Derbyshire Safeguarding Adults Board

SAR23B – ‘Karolina’

Derbyshire Safeguarding Adults Board

Safeguarding Adult Review
Learning brief for practitioners

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Learning brief: Safeguarding Adult Review – Karolina

Derbyshire Safeguarding Adults Board carried out a Safeguarding Adult Review (SAR) following the death of Karolina.

A SAR is a statutory duty under the Care Act 2014. The aim of a SAR is for agencies to learn from serious incidents and deaths of adults with care and support needs, to reduce the likelihood of similar incidents from occurring.

Background

Karolina was an Eastern European woman in her 20's who died in October 2022. She was living in Derbyshire at the time of her death. Although she could understand and speak some English it was not her first language. Karolina's mother, who was her main carer, could not speak or understand spoken or written English. Karolina moved several times between Cheshire and Derbyshire within the timeframe of this review. The primary concerns in relation to Karolina were deterioration of mental health issues resulting in significant self-neglect. There were also concerns about domestic abuse raised during the earlier timeframe of the review.

Karolina had four Mental Health Act assessments in the timeframe covered by the SAR. In December 2021 she was detained under section 2 of the Mental Health Act in Cheshire for a period of 27 days, then in May 2022 she was detained in Derbyshire under section 2 and section 3 for a period of 91 days and lastly in October 2022 in the two-day period leading to her death, when she was assessed twice as liable for detention.

In October 2022 whilst being conveyed to a mental health bed, Karolina collapsed in the secure patient transport outside her mother's home. She was attended to by a bystander for immediate life support and subsequently by paramedics but sadly she later died in hospital.

The SAR concluded that there were opportunities to use statutory frameworks differently to consider approaches to working with Karolina, and this was underpinned by an absence of effective multi-agency working and a lack of insight into the language difficulties that acted as a barrier. With professional curiosity and a full understanding of Karolina and her circumstances, services could have applied a more holistic approach to consider both her own needs, and the impact on her mother to support her in the best way.

It is likely that Karolina would have experienced an improved quality of life and a better opportunity for mental health recovery if her overall care and support had been responded to in a more connected and multiagency way, using the range of legal powers available. This was further compounded by the geographical moves, the national and local position of mental health beds, and the language barrier.

Learning for all professionals

Cross-boundary and multi-agency working

The review highlighted opportunities where cross-boundary transfers of care could have been more robustly managed to jointly ascertain risk and share information. Overall, the review found that there were missed opportunities for agencies to come together to explore their full understanding of what was happening and to establish a shared understanding of risk.

Person-centred care planning and professional curiosity

There is very little reflected in the agency chronologies or discussions about Karolina as a person, in terms of her likes, dislikes, life and lived experiences. There was also a limited understanding of her living arrangements, her relationships and potential risks posed by them, her wider support network and her relationship with her mother, who was relied upon to be her main source of support upon discharge. Exploration of safeguarding issues and wider risk factors (such as exploitation) could have been applied.

Legal literacy

This report focuses attention on the Care Act, the Mental Health Act, and the Mental Capacity Act. The review found that in respect of “unwise decisions”, the Mental Capacity Act could have been better considered. Additionally, the Care Act could have been used to conduct a carers assessment and to consider wider safeguarding issues including previous domestic abuse. The review found that multi-agency communication and absence of professional communication contributed to this.

Language and cultural barrier

The review found that there were several occasions where language barriers were not considered for Karolina and her mother, and assumptions were made that they understood how to navigate health and social care systems.

Bed challenges and processes.

Karolina's presentation was exacerbated on two occasions in Derbyshire due to delays in identifying a bed. Although there is local learning in terms of decision making and actions in relation to people who self-neglect, it is noted that this is not unique to Derbyshire and is a national challenge.

Professional supervision and escalation

The review found that the level of risk was not fully understood and the challenges in accessing ongoing community support for Karolina should have raised more concern than it did. The review found that this case should have prompted more robust "safety planning" steps via supervision and escalation provision. This is particularly relevant learning for the provider of community mental health services in Derbyshire.

Physical health management

The review found that outside of Karolina's time in hospital there was a lack of understanding about her physical health. There was learning identified prior to this review through the safeguarding process under section 42 of the Care Act, which has already been applied and changes in practice have been implemented through the secure patient transportation provider.

Learning for commissioners of mental health beds

The review found that there are local processes around decision making when a Mental Health Act assessment is conducted, and a bed is not available and further assurance is required in terms of risk assessment and application of those local processes. The review also acknowledged that as private mental health beds are frequently used, it is important for the learning of this SAR to be shared with independent providers.

Recommendations

The recommendations from this SAR relate to the following themes:

- Multi-agency working
- Carers assessment
- Application of the Mental Health Act for people who self-neglect
- Cultural competence

Recommendation 1

The DSAB Policy and Procedures subgroup are asked to develop and disseminate practice guidance in relation to mental health discharge planning arrangements. There should be particular attention to the following:

- Multi agency working, coordination and joint risk formulation in decision making within mental health discharge planning.
- Specific considerations when there is a cross border transfer.
- Specific considerations when the person/their carer is not British or English is not their first language.
- Professional curiosity and escalation of conversations into a multi-agency setting.
- Single and multi-agency supervision models and reflective practice opportunities.

Recommendation 2

The DSAB should strengthen communication and seek assurance that agencies are aware of the process for carers assessments; of how to identify need: and of how to refer. This is likely to require a specific communication campaign across member agencies.

Recommendation 3a

The DSAB's Performance and Improvement subgroup is asked to seek assurance in relation to Mental Health Act assessments for people who self neglect, in particular in relation to decision making and actions taken when beds are not available.

Recommendation 3b

Derby and Derbyshire ICB are asked to share the learning from this SAR with private mental health bed providers in Derbyshire.

Recommendation 4a

The DSAB is asked to ensure that the cultural competence guidance is available on its website and undertake a communications exercise to ensure that front line staff have access to this information.

Recommendation 4b

The DSAB's performance and improvement subgroup should seek assurance from DSAB partner agencies that professional interpreters are utilised at significant points of any provision of care and support.

Next steps

The DSAB has developed an action plan to ensure that the learning identified in this review is implemented.

The primary purpose of a SAR is for agencies and practitioners to learn and improve the services provided to people. Please take some time to reflect on the findings from the review.