not want involvement with mental health services.

In May 2023, her son phoned an ambulance, due to concerns about Jolaade not eating, or sleeping for a week. She was taken to Queen Elizabeth hospital, and she was once more admitted to a mental health inpatient ward, at the Woodlands Unit, which is situated at Queen Marys Hospital site in Sidcup, having been assessed under S2 MHA'83. Jolaade became physically unwell while on the ward, feeling dizzy and subsequently having chest pains. She was taken to Queen Elizabeth hospital for further investigations where she was found to have had a Pulmonary Embolism (PE), a blood clot, on her lungs. Jolaade had further tests and treatment for this; although despite the risks she then refused further medication. Jolaade was transferred back to the psychiatric ward 2 days after being admitted, despite her husband's concerns. She collapsed on this ward the next day, having suffered a cardiac arrest and despite Cardio Pulmonary Resuscitation (CPR) being commenced she sadly died 2 days later.

1.3. Timeframe, Terms of Reference, Methodology and Scope

A SAR Panel was established to work with the Reviewer, representing the key agencies involved and all submitted scoping reports of their contacts with Jolaade and her family. The Panel met regularly during the Review period. An integrated chronology was produced by the Independent Reviewer, covering the period from May 2021 to May 2023. This included the joint Oxleas and LGT Investigation Report.

The Following areas were agreed as aspects of the case to review as the Terms of Reference for the SAR.

1. What does the work done with Jolaade and her family reveal about how well the services available to parents and their children with mental health problems work together, including to what extent a “Think Family” approach was undertaken?

2. How well were Jolaade’s physical and mental health needs assessed and managed, both while she was in hospital?

3. Where treatment was considered under the statutory frameworks of either the Mental Health Act and/or the Mental Capacity Act, what was done in Jolaade’s case and what can be learnt about how are decisions taken, in acute and mental health inpatient settings?

4. When Jolaade was transferred between inpatient settings how well was information shared about her needs for treatment and were proportionate steps taken to manage associated risks?

5. To what extent were issues of Jolaade’s ethnicity, culture and family considered in how services worked with her and her family?

1.4. Agencies that were involved on the SAR Panel for the review:

- Bexley Adult Social Care Services. Head of Safeguarding Adults
- Bexley Adult Social Care Services. Head of Integrated Commissioning and Quality Assurance
- Dartford and Gravesham NHS Trust. Safeguarding Adults Lead
- South East London Integrated Care Board. Named GP and Designated Nurse for Safeguarding Adults
- Healthwatch Bexley. Local Authority Representative and Manager
- Oxleas NHS Foundation Trust. Trust Lead Safeguarding Adults Prevent
- London Fire Brigade. Borough Commander
- Bexley Housing Services. Manager
- Lewisham and Greenwich NHS Trust. Lead Nurse for Adult Safeguarding
- Metropolitan Police. Case Review Officer SCRG.

1.5. Reviewing expertise and independence

An Independent reviewer (Mick Haggar) was appointed by the SAB Chair to undertake the SAR and is the author of this report. Mick is a registered social worker, has worked in safeguarding adults, mental health and learning disabilities for over 25 years and is an experienced reviewer, having completed more than 30 reviews (SARs, SCRs). This report has been completed based on submissions of Individual Agency Documents, conversations with individuals, reports, and Chronologies from agencies (outlined above).

1.6. Structure of the Report, Acronyms and terminology explained.

Section 2 of the report considers what happened in the period subject to review, this is sub-divided into a series of periods of the chronology, called Key Practice Episodes. Section 3 then analyses the practice found against each of the Terms of Reference for the SAR. The Findings with associated recommendations for the BSAB following this review are set out in Section 4. In Appendix 1 the abbreviations used are explained. References are also made to professional jargon and key supporting documents, which are both in footnotes throughout the report and these are further explained in Appendix 2.

1.7. Involvement of family members

The input and opinions of family members are an important aspect of the SAR process, both to inform them of the review, and to take account of their first-hand experience of services provided to them/their relative. Both the Manager of the BSAB and the Independent Author wrote to Jolaade's husband to inform him of the SAR and invite his comments, however, to date no response has been received. In view of this, the report does not include the family perspective on care provided to Jolaade. This is acknowledged as a significant omission in the SAR process.

2. SUMMARY OF THE CASE

2.1. History and summary of events prior to the Period subject to review

Jolaade was born in Nigeria; she completed her primary and secondary schooling there. She studied Geography at University and worked as a teacher for 8 years. In 2004 she moved to Italy with her husband Tayo who had employment there, however she was unable to find work in Italy. Jolaade and her husband had 3 children, her son who was aged 20 and her two daughters who were aged 17 and 15, at the time of her death in 2023.

The family all moved to the UK in 2015 and became known to Bexley Housing Services, who accepted the family as homeless, and they were housed in Temporary accommodation. Jolaade worked as a support worker up to commencing her nursing degree course in 2021.

KPE 1 May 2021-September 2021
Tayo started to notice behaviour changes when she started her second placement for her nursing course, in May 2021. Jolaade had started to express that colleagues had been tampering with her card and other things in the clinical area. She had become increasingly paranoid believing that her WIFI had been hacked, she was talking about cameras in her house and Ju Ju[3]. Police were then called to the Greenwich University Campus, by Jolaade, in the belief that she was being followed and told officers she had electrical implants in her stomach and head. It was clear to the officers she was experiencing delusions and so they took her for assessment at QE Hospital.

