Bexley Safeguarding Adults Board

Safeguarding Adults Review on the Adult known as 'Jolaade'

What is a Safeguarding Adults Review? A Safeguarding Adult Board, as part of its Care Act 2014 statutory duty, is required to commission SARs under the following circumstances:

*(**1**) A SAB **must** arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if:*
(a) *there is **reasonable cause** for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, **And***
(b) *condition 1 **or** 2 is met (see below)*

(2) Condition 1 is met if: -
(a) *the adult has died, **and (b)** the SAB knows or suspects that the death resulted from abuse or neglect (whether or not It knew about or suspected the abuse or neglect before the adult died)*

(3) Condition 2 is met if: -
(a) *the adult is still alive, **and (b)** the SAB knows or suspects that the adult has experienced serious abuse or neglect.*

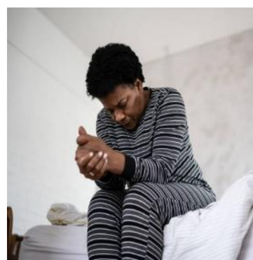
SABs can decide to undertake a SAR in any other situations involving an adult in its area with needs for care and support. Reviews should determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case, and those lessons applied to future cases to prevent similar harm occurring again. The apportioning of blame is not the purpose of the review.

About this briefing – A Safeguarding Adults Review (SAR) has been undertaken by the Bexley Safeguarding Adults Board (BSAB) in respect of an adult known as Jolaade. This briefing aims to summarise key learning from the review, to facilitate the learning being shared with SAB members, partner agencies and frontline practitioners so that learning can be embedded.

Please take time to reflect on the findings and consider how you can learn, develop, and work together to improve outcomes for, and prevent harm occurring towards, adults with needs for care and support.

Care and support needs are identified in the Care Act 2014 as the following – Jolaade was known to services prior to her unexpected death in May 2023. Jolaade's case review highlights the complexities professionals and families face when challenged with adults with both complex mental health and physical health issues.

Pen Picture of Jolaade is summarised below –



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

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.

Unfortunately, Jolaade did not engage well 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 Mary's 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 Cardiopulmonary Resuscitation (CPR) being commenced she sadly died 2 days later.

This is the learning brief on what was found and how you can make a difference to protecting other adults like Jolaade from experiencing abuse or neglect.

About the review process – 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[1]. 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.

Summary of Findings and Recommendations – 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.

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.*

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*

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

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.

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.*

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[2] 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.*

Overarching Themes –

- Sharing Information in a timely and accurate manner – including raising safeguarding concerns
- Understanding Mental Capacity and Best Interest Decision Making
- Think Family

Questions for you to consider –

1. An adult with complex health care needs were quite significant in Jolaade's case – where was the multi-disciplinary team meetings to discuss best interests and engagement for Jolaade and her family?

2. Where was the Joint Think Family application by Adult and Children's Services including Mental Health Teams?

3. What happens with the records, paperwork that is sent with patient's when they are conveyed by ambulance to hospital without a professional/family member present?

4. How well / confident are you with applying the Mental Capacity Act?
5. How well / confident are you working with diverse cultural and religious needs that are not mainstream? There was a conflict between Jolaade and her husband's faith and background, was there a need to explore this further?

Resources to assist you further –
www.safeguardingadultsinbexley.com

THE FULL JOLAADE REPORT

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