BROMLEY

SAFEGUARDING ADULTS

BOARD

SAFEGUARDING ADULTS REVIEW

Ms. A
March 2019

Bromley Safeguarding Adults Board
Bromley Civic Centre
Stockwell Close
Bromley
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Executive Summary - Safeguarding Adults Review (SAR)

In the case of Ms. A

Section 1 – Introduction

The Bromley Safeguarding Adults Board (SAB) commissioned the SAR (September 2018) to elicit learning from this case, which met the statutory SAR criteria set out in section 44 of the Care Act 2014. The Terms of Reference confirmed that the SAB wanted to explore the complex issues that practitioners engage with when working with adults who have a combination of serious physical health conditions, significant psychological presentations, and a history of resisting treatment and support. Ms A was assessed as having the mental capacity to make 'unwise decisions' about her care and treatment. The SAB wanted to understand what changes could be made to local systems to improve practice in relation to self-neglect in the future.

Whilst living with her grandmother, Ms A died in 2017 at the age of 28 due to physical complications relating to Type 1 Diabetes and kidney disease. Records indicated that Ms A had shown some early signs of emotional distress as a child, and had been diagnosed with Diabetes Type 1 at age 15, but she had little contact with services until her early 20s when symptoms of depression, anxiety and bulimia emerged. The SAB focussed the attention of the SAR on the two years prior to Ms A's death (May 2015 – May 2017) to keep the primary focus on looking at the way agencies work locally.

Section 2 – Summary appraisal of professional practice during the period under review

On 1st May 2015 Ms A was admitted to Princess Royal University Hospital (PRU), an acute hospital, following a seizure, which had been caused by diabetic ketoacidosis[1]. Ward staff observed that she had a combination of serious physical and emotional needs. There were lesions all over her body and pressure ulcers on both knees and elbows. Hospital staff raised a safeguarding concern. A LBB safeguarding enquiry was co-ordinated and meetings were held while Ms A remained in hospital. The hospital also arranged for a dermatologist, who diagnosed Ms A with the rare psychological condition known as Dermatitis Artefacta (DA). The diagnosis accounted for her self-inflicted sores and explained why they took so long to heal. The implications of this diagnosis were very significant, offering the potential for a more informed way of understanding Ms A's complex psychological and behavioural presentation.

While Ms A was in hospital an initial assessment of her mental capacity indicated that she lacked the mental capacity to make decisions about her treatment and care, however assessments undertaken in following weeks (by a liaison psychologist) determined that she had mental capacity in relation to

[1] Diabetic ketoacidosis is caused when the body cannot produce enough insulin, and produces high levels of acids called ketones which can cause seizures and coma.

that decision. The changes in Ms A's mental capacity during her hospital admissions may be explained by the physiological changes connected to her medical condition and also the psychological factors associated with one of her anxieties which was a fear of hospitals. Although representatives from the District Nursing service and the Diabetic Team attended the safeguarding meetings, feedback from those meetings was not communicated to frontline colleagues (e.g. District Nurses and the Community Diabetic Consultant) who subsequently worked directly with Ms A during the following two years but were unaware of the issues of self-harm. **Finding 1** explores some of the limitations to effective information sharing between professionals that can occur, even when risk information is held on the various electronic databases.

A discharge and protection plan was developed in July 2015, including district nurses to visit to dress her wounds, and short-term follow up mental health appointments. However other elements of the protection plan relied quite heavily on the hope that Ms A's mother would be able to encourage her daughter to follow medical advice and undertake self-care. Good on-going support was provided however the District Nurses (DNs) struggled to persuade Ms A to follow advice to improve her physical health. Ms A would not let them treat or even look at her feet, which were in very poor condition, with pressure ulcers on her heels. The DNs felt that Ms A was able to understand the consequences of the decisions she made about her treatment. They managed to build up a valuable relationship with Ms A over time, which was notable given the few relationships Ms A was able to develop. The community diabetes nurses also undertook occasional home visits to support Ms A with the management of her diabetes. Like the DNs they had no concerns about Ms A's ability to make informed decisions about her treatment despite the continuing deterioration in her medical condition. The challenges in relation to the assessment of mental capacity in cases where there are high risks are explored in **Finding 2.**

