

Safeguarding Adults Review

**Tower Hamlets Safeguarding Adults Board**

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Overview Report Writer

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# 1. **Summary**

1.1 This is a Safeguarding Adults Review (SAR) commissioned by the London Borough of Tower Hamlets Safeguarding Adults Board who agreed to commission the review in March 2018. The Care Act 2014[[1]](#footnote-1) sets out a clear legal framework for how local authorities and other parts of the system should protect adults at risk of abuse or neglect.

1.2 When someone with care and support needs dies as a result of neglect or abuse, or it is suspected and there is a concern that the local authority or its partners could have done more to protect them, the Safeguarding Adults Board can commission a review to identify learning.

1.3 This Safeguarding Adults Review has considered the care and support Miss E[[2]](#footnote-2) received from the London Borough of Tower Hamlets (LBTH) adult social care service and The East London NHS Foundation Trust (ELFT), as well as local partners, commissioned both directly and indirectly including the housing and care provider.

1.4 The review primarily focused on the care and support Miss E[[3]](#footnote-3) received for the two years prior to her death (February 2015 to February 2017) but does also include relevant information from before that time, to assist in giving a wider context to the events.

1.5 Miss E was a 73-year old woman who was described by her niece as an intelligent woman, who loved animals and the garden. Her family say that she had worked for the Metropolitan Police Service in London.

1.6 Miss E had a long-standing history of mental ill health and latterly was diagnosed with a Bipolar Affective Disorder. Reportedly, Miss E had her first admission to a general hospital ward due to an overdose in 1986 and was also reported to have become unwell after the death of her mother in 1993. She had received support from ELFT’s Stepney and Wapping Community Mental Health Team until 2010 when Miss E’s support was transferred to ELFT’s Tower Hamlets Community Mental Team for Older People (ELFT). This team was a multi-disciplinary team and was staffed by Mental Health Nurses, Social Workers, Occupational Therapists, Psychiatrists, Support Workers and Psychologists.

1.7 Miss E was under the care of ELFT from 2011 until her death in February 2017. The LBTH had delegated the discharge of its statutory adult social care functions to the ELFT.

1.8 Miss E was in a residential care home (RCH) placement arranged by LBTH from July 2014 until February 2017.

1.9 Throughout the period of Miss E’s care and treatment under ELFT, the LBTH had seconded a social work senior practitioner and a number of social workers into the team to work alongside ELFT staff to provide an integrated health and social care service for the team’s patients.

1.10 Miss E’s health and social care was care co-ordinated from 2011 to January 2016 by three successive staff members in ELFT under the Care Programme Approach (CPA). Two of these were nursing members of the team until July 2014 when Miss E was allocated to a social worker. It was at about this time that Miss E agreed to move from sheltered accommodation to a 24-hour RCH.

1.11 Throughout this period all records of contact and work undertaken were recorded on the ELFT patient information system. The team, including the LBTH employees, did not record on LBTH service user records.

1.12 The residential placement was arranged by the social worker and the placement at the RCH was commissioned by the LBTHs Adults’ Brokerage team on behalf of LBTH.

1.13 Annual financial assessments were completed by the LBTH Finance officers. The LBTH Brokerage team entered basic details relating to the placement on the LBTH financial records system.

1.14 Throughout this period the ELFT team managed Miss E’s treatment and support under the CPA or via the out-patients clinic. They were also responsible for undertaking risk assessments and for providing a care plan that was reviewed regularly across both health and social care.

1.15 LBTH’s duties under the National Health Service and Community Care Act 1990 were integrated into the CPA documentation but this did not include reference to the financial (FACS) eligibility thresholds.

1.16 With the introduction of the Care Act in 2015, LBTH established an explicit framework for recording Care Act Assessments/Reviews and Support Planning and all ELFT and LBTH staff undertaking LBTH functions under the Care Act were trained in this.

1.17 There was no formal section 75[[4]](#footnote-4) agreement in place between the LBTH and the ELFT at this time. However there was an expectation on the part of LBTH that staff working in ELFT services would meet all Care Act requirements in terms of Assessment, Review and Support planning using the LBTH’s Care Act documentation alongside the CPA work. Care Coordinators, whether ELFT or LBTH employees, were effectively undertaking duties in regard to both Social Care on behalf of LBTH, and NHS duties on behalf of ELFT.

1.18 There was no evidence of a formal assessment of Miss E’s capacity; but there was reference to Miss E having capacity within the ELFT records.

1.19 Care co-ordination was discontinued via a decision made by Miss E’s Care Co-ordinator and her manager (Team manager) in supervision in January 2016 and not via a Care Programme Approach meeting with Miss E and the Multi-Disciplinary Team.

1.20 There was no evidence that LBTH’s responsibilities in regard to a minimum annual review under the Care Act were considered and Miss E was not herself involved in the decision to discharge herself from the CPA.

1.21 There was no evidence that Miss E received holistic assessments, focusing on her strengths and looking at the outcomes she desired.

1.22 The RCH was not supported by mental health professionals to work effectively with Miss E and find strategies to ease the symptoms of her mental ill health and unhappiness.

1.23 The placement at the RCH was not reviewed to establish whether it was meeting Miss E’s needs.

1.24 Miss E died on 4th February 2017, taking her own life. The Coroner recorded her cause of death as: Multiple traumatic injuries, including severe head injury. The local press reported that she had left a short note at the RCH for two of her nieces.

1.25 After Miss E’s death the RCH closed, and they destroyed all their care records for the residents that were not part of the closure process.

1.26 The report makes recommendations for health and social partners on:

* the governance arrangements between the LBTH and ELFT;
* monitoring the quality of work undertaken under The Care Act;
* ensuring people receive an appropriate holistic strengths-based assessment to support their needs;
* reviewing the CPA process and its alignment with The Care Act;
* ensuring the CPA is properly implemented and audited at regular intervals;
* ensuring that health and social care legal duties and responsibilities and perspectives are fully understood with ELFT;
* ensuring that providers have access to specialist mental health support for their residents; and
* the retention of records.

# 2. **Background**

## 2.1 Miss E background

2.1.1 Miss E was born in 1943, she was of mixed heritage recorded as English Indian. and was part of large family with many siblings. She attended Pitman’s typing school and looked after her mother until her death in 1993. At this time, she lived in Stepney Green.

2.1.2 She worked for a number of employers during her life including the Metropolitan Police in London.

2.1.3 She was described by her niece as being very independent; someone who wanted to look after herself. She could sometimes come over as having a ‘stiff upper lip’ and being strict. She liked silk gloves and perfumes, and had many trinkets. She used to write poetry.

2.1.4 Miss E liked animals and birds. She would visit Stepney City farm to feed the birds.

2.1.5 At the time of her death Miss E had limited family contact.

2.1.6 Miss E died on 4th February 2017, taking her own life. The Coroner recorded her cause of death as: Multiple traumatic injuries, including severe head injury. The local press reported that she had left a short note at the RCH for two of her nieces.

