Lewisham
Safeguarding Adults Board
A working partnership to prevent abuse

SAFEGUARDING ADULT REVIEW

EXECUTIVE SUMMARY
LEE

MAY 2020

Contents

1. Introduction

On 11th January 2016 sometime in the early evening Lee walked out of a local hospital where he had been an in-patient and did not return. The following day he made one telephone call to a family member but the line disconnected during the call. Family members tried to telephone Lee throughout the day but to no avail. On 14th January 2016 Lee was found dead in the street some eight miles away from his home area. He was still wearing his hospital identity wrist band. It is not known why he had travelled to the area in which he was found dead.

The Coroner recorded that the causes of death were Asphyxia, Epileptic Seizure, Alcohol Dependency and Metabolic Ketoacidosis/Diabetes Mellitus.

2. SAR Process

The Independent Chair of Lewisham Safeguarding Adults Board (LSAB) decided that the circumstances surrounding Lee's death met the criteria for a discretionary Safeguarding Adult Review (SAR)[1]. The review focused on the period from 2nd October 2015 to 14th January 2016, the date of Lee's death.

A SAR Panel was established to oversee the SAR. An independent reviewer was appointed to chair the panel and to produce a report for the LSAB. The SAR Panel met on three occasions. After the third panel meeting production of the SAR was significantly delayed by the independent reviewer's terminal illness.

The purpose of a SAR is to gain, as far as is possible, a common understanding of the circumstances surrounding the matters under review, to identify if agencies, individually and collectively, could have worked more effectively together and to recommend how practice could be improved. A SAR is about learning, not blaming, and aims to improve future practice.

As advised by statutory guidance[2], family members were invited to contribute to the report. A letter was sent to Lee's mother informing her of the review: she indicated that she did not feel able to participate in the review but would wish to be kept informed of progress.

This SAR primarily used an investigative, systems focus: relevant agencies were asked to provide a detailed chronology and, in some cases, additional reports, of their involvement. These enabled the panel to gain a comprehensive overview of what took place. The Joint Commissioning Team (Addictions) at the Council also provided a copy of a Death Investigation Report that had undertaken to identify lessons learned from Lee's death.

[1] Section 44 (4), Care Act 2014.

[2] Department of Health and Social Care (2018) *Care and Support Statutory Guidance: Issued under the Care Act 2014*. London: The Stationery Office.

Specific lines of enquiry were set for the review, namely:

- Whether policies were fit for purpose and used, especially regarding missing patients, referral amongst specialist services and alcohol detox pathway.
- Consideration of and assessment with respect to the Mental Capacity Act 2005, Deprivation of Liberty Safeguards and Mental Health Act 1983.
- Recording, storage, sharing and acting upon information amongst agencies.
- The use of specialist expertise.
- Staffing levels and any potential impact on decision-making and practice.
- Previous admissions and access to records, especially records relating to drugs previously prescribed.
- Risk assessment to inform decision-making.
- Previous medical history/diagnosis/medication.
- Maintaining contact with the family, and acting upon information received from his closest relatives regarding his mental health.
- Referral processes.
- Connecting episodes of presentation/engagement/treatment.
- Knowledge and skills of professionals working with alcohol dependent clients.
- Examples of good practice.

3. Pen Picture

Even though Lee was supported by several different agencies over a lengthy period, his biographical details are sketchy. Other SARs[3] have observed how little is known sometimes about patients/service users and have commented on the importance of recording information about a person's history and relationships.

What is reported follows. Lee started drinking alcohol at the age of thirteen and felt he had developed a problem by the age of sixteen. He was in a long-term relationship (but it is unclear whether he was married) and had both children (records differ on how many) and grandchildren. It is documented that Lee consistently had support from his family but irregular contact with his children and grandchildren due to depression and alcohol use. Lee lived alone but would also stay with his mother. His mother was extremely supportive.

Lee had a history of alcohol related illnesses and joint pain, epilepsy, seizures, asthma, delirium tremors and gastrointestinal disorders. He also had a history of depression and anxiety; this was managed by his GP.

During an assessment in 2015, it was noted that he had not worked since 2013 as he was suffering from long term illness(es). It has not been possible to find any details on his employment history.

He was abstinent for ten months in 2010/2011 but relapsed as his long-term relationship broke down. It is documented that there was another relationship in later years but this also broke down and further relapse followed.