On assessment by the MH Liaison, she presented with paranoid beliefs and delusional thoughts, consistent with a first onset of psychosis. The outcome of this was she was referred onto Greenwich Home treatment Team (GHTT) and staff from ED referred the family to Children's Services, via a MASH Referral, however there was no record of a response to this referral from Bexley MASH, so this may have been to Greenwich MASH Team. Due to her mental health Jolaade had to defer her nurse training course.

As her home address was then in Greenwich she was followed up by the Greenwich Home Treatment Team (GHTT) after this assessment, but she did not engage with them. Her children were looked after by her husband and Jolaade did not wish to take prescribed medication

In June 2021 the GHTT referred Jolaade to the Bexley Early Intervention in Psychosis Team, however Jolaade was inconsistent with her engagement with this team. Jolaade denied having been psychotic and was discharged from GHTT in July 2021. Then

[3] Juju is a spiritual belief system incorporating objects, such as amulets, and spells used in religious practice, as part of witchcraft in West Africa. The term has been applied to traditional African religions. https://thenationonlineng.net/nigeria-under-the-spell-of-juju/

Jolaade called the Met Police in August and September 2021, who subsequently shared information with Oxleas, via Merlin Reports as her conversation sounded paranoid in nature.

KPE 2. March 2022-July 2022

Jolaade was visited by the Bexley Home Treatment Team (BHTT), who subsequently transferred her case to the Bexley Early Intervention in Psychosis Team (BEIP). Jolaade had engaged well with the BEIP, her medication and health plans were reviewed. She was allocated to a Care Coordinator and engaged well with a women's group. Oxleas checked with Bexley Children's services but were told that the family were not known to them.

Jolaade was seen at her GP surgery in July 2022 for a pre-diabetes check by the practice nurse. She did not want to discuss options around diet and exercise to manage this and did not to be referred onto the diabetes prevention team. This was her final contact with the GP practice. Jolaade also disengaged from BEIP Team and despite encouragement including a door step visit she stopped taking her anti-psychotic medication. Her husband was contacted later in July and said there was now a focus on their son, who had started showing symptoms of a mental health problem and was under the care of the Bexley Home Treatment Team (BHTT). The BEIP Team continued to attempt engagement with the whole family until Jolaade's mental health declined in September 2022.

KPE 3. September 2022-April 2023.

An approved Mental Health Professional (AMHP) called police for attendance to implement a warrant under s135 (1) MHA'83 to enable Jolaade to be removed to a place of safety for an assessment of her mental health. There was a significant delay in police response to this (due to the death of the Queen) and the request was chased up again in mid-September, with the MHA '83 assessment completed on the 21st September, resulting in Jolaade being admitted into the Woodlands Unit under S2 MHA'83. Her Care Coordinator from the BEIP Team stayed in touch with her throughout her admission and offered support groups for her partner.

At the end of October another MASH Referral was made to Bexley Children's Services, as Jolaade was caring for her children during home visits from hospital. Jolaade was then discharged home and back to the care of the BHTT. They reported that Jolaade still had no insight into her mental health, and they transferred her in November back to the care of the BEIP Team. Her Care Coordinator then chased up the earlier MASH referral to Children's Services, who informed that there was no role identified for Children's Services, as her children were in the care of their father.

Jolaade had sporadic engagement with her Care Coordinator (CC) from the BEIP Team from November onwards. Jolaade was prescribed Zuclopenthixol[4] tablets 2mg twice daily. In November 22, her CC from the BEIP team had some contact with

[4] Zuclopenthixol is a first generation antipsychotic. It is also known by the trade name Clopixol, Clopixol Acuphase and Clopixol Concentrate. https://www.mind.org.uk/information-support/drugs-and-treatments/antipsychotics-a-z/zuclopenthixol/

Jolaade's husband, who reported that she was taking her medication and was doing well.

There were attempts to arrange a handover meeting and she was seen at home, where she reported feeling sleepy from the medication but otherwise was ok, apart from her financial difficulties. She continued to be seen sporadically by the BEIP CC.

At a Care Programme Approach (CPA) review she was reluctant to remain on medication and to meet with her CC, who she blamed for her admission. She gave permission for her previous employer to be contacted, as she wanted to return to work. She declined to be seen in December by her CC but was seen for a review in January 2023, at which she wanted to stop her medication, as she felt it was preventing her return to work. In February, she was seen in person, she declined offers of follow up and did not attend appointments with her CC, she was spoken to on the phone at which she requested a reference and felt her problems were spiritual, rather than with her mental health.

In March again this pattern of disengaging continued, with Jolaade refusing offers of appointments with her CC and she did not attend a medical review. When she was spoken to by phone in April she wanted to be discharged from services so she could get a job. She was angry when asked about her son and did not want to meet or to discuss him with her CC. She did not attend appointments offered throughout April.

KPE 4. 3rd May 2023-14th May 2023

On the 3rd May 2023, the BEIP Team consultant and Care Coordinator both met with Jolaade's husband, he spoke of being under financial strain and asked for support in obtaining a Personal Independent Payment (PIP) application form for Jolaade. He reported that Jolaade was 50-60% like her normal self and that her sleep was poor. She rarely mentioned anything about people taking her identity or entering their home. However, he did ask for her medication to be given in the form of an injection, although he was told that she would have to agree to this and it does not appear that she did. The following day it appeared that Jolaade booked a GP appointment for stomach pains, but she did not attend this. There was consideration of discharging her from the service if she did not attend appointments with BEIP.