A care package was commissioned by the London Borough of Bromley (LBB) to provide on-going support and monitoring. The care plan set by the LBB Care Manager was well informed, including not only physical elements such as promoting a routine for personal care and prompting Ms A to undertake her insulin injections, but also psycho-social needs e.g. encouraging socialisation. However Ms A was reluctant for care-workers to visit and records suggest that the relationship building and socialisation elements of the plan were not effective. Over the summer 2015 the pattern of Ms A not attending all her outpatient appointments re-emerged, despite multiple reminders. At the end of October a safeguarding review meeting was co-ordinated and chaired by LBB. Later in the autumn Ms A attended appointments with the Oxleas Mental Health Stepping Stones service who confirmed that she did not have a mental illness, so on-going involvement with secondary mental health services was closed.

By spring 2016 Ms A's physical condition deteriorated further requiring a lengthy hospital admission and surgery, a debridement of her right heel. There was a real risk that she might require an amputation of her whole limb. She refused treatment at times. No safeguarding review or multi-disciplinary discharge meeting was held, which would have been appropriate given the picture of deteriorating health. Ms A was discharged and the Safeguarding Co-ordinator reviewed the support package with her, her mother and the District Nurse. The Care Manager decided to maintain the package to provide some protective involvement despite Ms A's wish to disengage from services.

The importance of the specialised role of care workers in supporting adults at risk of self- neglect is discussed in **Finding 3**.

A safeguarding review was held in July 2016, attended by Ms A and her mother, along with key professionals. The meeting took a view of the situation and devised a comprehensive plan, with all agencies agreeing to feedback any concerns to LBB. On 7th September 2016 the case was closed to safeguarding as it was felt that the risks seemed reduced and handed to the Complex Care Team to oversee the on-going care management package – a comprehensive risk assessment and plan was provided.

In January 2017 Ms A was admitted briefly to hospital in an agitated state due to hypoglycaemia[2], and the medical team raised a safeguarding concern due to Ms exhibiting cigarette burns and bruises. The allocated social worker in the area team was informed and called the hospital to obtain more information, however no further actions were taken in relation to the safeguarding concern. **Finding 4** explores the wider system learning in relation to the importance of co-ordinated multi-agency responses even when a case is not open to a safeguarding process. Following her discharge home there was no communication between the family and the care agency so the package did not restart, although LBB were under the impression that the care workers were still visiting. In March 2017 Ms A was reviewed by the Diabetic Consultant. She presented well and seemed engaged with her treatment plan. In early April 2017 the case was transferred to a different social worker.

When the social worker next contacted the family, she found that Ms A had been admitted to the Intensive Care Unit following a seizure on 29 April 2017. Ms A was assessed by the mental health team who felt that she had mental capacity in relation to her treatment and care decisions. Her kidney function was very poor but she wanted to discharge herself. Her Diabetic Consultant assessed her as having capacity to make decisions about her care and treatment, and the Ward Consultant strongly advised her to have a blood transfusion but she refused this, saying she would have it as an outpatient. The Ward Consultant explained to Ms A that he was worried by the high potassium levels[3] in her system, which created a considerable risk. Her presentation did not suggest that the use of Mental Health Act 1983 would be appropriate or possible, leaving no firm legal basis to prevent her from leaving the hospital on 5 May. Ms A sadly died of physical complications three days later.

Section 3 – Summary table of the Findings

1.	**Even when key case details are recorded on a case file, the nature of electronic databases do not always support frontline staff to be able to effectively access key information, leaving them with only a partial picture of an adult's needs.**
2.	**In circumstances where the consequences of an apparently capacitous adult's decisions over time may be life-threatening, practitioners need to be well supported to understand which practice, legal and ethical approach to take.**
3.	**The commissioning of care and support for adults who self-neglect, is not making full use of the potential for care workers to work alongside those adults.**
4.	**If a complex case is not being managed using an existing multi-agency process, no individual**

[2] Caused by low blood glucose levels
[3] Very high potassium levels in the blood can lead to kidney failure or cardiac arrest

	professional is responsible for drawing agencies together so there is a risk that an adults changing needs and risks will not be responded to quickly.

Section 4 – Actions

Through the Performance Audit and Quality sub-group an action plan from the findings will be formulated and SMART objectives defined. This will be monitored on a quarterly basis by the Performance Audit and Quality sub-group, as well as annually by the Safeguarding Adults Board. Part of this review will include an impact analysis over a 2 year period.