[3] Preston-Shoot, M. (2019) 'Self-neglect and safeguarding adult reviews: towards a model of understanding facilitators and barriers to best practice.' *Journal of Adult Protection*, 21 (4), 219-234.

4. A Brief Chronology of Events

Of necessity this section only includes key events. A few events which pre-date the review period are also summarised to aid a greater understanding of the matters under consideration. The details here are taken from the various reports and chronologies provided by partner agencies.

4.1 Summary of Total Number of A&E and Hospital Admissions.

From June 2011 to the date of his death, Lee attended a hospital Accident and Emergency department on, at least, eighty occasions, and was admitted for in-patient treatment (at a variety of hospitals) on, it is believed, twenty eight occasions. The majority of A&E admissions were through the ambulance service, but the service also attended at Lee's home significantly more than eighty times. The calls were prompted in the main by Lee experiencing an alcoholic/epileptic seizure but also included head injuries and hypothermia, with a fractured wrist and leg, when Lee had 'fallen' into a stream. On one occasion, Lee had pneumonia.

Most of the hospital admissions only lasted between a day and a week (one lasted for a month) – Lee often chose to discharge himself, against medical advice, or was recorded as having 'absconded' from the ward. On several occasions, he would re-present at the same hospital some hours or days later.

In the same period, Lee received an in-patient detoxification treatment programme on, at least, five occasions and, in March 2015, he had a period on a residential detoxification programme, in the south west of England, but discharged himself after 28 days.

There were rent arrears and contacts with the housing provider were not effective in getting his account back on track. No court action was taken, however, due to his vulnerability.

4.2 Key Events from 2 October 2015 to 14 January 2016

4.2.1 On 2nd October 2015 Lee was admitted to one of his local acute hospitals, by ambulance, having had a series of seizures. It is reported that, at this time, he was abstinent but was experiencing withdrawal symptoms and was suffering from pneumonia. He remained in hospital for six days. It was recorded that *'the admission was due to alcohol seizure, he is also epileptic and suffers from depression'*. On discharge, Lee was (re)referred to the community-based alcohol treatment service. It was noted that he was reluctant to be discharged – it is believed that this was because he was unhappy about the accommodation to which he was returning. It should be noted that the housing association providing the accommodation had been and continued to be prepared to discuss these issues with Lee but he would not engage with them.

4.2.2 On the 9th October 2015, Lee attended a post-discharge appointment with the Alcohol Hospital Liaison Team who noted that he *'presented as frail following discharge from hospital – no reported alcohol use or concerns regarding mood – reported that he had thought about drinking, but it repulsed him – [says he is] motivated to maintain abstinence'.* The Alcohol Liaison Team arranged for a follow up in three days and planned to liaise with the GP and obtain a copy of the hospital discharge report.

4.2.3 On the 14th October 2015, Lee failed to keep an appointment with the community-based alcohol service: his non-attendance was followed up, by phone, on the following day but there was no reply. On 20th October 2015, Lee left an answer-phone message at the service querying his next appointment date. It is not known if this message was responded to.

4.2.4 In late October 2015, Lee's GP wrote to him, twice, about the need for asthma monitoring.

4.2.5 On 26th November 2015, Lee called the police (he was '*very drunk'* at the time) alleging that he had been slapped in the face by an unknown person, Lee was at his mother's address at the time and she was advised, by the police, that Lee would need to make a formal complaint about the incident. There is no record that Lee followed this up.

4.2.6 On 10th December 2015, the community-based alcohol service updated their Safeguarding Review Notes to include details of Lee's admission to and treatment at the hospital some five weeks earlier. They also attempted to contact Lee by phone but were unable to do so. A letter was sent to Lee offering him an appointment on 14th December 2015.

4.2.7 On 15th December 2015, Lee attended a meeting with his keyworker from the community-based alcohol team. The keyworker recorded that she '*had no concerns in presentation – [Lee] communicated well and was clean and well dressed. Looked slightly frail in appearance, could smell alcohol [on Lee] but [he] did not present as overly intoxicated. [Lee] reports to be drinking again daily'*. Lee agreed to (re)attend weekly [support] groups and it was agreed that a medical assessment should be booked. The plan for Lee to attend the weekly support group *"would have triggered an Alcohol Care Team assessment by [a] clinical team. This would have ensured that he was seen over the Christmas period".*

4.2.8 On 21st December 2015, Lee's GP received a request from the community-based alcohol (and substance misuse) service for information about Lee and this was complied with.

