Havering Safeguarding Adults Board

SW: Safeguarding Adult Review

Executive Summary: draft 2.1

March 2020

Independent Reviewer and Report Author:

Alastair Kidd, Pr@xis Ltd

1. Introduction

1.1. SW was a 56-year-old woman with a diagnosis of depression, panic attacks, and borderline personality disorder, with persistent agoraphobic symptoms, since 1984. She had been receiving services from North East London NHS Foundation Trust (NELFT) since moving to Havering in 2010.

1.2. She died in May 2017, three weeks after moving to a bed sit in Harlow. The inquest concluded that she killed herself, and death was due to suspension by ligature and multiple drug toxicity.

1.3. A Case Review Working Group meeting, held on 07/11/2017, recommended undertaking a Safeguarding Adult Review (SAR), to the Chair of the Safeguarding Adult Board (SAB). It was determined that the criteria for an SAR had been met because she was an adult in the area with a need for care and support; taking her own life was seen as self-neglect; and there were reasonable concerns about how the agencies had worked together to safeguard her.

2. Methodology

2.1. The following agencies contributed to the review:

- North East London NHS Foundation Trust (NELFT)
- London Borough of Havering (LBH) Housing Services
- Essex Partnership University NHS Foundation Trust (EPUT)
- Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT)
- Barking & Dagenham, Havering and Redbridge Clinical Commissioning Groups (BHR CCGs)
- London Ambulance Service (LAS)
- Peabody (formerly Family Mosaic)

2.2. Each agency undertook an Individual Management Review (IMR). A panel, with all key agencies represented, reviewed and discussed the findings of the IMRs, identified key lines of enquiry, and reviewed drafts of the Safeguarding Adult Review report written by an independent reviewer.

2.3. The independent reviewer met the family, liaised with them and sought their views; reviewed and coordinated the chronology and IMRs; and wrote the review report.

2.4. The review looked at any lessons that could be learnt about the way local professionals and agencies worked together, reviewed the effectiveness of local safeguarding practice and policy, and made recommendations that would improve the safeguarding of adults in the future.

3. Background summary

3.1. SW was born in 1960, the third child of four siblings born to her Irish father and Italian / Irish mother. Several members of the family live in Dagenham and Chadwell Heath.

3.2. She suffered several losses from her nearest family. The most significant was the death of her one-year old daughter in 1984. Her daughter's father died in 1986, her father in 1993 and her mother in 2011. She lost her husband in an accident at work in 2014.

3.3. SW had a long history of depression, and persistent agoraphobic symptoms which began following the death of her baby in 1984, and gradually worsened.

3.4. When she was first referred to NELFT services in March 2010, she reported a history of ten drug overdoses and attempts to take her own life. She often expressed suicidal thoughts including an overdose and attempt to hang herself on 07/03/2017.

3.5. She was diagnosed as having an Emotionally Unstable Personality Disorder in 2016. At her care plan meeting on 15/03/2017, this diagnosis was reconfirmed and accepted by her.

3.6. Staff that worked with her closely said that SW's appearance was often at odds with what she was saying at the time. She often told them she wanted to take her own life and wished to die. Her family also said she often threatened to kill herself.

4. Chronology of key events prior to her death

4.1. During the last three years of her life, several losses and changes intensified SW's mental health problems. In 2014 her husband was killed in a work-related accident. The inquest was not held until January 2017 and she was greatly upset by the verdict of accidental death.

4.2. In April 2016, her landlord stated his intention to take back the home she had lived in with her husband. She applied to be rehoused by LBH Housing Services, but her application was refused until she was homeless. Formal eviction action began in January 2017 with an eviction date of March 2017. During these two months a homelessness assessment was undertaken by Housing Services and she self-harmed twice, requiring hospital treatment. On the night before her eviction date of 07/03/2017, she took an overdose and tried to hang herself.

4.3. Following her eviction and overdose, SW's nephew agreed that she could stay with him and his family, until she was offered permanent housing by Housing Services. Her presence caused some tensions within her nephew's household, including concerns about the welfare of his son. She stayed there for six weeks until her homelessness application was approved, and an offer of accommodation made.

4.4. SW was offered a bed sit in Harlow. Although she was reluctant to move away from her home area, she was told that this would be the only offer made and, because the accommodation offered by her nephew had broken down, she accepted the offer.

4.5. The approval of SW's homelessness application and the housing offer were both made on 13/04/2017, the Thursday before the Easter break, and she had to accept and move in by 18/04/2017, the Tuesday after the Easter break. Without prior notice, no local support services had been arranged for her, and she was faced with considerable practical and administrative difficulties in trying to access them.

