Bexley Safeguarding Adults Board Safeguarding Adult Review (SAR) –

Mrs BA Learning Event Programme Schedule & Workbook

Date: 18th July 2019

Location: Bexley Civic Offices, Room – Council Chambers

Parking: Please note there is **no** parking available on site at the Civic Offices but details of parking options are detailed on the map link – **click here**

Arrival: If you don't have access to the Civic Offices, you will need to sign into the Civic Offices in Reception. This will be available from 9 a.m. and we have an on-site café for refreshments for you to purchase prior to the event. The start time is promptly at 10.00 a.m. and will finish by 1230 p.m.

09.30 – Registration Opens
(Location: Council Chambers; Note: Name badges will indicate your table assignment; and teas, coffees and water will be available)

10.00 – Opening, Welcome and Review Scope –

- **Eleanor Brazil, OBE – BSAB Independent Chair:**
  - Bexley Safeguarding Adults Board Introduction
  - Safeguarding Adult Review – Statutory duties under Care Act 2014

- **Mick Haggar, Independent Reviewing Officer, BSAB SAR-MRS BA**
  - SAR Methodology and Review Scope

➢ **Questions, Comments from Attendees**

10.30 – Findings and Lessons – led by Eleanor

- Workbook Groups 1- 5; Findings 1 and 2; Finding 4
- Workbook Group 6-10; Findings 3 and 5; Finding 6

10.50 – Workbook Feedback Session with Recommendations – led by Eleanor

- Findings 1, 2, and 4
- Findings 3, 5, and 6

11.15 – BSAB Action Plan – led by Eleanor

11.30 – Presentations from Partners – led by Eleanor

- Dian Stanley, Home Office Safeguarding Lead
- Jo Songer, No Recourse to Public Funds Team, London Borough of Bexley (LBB)
- Jane Wells, Director of Nursing, Oxleas NHS Foundation Trust
- Derek Tracy, Clinical Director, Bexley Care / Yolanda Dennehy, Deputy Director Adult Social Care, LBB
- Natasha Pavey, Bexley Safeguarding Partnership for Children and Young People

12.00 – Next Steps – led by Eleanor

12.15 – Feedback to BSAB Questionnaire

SAR-MRS BA Learning Event Workbook

Welcome to the BSAB SAR-Mrs BA Learning Event.

Section 1: Executive Summary - http://www.safeguardingadultsinbexley.com/wp-content/uploads/BSABSA2-1.pdf (full report)

This Safeguarding Adult Review was carried out so that the agencies involved in providing services to Mrs BA could learn lessons and improve practice. Agencies looked at how they worked as individual agencies and how they worked together. The aim of this work is to provide information, understanding and insight. The overall aim is to improve services because of that learning.

Bexley Safeguarding Adults Board agreed that the circumstances of Mrs BA's death from suicide met the criteria for a statutory Safeguarding Adults Review under the Care Act 2014. Mrs BA had been receiving secondary mental health services, for over ten years, since first becoming unwell in 2006. Mrs BA had three children, two of whom who lived at home with her and her husband, they had been the subject of input from Children's Services until shortly before her death. Bexley Safeguarding Adults Board involved Bexley Safeguarding Children Board and key partners from Children's Services so that a Safeguarding Adults Review would seek to learn lessons as to how Mrs BA took her own life whilst services were involved with her and her family.

This SAR has been externally reviewed at the request of the Independent Chair, Annie Callanan, in January 2018. The Independent Reviewer has clearly identified areas of learning and practice improvement. It is important to remember the purpose of a SAR is not to proportion fault to an agency or individual, but to seek learning and assurances on how service development that the potential have to significantly improve the way in which adults at risk of abuse and neglect are safeguarded in the future.

The BSAB has a good working relationship with all its key partners and we will use the integrity of the independent scrutineer and have signed off this report as statutory partners to address all the recommendations and findings therein. We seek assurances as outlined in our Action Plan to ensure agencies working in Bexley continue to focus on improving services to adults at risk in Bexley.

In closing, it is essential that at the centre of this work is, of course, a 42-year-old woman who had been in receipt of services in Bexley at the time of her death. We must retain her and her life in our sights and I know the agencies working across the services have done so. I also want to extend sincere condolences to Mrs BA's family and friends, who have suffered significant loss.