4.2.9 On the same day Lee attended a medical assessment at the community-based alcohol service. A service plan was drawn up and it was agreed that Lee's GP would be briefed. In the period from June 2011, this was the fifth medical assessment or review undertaken at the community-based alcohol service.

4.2.10 Lee failed to attend the support group meetings on the 23rd and 30th December 2015 and the 6th January 2016.

4.2.11 On 9th January 2016, Lee was self-admitted to one of his local acute hospitals suffering from alcohol related seizures. This was a different hospital from the one to which Lee was admitted in October 2015.

4.2.12 In the early hours of 10th January 2016, Lee was transferred to the acute medical unit, it being noted that he was verbally communicating and medically stable. Later the same day, Lee was transferred to a general medical ward for detoxification. He was settled and calm and independently mobile.

4.2.13 Around midday on 11th January 2016, Lee threatened another patient's relative, and hospital staff, with a dinner knife. The police were called. The police "*attended ward and spoke with the Matron who stated that the male in question was currently detoxing from alcohol and*

had become paranoid. He had shouted, which had frightened the caller, who panicked and called the police. No offences were alleged or apparent", and it was decided that no formal action should be taken against Lee. He was seen by a Consultant and a Senior Registrar and moved to a side ward. He became calm. The Alcohol Liaison Team Leader, who also saw Lee at this point '*recommended that [Lee] remained in hospital as he was confused and paranoid as he was presenting in delirium tremens and needed one-to-one nursing with an RMN (Registered Mental Health Nurse)'*. At about this time, Lee was escorted off the ward, by a Health Care Assistant, to have a cigarette.

Lee was seen again by the Registrar at 13.50 hours. Lee asked to leave but did not do so. At 15.00 hours, Lee was seen by a Consultant: *'reasonable conversation with patient who asked if [he] could go home, Consultant said no, and patient asked to call his mother. Did the patient have capacity? Consultant believed the patient did not require an RMN, if support was required, a Health Care Assistant would have been sufficient'*.

4.2.14 At 17.45 hours, Lee asked the Nurse in Charge if he could borrow a charger to charge his mobile phone. When no suitable charger could be found, Lee '*very calmly said that he was going to find a charger [in the shop] downstairs'.* Before Lee left the ward, the Nurse in Charge asked a doctor present if Lee should be prevented from leaving – the doctor stated that as Lee '*is not sectioned, therefore we cannot stop [him] leaving the ward'.* Lee left the ward some twenty minutes later, taking the lift downwards. He left the lift at the first floor where he met, and spoke to a Health Care Assistant, but he continued on his way. At 18.13 hours, Lee was seen, on CCTV, walking towards the stairwell. There were no further reported sightings of Lee at the hospital.

4.2.15 Some seven minutes later, one of Lee's relatives, a sister, arrived on the ward – the relative was informed that Lee had gone to the phone shop.

4.2.16 At 19.30 hours, the Nurse in Charge of the night shift was notified that Lee had not returned to the ward. The Nurse in Charge called security, and, on their advice, the Senior Staff Nurse from Lee's ward contacted the police at 20.30 hours. The Senior Staff Nurse was of the view that Lee was vulnerable, and that the hospital had a duty of care. The Head of Nursing (Site Manager) was also informed of Lee's absence: she stated: '*my belief at the time was that [Lee] was a competent adult who had chosen to leave hospital possibly secondary to the incident earlier in the day*'. She confirmed that the police should be informed. Initially, the police responded to the notification from the hospital that officers would attend within an hour. However, the call was subsequently down-graded – Lee was not subject to any order that would prevent him from choosing to leave the hospital and the police did not initiate a Missing Person's Report/Enquiry until the 14th January 2016, by which time Lee was already dead.

4.3 <u>Events Following the Hospital Report to the Police</u>

4.3.1 On 12th January 2016, at approximately 09.00 hours, Lee contacted a family member, by telephone, but the line disconnected during the call. The family tried to phone Lee throughout that day but to no avail.

4.3.2 On 13th January 2016, Lee's niece made two calls to the police about her missing uncle asking if there was any news of him. There was not.