On the 5th May 2023 Jolaade's son phoned for an ambulance, as he was worried about her, stating she had not been eating, drinking, or sleeping for a week and had been experiencing hallucinations again. Her son stated that his father was on his way to the airport to fly to Italy and had advised his son to call an ambulance. When the ambulance crew attended Jolaade's home she shouted at them to go away and that she did not want to be injected. The ambulance crew phoned for police assistance, who also attended and took Jolaade to Queen Elizabeth hospital and her care was handed over at 1.30 am. Her husband had returned from the airport to care for his children, due to this situation, the police had stayed with the children until he returned.

The Mental Health Liaison Team (MHLT) were asked to assess Jolaade and an assessment was carried out at 05.40 am. Jolaade had previously had blood tests done

by the Emergency Department Dr and refused to engage with this mental health assessment until she knew the results of her blood tests, which subsequently were reported to be normal at that time. Jolaade did not want to remain in hospital for further voluntary assessment and she was then referred for an assessment under the MHA'83. Her risk to both herself and others was viewed as high. Her son was with her at the hospital.

At 11.00 am, having been moved to the Mental Health Assessment area of the hospital, Jolaade agreed to have her vital signs checked and these were all within the normal range, including a blood test. No imaging was done, but there was no indication this was necessary. Later that afternoon the MHA'83 assessment was undertaken, and Jolaade remained in this assessment area overnight, while a bed was sought for her on a Mental Health Ward. Jolaade refused medication and accused staff of trying to kill her with electricity. Also, that the NHS wanted to take away her children. She was transferred to the Woodlands Mental Health Unit in Sidcup, under S2 MHA'83 at 16.30 pm, the next day (7th May 2023).

Her 2 teenage daughters were thought to be under the care of their elder brother, as Jolaade's husband was believed to be out of the country at this time and a referral was made to Children's Services by Lewisham and Greenwich Trust (LGT). However, her husband had remained in the UK, he was spoken with and agreed for a referral to Children's services.

When she was admitted, the Dr reviewed the bloods which had been taken the previous day and found evidence of mild dehydration and she had a high Blood Pressure, but they were otherwise unremarkable. An assessment of her capacity was also documented, Jolaade was unable to engage in her discussion about her admission and lacked insight into her mental health, she was therefore deemed to lack capacity regarding her admission. Her clerking assessment was completed at 18.30, Jolaade declined to have an ECG at this time and when this was offered again the next day (8th May 2023).

On the 9th May the MASH Team reviewed the referral from LGT for Jolaade's daughters and contacted their father, resulting in the case progressing for an assessment, with the family allocated to a social worker. The Referral and Assessment team manager provided case direction to the allocated social worker in Children's Services;

- to contact Tayo and arrange to see the daughters at home,
- complete an interim safety plan,
- undertake direct work,
- consider a referral to young carers,
- explore the family network and what support might be needed,
- confirm Tayo's residence and, if regularly in Italy, who cares for the children,
- explore Jolaade and SB's mental health
- liaise with the mental health team alongside other agency checks.

Meanwhile Jolaade complained of back pain and was given paracetamol for this, later that evening Jolaade was seen to be lying on the floor, having urinated. Jolaade refused to have her vital signs checked but was observed to be breathing normally at

this time. Two days later (10th May 2023) Jolaade again refused offers of a physical examination and for her vital signs to be checked.

On the 11th May her CC visited her on the ward, she believed staff were trying to poison her and she wanted to be discharged. Her husband visited her on the ward and wanted a carer to be arranged for Jolaade and her son, which her CC said she would pass on to her son's CC. The next day (12th May 2023) Jolaade reported feeling dizzy, with the duty doctor advising fluids and monitoring to be done. Jolaade said this feeling had started when she came onto the ward and felt she had difficulty walking. The doctor noted her vital signs that had been taken earlier (Oxygen Saturation 96%, Pulse 116, Blood pressure 94/67, temperature 37.1, Respirations 18, blood glucose 8.9). Blood samples were also taken, and the doctor advised for her to be taken back to ED for more tests to be done. He prepared a letter to accompany Jolaade and informed the night duty doctor of this plan, however Jolaade was not transferred to ED that evening or the next day, it was not clear from the records why this was not done during this time.

In the afternoon of the 14th May 2023, the duty doctor was asked to see Jolaade again, as she was refusing to have her vital signs checked and reported feeling dizzy. Jolaade stated that she felt "staff were trying to kill her and had spread toxins and medications everywhere". She wanted to know the results of her blood tests that had been taken on the 12th May, when these were reviewed the duty doctor recorded they along with her chest pains, were indicative of Jolaade having had a likely Myocardial Infarction (cardiac arrest) or type II cardiac ischemia[5] (heart disease) along with an acute kidney injury.