Michael Boyce, Acting/Vice Chair, Bexley Safeguarding Adults Board, Deputy Managing Director, Bexley CCG
Stuart Rowbotham, Director Adult Social Care, London Borough of Bexley
James Foley, Detective Superintendent – SE BCU, London Metropolitan Police Service

SAB Sign off date: 8th March 2019 **Full SAB Sign off date: 15th March 2019**

Section 2: Summary of Findings and Appraisal of Practice for Each Key Practice Episode (KPE)

KPE - (Dates)	Summary and Appraisal of Practice for Each KPE - (Links with Findings and Recommendations)
KPE1 (15/05/07-11/04/08)	• Poor Transfer of Care between Bexley & Greenwich Children's Services when YO moved area after TO place in foster care by Bexley. • Lack of coordination between Mental Health (both community and hospital services) and Children's Services to keep Mrs BA and TO together. • Inappropriate refusal for Mother & Baby Unit admission. • Use of unqualified and inexperienced staff for a complex case by both boroughs may have contributed to poor practice. • Lack of support for Mrs BA, no legal advice offered and decisions about removal of daughter rather than help to keep the family together. ***(Finding 1)***
KPE2 (16/03/12-04/08/14)	• Pre-birth conferences were not held prior to the children being born, possibly due to staffing pressures with Children's Services. • Good leadership from Children's Services and multi agency work from Mental Health was effective in maintaining the family unit and Mrs BA's mental health. • The Home Office refused all Mrs BA's solicitor's applications to permit the family to remain in the UK, but at this time it did not lead to any relapse in her mental health. • Mrs BA continued to seek permission to return to work, which was being monitored by the NMC, despite her being stable for the past 6 years.
KPE3 (17/01/15-21/07/15)	• Domestic abuse was alleged but not investigated by Children's, Adults or Mental Health Services, in line with Safeguarding procedures. • There was a 4-month delay in Children's services response, via a telephone call, which determined no risk and led to a decision to close the case, as the situation was deemed to be low risk. ***(Finding 2)***
KPE4 (07/07/16-23/08/16)	• Reorganisation of Oxleas Mental Health Services led to the loss of Mrs BA's long-term support worker. • Reorganisation of Support to Families in Bexley, with the establishment of the NRPF Team, led to an overpayment of subsistence payments to Mrs BA and her family, which were not identified for over 12 months. • Both these changes adversely affected Mrs BA's support network and caused her additional stress.
KPE5 (09/11/16-09/01/17)	• Several stress factors (immigration status and applications all being refused, hearing scheduled at NMC for her fitness to practice, threatened with eviction, as NRPF team stopped paying rent) were present at this time, which precipitated an acute relapse in Mrs BA's mental health, after many years of stability. • Police were needed at her address to convey her to hospital and return her x2 when she was deemed AWOL from section.

	• A lack of available female inpatient beds led to Mrs BA initially not being re-admitted when she went AWOL on the first occasion and subsequently being transferred out to a private PICU, as no intensive care female beds are commissioned from the Trust. • A further lack of available local beds led to Mrs BA being then discharged directly home from the PICU, with insufficient transfer to local services, whilst she was still unwell.
KPE6 (13/02/17-23/05/17)	• Following a "poor handover and a premature discharge" (as reported by YO) from the private PICU, Mrs BA was sent directly home, whilst still mentally unwell, leading to risks to both BA and potentially to her children. • A plan by the HTT to monitor medication in the community led to delay in her reassessment and readmission to hospital, due to a delay getting a warrant, until a crisis event where Mrs BA locked her husband out of the house, waving a knife through the letterbox and leading to police attendance and ultimately breaking down her front door and arresting her. This would have been frightening for both Mrs BA and her 2 young children. • Children's Services responded to a safeguarding referral by assessing risks as low, but this was closed prior to Mrs BA being discharge home from this admission, therefore without a full understanding of the family situation. • Children Services closed the referral without the involvement of the ICMP Team, who had raised the referral, which was not good practice. • The financial and immigration stress factors were not addressed during this period, thereby exposing Mrs BA and her family to on-going risks of further mental ill health. • There was better coordination between private PICU and local psychiatric services, including authorised discharge with compliance with medication through a Community Treatment Order. ***(Finding 3)***
KPE7 (06/06/17-27/06/17)	• A debt recovery letter was sent without explanation, which was threatening legal action and unrealistic to expect repayment, given that the family were destitute. Increased pressure and stress on Mrs BA at a time when she was mentally fragile. • Home Office had advised that Mrs BA's only option to remain in the UK was to seek asylum, which showed some good practice by the Removals Preparation team. But she was never supported to consider this. Due to her poor mental health it is unclear whether she was able to make such an application. • Mrs BA's depot medication was reduced, at her request due to side affects, but given increased pressures on her this may have increased the risk of further psychotic breakdowns. ***(Findings 4 & 6)***
KPE8 (14/07/17-18/08/17)	• The communication of the Home Office's final decision regarding Mrs BA's application to remain in the UK was poorly managed. • There was a significant deterioration in Mrs BA's mood following this and she expressed suicidal ideas, including hearing voices with specific plans as to how to end her life. • Mrs BA was felt to be in crisis by her Care Coordinator and was seen by the HTT, who felt an admission would be of benefit, but once again there were no local beds in the Woodlands Unit and Mrs BA was advised to present at A&E but refused to go.