## 2.2 Arrangements between LBTH and ELFT

2.2.1 The functions of LBTH, under the National Health Service and Community Care Act 1990 and then, from 2015, under the Care Act, were undertaken by both LBTH social workers and ELFT nurses with a single team manager arrangement. Until March 2015, the team manager post, whilst funded by LBTH, was filled by an ELFT employee with a nursing background. In March 2015 a LBTH employed social worker was appointed to the joint team manager post.

2.2.2 Until April 2017, management of the service on behalf of both ELFT and LBTH was undertaken by an ELFT service manager. However, in April 2017 the ELFT mental health care of older person’s Directorate was dissolved and the service joined the ELFT Tower Hamlets Locality Directorate. At this time the LBTH Service Manager for Mental Health Social Care took over both the line management of LBTH staff and responsibilities in the service, with the ELFT Tower Hamlets Deputy Borough Director managing the service on behalf of ELFT. The team manager reported directly to both LBTH and the ELFT service managers.2.3 Admissions to ELFT

2.3.1 Miss E was admitted to ELFT usually with depression and suicidal ideas. Miss E had taken 3 overdoses, beginning in the 80’s, including a life-threatening overdose of 60 Paracetamol in 2011. Miss E had 6 admissions to ELFT inpatient wards, one under Section 2. Each time, she was refusing food and fluids, and asking to die. Miss E was reported to have been reluctant to accept her diagnosis or treatment and often discontinued antidepressants and mood stabilisers. Miss E was known to have relapsing illness.

2.3.2 However Miss E was noted to be very compliant with physical medicines and was proactive in seeking physical health care and occasionally was keen to pursue occupational therapy activities such as swimming and engagement with Stepney farm.

2.3.3 Miss E was under outpatients care at the time of her death. Care co-ordination was discontinued via a decision in supervision in January 2016 and not via a Care Programme Approach meeting with Miss E and the Multi-Disciplinary Team.

## 2.4 Commissioning and funding

2.4.1 Miss E’s support was funded and commissioned by the LBTH, and her mental health care was provided by the NHS through the ELFT.

2.4.2 The IMRs indicated that Miss E’s placement was made by a social worker working within ELFT. The LBTH finance team reviewed her finances. The RCH was commissioned by the LBTH.

## 2.5 Services received by Miss E

2.5.1 Having lived independently and then looking after her mother Miss E initially moved into a sheltered housing scheme run by a housing association (HA1). Miss E was reportedly a very active member of the scheme, participating in many activities and was a keen gardener. While not a mental health resource the manager and her deputy are reported to have become familiar with Miss E’s needs and how to support her. This sheltered housing scheme closed in 2009.

2.5.2 Miss E was moved to another sheltered housing scheme run by the same housing association where she seems to have lived successfully for five years.

5.2.3 Following an admission to hospital on 29 July 2014 Miss E moved into a residential care home managed by the same housing association. This was directly from the hospital. From the hospital notes (there are no application papers or records from the residential care home or from LBTH) it seems that Miss E was anxious about her garden being overgrown and hospital staff were concerned about her continued admissions to hospital. During the admission Miss E was clearly ambivalent about her move to a residential care home and while a move to another sheltered home was considered she was told she would have had to use the regular transfer process and receive no special assistance within the housing allocation system.

2.5.4 The RCH was a residential home for adults over 65 years of age. It was registered with the Care Quality Commission (CQC), the independent regulator of health and adult social care in England. It was not registered for people with mental ill health nor as a nursing home.

2.5.3 It was a three-floor building situated in East London. There were 32 en-suite rooms and six one-bedroom flats. At the back of the building was a garden and car park for staff and visitors.

2.5.4 The RCH had undergone a number of changes in recent years. The building was owned by a housing association and in 2014 the housing association took over the provision of regulated services on the site, which up to then had been provided by another care provider. While at the time staff transferred under TUPE arrangements, subsequently many left after the transfer.

2.5.5 When CQC inspected this service in December 2014 they found breaches of three regulations relating to repairs and maintenance, medicines management, assessment and care planning. In 2015 when they re-inspected they found significant improvements had been made in relation to repairs and maintenance, and there were robust arrangements for carrying out health and safety checks and a prompt response to repairs. Medicines were now managed safely, although some minor issues were noted which staff quickly rectified. Sufficient progress had been made with assessment and care planning to ensure the service was no longer in breach of the regulations, but more work was needed in this area and the service was rated as ‘Requires Improvement’ overall and across four of the five domains.

2.5.6 In 2016 when CQC inspected they noted: ‘At the time of the inspection the service was in a period of transition. A consultation period was just coming to an end about staff having to be reassessed and they were concerned about their positions, which led to a feeling of low morale amongst the staff team. Management were aware of this and had meetings to try to reassure staff as best they could’. The service was again rated as ‘Requires Improvement’ overall and across four of the five domains.

2.5.7 In 2017 CQC inspected again and wrote: ‘At the time of the inspection the service was in a period of transition. A new registered manager was in post who was trying to create a settled environment. People who used the service and their relatives spoke positively about them, and staff felt confident that the appointment could bring a level of stability to the service’. The service was again rated as ‘Requires Improvement’ overall and with the service being effective, moving to good, along with the caring domain meaning that three of the five domains remained at requires improvement.

2.5.8 The RCH subsequently closed as the housing association exited the care provider market. The housing association destroyed all the care files of the residents who were not part of the closure process when the home closed in April 2018 – over a year after the death of Miss E. While the LBTH made the decision to commission this SAR in March 2018 it wasn’t until November 2018 that the first SAR Panel met and agreed the Terms of Reference and documents to be requested.

# 3. **Purpose and Terms of Reference**

3.1 The purpose of a Safeguarding Adults Review (SAR) is neither to investigate nor to apportion blame. It is only relevant when professionals can learn lessons and adjust practice in the light of lessons learnt. It therefore requires outcomes that:

* Establish what lessons can be learnt from the particular circumstances of a case in which professionals and agencies work together to safeguard adults
* Identify what those lessons are, how they should be acted upon and what is expected to change as a result.
* Review the effectiveness of procedures, both of individual organisations and multi-agency arrangements
* Improve practice by acting on the findings (developing best practice across organisations)
* Improve inter-agency working to better safeguard adults
* Make a difference for adults at risk of abuse and neglect

## 3.2 The Terms of Reference of this Safeguarding Adult review included:

3.2.1 Areas for consideration:

The 6 Principles of Safeguarding:

* + **Empowerment** - People being supported and encouraged to make their own decisions and give informed consent;
  + **Prevention** - It is better to take action before harm occurs;
  + **Proportionality** - The least intrusive response appropriate to the risk presented;
  + **Protection** - Support and representation for those in greatest need;
  + **Partnership** - Local solutions through services working with their communities. Communities have a part to play in preventing, detecting and reporting neglect and abuse; and
  + **Accountability** - Accountability and transparency in safeguarding practice.