4.6. Despite regular phone calls to mental health and acute crisis services in both Havering and Harlow, and threats to kill herself, SW had not been able to register with a GP, access her regular medication, or be referred to local support services by the time of her death, three weeks after she moved.

4.7. SW died, taking her own life, on 09/05/2017. The inquest on 04/09/2017 concluded that she had killed herself and death was due to suspension by ligature and multiple drug toxicity.

5. Main themes and findings of the review.

5.1. Several interrelated themes, in the form of questions, were explored, conclusions arrived at, and recommendations made. There is some overlap between the themes and interaction between them.

5.2. Was there sufficient recognition by all agencies that several losses were creating a major personal crisis for SW?

5.2.1. Over the last three years of her life, SW lost a number of protective factors that helped maintain stability in her life. This had the greatest impact after her move to Harlow.

5.2.2. Her husband was killed in a work-related accident in 2014 and the inquest verdict of accidental death in January 2017 compounded her distress. In March 2017 she lost the home she lived in with him. She was not able to take her dog and cat with her to the bedsit in Harlow and lost the comfort they provided.

5.2.3. SW's relationships with her family were changeable and volatile, but she had a lot of contact with family members who lived locally, and they provided her with a sense of identity and support. The move to Harlow cut her off from this potential source of support.

5.2.4. The potential impact of the loss of these protective factors, in a short period of time, on a woman who had made previous attempts to kill herself, were not sufficiently taken into account in the housing allocation process and led to an unsuitable offer being made.

5.3. Could a more co-ordinated multi-agency approach have helped manage the risk better during the big changes that SW was going through?

5.3.1. It is striking how much individual time and commitment was spent by professionals trying to help SW. The Havering Psychological Service, HAABIT workers within NELFT and her Peabody Support Worker all provided substantial support, sometimes daily. Individual liaison between professionals was undertaken but this was insufficient in the complex situation caused by her homelessness.

5.3.2. All the IMRs identified the lack of a coordinated response from the agencies. Housing and NELFT both concluded that there was a need for a multi-agency meeting or information sharing for complex, high-risk cases, when planning a move away from the local area, to ensure a safe transition and a transfer of access to required services.

5.4. Should problems have been escalated within agencies at key times?

5.4.1. There were occasions when regular processes were ineffective at problem solving. Escalating the case to nominated management or professional staff could have helped unlock access to services or enabled a more flexible response.

5.4.2. When SW overdosed and tried to hang herself at the time of her eviction, escalation could have initiated a more co-ordinated future approach to her care and her housing.

5.4.3. When SW moved to Harlow she was unable to sign on with a GP and thereby access services. This took no account of her eligibility, through ordinary residence, for care services under the Care Act 2014. Escalation to Senior Managers might have been able to cut through this impasse.

5.5. Were risk assessments sufficiently robust or consistent to provide an effective framework for safeguarding SW?

5.5.1. Risk assessments that effectively monitored SW's mental state and capacity, could have prompted multi-agency planning or started safeguarding procedures.

5.5.2. NELFT had primary responsibility for risk assessment while SW was resident in Havering. The use of risk levels in NELFT's Clinical Risk Assessment and Management Policy was inconsistent and never marked as high. It changed with individual factors or events, rather than relating to underlying trends such as her loss of protective factors.

5.5.3. It is possible that NELFT workers, while committed and caring, when faced with SW's constant expressed wishes to die, or intention to take her own life, became largely 'immune' to such threats, and hence less likely to notice changes which might increase the likelihood of her carrying them out.

5.6. Were there occasions when a safeguarding referral should have been made, instigating a multi-agency safeguarding plan?

5.6.1. There were two main opportunities to make a safeguarding referral, which would have instigated multi-agency safeguarding planning. The first was on 07/03/2017, following her eviction, when SW attempted to overdose and hang herself. Safeguarding concerns were not followed through because she was discharged to a place of safety, her nephew's home, with community support. However, this arrangement was only temporary.

5.6.2. The second missed opportunity was after SW's move to Harlow. She was in a new situation, clearly in a state of high distress, without any of the support or protective factors she had been used to. None of the agencies questioned her ability to make reasonable decisions about her own safety and ask if protection was required

5.7. Could family members have been engaged in a way that would have increased the support available to SW and reduced the risk of self-harm?

5.7.1. SW's relationships with her family were complex and contradictory. At different times she was very close to, and dependent on, different family members. At other times she did not want them involved.