4.3.3 At 07.00 hours on 14th January 2016, Lee was found dead in the street. The police were unable to establish an address for any next of kin for some time and it was not until late in the day that the family were notified of Lee's death.

5. Analysis

5.1 From panel discussions and information provided by agencies, learning emerged in relation to several of the key lines of enquiry.

5.2 Policies. Both NHS Trusts that contributed to the review had policies and procedures relating to missing persons, one considerably more detailed than the other. One referred to national adult safeguarding guidance that had been replaced by the Care Act 2014. Reviewing the policies of the NHS Trust from whose ward and grounds Lee left, if staff had followed the procedures it is possible to conclude that Lee would have been assessed as high risk for going missing.

5.3 Mental Capacity. In the period under review no formal mental capacity assessment was completed. Lee was felt to have capacity but it was a missed opportunity not to formally assess his capacity.

5.4 Records. Discrepancy was found in the recording of Lee's ethnicity. Little appears to have been recorded relating to some events in his life, for example brain injury. There does not appear to have been an official record of Lee being diabetic although people thought he was.

5.5 Use of Expertise. Advice from the Alcohol Liaison Team that a healthcare assistant should stay with Lee after an earlier incident in the hospital (on the day he left the ward) was not heeded and appears to have been overruled by ward staff.

5.5.1 A review of treatment records demonstrates that previous admissions and treatment for substance misuse followed established guidelines but that Lee did not engage consistently and could be non-compliant with advice and medication.

5.6 Staffing Levels. There is no evidence to suggest, on appraisal of staffing available to the ward at the time, that staffing levels were inappropriate and a contributory factor to the events that unfolded.

5.7 Risk Assessment. There does not appear to have been a formal assessment of risk when Lee left the hospital that drew on previous knowledge of him. Connecting the events in the period under review, namely when Lee was taken and admitted into hospital, with previous episodes of engagement, presentation and treatment, might have enabled a more thorough assessment of risk. There does not appear to have been consideration of self-neglect and whether safeguarding pathways should have been activated because of information that Lee was unable to protect himself from self-neglect as a result of his care and support needs. It took three days before Lee was formally recorded as missing by the police.

5.8 Working Together. There was miscommunication involving the Police, Family and Hospital with respect to whether Lee was missing and then whether a missing person enquiry should be raised. There appeared to be some confusion regarding who was conducting enquiries.

Had the Police been given more information about Lee's history, it is possible that this might have raised perceived priority or urgency once he had left the hospital.

5.8.1 The panel felt that there was a missed opportunity to offer a carer's assessment to Lee's mother and to involve his sister in his care and support. From the records it appears that some family members were supportive, especially when Lee was in crisis. There is also evidence of strong disagreements between Lee and another family member in relation to how he was funding his alcohol use. It would appear that they believed that he could and should "just stop" drinking. This was not the advice Lee was being given by addiction and health specialists who were aware of the amount he was drinking and planned safe reductions in his alcohol use so that he did not experience withdrawal symptoms. It is possible that Lee battled with his family over this advice. The offer to support Lee explaining this to his family was made but there is no reference to this being taken up. In self-neglect cases it is advisable to consider family dynamics and relationship as part of assessment.

5.9 Good Practice. The panel agreed that there was evidence of individualised care and support, and appropriate liaison, amongst the substance misuse service and Lee's GP, the two NHS Trusts involved historically and Lee's GP, and the social housing provider and his GP.

5.9.1 The panel was impressed with the openness with which the services involved with Lee had engaged with the SAR process.

6. Parallel Investigations

6.1 The Police referred the matters outlined above to the Independent Police Complaints Commission. Their investigation concluded as follows:

6.1.1 The initial grading of the call from the hospital reporting that Lee was missing was appropriate.

6.1.2 A subsequent decision to downgrade the call was reasoned that insufficient information had been provided to determine if Lee should be considered a missing person.

6.1.3 Information in a second call from the hospital was recorded and graded appropriately. However, there was now sufficient information to question whether the earlier downgrading decision remained appropriate.

6.1.4 The first and second call from Lee's niece there was sufficient information to consider a grading suitable for a missing person.

6.1.5 If a missing person report had been taken it is possible that quicker identification of next of kin would have been achieved through cross-borough liaison.

6.1.6 On the basis of all the available information and evidence there may be a case to answer for misconduct and/or to use unsatisfactory performance procedures in respect of some of the personnel involved.