And:

* The care and support arrangements in place for Miss E. How these worked effectively together and were commissioned, contracted, funded and reviewed.
* If any of the care or support contributed in any way whatsoever to Miss E’s death.
* If all appropriate practices and professional standards were followed by staff and agencies assigned to Miss E’s care. In particular, how the CPA was managed and how LBTH’s care management responsibilities were fulfilled.
* If the staff involved in Miss E’s care and support were appropriately trained, qualified and experienced to provide the care they were giving. Did staff receive adequate supervision and support?
* If the agencies involved in providing Miss E’s care and support had appropriate training and support in place for their staff.
* If there were robust legal agreements between the agencies involved, particularly in relation to any formal arrangements between LBTH and ELFT in relation to any delegated duties.
* If there was sufficient co-ordination and communication amongst all agencies involved.
* If there is any learning from this event and to make recommendations to improve future working practices. To particularly consider the multi-agency learning for preventing self-harm and suicide.

## 3.3 Specific areas for consideration:

3.3.1 To consider the CPA and how it was used in relation to Miss E

3.3.2 To consider how well care co-ordination/CPA and care management processes worked together.

3.3.3 To consider what evidence there was of Making Safeguarding Personal and of work to prevent self-harm.

3.3.4 To consider the appropriateness of where Miss E lived and the support available to her.

3.3.5 To consider if appropriate consideration of the Mental Capacity Act 2005[[5]](#footnote-5) had taken place.

3.3.6 To consider whether there were multi-agency issues in relation to:

* Commissioning care and support for Miss E
* The contract monitoring and review of commissioned services
* The reviews of Miss E
* Sharing information between agencies
* Governance and accountability arrangements

3.3.7 To consider what agreements, legal or otherwise, existed between ELFT and LBTH in relation to any delegated responsibility for care management and the provision of social work and to make any recommendations as necessary.

3.3.8 To consider learning for development in the context of the s75 (National Health Service Act 2006) agreement between Local Authority and ELFT on Health and Social Care responsibilities for integrated teams, with particular regard to safeguarding and suicide prevention.

3.3.9 To consider if and how family members were communicated with and involved with Miss E’s care and support.

3.4 The Purpose (outcome)

* To provide insights into the way local organisations are working together to support adults with mental health issues
* To learn lessons from how professionals and their agencies work together
* To improve local inter-agency practice
* To identify service improvement or development needs for one or more service or agency.
* To explore examples of good practice

# 4. **The review process**

4.1 The methodology applied for this SAR combined formal individual management reports and a chronology from each agency with discussion at multi-agency panel meetings.

4.2 The main focus of this review was on the 2 years preceding Miss E’s death. However where relevant, references are made to information prior to 2015.

4.3 The Independent Author and Chair met with agency authors at the beginning of the review to discuss the terms of reference.

4.4 The reports were reviewed and discussed in detail at meetings between the panel and authors.

4.4 The Independent Author and Chair was supported in the review by a panel. The panel members were from the SAB partner agencies and brought a further level of expertise and scrutiny to the individual agencies’ reports. The panel membership included[[6]](#footnote-6):

* SAR Panel Chair
* Independent Overview Author
* Service Manager ELFT
* Senior Solicitor - Legal, LBTH
* The Metropolitan Police
* Commissioning Manager, LBTH
* Service Manager Vulnerable Adult Safeguarding
* Joint Safeguarding Adults Strategy and Governance Manager (Interim), LBTH).
* Joint Senior Strategic Safeguarding Adults Lead in the Local Authority and Clinical Commissioning Groups
* Safeguarding Adults Board Coordinator, LBTH
* Executive Director – Housing Association

4.5 Organisations that had significant involvement with Miss E prior to her death completed a chronology of events outlining their involvement.

4.6 Individual management reviews (IMRs) were requested from all of the organisations that had significant involvement with Miss E and were received from:

* LBTH Adult Social Care
* Tower Hamlets CCG
* ELFT
* The Housing Association
* GP Practice

Further information was received from:

* The Care Quality Commission
* The Coroner
* Metropolitan Police
* Miss E’s niece and her great nephew who had a meeting with the Independent Author on the 29th April 2019.

4.7 The RCH commissioned their own report into the circumstances surrounding Miss E’s death in March 2017 and this was made available to the panel.

4.8 The panel met in February 2019 to consider the IMR reports. The IMR authors presented the reports to the panel, answered questions and contributed to discussions.

4.9 The author also met Miss E’s niece and great nephew who were very helpful in giving a richer picture of Miss E’s life and who she was. They were also keen to understand:

* Why Miss E was moved to a residential care home
* Whether she received the appropriate care at the residential care home; and
* Why Miss E seemed to stop having support from ELFT

4.10 In the following pages the report tries to answer these questions and the areas covered by the terms of reference.

4.11 The finalised report was then shared and discussed with the family by the author in September 2020 prior to publication. Miss E’s niece and great nephew were keen to ensure that there had been learning particularly in the areas of: training for care home staff; communication between agencies; and care plans being up-to-date and shared.

# 5. **Who was Miss E – a description**

5.1 Miss E was born during the second world war (1943) and was the youngest of a large family with many siblings (13). Her ethnicity was described as mixed heritage English Indian. One of the documents reviewed suggests Miss E did not have a particularly happy childhood, leaving school at 15 years old without qualifications, and subsequently working in mostly clerical jobs. She attended Pitman’s typing school.

5.2 Miss E worked for a number of employers including the Metropolitan Police in London.

5.3 Miss E looked after her mother for a number of years. Her mother declined support from social services as she preferred Miss E to care for her, which she did for a number of years until her mother’s death in 1993, when Miss E would have been 50. At this time she lived in Stepney Green.

5.4 Miss E was reported to have often described herself as "the odd one" in her family; as all her siblings got married and had their own families while she remained unmarried.

5.5 Miss E was described by her niece as being very independent and someone who wanted to look after herself. She could sometimes come over as being ‘harsh’, or strict and had a ‘stiff upper lip’.

5.6 However Miss E also liked silk gloves, perfumes and had many trinkets. She used to write poetry.

5.7 Miss E liked animals and birds. She would visit Stepney City farm to feed the birds and was recorded as saying that she ‘prefers the company of animals than human beings’. Before her death she had planned to have a day at the races. While in her sheltered accommodation, where she had her own garden, she would spend much time in the garden and was noted to have asked if she could keep chickens.

5.8 CPA documents note that Miss E said she preferred her own company and described herself as a ‘recluse’; willing to do anything to avoid other people’s company. She was also noted as saying that she preferred to watch the CBBC channel on television as this appealed to her more, with no adverts, and helped her stay away from ‘this ugly world’. She said she never attended a nursery herself and enjoys reliving what she missed out on. It was noted Miss E used to attend a day-centre but stopped going due to age eligibility – she became too old. She had in the past agreed to a befriender and attended ballet classes in the community. She had also attended a seated movement and gardening group at another day centre.