He advised Jolaade to go to ED at 16.39 for further tests, but she refused despite encouragement from staff and her husband, who had visited the ward. The duty doctor then took advice from a senior that Jolaade likely needed urgent medical treatment under the MCA '05, as she lacked capacity and to prescribe a sedative to make her more amenable to be transported to ED. At 20.42 that evening a secure ambulance arrived by Jolaade still refused to go and the ambulance left. A further discussion with the doctors at 23.28 stated that as her life is at risk rapid tranquilisation, or as a last result restraint is warranted to facilitate her transport to hospital. She was finally transported to Queen Elizabeth hospital at 1.55 am of the 15th May 2023, after being given Lorazepam at 1.25 am. The on-call SHO wrote a letter to accompany her transfer, which summarised her recent physical symptoms and blood test results. This letter advised that she was detained under S2 MHA, as was felt to lack capacity and that as her physical health takes priority it was best to transfer her where she can be managed under the Mental Capacity Act. The ward contact details were also included.

KPE 5. 15th May 2023- 30th May 2023

On arrival Jolaade was declining all medical interventions but was given an x-ray and IV fluids. She was reviewed by the medical team at 5.38 am at which point she was

[5] **https://www.nhsinform.scot/illnesses-and-conditions/cardiovascular-disease/heart-disease/coronary-heart-disease/#:~:text=Coronary%20heart%20disease%20(CHD)%20is,flow%20is%20caused%20by%20atherosclerosis.**

told it was a high probability she had a Pulmonary Embolism (PE)[6]. It was felt Jolaade lacked capacity to consent to investigation or treatment for this, as she was unable to retain or weigh up the information given to her. At 5.57 am, an Echocardiogram showed that she had a significant PE and was given anticoagulant medication (Clexane and Enoxoparin) for this at 8.00am. At 9.40 am Jolaade was reviewed by a consultant and was very anxious, her husband was called and asked to attend the hospital.

On 15th May 2023 the allocated social worker from Children's Services contacted Tayo. He reported Jolaade was in the hospital, he was driving and could not speak.

At 12.00 Jolaade was cannulated and given IV fluids and medication (Sodium Bicarbonate) to help with her acute kidney injury. She had a pulmonary angiogram (an x-ray of the lungs blood vessels) at 17.00, which confirmed the PE, and the plan was for Jolaade to be admitted ensuring compliance with the treatment for this. She was then transferred to Ward 1 (a general medical ward).

On 16th May 2023 Jolaade had her blood pressure and pulse taken and was reviewed by a consultant at 12.37, with a resultant plan to change her medication (to rivaroxaban[7], another anticoagulant) however no blood samples were taken at this time. At 13.51 and again at 18.31 it was recorded that Jolaade refused to take her medication, she told the nurse that she did not trust anyone and that was why she refused this. The nurse recorded that Jolaade was orientated in time, place, and person. However, the prior judgement around Jolaade's capacity was not considered, she also refused to have a bladder scan at this time. No medication was given as a Best Interests Decision at this time. Jolaade's antipsychotic medication had been stopped by the pharmacy when she was admitted to QE. She did say she may take medication if her husband was present, and the doctor attempted to contact him on 3 occasions.

On the 17th May 2023 Jolaade complained of feeling feverish at 7.00 am and was given paracetamol, without being reviewed and at 12.44 she was reviewed at a ward round, at which the doctor documented that her acute kidney injury had resolved, although no blood tests were done to confirm this. He later stated he should have said it was resolving, especially as this was taken as a reason to support her discharge. Later the Senior House Officer (SHO) recorded a conversation with her husband, who was concerned that she was not taking medication, he was told this was Oxleas responsibility. He also stated that there was an Oxleas staff member at her bedside throughout the admission and on discharge he would include in the discharge letter that Oxleas are to ensure her compliance with medication, due to their importance.

Meanwhile the social worker from the Children's Services contacted Jolaade's husband again about the previous referral concerning his daughters. He reported that his wife was due to be discharged and had an allocated care coordinator from the Mental Health team. He stated the family had financial difficulties but were otherwise ok, he was caring for his daughters, and they were doing well. He declined an

[6] https://www.nhs.uk/conditions/pulmonary-embolism/
A pulmonary embolism is when a blood clot blocks a blood vessel in your lungs. It can be life-threatening if not treated quickly.
[7] https://www.nhs.uk/medicines/rivaroxaban

assessment as he did not think this was needed. He did not feel his wife's mental health had impacted her parenting, reported the children were ok and they had the support they needed. The child and family assessment was completed with this information and, as father had declined to work with the social worker, neither of his daughters were seen as part of this. There was also no contact with Jolaade, her son (SB) or any professionals working with either of them and the case was closed to Children's Services.

At 16.12 Jolaade again refused her medication and wanted to go home. Her husband was not called to persuade her, and no best interests decision was taken to administer these. Her compliance with medication was not further explored and her vital signs suggested Jolaade's observations were not normal, slightly tachycardic and hypotensive (low blood pressure and high pulse)[8]. Jolaade was irritable with nursing staff, shouting, and disturbing other patients overnight. A secure ambulance was booked to return her to the Woodlands Unit, and she arrived there at 21.00

No handover took place between the medical teams, as this transfer happened overnight, but the Oxleas escort, a non-qualified member of staff, did return to the MH Trust with Jolaade. The duty doctor then reviewed her at 22.18, having reviewed the discharge letter and London care Record. However, this information stated she had refused medication on the day, but not that she had refused this for 2 days previously.