6.1.7 The investigation report recommends staff training to ensure understanding of the role of missing persons units, review of the approach to call handling, and completion of MERLIN reports on any person missing from hospital, regardless of whether a missing person's report is taken or initial enquiries made.

6.2 The NHS Foundation Trust conducted a serious incident investigation. The report concludes that:

6.2.1 Recording was excellent, with all relevant conversations and actions explained.

6.2.2 All appropriate reviews and medication were given.

6.2.3 Staff were prompt in calling the police for both incidents on 11th January 2016.

6.2.4 Lee could not be prevented from leaving without restraint and this would not have been appropriate.

6.3 Lee's death was also reviewed by the Drug and Alcohol Review Death (DARD) panel. The report contains a chronology from 2010 that includes mention of non-compliance with advice regarding alcohol withdrawal, detox and rehabilitation episodes and plans, and disciplinary discharges from placements.

6.3.1 There are references to episodes of confusion and disruptive behaviour, non-attendance at a health and wellbeing group, and missed safeguarding opportunities when he was physically abused.

6.3.2 Hospital records note depression but GP records do not refer to this. Different medical information is recorded on different records. The records also appear to evidence different opinions amongst primary and secondary healthcare doctors regarding his fitting.

6.3.3 A diagnosis of epilepsy appears to have been made for which medication was prescribed. Lee appears to have engaged only sporadically with this treatment. The GP was also giving pain relief for joint pain and gastritis.

6.3.4 The report observes that there appeared to be a pattern of Lee becoming unstable when in hospital for detox and of leaving.

6.3.5 Lee appeared at times to be living between addresses. This complicated making contact with him.

6.3.6 No carer assessment was offered to his mother and the report questions whether there was adequate liaison with family members.

6.3.7 When Lee missed appointments this does not appear to have prompted a review of his case. The report also observes that missed appointments should have been followed up and also that his mental capacity for specific decisions should have been assessed. The consequences of long-term alcohol abuse should have been explored further. The impact of epilepsy and also a reported head injury could also have been further assessed.

7. Conclusions and Recommendations

This was a very sad case. It was not unusual for Lee to leave hospital wards where he was being treated for substance misuse but he usually returned. On this occasion, sadly, he did not. As a result of learning from this case (section 5.2), the NHS Trusts and the Police have reviewed their policies and approach towards missing persons, as recommended. All agencies should review their procedures with respect to self-discharge, non-compliance with medication and dis-engagement from appointments.

Leaving hospital appears to have been a pattern of behaviour for Lee in all hospitals he detoxed in. This historical pattern would suggest that a formal mental capacity assessment and risk assessment would have been appropriate. This case demonstrates the importance of mental capacity assessments (section 5.3), including consideration of functional and executive decision-making, as advised by NICE[4]. This would explore the impact of prolonged substance misuse in respect of impairment of mind and brain, and the ability to use and weigh, retain and make use of information. It has been reported that Lee did show insight when interviewed. However, his behaviour did not necessarily reflect the insight that he showed, which indicates the importance of assessment of executive capacity. It is recommended as good practice that mental capacity assessments include a focus on functional and executive decision-making. It is recommended that risk assessments focus on patterns of behaviour.

Learning from this case about a pattern of sporadic engagement and non-compliance with medication and alcohol withdrawal advice indicates the importance of primary and secondary healthcare professionals, along with substance misuse professionals, working closely together (section 5.8), sharing risk assessments (section 5.7) and determining how best to respond to non-concordance (section 5.5).

For this review Lee's GP has clarified that he did have a diagnosis of epilepsy, alcohol withdrawal fitting and depression but not anxiety or Wernicke-Korsakoff syndrome. Lee did not report domestic abuse or safeguarding concerns to his GP although incidents were known to other staff involved with Lee. The medical, healthcare and substance misuse professionals may well not have all had the same information about medication being prescribed and whether Lee was complaint with it. In complex cases, multi-disciplinary team meetings as a form of working together (section 5.8) enable the sharing of information and focus on risk assessment and mitigation (section 5.7). It is recommended as good practice that multi-agency and/or multi-disciplinary meetings are convened in long-running complex cases where risks are known, likely to arise and likely to be significant if they occur.

[4] NICE (2018) *Decision Making and Mental Capacity*. London: National Institute for Health and Clinical Excellence.