5.9 Her niece said she had panic and anxiety attacks which her aunt attributed to her mood swings due to the menopause.

5.10 While Miss E came from a large family and her brother was noted as the contact on her financial assessment forms, the ELFT records and CPA forms noted that Miss E did not want her family informed of her admissions to hospital. At the time of her death Miss E appeared to have most contact with her nieces and her great nephew and limited family contact with other family members

# 6. **Narrative chronology of events concerning Miss E**

6.1 Following a history of admissions to hospital over a number of years in June 2014 Miss E’s Care Coordinator (CCO1) telephoned Miss E, who informed the CCO1 that she had not been eating or drinking for days. She was recorded as saying that she wanted to be in a coma and die. The record noted that there was a previous history of admissions following a period of low mood and thoughts of ending her life. The CCO1 discussed admission with a doctor and he agreed to an admission.

6.2 The Duty Doctor saw Miss E. and noted:

*Miss E reports that she hasn't been eating well over the past few days, says that it is because she lacks motivation to go out to buy and then cook food. Talked of not wanting to be alive for the past few years 'I don't want to live, I haven't got the energy...just want to lie there and be put on a drip'. Says that her mood has been bad consistently for past few years, her main problem was managing to look after herself. Says that her sleep pattern varies and tends to oversleep 'I want to sleep my life away'. Doesn't have a good appetite, unsure about any weight loss, poor concentration. No active plans to harm herself. Nil psychotic features noted. Feels safe on ward*.

Miss E’s past mental health history was also noted.

6.3 At the time of this admission Miss E was living in Sheltered Accommodation provided by a Housing Association where she had lived for some years.

6.4 The plan at admission was:

* To continue to support Miss E
* To empower her in taking control of her life by building on identified strengths.
* To support her in building individual emotional regulation strategies that will help her better control her feelings.
* To monitor her mental state especially for any active suicidal and relapse symptoms. Increase home visit to de-escalate relapse symptoms and initiate psychiatric review.
* To offer information and advice to Miss E on the benefits of antipsychotic medication in reducing her negative symptoms.
* For her to receive regular reviews in line with the CPA process and earlier if necessary.

6.5 On 29th July 2014 Miss E was admitted from hospital to a residential care home (RCH). This care home was managed by the same housing association she had been a tenant of in her sheltered accommodation. The housing association was also the registered care provider and registered with CQC as such.

6.6 The IMRs from both ELFT and LBTH lack any detail about the decision for Miss E to move to RCH from her sheltered accommodation. Discussions did take place with Miss E when she expressed concern about her garden being overgrown and discussed moving to an extra care or residential placement where she did not have her own garden. The casefile recording notes:

*She felt the residents at the Residential Homes were older and more debilitated than herself she does not feel she would fit in there. She feels she is (able) to (be) independent and feels if she could keep well she would be able to manage living in supported accommodation*

6.7 Miss E was noted to have visited two residential care homes. The care records note that she particularly liked one of the houses and made positive remarks about the layout of the home, the location and especially, the spacious bedrooms. That she had viewed four flats and was particularly keen with one on the second floor. She was noted to have liked that the flat was situated at the far end of the corridor, with a window view over-looking the main street. It was also noted that she commented on the home surroundings smelling "nice".

6.8 However a few days later at a ward round it was noted that:

*Miss E had viewed Residential Care Homes but feels she can stay where she is for the next 10 years or so. Her main source of anxiety is not being able to manage her garden. She does not want to consider moving to another flat or any other sheltered accommodation as she feels it would be too stressful for her. She would not like residential as she says she enjoys her niece staying over occasionally she says she also enjoys her garden regardless that it’s overgrown. She would be willing to pay someone to attend to it.*

6.9 On the 30th June 2014 Miss E returned home on ‘leave’ from the hospital. On 4th July 2014 she was contacted by a mental health social worker who noted that:

*Miss E said she would like to move to RCH as she has realised that she needs a smaller place and her current flat is becoming too overwhelming. She would like to view the room again.*

6.10 The placement request was presented to Combined Adults Social Care Panel on the 11th July 2014 for placement at RCH, it was agreed for a trial of 4 weeks, and to be reviewed after 3 weeks and represented if trial period successful. There was no note of any discussion around the suitability of the home to meet the needs of an older person with long-term mental ill health. The approval proforma while not noting any detail does indicate that this admission was for ‘respite’ and a ‘trial period’.

6.11 Miss E moved to the RCH on 30th July 2014. The mental health social worker notes: *helped Miss E move to RCH. No concerns and Miss E is embracing the change*.

6.12 On 12th August 2014 a further funding proforma noted agreement to the residential placement with an ‘ongoing’ end date. It should be noted this was just 12 days after Miss E actually moved in. None of the other assessment or admission papers were available for this report including any information about a 3 week review as requested by the original funding panel.

6.13 On 6th November 2014 a LBTH financial assessment was undertaken in relation to funding the residential care home placement.

6.14 The ELFT IMR indicated the next hospital admission was on 28th November 2014 with a discharge of 8th January 2015 – just over 5 weeks. It was noted on the CPA form that Miss E had ‘stopped eating for days and had indicated that she wanted to die’.

6.15 During this admission a fairly full assessment template was completed by the named nurse which included previous history and a useful formulation of need and risks. However, there were some factual inaccuracies e.g. accommodation was given as sheltered; and the rather complex form which seemed to be both a CPA form and an assessment template was only used as an assessment tool and to formulate the in-patient care plan.

6.16 The LBTH ASC IMR noted a CPA taking place on 5th December 2014 but the Care plan review form was dated 11/12/14 and dated at the end of the form as 20/12/14. This was a review of the in-patient care plan.

6.17 The next review was on 8th January 2015. This acted as the hospital in-patient discharge CPA meeting.

6.18 The CPA proforma used seems to combine information from previous admissions and be updated for this admission i.e. a completed previous CPA form with additional text noted on it. This does not make it an easy document to use. The updated sections of the CPA form noted that:

*During this review, it was established that Miss E’s mood had improved. She had had some leave which were reported to be successful.*

*Miss E reported that she* (was) *not happy to continue to leave at RCH permanently as she wants her own front door so as to live her life the way she wants it. She reported that her continuous stay at RCH is making her have mood swing(s) leading to her decision not to eat and die away.*

*Miss E presently lives in a RCH. She moved into RCH as a result of not coping in her previous sheltered accommodation. She has not been able to settle as she would like to go back into a sheltered accommodation. Miss E reported during this review that it is her inability to move back into sheltered accommodation that has affected her mood leading to her hospitalisation. She reported that she would like to move back into the community, have her ‘own door’ and cook what she wants and also live her life the way she would like to. It was agreed during this review that she will be supported to re-apply for sheltered accommodation.*

6.19 The care plan for discharge noted amongst other actions:

* Miss E was being supported to secure a sheltered accommodation facility. She has applied and she has attended an interview
* To monitor her mental state, especially for any active suicidal and relapse symptoms. Increase home visits to de-escalate relapse symptoms and initiate psychiatric review.
* To offer information and advice to Miss E on the benefits of antipsychotic medication in reducing her negative symptoms.
* For her to receive regular reviews in line with the CPA process and earlier if necessary.
* To be referred to ward psychologist
* To receive monthly visits from care coordinator who will monitor mental state and initiate timely interventions.