The discharge summary stated that she was put on a treatment dose of enoxaparin[9] (injectable anticoagulant) and switched to Rivaroxaban[10] (a tablet form with a recommendation for 21 days of the anticoagulant at dose 15 mg BD and 20 mg OD for 6 months) and for staff to encourage her to take it. The discharge summary stated she was medically stable and fit for discharge. It also stated that the receiving team ensure medication is administered and ensure any necessary protocol which was applicable. It did not specify the importance of the medication, nor that Jolaade was not accepting or taking this. It did state she had refused her antipsychotic tablets and that these had been stopped as a result, despite the fact that she remained under S2 of the MHA '83.

On the 18th May 2023 her husband shared his concerns over Jolaade still not taking her medication and mentioned he had previously said the same to the team at QE hospital before she was discharged. At 9.53 the doctor from the Mental Health ward attempted to contact the consultant at Ward 1 in QE. Jolaade's husband then left the ward and Jolaade was grabbing his clothes to prevent this. At 10.23 am it was documented again she refused medication and to have her vital signs monitored. At 11.00 Tayo was contacted by the ward and agreed to attend ED with her if she was returned to QE hospital.

At 11.57 the consultant called back, and it was agreed to return Jolaade to ED. As Jolaade looked OK in the words of the doctor on the MH Trust ward, there was no sense of urgency about her return to ED. At 12.15 doctors were called to attend

[8] https://www.medicalnewstoday.com/articles/low-blood-pressure-high-pulse#:~:text=If%20the%20blood%20pressure%20is,blood%20pressure%20and%20high%20pulse.
[9] https://bnf.nice.org.uk/drugs/enoxaparin-sodium/
[10] https://bnf.nice.org.uk/drugs/rivaroxaban/

Jolaade, as she collapsed and was gasping for air. The doctor checked for a pulse but could not find one and started CPR. Oxygen and a Defibrillator were brought from another ward. When this was attached it advised a non-shockable rhythm. Jolaade had suffered a cardiac arrest and was conveyed to Princess Royal Hospital, where she sadly died.

3. Analysis of Practice against Terms of Reference

This section contains comments on the practice found in this case, set out against the agreed Terms of Reference for the SAR. These are taken from a review of the information set out in Section 2 and currently contain questions that require further follow up information and discussions with SAR Panel representatives for agencies involved with Jolaade during the period subject to review.

3.1. Term of Reference 1. What does the work done with Jolaade and her family reveal about how well the services available to parents and their children with mental health problems work together, including to what extent a "Think Family" approach was undertaken?

When Jolaade became known to mental health services in 2021, she was known to be the mother of 3 children. At that time her daughters would have been 16 and 13, her son would have been 17-18. As Jolaade became unwell and was first taken to QE for assessment in May 2021, her husband appeared to be looking after the children. Jolaade was known to GHTT, and they referred the family to Children's Services via a MASH report (this may have been Greenwich as Bexley Children's Services have no records of this)

Jolaade made calls to Police in August and September of 2021, which precipitated Merlin Reports being sent to Adult Services and then onto Oxleas, as they were described as paranoid in nature. There were no records available from either Children's Services nor Oxleas on any specific response to these, however as she was open to services at the time there was no requirement to do so.

In March 2022 Jolaade had been allocated to Bexley services and was visited by the BEIP Team, it appeared that Oxleas contacted Bexley Children Services but were told the family were not known to them.

In July 2022, Jolaade had disengaged with BEIP Team, and her husband stated the focus was now on their son, who had shown signs of his own mental health problems and had been referred to and accepted by the Bexley HTT.

In October 2022, Jolaade had been detained under S2 MHA'83 and was an inpatient of the MH Trust, she was visiting her children at home during periods of leave, and she returned home. A MASH referral was made to Children's Services about this, for support with the care of children. Her Care Coordinator from BEIP Team chased up this referral in November and was informed there was no role for Children's Services, (although CS had not given any feedback to CC).

On 3rd May 2023 her husband had a meeting with Jolaade's Care Coordinator and Consultant from BEIP Team and discussed family financial concerns and Jolaade's current mental health issues. The arrears team from the Bexley Housing Department were in regular contact with Tayo at this time, having previously issued a notice to quit the temporary accommodation over rent arrears. He worked with the team to resolve this and the notice to quit was withdrawn.

On the 5th May 2023, it was Jolaade's son who called an ambulance for his mother, as he was concerned about her mental health, and it was this that precipitated her subsequent hospital admission. There was then a further referral to Children's Services by Lewisham and Greenwich Trust (LGT) as her 2 daughters were in the care of her son. It appeared from notes available her husband had returned home from the airport, as he visited Jolaade at QE and was spoken to both then and on the ward on the 14th May 2023.

From information available to review regarding the response to the MASH in 2023 by Children's Services contact was made with Jolaade's husband. Tayo declined intervention, limiting the possibility of information sharing, in the form of agency checks, with multi-agency partners. Consequently, there is no evidence of liaison with mental health services during the assessment aside from MASH utilising the information provided by them in their referral throughout the triage. Furthermore, there is no evidence the social worker revisited the importance of liaison with these colleagues to assure them of the information he was providing and to plan together with how to support him and his family. (The family has since accepted an offer of accommodation via Bexley Housing Department, from the private sector, and been re-housed in a 4 bed maisonette.)

Finding 1.

3.2. Term of Reference 2. How well were Jolaade's physical and mental health needs assessed and managed, both while she was in hospital?

Several issues arose during the review of Jolaade's medical care while in both the MH Trust and Ward 1 of QE Hospital. These were highlighted through the SI report, undertaken jointly by Oxleas and Lewisham and Greenwich Trusts.

