Southwark Safeguarding Adults Partnership

Safeguarding Adults Review

Adult B

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1. Introduction

1.1 This report was commissioned by Southwark Safeguarding Adults Board to investigate the events leading to Adult B's death following a fire at her home on 4 October 2016. Adult B had been known to a variety of agencies in the years leading up to her death. Management reports were commissioned from all the agencies working with Adult B and a round table learning event took place in May 2017. Recommendations were agreed at this event and these are included in this report.

2. Background Information

2.1 Adult B was a 50 year old white British woman who lived alone at the time of the incidents leading to the review. She had lived at the same flat since 1985, originally with her previous partner who moved out in 1997 and her daughter who moved out in 2012.

2.2 She had a long standing partner who did not live with her but provided a significant amount of support. Her daughter was also heavily involved with her care. Adult B was reported to be very house-proud and kept her home neat and tidy. She also took pride in her personal appearance and enjoyed shopping. She was close to her family members and was described as getting on well with her neighbours.

2.3 She had suffered from Type 1 diabetes for many years and had been known to the District Nursing Service since 2006. The District Nursing Service was withdrawn from her in February 2016 as she no longer met their criteria as she was not housebound. There had been incidents of her refusing insulin injections and being challenging to staff who had been visiting 3 times a day to administer the injections. She was said to have needle phobia and therefore was unable to administer her own insulin. It was difficult to put in place alternative arrangements for the administration of the insulin following this withdrawal of service.

2.4 In March 2016 a Safeguarding referral was made because Adult B had been admitted to Kings College Hospital suffering from the consequences of insulin not being administered. By the end of March she was recorded by the London Ambulance Service as being self-neglecting, not eating or drinking and her home was described as untidy and cluttered. She was alleged not to have had insulin for 6 days.

2.5 Adult B had also been diagnosed with recurrent depression and more latterly with mixed personality disorder. She had originally been known to South London and Maudsley NHS Foundation Trust in 2007 after threatening suicide

and after this had intermittent contact with the Community Mental Health Team between 2007 and 2016.

3. Agencies working with Adult B

- GP practice
- South London and Maudsley NHS Foundation Trust
- Guys and St Thomas's NHS Foundation Trust Acute and Community Services
- Kings College NHS Foundation Trust
- London Borough of Southwark Housing Services
- London Borough of Southwark Adults Services
- Metropolitan Police

4. Events Leading to this Review

4.1 This review focuses on the period April to October 2016. In the months leading up to her death Adult B's health seems to have significantly deteriorated. She had disagreements with her neighbours, family and partner and expressed paranoid ideas that they were plotting to kill her. Her control of her diabetes deteriorated too and she had frequent admissions to hospital with extremely high blood sugar and other complications. Her flat was reported to be neglected and messy and Adult B herself to be dishevelled.

4.2 In April 2016 Police were called to Adult B's home 6 times as she was making threats to neighbours and family, absconding from hospital and injuring herself. A safeguarding referral was made to Southwark Council by Guys and St Thomas's Safeguarding Adults Team and the risks identified were lit cigarettes being left lying around and questions about whether there was a functioning smoke alarm. There were also concerns about the insulin administration and possible mental capacity issues. Upon receiving this safeguarding concern, the safeguarding enquiry process was undertaken followed by a closure decision. This was followed up by liaison with the GP and mental health services but no case conference was held and the issues concerning fire risk were not followed up. The GP surgery made several attempts to try to ensure Adult B had her insulin administered appropriately. On 26th April 2016 they also made a joint home visit to Adult B with the Community Mental Health Team. Adult B did not wish to attend the surgery for insulin injections. The Psychiatrist advised Adult B had capacity. The surgery arranged training for family members in administering insulin injections.

4.3 On 28th April 2016 she was brought to Kings College Hospital Accident and Emergency by the Police and subsequently detained under Section 2 of the Mental Health Act on 30 April 2016 and admitted to the Maudsley Hospital. What followed was a fairly chaotic period of almost 3 weeks where she was

transferred backwards and forwards between St Thomas's Hospital and wards managed by South London and Maudsley NHS Foundation Trust. On 1st May 2016 she was transferred to St Thomas's Hospital with poor glucose control. She was reported to be refusing insulin. This was stabilised and on 3rd May 2016 she was deemed fit to be transferred back to the care of South London and Maudsley. She attempted to abscond and was provided with 1:1 support overnight while a secure transfer was arranged for 4th May 2016.