6.20 Relapse Indicators/Warning Signs, Crisis Plan, Contingency Plan were all completed, but looked as if they were carried over from a previous plan. It was unclear as to whether they were updated or if they needed to be.

6.21 The care co-ordinator saw Miss E for the last time in 2015 and in 2016 Miss E was discharged from CPA to outpatient clinics. Care co-ordination was discontinued via a decision made by Miss E’s Care Co-ordinator and her manager (Team manager) in supervision in January 2016 and not via a Care Programme Approach meeting with Miss E and the Multi-Disciplinary Team.

6.22 The ELFT Serious Incident Review noted that the last two Care Programme Approach reviews (19th January 2016 and the 3rd March 2016) recorded on the RiO records were not in fact Care Programme Approach reviews but were an administrative exercise and they were recorded on the RiO system by the team administrator as was the practice at the time.

6.23 The ELFT IMR noted on 19 January 2016 a Community Mental Health Team – Older People Multidisciplinary Team (MDT) Clinical meeting took place. There was no refence to Miss E attending or being invited to attend this meeting. Although CPA documentation was completed, the meeting was also referred to as an MDT Clinical meeting in the ELFT IMR. The separate CPA form noted that Miss E was reviewed in the outpatient clinic by Dr A in December 2015. She was seen at RCH on 18/01/2016. She was low in mood but denied any plan to harm herself or others. She had insight into her mental health and she was managing to cope with it.

6.24 The ELFT IMR noted from the same meeting that:

* Miss E was now ‘settled in to RCH’ (this was also documented on the CPA form)
* Diagnosis: Severe Depression (the CPA form noted BIPOLAR AFFECTIVE DISORDER (in red capitals) and ICD10 Code(s): F31.4[[7]](#footnote-7))
* Lives at RCH. There are no major risks identified. But this was contradicted by a further note that when Miss E relapses she can overdose.
* Plan: To step down from CPA to Outpatient clinic
* Arrange a discharge CPA meeting:

6.25 The CPA document of that date makes no reference to any discharge from CPA and noted: To receive monthly visit from care coordinator who will monitor mental state and initiate timely interventions. There was also no indication as to what follow up had taken place since the previous CPA on Miss E’s wish to return to sheltered accommodation – just the note that she was now settled at RCH.

6.26 On 15th March 2016 an outpatient appointment noted:

*no changes in Miss E - she described reasonable mood, sleep and appetite, but she was worried about cyclists on the pavements. Speech was slightly pressured but no flight of ideas.*

The plan was noted by the doctor as:

*I will ask her care-coordinator to consider a referral to a support worker to help her with going out. I will see her in 3 months or earlier if necessary. Spoke to care home and they do not report any concerns.*

6.27 By the 15th March 2016 there was no CPA care coordinator, and it was unclear who within the ELFT team was responsible for reviewing her support at the RSH.

6.28 On 21st June 2016 Miss E was seen in the community by Dr A. The CPA document noted Miss E very distressed, feeling giddy and tremors. She said she wanted to die: ‘can’t you give me something to put me to sleep’. It was noted that it was difficult to move her away from this train of thought and that she was anxious and agitated and unable to relax. She also described a severe insomnia.

6.29 Miss E was offered a hospital admission which she accepted. The doctor’s impression was relapse of mixed episode/agitated depression. The plan was for this to be a short admission; Miss E discharged on 28th June 2016.

6.30 An in-patient ward round took place on 28th June 2016 During the multi-disciplinary team discussion it was noted that Miss E had been mostly confined to her bed, not interacting very much. Miss E was seen as part of the discussion and said she felt much better now and would like to go home. Miss E reported she was sleeping well and has been taking her medications and felt that olanzapine was helping. It was noted that Miss E said she has no friends ‘they all got married and moved off’. It was noted Miss E had constant passive thoughts of suicide, and had said to the team ‘I wish I could just go to sleep and never wake up…I wish I went off when my mum died’ and reported that she had no future hopes and felt anxious for everything. It was noted Miss E has had psychology input in the past but did not think this was useful and refused to have any further sessions.

6.31 The team concluded that Miss E had a stable mental state, with no evidence of affective disorder. No current suicidal ideation. The plan was to discharge her home that day and follow up in Community Mental Health Team with Dr A undertaking the seven day follow up with Community Mental Health Team. There was no evidence of an updated care plan on discharge, whether CPA was re-instituted or if any guidance was offered to RCH staff on how to support Miss E nor whether Miss E was informed about what support she could expect.

6.32 On 30th June 2016 Miss E was seen by Dr A at the RCH for a seven day follow up appointment. It was noted she was settled and said that she was eating and sleeping well. She still noted periods of distress but felt that they were less than before. She said she felt better since being in hospital and denied any suicidal thoughts or plans. A further appointment was made for July.

6.33 On 6th July 2016 Dr A contacted the GP to inform them that Miss E had contacted him the day before and reported that she did not want to change her medication. Dr A requested the GP note this.

6.34 The IMRs note that on 28th July 2016 Miss E came to see Dr A in the outpatient department. She described herself as being fine at present. She requested a reduction in medication which was agreed and actioned. This seems to be the last contact that Miss E had with mental health services. No further reviews were set and no further outpatient appointments were made.

6.35 At the end of November 2016, Dr A left the service of ELFT and the patient was not reallocated to another doctor. The ELFT Serious Incident Review noted that Miss E should have had an outpatient appointment in October 2016. It further notes that did not happen and it was difficult to determine why this was the case. Therefore, last face-to-face contact with Miss E was on 28th July 2016 this was the last contact the patient had with ELFT services. The report goes on to say that Miss E ‘became effectively “lost to services”’.

6.36 On 7th September 2016 a duty entry noted a telephone call from a team leader at the RCH stating that Miss E was refusing some of her medications, and wanting advice whether a review of Miss E’s medication was necessary. A discussion with Dr A was noted and it was agreed that as Miss E was not expressing any psychotic symptoms and the staff at RCH were able to manage her it would be best to keep an eye on her and staff should contact us should they need any support. This information was relayed to the Deputy Manager at the RCH who confirmed that Miss E had been settled and ok.