Prior to her admission to Woodlands Unit, she was detained under S2 MHA'83 and it was documented that she lacked capacity to consent to treatment. These issues are explored further below in 3.3 but are relevant here for both what treatment she was thought to need for her physical and mental health problems and what the response was to her refusal to accept this.

Her mental health needs appear to result from a deteriorating psychotic and paranoid mental illness, for which she was prescribed anti-psychotic medication (Zuclopenthixol 2mg tablets twice a day) but which she had not been taking in the community.

Her physical health while in MH Trust for this 8-day period was checked on several occasions, her blood results for a test given while awaiting her MHA Assessment in the Mental Health Assessment area at QE showed she was dehydrated (her son had previously called the ambulance on 5th May, partly as he was concerned she had not been drinking). During her clerking in process on the 7th May, her vital signs were checked as being normal, with a slightly high Blood Pressure, but she declined an ECG.

At this time, she believed there were bombs in her house and her food was being poisoned, so clearly her untreated paranoia had a direct bearing on her decision making regarding medical treatment and she again refused an ECG on the 8th May,

after being found on the floor and having urinated. On the 10th May she was again offered physical investigations but refused to engage, she was seen on the ward by her Care Coordinator, her husband was present, and she was concerned her identify had been stolen, clearly she was still quite unwell. She wanted to go home. Her husband had requested a carer for her and the children.

On the 12th May she was reported to be feeling dizzy on the ward and again refused to engage with the duty doctor, however bloods were taken from her and sent for analysis, and she did tell the duty doctor she was finding it difficult to walk as she felt like falling. She wanted to be seen by a physical health doctor at the Urgent Care Centre on the same hospital site. Her vital signs (Blood Pressure, Oxygen Saturation and Pulse Rate) were taken, and the doctor recommended she be taken to ED, for further evaluation. She was encouraged to take fluids. On the afternoon of the 14th May, again the duty doctor was called as Jolaade was feeling unwell, while refusing to have her vital signs monitored. The duty doctor then reviewed her earlier blood test results for the first time and identified a likely cardiac arrest and acute kidney injury.

The SI report recommendations around ensuring timely review of blood tests and as an action the trust had reviewed its policy and now there is a report template for the duty senior nurse which has been updated and the shift coordinator to ensure where the patient needs to go for acute hospital assessment this is actioned as a priority. It has been checked via audit and shown to have been completed.

Following the review at 16.00 on the 14th, there was then a significant delay until Jolaade was conveyed to ED at 2.00 am the next morning 15th May, after being sedated through rapid tranquilization, as a Best Interests Decision, following a Mental Capacity Assessment and in consultation with SpR during the evening of 14th. She had previously declined to go to ED, or have further checks, she also refused to get into an ambulance earlier in the evening. A letter summarising her mental and physical health problems was sent to Hospital with her, for information by the receiving Dr. This did include a view that Jolaade lacked capacity, which was why she was detained under S2 MHA'83 and advised she could be managed under the Mental Capacity Act. It did not specify what decision she lacked capacity for (it implied but did not state this was for her mental health) and did not include an actual MCA assessment which would have a been helpful prompt for QE staff to consider, although QE would still have needed to complete their own time and decision specific assessments, to determine whether Jolaade could take a decision about her physical health and associated treatment.

When Jolaade was seen at ED on the 15th she was diagnosed with a Pulmonary Embolism and her capacity was assessed for treatment for this, by the senior doctor at ED, following which she was deemed she lacked capacity for investigations and treatment, so she could be therefore treated in her Best Interests. Medication for her PE was prescribed for her in an injection form and security were called to restrain Jolaade for this to be given and she was admitted to Ward 1. She was changed to a tablet-based medication for anti-coagulants to treat her Pulmonary Embolism when she moved upto Ward 1, but she refused medication from this time on the 16th.

Jolaade was clearly paranoid and refused physical examinations, for example further scans and blood tests. However, the medical team in charge of her care were not

subsequently involved in any further review of her capacity to take these decisions to refuse critical and life sustaining treatment while on Ward 1 and no capacity assessments were done from this time onwards.

Despite her husband's concerns about her ongoing refusal to take medication to treat her and his related objections to her being discharged, she was transferred back to MH trust in the evening of the 17th, with a discharge letter but no verbal handover to the medical or nursing team there.

The SI report also recommended Queen Elizabeth hospital and Oxleas Mental Health Trust ensure adequate handover when patients are transferred to Oxleas.

Jolaade was then seen by a duty doctor at Woodlands Unit, who prescribed her anticoagulant medication still in tablet format, as advised by the QE discharge summary, which also advised the treating team should follow any necessary protocol. This implied the treating team should respond to any changes in her condition or compliance but did not specify either of these things. The duty doctor advised nurses to encourage Jolaade to take her medication and monitor her vital signs (Sats) and consider medication in injectable form if she refused the tablets. However, Jolaade continued to refuse medication and further refused to have her vital signs monitored by nursing staff at the ward over the evening of the 17th and morning of the 18th. No capacity assessment was done of Jolaade's ability to take these decisions to refuse treatment. The duty doctor then had a telephone consultation with the medical team in QE the next day and subsequently planned for Jolaade to return to ED again on the 18th just before 12 mid-day, but 15 minutes later she collapsed on the ward and suffered a cardiac arrest. She then is moved to another hospital (Princess Royal University Hospital ICU), where she died on the 21st of May 2023.