4.4 By 6th May 2016 she was back in St Thomas's Accident and Emergency, this time with very low blood sugar. She was agitated during this stay and was provided with 1:1 mental health nurse support. It was suspected that she had also ingested an excess of a paracetamol based medication. During this stay there was some confusion about which unit from South London and Maudsley NHS Foundation Trust would assume responsibility for her. St Thomas's Hospital team recommended that she requires 1:1 supervision and strict monitoring of food intake which could be done under the Mental Capacity Act. On 11 May 2016 she was transferred to the care of South London and Maudsley Trust. On the 13 May 2016 she was allowed home on leave and subsequently had to be transferred back to A&E in St Thomas's again with very high blood sugar. On 14 May 2016 she was deemed to be medically stable but was not accepted by South London and Maudsley until the following day, 15 May 2016. Her Community Psychiatric Nurse raised concerns about risks to Adult B resulting from the deliberate ingestion of sugary substances and refusal of insulin and pointing out that one of these incidents had almost resulted in her death. She was reported as paranoid about staff and relatives. On 16th May 2016, while on the ward it was decided her Section should be rescinded and she was sent home. It is unclear what assessment had been undertaken and what her care plan was in the community.

4.5 Her partner immediately took her on holiday to a caravan in Kent but by the following day he was saying he could not cope with her as she was expressing paranoid ideas about him and had called the police. On 18th May 2016 there was a multi-disciplinary planning meeting with the GP Community Services and South London and Maudsley. Adult B was no longer living in the area but plans were put in place should she return. By 23rd May 2016 Adult B had returned to her flat for the day but the relationship with her partner had broken down. She was reported to be staying with her daughter. Relationships with other family members had also broken down. In June 2016 the relationship with her partner was reinstated and she was staying with him or in a hotel but not living in her flat. Between June and September 2016 she was in touch with SLAM intermittently concerning issues with her flat and her request for rehousing and repairs to the door. There were no admissions to

hospital in this period. It appears her diabetes was being better managed, possibly by her partner administering the insulin.

4.6 On 2nd October 2016 Adult B was brought by the Police to a place of safety at Lambeth Hospital which is part of South London and Maudsley Foundation Trust. She had been reported missing by her partner and was found several hours later hiding in bushes near her home. Upon returning home she took a kitchen knife and threatened to kill herself. She was assessed and it was agreed that she should return home with support from the Southwark Home Treatment Team. The Home Treatment Team visited her on 3rd and 4th October 2016 where she expressed concern about debts and lack of support around insulin administration. In the early evening of the 4th October 2016 the Home Treatment Team visited her to drop off some medication. They noticed a smell of smoke and blackened windows and the emergency services were summoned. The London Fire Brigade gained access to the flat and found Adult B on the sofa dressed in a dressing gown. She was removed from the property and resuscitation was commenced. A pulse was regained but breathing was not restored. She was taken to Kings College Hospital where she was declared dead at 2.50am on 5 October 2016.

5. Summary

5.1 Every agency missed opportunities to refer Adult B to the London Fire Brigade for a fire safety assessment. It is clear that knowledge about the availability of this service, the criteria for referral and the fire safety measures that can be put in place are not known by front line staff in all the agencies involved in this review.

5.2 Adult B had very complex physical and psychological problems. It was clear during the process of this review that agencies did not understand the level of involvement by partner agencies and did not fully use opportunities to share information and arrive at a multi-agency plan to address the issues which were arising.

5.3 There was consideration of mental capacity by several agencies but this was not formally documented. The partnership would benefit from having a collective understanding as to who completes a Mental Capacity Assessment, when and where this is recorded and if capacity is assumed, should this be referenced?

6. Recommendations

All Agencies

6.1 To promote and embed the use of the London Fire Brigade risk assessment tool to identify those at risk of fire

6.2 To make appropriate referrals to the London Fire Brigade for Fire Safety visits

6.3 To incorporate awareness raising training for fire safety referrals in the multi agency programme and cascade to front line staff

South London and Maudsley NHS Foundation Trust

6.4 To consider application of the Care Programme Approach when working with people who present with a high degree of clinical complexity, in line with the inclusion criteria set out in the revised CPA policy (June 2017)

6.5 To review the CMHT Care plans to ensure they are regularly updated and explicit

6.6 To prepare a briefing paper for dissemination to the partnership outlining when someone should be considered for a CPA.

Guys and St Thomas's NHS Foundation Trust

6.7 In cases where patients are refusing to take the prescribed dose of medication, to develop a process of escalation whereby there is a multi-disciplinary meeting involving all relevant staff. This process should also be undertaken before a service is withdrawn

Kings College Hospital

6.8 Ensure there are robust arrangements for discharge summaries to be sent to GPs when patients self-discharge

Adult Social Care

6.9 To undertake an audit on how closure decisions are made following a safeguarding concern and enquiry, to provide assurance about the robustness of these decisions

GP Practice

6.10 To make a note on their records for safeguarding cases to be discussed at practice meetings.

7. Example of Good Practice

7.1 The work undertaken between the CCG Safeguarding lead and the GP practice was an example of a way of supporting GP practices who are having difficulty managing patients with complex problems. This was particularly important in helping to address the safeguarding aspect of this situation particularly in relation to self-harm and self-neglect