Safeguarding Adults Review Learning Brief for an adult known as "Miss Potter"

April 2025

The subject of this review has been anonymised to protect their identity, and the name Miss. Potter was chosen by the family.

This learning briefing looks at the circumstances and learning surrounding Miss Potter a 22yr old woman who sadly passed away on 30th January 2023.

Please take time to reflect on the findings and consider how you can learn, develop, and work together to improve outcomes for, and prevent harm occurring towards, adults with needs for care and support.

What is a Safeguarding Adults Review (SAR)?

A Safeguarding Adult Board (SAB), as part of its Care Act 2014 statutory duty, is required to commission Safeguarding Adults Reviews under the following circumstances:

*SABs must arrange a SAR when an adult in its area **dies as a result of abuse or neglect**, whether known or suspected, and there is concern **that partner agencies could have worked more effectively** to protect the adult. SABs are free to arrange for a SAR in any other situations involving an adult in its area with needs for care and support.*[1]

About this review process

Miss Potter came to the attention of the Royal Greenwich Safeguarding Adults Evaluation Group (SEG) in April 2024 where a recommendation was made to the Independent Chair that the case meets the criteria for a SAR as set out in S44 of The Care Act 2024. The case was subsequently discussed again at the SEG in June 2024 to discuss commissioning options. It was agreed a learning brief would be produced rather than a traditional SAR given the comprehensive reports that have already been produced by agencies. Panel meetings were held in September 2024 and October 2024 and information gathered. The family met with Miss Potter's Social worker to share their views in November 2024. Reports and information were considered from the following agencies: Oxleas NHS Foundation Trust, Royal Borough of Greenwich Adults Social Care, Lewisham and Greenwich NHS Trust, 24 Hour supported accommodation.

Pen picture of Miss Potter

Miss Potter has been known to adult social services since she had turned 18 years old and received a Care Act Assessment to review her care needs under the Care Act 2014. Due to her care needs and as requested by Miss Potter she was moved in December 2021 to a 24-hour supported living setting. She received 7 hours weekly additional 2:1 support with mobilisations and transfers as she was a wheelchair user and her ability to self-propel and mobilise was at times impaired by her energy levels and overall health.

Miss Potter was diagnosed with Cerebral Palsy, Post Traumatic Stress Disorder, Emotionally Unstable Personality Disorder, Depression and Anxiety and Hydrocephalus. She also received a diagnosis of Functional Neurological Disorder (FND) from Kings College Hospital. Miss Potter had a Ventriculoperitoneal (VP) shunt to enable fluid on her brain to be drained when required. She had frequent admissions to hospital to support with her Hydrocephalus and VP shunt draining, and in relation to episodes of suicidal thoughts/ideation and self-harm. Miss Potter had approximately **87** admissions to hospital in the past 12 months.

Miss Potter attended Queen Elizabeth's Hospital in the evening of 27th January 2023 after having reportedly called an ambulance in relation to her VP shunt and headaches. She was seen by a doctor and prescribed 2 weeks of pain relief

[1] Care and support statutory guidance - GOV.UK

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medication. Miss Potter decided to wait until the pharmacy opened as she would find it difficult to return later to pick up her prescription. While waiting she booked back into the Emergency department with suicidal thoughts and was seen by the Mental Health Liaison Team who discharged her back to her community mental health team, no notes were made on her record at this time. At 11:20am on the 28th of January 2023 she collected her prescription from the hospital pharmacy and at 12:49pm rebooked into the emergency department for the third time reporting she had taken an overdose of her pain medication, she went into cardiac arrest and sadly passed away 2 days later.

Family views

This learning brief would like to thank the family of Miss Potter for being actively involved in sharing their views and experience of what happened to Miss Potter. The family shared that nothing would bring Miss Potter back however hope that this review can help to ensure the same situation doesn't happen again. Miss Potter's family raised concerns that she was prescribed two weeks of medication despite services knowing she had previously taken overdoses. The families belief was that Miss Potter was seen as a "problem patient" due to her frequent attender status and that staff were keen for her to leave rather than understanding the severity of the situation and attributed risks. Miss Potter's family raised concerns around the recording of information and sharing information between departments and services, specifically Mental Health Liaison Team and the A&E department.