6.37 On 7th October 2016 an email from LBTH finance team was received by ELFT. The finance team worker noted they were unable to find an allocated worker on their database but wanted to inform the team about a home visit made by the finance team to Miss E because she seemed unhappy and distressed about her life and the worker wanted to feed this back in case anything could be done to help her. The LBTH operational lead (team manager) contacted the finance team back thanking them and reassuring them that Miss E was recently reviewed by Dr A (the only record was the July 2016 review 3 months earlier) and had regular outpatient appointments (which she did not). The LBTH lead also noted that Miss E was monitored ‘through the clinic and has no allocated worker’. There was no evidence that at this time any worker checked to see when the next review, outpatients appointment or follow up was due.

6.38 There was evidence from the RCH’s own review that from mid-January 2017 Miss E was spending more time alone, isolated in her room and was disengaging with care staff; this may have been a potential relapse indicator for Miss E. The ELFT Serious Case Review notes:

*This may have been picked up if she had either been seen in the outpatient’s clinic in January 2017 as she should have been; or if the care home staff had recognised the significance of the change in the behaviour of the patient and sought advice from the Community Mental Health Team.*

6.39 It was reported that Miss E was last seen by staff at the RCH around 6:30pm on Saturday 4th February 2017 when she brought in her plate to the communal area, following supper in her room. It was reported she was seen by staff at the time, who greeted her, and she responded appropriately. RCH staff reported they were not aware that Miss E had left the building after supper time. The RCH daily record noted that at 8pm staff went to check on Miss E and that she was not in her flat. Later that evening the police contacted the LBTH Emergency Duty Team (EDT) to inform them of Miss E's death.

6.40 The next day EDT alerted the Assessment and Intervention Team (LBTH) of Miss E's death via an emailed Out of Hours Report. On Monday 6th February 2017 the Assessment and Intervention Team informed the ELFT mental health team of Miss E's death

6.41 According to the information obtained via the Coroner’s Officer, Miss E was witnessed to have fallen from a bridge in central London onto the ground below. She suffered severe internal injuries and a severe head trauma and according to The Coroner’s post mortem report her injuries would have been immediately fatal and recorded her cause of death as: Multiple traumatic injuries, including severe head injury. The toxicological tests showed the presence of paroxetine (an antidepressant) in a high therapeutic amount and there was no evidence of other drugs or alcohol.

# 7. **Analysis**

## 7.1 Care Programme Approach and Care Act duties

7.1.1 It was evident from the IMR reviews that Miss E was at risk of self-harm for a significant period of her life and remained a person at risk of self-harm throughout her time at the RCH.

7.1.2 It was unclear from the limited information available how much the causes of Miss E’s distress had been explored. She had the involvement of a psychologist at one point but declined further interventions. With hindsight and the time to look at a fuller history it may be of note that Miss E referred to ‘a not so happy childhood’ in a large family, and that she lacked the potential support of a circle of friends or partner. The protective factors that we know employment gives ended early. Miss E was a lone carer for an older parent who died.

7.1.3 Miss E was clearly unhappy and preferred to be alone. When her unhappiness got too much she often recognised it and she was admitted to hospital, and if she didn’t recognise it others around her did and she received support.

7.1.4 The mental health services were clearly a key support in Miss E’s life. She had a number of admissions to in-patient services – her penultimate admission being for over 5 weeks. Miss E attended appointments with her doctors and other mental health staff, even though she often said she didn’t want to see them or asked them to go away. The same was true for the staff at the RCH – often in her room, or her bed, she didn’t use the communal facilities much; didn’t have friends and may have been seen by some as difficult or verbally harsh.

7.1.5 The LBTH care management functions in regard to assessment and review were not clearly documented within the CPA documentation or on either the ELFT’s or LBTH’s databases.

7.1.6 The ELFT CPA documentation was often used in an updating format, making it difficult to see what was new or current and what was transferred across from previous documents. The forms did not lend themselves to enabling and documenting work under the Care Act (or previously the National Health Service and Community Care Act 1990). There were few prompts and little dedicated space for care management assessments, interventions and outcomes.

7.1.7 The evidence from the IMRs suggests that Miss E was not reviewed as required under the Care Act (or previous duties). None of the documents seen were outcome based or designed to support strengths-based working and creating co-produced and owned plans. If they had been it may have facilitated greater discussions about Miss E’s strengths – there were clearly many – and how to build on them and to also focus on her concerns about her accommodation and feelings of hopelessness.

7.1.8 Likewise there was no evidence of specific measures to facilitate or even offer advocacy / empowerment for Miss E in the process of negotiating care and support – e.g. an advocate under the Care Act.

7.1.9 There was no evidence that Miss E’s wider life, likes and dislikes had been discussed with her. For example, what was her love of animals and birds built upon? Did the RCH consider her having a cat? Was Miss E asked to look after bird feeders on the site?

7.1.10 It was of note that the RCH as the care provider did not appear to have been routinely included in reviews.

7.1.11 While there was some recording of crisis / contingency plans in the documentation and some advice regarding interventions to address relapse these seem to have been copied from one CPA form to the next. They don’t seem to have been updated or to have been a ‘living’ plan.

7.1.12 It was unclear from the IMRs and the documents how care coordination/care management was implemented during the period of this review. The ELFT IMR makes note that a care co-ordinator last saw Miss E in June 2015. The last contact the Care Coordinator had with Miss E was noted in the ELFT IMR when a joint review with a previous consultant psychiatrist took place because Miss E did not want further contact with the care coordinator. However, this was not noted within the IMR chronology and there was no evidence of supporting documents. There was evidence in the ELFT database records that Miss E was followed up by a physiatrist, however following discharge from hospital in June 2016 and the subsequent follow up in July 2016, there were no further records that Miss E was seen.

7.1.13 There was no documentation to explain the discharge of Miss E from CPA or Care co-ordination in 2016 on the ELFT database but the ELFT IMR concluded that discharge from CPA to outpatient clinics was agreed in supervision. The IMR further noted that this decision to discharge from CPA outside of the CPA process was a poor decision and that there was no evidence of attention to the duties placed upon the team under the Care Act i.e. Miss E was not allocated for review in line with the Care Act requirements.

7.1.14 Miss E should have had an outpatient appointment in October 2016 and another in January 2017. These did not happen and it was difficult to determine why this was the case. The last face-to-face contact with Miss E was on 28th July 2016; this was the last contact Miss E had with ELFT services.

7.1.15 At the end of November 2016, the consultant psychiatrist left the service of ELFT and Miss E was not reallocated to another consultant so becoming effectively as, the ELFT IMR puts it: ‘lost to services’.

7.1.16 The concerns reported by the LBTH finance officer on 7th October 2016 should have triggered a review or at least confirmation of the next review date to ensure that the support being provided was adequate to Miss E’s needs in light of her reported deteriorating presentation and to guide and support the provider in meeting her needs.