	• This was not pursued, and Mrs BA was given sleeping pills prior to being discharged back to ICMP team after a brief period of assessment by the HTT • This case clearly highlights how crises are defined within HTT and ICMP teams, and how risks of suicide assessed and managed in the community.
KPE9 (01/09/17-10/09/17)	• The 10 days prior to Mrs BA's suicide included a decision by her mental health team to stop her depot medication, at her request due to her reporting side effects and to increase her oral medication. • The potential increase in risks of suicide following the above change to treatment were not monitored, or managed by ICMP, or the HTT. • Mrs BA was not seen again by mental health services after this reduction in treatment to review her mental state and the associated risks to her welfare. • Her husband reported difficulties contacting mental health crisis services when Mrs BA deteriorated in the days prior to her suicide and he tried to call for help. • The risk of suicide was not immediately communicated by MPS to the BTP as tragically she had died prior to a report being taken by MPS. Mrs BA took a train to Victoria station, where she went to the Victoria Line underground platform and shortly afterwards jumped in front of an oncoming tube, resulting in her death, due to multiple injuries. ***(Finding 5)***
Legal review	• That the unstable nature of Mrs BA's mental health could have been better presented to the FTT, with an up to date psychiatric report in 2016. The report submitted was 2 years old, at which time her mental health was stable, prior to her relapse later in 2016. • The realistic likelihood of Mrs BA being able to access sufficient mental health care should she return to Nigeria and the impact on her health were this unavailable could have assisted the FTT to consider the Human rights submission at this time, given reference to relevant case law, (Bensaid v UK [2001] 33 EHRR). • If Mrs BA's first child (TO) was not removed from the UK and placed with her maternal grandmother to be raised in Nigeria then Mrs BA and her family may have been granted leave to remain in the UK, as TO would have spent at least the first 7 years of her life in the UK. • Although appropriate submissions were made by Mrs BA's representative during this period an application for asylum should have been made, as grounds were present for this (FGM) and the Home Office encouraged consideration of this when refusing all other grounds for her to remain in the UK. • The refusal to allow any of Mrs BA's submissions may have been a significant contributory factor to her becoming suicidal.

Section 3: Workbook Feedback Session with Recommendations

Summary of Findings:

1. Concerns regarding a new mother's poor mental health and potential risks to her new born child should be carefully considered with all viable options explored to keep the family together. Where alternative arrangements are made, due to assessed risks to the child, a parent's rights to independent legal advice must be upheld and the child's father included in any parenting assessments.

2. Reports to Children's Services about domestic abuse need to be robustly dealt with under local Safeguarding Procedures and where the victim is an Adult with Care & Support needs this should be coordinated with the appropriate Adult, or Mental Health Services, who would be responsible for the S42 Enquiry.

3. Lack of availability of local psychiatric inpatient services due to patient flow can be associated with problems caring for people in mental health crisis both in the community and in hospital, with increased risks to them and their families. This puts pressure on local community mental health services to try to manage admissions when there is a clinical need and on the inpatient services to discharge people too quickly. The use of out of area private psychiatric hospitals may ultimately adversely affect the handover of care when patients are discharged back to local community mental health services.

4. The immigration status of people being deemed unable to remain lawfully in the UK with No Recourse to Public Funds requires complex decisions including appeals to the Home Office. For people who in addition also have mental health problems, this process can be difficult and stressful, with an increased risk to both their mental health and subsequently their safety.

5. The assessment and management of the risk of suicide for people with mental health problems in community mental health services needs to include a structured model incorporating social and psychological stress factors, enabling information sharing by all health and social care professionals, involving families where appropriate. This should include a pathway to access to emergency hospital admissions where people are identified as both experiences mental illness and at high risk of suicide following this assessment.

6. The use of a standardised and corporate debt recovery process, including automated letters threatening legal action, is not always appropriate. Sending letters to residents with serious mental health problems may cause them harm, including potentially increasing the risk of suicide amongst this group. Interdepartmental systems need to take account of the vulnerability of residents prior to formal debt recovery processes being implemented.

Findings	Questions to explore in Groups	Answers	Further Notes / Actions needed
Findings 1 and 2 are similar so for this exercise combined	**Do you agree or disagree with these findings? Why and why not?** **What do you think are the key issues relating to mental and domestic abuse impact on safeguarding services for parents with children in Bexley?** **What is your understanding of 'Whole Family Approach' and how is it applied in Bexley?**		
Findings 3 and 5 are similar so for this exercise combined	**What are the key issues in Bexley relating to access to mental health and domestic abuse services?** **How effective is discharge planning?** **What could be done better or improve services?**		

Finding 4	**Do you understand access rights under Immigration Laws for the UK?** **How do you apply them in Bexley?** **What is the Joint Working Protocol for handling complex cases across statutory and non-statutory services?**
Finding 6	**How do you balance sensitive approaches with adults at risk when you need to enforce?**