5.7.2. SW's sister, her closest relative, and niece contacted the mental health team to express concern about her mental health. They said they wanted to give information not receive it and to be part of her care plan and were critical of the decision not to do this. It should be noted that no consent is required to listen to a message or concern and take those into account in evaluating risk.

5.7.3. Her nephew was effectively her carer when she was staying with him, but he was not offered support in this role. Engaging with him by means of a carer's assessment under the Care Act may have helped support her stay there and avoided a sudden and unplanned move to Harlow.

5.7.4. NELFT is currently leading on a national multi-centre Open Dialogue pilot that involves working with the whole family or network, and not the individual alone. In future this might open up alternative solutions or sources of support, through a more systemic understanding of similar situations.

5.8. Could a more responsive approach from the GP's surgery at the time of her housing crisis have helped reduce the risk of SW self-harming?

5.8.1. SW's surgery was a single-handed practice and SW would have been challenging to work with due to her complex needs. However, both professional staff and SW and her family reported difficulties trying to contact SW's GP. The surgery acknowledged that more direct communication with the mental health team would have helped them provide SW with more effective support. Guidance from Housing to GPs about what information would assist Housing in their decision making, would be helpful.

5.8.2. Of greater concern were the delays in providing prescriptions once she had moved and, given her agoraphobia, sending them to local pharmacies where they could be collected for her. The surgery has since put a system in place where prescription requests can be sent electronically to a patient's nominated pharmacy.

5.9. Could better management of SW's medication, following her overdose and attempt to hang herself on the day of her eviction, have made the fatal repeat of this action, three weeks after she moved to Harlow, less likely?

5.9.1. Following SW's overdose on the day of her eviction, when she went to live with her nephew, he estimated that she was without prescriptions for 2-3 weeks. The lack of anti-depressants would have had an effect after about a week, therefore this period without medication was too long.

5.9.2. Once she moved to Harlow on 18/04/2017, her inability to register with a GP meant she had no local access to medication. This was one of the consequences of the lack of a planned transfer of care. Again, she would have been without medication for two weeks, which would have impacted on her mental health at a time of acute stress.

5.10. Could the decision-making process within Housing Services have led to a different offer of housing that might have better met her needs and reduced the risk of self-harm?

5.10.1. Housing Services knew that SW was going to be homeless but waited for her to be evicted before acting. The Homelessness Reduction Act 2017 has since introduced a duty to prevent homelessness and produce a personalised housing plan. Such an approach here may have helped avert a crisis.

5.10.2. The second medical advice report from the Housing Services Medical Adviser appears to have been based on an out of date care plan before her overdose on 07/03/2017 and concluded she would not be vulnerable if homeless. This recommendation was, however, overridden and SW was considered vulnerable.

5.10.3. Concerns were expressed by the family and NELFT about difficulties in contacting Housing throughout the process to discuss mental health concerns. The allocation of a property in Harlow was made on a flawed assumption that relevant services and support would be readily available there and highlighted the lack of multi-agency working and prior planning required in complex care cases.

5.11. How could the implementation of the offer of a tenancy in Harlow have been managed better to improve the support available to SW and reduce the likelihood of her self-harming?

5.11.1. The timing of the property offer, just before Easter, meant that SW had to make an immediate decision on whether to take the property or not, without professional advice or support. With no prior knowledge of the move, Havering mental health services had no opportunity to set up services for her in Harlow.

5.11.2. Most significantly she had no GP, the key gateway for services in Harlow, and her agoraphobia prevented her attending a GP surgery to register with one. An immediate impact of having no GP was a lack of local access to prescriptions. The effects of having no medication would have happened at a time of isolation in an unknown area.

5.11.3. Additionally, family support was lacking at this time because relationships had become strained with her nephew, and her sister was unaware of her address.

5.11.4. The lack of multi-agency planning led to a breakdown of care arrangements that would be likely to have increased the chances of her self-harming.

6. Recommendations

6.1. The following agencies – NELFT; LBH Housing Services; BHRUT; EPUT; GPs; Peabody and other agencies such as Adult Social Care - should include the role of protective factors in mitigating the risks of self-harm and the impact of their loss or reduction on assessments of risk, in their training and procedures. BHR CCGs and West Essex CCG should give due regard to this recommendation in their quality assurance and commissioning role.

6.2. The following agencies – NELFT; LBH Housing Services; BHRUT; EPUT; GPs; Peabody and other agencies such as Adult Social Care - should review their thresholds and procedures for initiating a multi-agency approach to planning around particular types of complex or high-risk cases, and ensure

staff receive appropriate training or briefing in these. BHR CCGs and West Essex CCG should give due regard to this recommendation in their quality assurance and commissioning role.