## 7.2 Accommodation and the residential care home

7.2.1 Miss E had an ambivalent view about the RCH. While it was noted that she became more settled while there, she clearly missed her own garden and level of independence her previous sheltered accommodation had afforded her. It was unclear from any of the IMRs or records explicitly why she moved to the RCH, what different outcomes were hoped for; and what further work was done when she asked to move back to sheltered accommodation.

7.2.2 There was little evidence of any support to the RCH from the mental health service in relation to Miss E. The home, which is no longer operating, was registered as a residential care home caring for adults over 65 yrs. It was not registered for people with mental ill health, nor was it a specialist residential care home. While this may have been appropriate for Miss E (it was difficult to tell with no referral records, or record of desired outcomes) she was clearly different to other residents and had found it hard to settle in. CQC reports and the housing association note that staffing was in transition at the home over a significant period. The home could have benefitted from input around strategies to support Miss E when she didn’t want contact or just stayed in her room.

7.2.3 While Miss E was assessed and deemed to have capacity, the RCH could have been helped to explore if Miss E’s ‘choices’, such as not eating / staying in her room were lifestyle choices or choices she felt compelled to make because of her mental ill health? Were these indicators of self-neglect?

7.2.4 It has been very difficult to make judgements about the actions taken by the RCH on the night of Miss E’s death and beforehand as when the RCH closed in 2018 the housing association responsible for the home destroyed all their records. However, some records have come to light via the family members with whom the RCH shared them before the closure, for which the author is very grateful.

## 7.3 Delegated statutory arrangements made with ELFT by LBTH

7.3.1 It was clear that LBTH’s oversight of their ASC functions delegated to ELFT was weak and there was a lack of senior engagement to ensure that LBTH’s responsibilities were understood and addressed by staff. The formal arrangements for the delegation of these responsibilities to the team were known to be unclear at the time; and subsequently there has been work on a s75 Partnership Agreement which will address these weaknesses.

7.3.2 There was also a lack of clarity around the LBTH’s expectations regarding its delegated functions. It was further unclear at the time how the successful delivery of these functions were overseen and monitored at a senior level within LBTH.

7.3.3 Over the decades much has been written about the effectiveness of MDTs and the role of social care in those teams. As the SCIE[[8]](#footnote-8) paper ‘Highlights No 4 – July 2018 Delivering integrated care: the role of the multidisciplinary team’ points out in its key messages:

* Successful working requires at minimum an identified manager or coordinator, regular joint meetings and the effective sharing of electronic records; and
* The success of the MDT approach is not guaranteed: without strong organisation the impact may be negative rather than positive.

7.3.4 In part, due to the lack of LBTH oversight and performance measures, it seems to have been unclear to staff where they recorded social care actions, and how actions from central functions like brokerage or finance were captured for mental health service users and likewise how mental health information was accessed by other ASC workers. Even the two IMRs (ELFT and LBTH) for this review showed a level of duplication and confusion regarding the provision of information to the review – reflecting the confusion on the ground for staff working between these two organisations.

7.3.5 As can happen in some MDTs without access to good ASC leadership and oversight, some basic social work practice disappears. While some of this may be process led (e.g. reviews/finance), more importantly there can be a lack of focus on strengths-based social work; working with people to achieve the outcomes they wish for; consideration of advocacy, and the wider community the person is part of. This was clearly the case for Miss E.

## 7.4 Safeguarding issues

7.4.1 Miss E’s self-harm (a history of overdoses) and self-neglect (not eating, staying in bed) were not seen as safeguarding issues. This may have been appropriate if there was a clear relapse plan and a plan to keep her safe when unwell. There was no evidence that there were up-to-date or well-developed plans of this nature.

7.4.2 When it was noticed that Miss E was not in her room on the evening of her death, what action was taken by the RCH? Because of the destruction of their care records the RCH was unable to provide a definitive account of what happened that evening.

## 7.5 Retention of records

7.5.1 The housing association that ran the RCH and was registered by CQC to do so, destroyed the care home records for the residents that were not part of the closure process before they were asked to contribute any information to this SAR.

7.5.2 The Records Management Code of Practice for Health and Social Care 2016[[9]](#footnote-9) sets out what people working with or in NHS organisations in England need to do to manage records correctly. Itis based on current legal requirements and professional best practice and was published on 20 July 2016 by the Information Governance Alliance (IGA).

7.5.3 Appendix 3 of the Code[[10]](#footnote-10) contains the detailed retention schedules. It sets out how long records should be retained, either due to their ongoing administrative value or as a result of statutory requirement.

7.5.4 Within this appendix it states that Adult social care records should be retained for 8 years. This retention should start at the point of the end care or when client is last seen. For Miss E’s records this would have meant retention until February 2024. This could have been used as a guiding principal when the Housing Association closed the care home and reviewed the care records they held.

7.5.5 A standard pre-placement agreement was in place between the LBTH and the RCH. In this agreement at 3.32 reference is made to record keeping but there is nothing explicit on the retention of records. However, at the time of Miss E’s death the LBTH Retention Schedule: Education, Social Care and Wellbeing (ESCW) and Public Health May 2014 v2[[11]](#footnote-11) was extant. This clearly set out retention requirements for Residential Homes in section AC1.5. It requires the permanent retention of records in line with national guidance as outlined in sections:

AC1.5.1: Summary management systems that manage children/adults housed by the Local Authority.

* Children's/adults home registers
* Admissions registers
* Discharge registers

AC1.5.2 Operation of homes: Relating to the operation of the establishment:

* Diaries
* Rotas
* Daily logs
* Menu
* Secure unit records

7.5.6 The RCH management did not meet this standard in relation to the retention of records.

7.5.7 In October 2018 The National Housing Federation published: ‘Document retention and disposal for housing associations’[[12]](#footnote-12). The document explained the requirements to retain and dispose of data for housing associations and provided guidance on appropriate data handling and disposal. In section 11: Application and Tenancy Records, the guidance states: Care plans/case files for adults and related documents – retention for 8 years from end of care. (Adult Social Care).

7.5.8 This document was published after the RCH was closed, but clearly the RCH management did not consider that this level of retention was necessary.

## 7.6 Professional practice

7.6.1 From the documents reviewed there seems to have been a lack of any recorded social work interventions. There were MDTs but these seemed to focus on discharge when Miss E was an inpatient, or admission when she was in the community. There was an apparent lack of holistic assessment, followed by a strengths-based plan.

7.6.2 There was evidence of Care Programme Approach documentation on ELFT systems however it was not up to the standard expected and there were gaps in the documentation in both the Community Mental Health Team Older People and inpatient team. There was no evidence to support the discharge of Miss E from CPA or Care co-ordination on the database.

7.6.3 The ELFT records suggest that managers were involved, however the decision to discharge from CPA and the Care Co-ordinator was not taken in the correct way and a manager was involved in this decision.

