Catherine
7 Minute Briefing

https://www.croydonsab.co.uk/about-us/safeguarding-adult-reviews/

Recommendations

1. Opened safeguarding cases should not be closed until assessments have been fully completed with evidence of contact with the client [ASC].
2. Ensure that referrers of safeguarding referrals are provided with feedback as to action taken. [ASC]
3. CSAB to be assured of good practice, upon receipt of information to search their systems to identify previous involvement with that individual or address including details of next of kin. [All]
4. CSAB to be assured that cases that fit the S42 enquiry threshold are being progressed as such and not left on waiting lists.
5. CCG to ensure the GP practice reviews the use of letters when they have had no contact/response from elderly individuals with a MH history.
6. CCG to remind GP practices about the need to maintain accurate patient information including review meeting outcomes.
7. Suspected crimes should be recorded and investigated. [Police]
8. CHS Emergency Department triage nurses to be reminded of the need to fully complete the safeguarding assessment process.
9. CSAB to remind all agencies about the important of the use of advocacy, MCAs and to ensure best interest decisions are made.
10. SLaM to ensure discharge policies reflect the most recent NICE guidance.
11. When agencies raise concerns with police about an individual which may result in a forced entry, where possible they should accompany officers.
12. Assurance that One Croydon Alliance is being utilised and making a difference to outcomes. [CSAB]
13. Suspected crimes against vulnerable adults should be reported to police. [CSAB]
14. CSAB to produce an escalation policy.
15. CSAB to be assured that the VB SAR recommendations have been progressed.
16. Arrangements are made for cleaning properties before handing back to a family following scenes of a death that pose environmental health hazards, . [Police/Coroner]

Case Summary

Catherine was a 85 year old women, born in Ireland and a widow, her husband died in 2002. She owned her own property, a flat which was situated above a business premises which she also owned and rented out. Her first contact with mental health services was in 1974 when she had a diagnosis of Paranoid Schizophrenia. She had further contact with Mental Health Services between 2002 – 2011 receiving both inpatient and community services, she was last seen by her GP in 2014. She was referred to Adult Social Care in 2003, 2004 and 2008. Catherine was a vulnerable adult who had been in receipt of services throughout her life.

Her family and friends, both in the London and Ireland were supportive and engaged throughout the SAR process and worked closely with the CSAB and the author. They have also offered to engage in any training sessions and this offer has been accepted.

Learning

- Multi agency Bitesize training which ASC will lead, sessions held across the partnership connecting both the Catherine and VB SAR for training purposes.
- Waiting lists in ASC lower, Senior Management Team reviewing lists on a regular basis, a tracking system in place which also tracks timeliness.
- SLaM reviewed discharge policy in line with NICE guidance. Audit to take place in 2021.
- Shared learning through the integrated systems in place such as the Huddles assisting enhancement of partnership working.
- Police using the case for training and recommendations from the review shared with Chief Inspectors.
- Specialised tracking audits across ASC to be undertaken, mental health already completed – reports to be shared with the CSAB quarterly meetings.
- CHS undertaking multi agency audits and work to strengthen discharge processes.
- CHS sharing SAR presentation to numerous teams (approximately 400 staff)
- SAR presentation shared widely at many forums and meetings, CCG shared with colleagues across South West London and on the NHS collaboration platform.
- Teams across the partnership shared the Bitesize presentation at awareness sessions.
- CHS built action of sharing the learning into their safeguarding annual audit to ensure learning has been embedded.
- Draft Escalation Policy developed by the Professional Standards Team.

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