Finding 2

3.3. Term of Reference 3. Where treatment was considered under the statutory frameworks of either the Mental Health Act and/or the Mental Capacity Act, what was done in Jolaade's case and what can be learnt about how are decisions taken, in acute and mental health inpatient settings?

As outlined above throughout the final admission Jolaade had been detained under S2 MHA'83 for assessment and treatment of her mental health. She was deemed to lack insight into her paranoid and psychotic symptoms and thought to be a potential risk to both herself and others. The AMHP assessment was provided for the SAR, and this clearly documented how her paranoid delusions had led to her refusal of food and fluids, due to her belief she was being poisoned. The reason for her detention under S2 MHA '83 clearly linked the risk to her physical health as a direct result of her paranoia and refusal to eat/drink.

Due to this legal status treatment for her mental disorder can be given against her wishes, but she couldn't be given treatment for her physical health unless this was viewed to be either a symptom or cause of her mental disorder, which was not the case. However, where treatment was deemed to be in the Jolaade's Best Interests and she lack capacity for this decision, it could have been lawfully given under MCA '05, if it was also given in the least restrictive way. There were several references to

her capacity recorded and she was thought to lack capacity for the investigation and treatment for her PE at several points. On the 14th May Jolaade was conveyed to QE hospital for this investigation and treatment as a Best Interests decision, although there was a significant delay from the day time when this was recommended, until 1.55 am on the 15th May. This delay was partly due to resource issues for a secure ambulance, as Jolaade persistently refused to go, despite staff attempts to encourage and persuade her. This complexity was resolved after guidance from an on-call senior at 17.30, but as above, she did not actually leave the ward for some hours.

In respect of the investigations and treatment offered to Jolaade during her transfer to and subsequent brief admission at QE, she could also have been lawfully given this under the Best Interests principle where she was assessed as lacking capacity. Interestingly this was done while she was in ED, where she had blood tests, a scan, IV fluids and medication for her subsequently diagnosed PE. However, when she was then admitted to Ward 1 she refused tests and medication, but this was not given to her as a Best Interests Decision, following a Capacity Assessment, as no such assessment was undertaken.

There seemed to be a lack of understanding and application of the MCA '05 during her stay on this ward from the 16th to 17th May and she was transferred back to the MH Trust. No MCA assessment or Best Interests decision was taken at that time to treat her, but there may have been some decision taken that she was physically well enough to return to the mental health unit.

In the SI report it states 'JB was not medically stable, JB was slightly tachycardic and hypotensive, and declining anticoagulant medication in the presence of a confirmed PE. JB should not have been discharged back to an acute psychiatric unit. JB had been refusing her critical medication throughout her admission and there was no exploration of this, and no measures were put in place to ensure that JB received critical medication'.

The recommendation for this states 'The case will be presented in the Divisional "Sharing the Learning" Event. The Consultant involved will reflect on the case. Given the non-compliance with medication, the patient should have been established on treatment before discharge'.

Again, from the time of her return to her collapse the following day no MCA or Best Interests Decisions were taken to treat her PE with an injectable form of anticoagulants, which undoubtedly increased the risk of her subsequent fatal cardiac arrest. Although her prescribed medication was in tablet form, with sufficient guidance from QE on this, it could have been switched to an injectable medicine (as was what had initially been prescribed and administered by the doctor following a MCA assessment, as being in her Best Interests when she was assessed in ED). However, this medication was not readily available to the Oxleas Team on the hospital site.

The SI report also identified the failures in knowledge and application of the MCA at QE hospital, in response to this training has been provided to staff, using this case and there are plans for a future learning event to explore the issues in more detail.

Finding 3.

3.4. Term of Reference 4. When Jolaade was transferred between inpatient settings how well was information shared about her needs for treatment and were proportionate steps taken to manage associated risks?

During the transfer of Jolaade from MH trust to ED on the night of the 14th/15th May there was little medical information shared as part of this process, other than a letter about her psychosis, chest pains and abnormal blood test results as the reason for this urgent transfer. This letter stated she was being treated under the MHA '83 as she lacked capacity and that her physical health was now a priority which should be treated under the MCA '05. It was noted that throughout her stay at ED and afterwards on Ward 1 she was accompanied by a unqualified member of staff from Oxleas as an escort only and so they did not have a role to support sharing of information, or advice to acute medical practitioners.

Of relevance here would have been a psychiatric assessment of the relevance of Jolaade's mental disorder for her capacity to make decisions about her physical health, which did not appear to have been explicitly provided and would have been helpful for subsequent MCA'05 assessments and related Best Interests Decisions. The SpR who reviewed her at ED was clearly of the view that she lacked capacity to consent to the transfer and proposed restraint/sedation to take her to ED, this would have been helpful to inform the subsequent need for further MCA assessments when Jolaade subsequently refused medical treatment in hospital.

Also, when Jolaade was transferred back to the MH Trust, in the evening of the 17th May, there was no handover done for the receiving team to consider the risks to her physical health and the urgency of ensuring she took required medication for her PE. The written transfer summary only specified that she had refused medication on that day and did not state she had also continued to refuse it since her admission 2 days earlier to Ward 1 from ED. This may have contributed to the lack of urgency for the decision on the 18th to return her to ED as she continued to refuse this medication prior to her collapse in the MH Trust ward the next day.