7.6.4 There was no evidence of assessment and planning under the Care Act or previous legislation.

7.6.5 There was no evidence of ASC reviews of Miss E’s residential support.

7.6.6 There was no evidence that the RCH was invited to, or involved in, any CPA reviews.

7.6.7 The last two Care Programme Approach reviews (19th January 2016 and 3rd March 2016) recorded on the ELFT records were not Care Programme Approach reviews but were administrative exercises which were recorded on the ELFT system by the team administrator as was the practice at the time. This was unacceptable.

7.6.8 There was a lack of robust systems to track and monitor patients within the Community Mental Health Team – Older People, and there were inadequate systems in place to ensure that when a consultant psychiatrist left, her or his patients were reallocated and received the appropriate appointments.

7.6.9 When the team received information from the finance team about their concerns, there could have been a greater level of curiosity shown. While Miss E was well known to the service and the behaviours were not unknown, her next appointment or follow up could have been checked to assure the team that Miss E was going to be followed up in a timely manner, and the concerns passed to the RCH.

7.6.10 It was clearly ill considered for the housing association to destroy their care records when the home closed. This destruction was not in line with good practice and does not seem to have been agreed with any other agencies nor based on any extant guidance published at the time.

## 7.7 Good practice

7.7.1 The communication between the consultant psychiatrist and the General Practitioner was helpful and happened after every outpatient appointment.

7.7.2 The referral from the finance team was highly appropriate and showed good insight. Information from finance teams and monitoring teams is sometimes overlooked, or not given the weight it deserves. Sometimes these teams have longstanding members who will have been in touch with people over a number of years and because of that can have real insights.

## 7.8 Learning

7.8.1 The need for clarity when a local authority delegates any of its statutory duties (under the Care Act 2014[[13]](#footnote-13)) to another body.

7.8.2 The need for proper and robust governance arrangements between LBTH and ELFT in order to effectively managed delegated duties.

7.8.3 The need to keep the patient / service user at the centre of all that is done – and to ensure that their strengths are built upon and their aspirations discussed with them and they are included in decisions made.

7.8.4 That processes such as CPA or care planning are only as good as the people implementing and overseeing them.

7.8.5 That all people working with an individual should be considered as part of the team. They should all be supported, and included in discussions and planning, whether they are clinicians, managers, support or residential staff.

# 8. **Conclusions**

8.1 There was a lack of governance arrangements between the LBTH and ELFT. This resulted in ELFT not discharging LBTH’s duties which had been delegated to ELFT. LBTH did not have performance systems in place to ensure that ELFT discharged their delegated duties effectively.

8.2 Miss E did not receive appropriate holistic strengths-based assessments of her support needs.

8.3 The CPA process did not facilitate the necessary ASC reviews and re-assessments.

8.4 The CPA process was not properly implemented.

8.5 Miss E was discharged from the CPA through an inappropriate process.

8.6 Miss E did not receive adequate and timely support form ELFT and in the words of ELFT’s IMR became ‘lost to services’.

8.7 The RCH was unsupported by ELFT MDT.

8.8 The RCH was not reassessed as to the appropriateness of the provision for Miss E.

# 9. **Recommendations**

9.1 That the governance arrangements between the LBTH and ELFT are reviewed and made fit for purpose, ensuring that there is a robust framework of oversight and support in place for LBTH’s delegated functions including:

* Monitoring the quality of work undertaken under the Care Act
* Ensuring governance references complaints/ incidents/ information sharing

9.2 That joint ELFT and LBTH services ensure people receive appropriate, holistic strengths-based assessments to support their needs.

9.3 To review the CPA process to ensure it facilitates the necessary ASC reviews and re-assessments and that people can only be discharged via a valid process.

9.4 Once the CPA process has been reviewed, to ensure that it is properly implemented and audited at regular intervals.

9.5 To ensure that health and social care responsibilities and perspectives are fully understood within ELFT and to recognise that while clinical and Care Act priorities may not always be aligned they must ensure that both are addressed when organising treatment, care and support.

9.6 Ensure that ELFT has processes in place and regular audits so that people are not ‘lost to services’ within ELFT.

9.7 Ensure that detailed crisis plans, relapse signature information and contact details are provided to providers and that they have access to specialist mental health support for their residents under the care of ELFT.

9.8 All patients who are subject to the Care Programme Approach and live in residential care should have a member of the residential care team invited to their Care Programme Approach review and a copy of the Care Programme Approach template and Care Plan should be shared with the residential care team (with relevant consent).

9.9 For the housing association responsible for the RCH to commission a short independent review of how the decision was made to destroy the RCH records and what learning has been made.

9.10 For the LBTH to ensure that their contracts with providers clearly articulate the requirement for retention of records even after a service closes.

9.11 That priority three ‘Identifying the needs of vulnerable people’ and priority four ‘Addressing training needs’ in the Tower Hamlets suicide prevention strategy[[14]](#footnote-14) are implemented with particular reference to front line staff in care homes.

1. The Care Act 2014

   <http://www.legislation.gov.uk/ukpga/2014/23/pdfs/ukpga_20140023_en.pdf> [↑](#footnote-ref-1)
2. During the whole of her life Miss E referred to herself as ‘Miss’ and was known to ask others to do so – we have respected this wish within this report. [↑](#footnote-ref-2)
3. [↑](#footnote-ref-3)
4. Section 75 of the National Health Service Act 2006 is used between local authorities and NHS bodies to make joint agreements that can include arrangements for pooling resources and delegating certain NHS and local authority health-related functions to the other partner/s [↑](#footnote-ref-4)
5. The Mental Capacity Act (MCA) is designed to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment [↑](#footnote-ref-5)
6. Due to changes in some agency staffing structures, post titles and designations may have changed during the course of the review. [↑](#footnote-ref-6)
7. ICD-10-CM Diagnosis Codes - F31.4 - Bipolar disorder, current episode depressed, severe, without psychotic features [↑](#footnote-ref-7)
8. Social care institute for excellence

   <https://www.scie.org.uk/integrated-care/workforce/role-multidisciplinary-team#keymessages> [↑](#footnote-ref-8)
9. <https://digital.nhs.uk/data-and-information/looking-after-information/data-security-and-information-governance/codes-of-practice-for-handling-information-in-health-and-care/records-management-code-of-practice-for-health-and-social-care-2016> [↑](#footnote-ref-9)
10. [↑](#footnote-ref-10)
11. This document appears to be no longer accessible [↑](#footnote-ref-11)
12. <https://www.housing.org.uk/resource-library/browse/document-retention-and-disposal-for-housing-associations/> [↑](#footnote-ref-12)
13. This would have also been true in relation to previous legislation e.g. National Health Service and Community Care Act 1990 [↑](#footnote-ref-13)
14. https://www.towerhamlets.gov.uk/Documents/Public-Health/THsuicidePreventionStrategy2018.pdf [↑](#footnote-ref-14)