6.3. The following agencies – NELFT; LBH Housing Services; GPs; Peabody and other agencies such as Adult Social Care - review how effectively the Havering Safeguarding Adult Board Escalation Policy, February 2019, is being implemented in their organisation, formulate an action plan for their organisation if required, and report back to the Havering Adult Safeguarding Board with any recommendations. BHR CCGs and West Essex CCG should give due regard to this recommendation in their quality assurance and commissioning role.

6.4. Endorsement of recommendation from NELFT Serious Incident investigation: risk assessment should reflect levels of risk across multiple areas, with risk mitigation measures, including the involvement of service users in the completion of care plans.

6.5. NELFT should undertake a review of risk assessment guidelines and staff training needs in this area, to address consistency of use by different staff, appropriate weighting of long-term underlying risks and immediate risks, and changes of circumstance that should prompt re-evaluation of risk and, if required, escalation. Other agencies should consider this recommendation in the context of their own organisation. BHR CCGs and West Essex CCG should give due regard to this recommendation in their quality assurance and commissioning role.

6.6. NELFT should implement a consistent approach to the recording of risk, according to the Clinical Risk Assessment and Management Policy, ensuring it is clear when a risk assessment has been undertaken and what the level of assessed risk is. Other agencies should consider this recommendation in the context of their own organisation. BHR CCGs and West Essex CCG should give due regard to this recommendation in their quality assurance and commissioning role.

6.7. NELFT should ensure that care plans are typed up and distributed within 24 hours of the review taking place, in line with NELFT policy, to ensure service users and professionals have up to date information. Other agencies should consider this recommendation in the context of their own organisation. BHR CCGs and West Essex CCG should give due regard to this recommendation in their quality assurance and commissioning role.

6.8. All organisations providing adult services in Havering should review their safeguarding guidance for working with service users with long term support needs, and ensure it includes advice on recognising the types of change of circumstance, that might trigger a safeguarding referral.

6.9. The following agencies – NELFT; LBH Housing Services; EPUT; GPs; Peabody and other agencies such as Adult Social Care – should review operational procedures for situations when service users with long term support needs move to a different area, to ensure that the responsibilities of both incoming and outgoing areas are clear, especially in emergency or crisis situations. BHR CCGs and West Essex CCG should give due regard to this recommendation in their quality assurance and commissioning role.

6.10. All organisations providing support to service users with mental health issues should consider how the learning from the Open Dialogue model could help promote better outcomes by involving wider family and support networks to tackle difficult family dynamics.

6.11. NELFT and other agencies such as Adult Social Care should consider, when someone becomes a carer, how that impacts on their own situation, and how they can best be supported, by for example a carer's assessment under the Care Act 2014.

6.12. All GP surgeries should review their procedures on the issuing of prescriptions to patients with mental health conditions, following an overdose and when they move accommodation, to ensure they

receive appropriate medication on a consistent basis. BHR CCGs and West Essex CCG should give due regard to this recommendation in their quality and commissioning role.

6.13. All GP surgeries should review their plan for supporting patients who are unable to attend the surgery, to ensure they are visited when appropriate. BHR CCGs and West Essex CCGs should give due regard to this recommendation in their quality and commissioning role.

6.14. LBH Housing Services should produce a pro forma with guidance notes for GPs and other professionals to complete, to support service users' housing applications, asking for the information that is relevant and helpful to the application.

6.15. West Essex CCG should review procedures on how to register with a GP locally when patients are unable to attend surgeries in person, to ensure they are not left without a GP and other services dependent on GP registration.

6.16. NHS England should be asked to ensure that all CCGs have proper procedures in place for patients to register with a GP if they are unable to attend surgeries in person.

6.17. LBH Housing Services should ensure that all potential housing allocations outside the borough, involving adults with care and support needs, are preceded by a multi-agency planning discussion or meeting to determine future support needs, how to access them and, dependent on those, the viability and timing of the move.

6.18. LBH Housing Services should ensure that high risk cases are escalated to nominated senior managers during the homelessness assessment and initial application stages.

6.19. LBH Housing Services and NELFT should work in partnership to initiate training sessions for housing staff, to improve their understanding of the nature and impact of mental health difficulties, and inform their decision making during the homelessness assessment and initial application stages.

6.20. LBH Housing Services should review their processes for referral to the Housing Medical Adviser to ensure that medical reports to decision making meetings are based on up to date information.

Alastair Kidd
Independent Reviewer
23/03/2020