Finding 4.

3.5. Term of Reference 5. To what extent were issues of Jolaade's ethnicity, culture and family considered in how services worked with her and her family?

No reference has been found to the relevance of Jolaade's ethnicity and culture in records supplied so far for this SAR, although her ethnicity was clearly documented in her notes. Her beliefs about her experiences as related to Ju Ju were relevant to her perception as to whether she had a spiritual rather than a mental health problem, but these were not considered nor explored with her in a culturally informed or sensitive manner. The issues in relation to her family situation as a mother to three children and to her relationship with her husband have also not been well addressed, for example there was no record of a Carer's Assessment for him, nor in relation to his feelings about his role as a carer and whether he was willing or able to continue to care for her.

Also, her son (18 at this time) who was also mentally unwell, was left in charge of his sisters and what his needs for support were as a young carer, especially considering

his mental health, which we have no details of for this review. Jolaade and her families' ethnicity and culture did not appear to inform and decisions about what might affect her understanding and ability to engage in discussions with professionals about physical and mental health, or the potential risks to her children arising from the social and economic pressures her family were experiencing.

Finding 5.

4. Findings and Recommendations from the Review

This section contains the priority findings from this SAR, from analysis of the work undertaken with Jolaade and her family. Recommended actions in response to each Finding for service improvement are set out for the Bexley Safeguarding Adults Board in this section of the report.

4.1. Finding 1.

From the information currently available to the SAR there is no evidence to support the work done with Jolaade or her family reflected a Think Family approach by Children's Services, despite several attempts to refer Jolaade and her children by Oxleas Staff where there was evidence of consideration of the impact of her mental health on her ability to parent her children.

Recommendation 1.
That Bexley Children's Services gather sufficient relevant information from Oxleas following the receipt of a referral to MASH, when considering the need to visit Families affected by risks associated with parents experiencing serious mental health problems, especially where a parent is subject to formal treatment under the Mental Health Act '83.

Recommendation 2.
That guidance for staff in Bexley Children's Services is developed to enable practitioners to evaluate one parent's refusal of consent to assessment or to share information in the light of a strengthened approach to Think Family work, with parents have serious mental health problems.

4.2. Finding 2.

From the information available to the SAR there were significant failures in both MH Trust and Ward 1 QE hospital in Jolaade's treatment for her physical health. There were several recommendations highlighted in response to these in the SI report and it remains necessary for both Oxleas and L&G Trusts to update the SAB on the progress made in response to these recommendations, including progress on an updates transfer of care policy.

Recommendation 3.

That Oxleas staff ensure completion of transfer of care checklists and include a relevant recent capacity assessment, alongside a medical opinion about capacity, where the patient has been refusing interventions in relation to a proposed plan to assess their acute physical health problems. As part of this transfer, that staff accompanying a patient to ED are aware of this and able to raise this with the receiving team, as part of the overall handover of care.

Recommendation 4.

That QE hospital discharge summaries for patients being transferred back to Oxleas after physical health treatment include sufficient details of the diagnosis, treatment and most importantly guidance on whether the patient is currently and has been compliant with prescribed medication for a serious physical health problem during their admission, and if not, whether this decision was accompanied by a capacity assessment, before they are transferred from hospital.

Recommendation 5.

Where a patient is recommended to be medically fit for discharge from QE hospital, this includes whether they are stable and compliant with essential treatment and that their family carers are involved wherever possible, as part of the consultation required in the Best Interest Decision Making by the medical decision maker, before the patient is subsequently discharged and that this is also clarified in the written transfer of care summary.

4.3. Finding 3.

There were significant failures in the knowledge and application of the MCA in QE hospital by nursing/medical staff and a review of progress in improvements of practice in this issue is clearly required. The assessment of Capacity which was done in ED showed Jolaade lacked capacity and needed urgent medication in her Best Interests, this was shared but this did not inform further assessments or treatment when she was admitted.

Recommendation 6.
Increase awareness and knowledge around critical medicines and escalating omitted drugs, especially where the patient is refusing to accept these prescribed medicines and may lack capacity for this decision.

Recommendation 7.
Lewisham and Greenwich NHS Trust policy for the Management and Prevention of Omitted and Delayed Doses of medication is reviewed to ensure that information is shared and that guidance is sought, if necessary, for medication which had been previously prescribed for a mental illness (particularly where this was authorised under the MHA'83) and is then stopped by the receiving clinical team as part a review/re-assessment of the patient's physical health.

4.4. Finding 4.

There were significant omissions in the written transfer of care summary of relevant and necessary information during Jolaade's discharge from QEH to Oxleas Trust care, which put her safety at risk.

(see recommendation 5)

Finding 5.
From the information available to the SAR, there was no written record of any evidence that Jolaade's ethnicity or culture were considered in how services worked with her and particularly how her difficulties with insight and engagement impacted on her immediate family.

Recommendation 8.
For Oxleas to review any guidance which is available for both Community and inpatient staff to include some specific prompts to ensure cultural competency[11] when completing Care Plans on the DIALOGUE system, by including a specific prompt to consider what impact the patients' culture and ethnicity may have on their beliefs about their mental health diagnosis and treatment.

Mick Haggar

Independent Author

2024

[11] https://www.gov.uk/guidance/culture-spirituality-and-religion