The family also noted that Miss Potter would have benefitted from a longer standing care coordinator who was able to bond, relate to and build rapport with Miss Potter, the family felt that mental health services needed to find out why Miss Potter behaved this way, to listen to her and allow her to heal.

The family commented that "mental health gave her the gun; the hospital gave her the bullets and Miss Potter pulled the trigger'.

It is hoped that this review will go some way to address the learning identified by the family and by services and provide some reassurance that actions have already been implemented to improve systems.

Key Findings from partner agencies

1) There was **no frequent attender plan** in place for Miss Potter at the Hospital, despite being a frequent attender.
2) There was **no alert or flag** on her patient record to identify that she was a high-risk patient.
3) Other pain relief options had been tried already, and in view of Miss Potter's allergies Nefopam was an acceptable choice of pain relief, although **it should have been tried in the Emergency Department** prior to a prescription being given.
4) **Fourteen days of pain relief medication were prescribed** for compassionate reasons, despite seven days recommended in trust guidelines. This was due to Miss Potter indicating she would find it difficult to come back to the pharmacy for a further prescription.
5) Miss Potter was reviewed by the Mental Health Liaison Team (MHLT) after describing feeling suicidal whilst she was waiting for pharmacy to open. They were aware that she had a prescription for medication and discharged her back to community care.
6) The formulation of risk on the **risk assessment form did not explicitly identify that the risk of overdose** in the community was being mitigated by Miss Potter having her medication supervised by staff in her placement, though there is reference to this in the progress notes.
7) **MHLT assessment was not documented on the Emergency Department records** as per the agreed process.
8) Specialist diagnosis of Functional Neurological Disorder (FND) was not fully communicated or understood by professionals involved in her care.

Actions already put in place.

1) **A generic alert for patients with more than 5 attendances** in the past year to be added to hospital shared documents. This would suggest discussion of the patient's treatment plan with a senior clinician.

2) Authors of Trust Medicines Policy to **review duration of supply of emergency Department prescriptions** at next policy review and remind ED prescribers that 7 days' supply should only be prescribed for ED patients. Pharmacy reminded that any emergency department prescriptions should be issued for a maximum of seven days or a full course of antibiotics.
3) **A new single assessment form for Mental Health Liaison Team** has been developed which will prompt the user to document on the iCare /EPR system also. This will ensure that patient's level of risk will be directly visible to the ED team.
4) **Learning shared within the Hospital via the Emergency Department Governance Meeting**, in the Quarterly Risk newsletter and in the six-monthly Collection of Completed Serious and Red Incident Reports booklet.
5) **All high-risk hospital patients who would qualify for an alert/flag on their record have been identified and alerts added where necessary**.
6) All risk assessments to have a clear formulation including maintaining and protective factors, and interventions for risk mitigation. Crisis relapse and prevention plans to include individualised crisis support strategies.
7) When complex patients are using multiple services and/or frequently attending the ED, the Care Coordinator **should initiate a professionals' meeting to agree a cohesive shared management plan** that can be accessed by Oxleas and ED colleagues.
8) Supported accommodation have reinforced safeguarding protocols concerning residents with high mental health needs, **ensuring comprehensive psychological support and collaboration with emergency services** when a client repeatedly requests hospital admissions.

Good practice

There appears to have been a good standard of care for Miss Potter most of the time. She was extremely dependant and notes from the placement were very succinct. The placement appears to be very highly staffed with lots of support. In relation to Mental health, she had a care coordinator who was a social worker in the ADAPT team which was an appropriate team given her complex mental and physical health needs. The hospital was always managing her symptoms and providing care in a supportive manner despite frequent number of attendances. Miss Potter was always treated with kindness and respect by services.

Key questions to consider.

Has a multi-agency meeting been arranged to agree a shared management plan for someone who regularly attends or calls emergency services?

Have case notes/ records been updated immediately after contact with a high-risk patient?

Have risks been identified (including suicide risk) and is there a clear risk management plan in place? If so, has this been shared with the relevant professionals.

Have you considered the duty to share information can be as important as the duty to protect patient confidentiality' when mitigating risk.

Resources to help you further.

Care and support statutory guidance - GOV.UK (https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance#safeguarding-1)

Functional Neurological Disorder (FND) rehabilitation service : University College London Hospitals NHS Foundation Trust – (https://www.uclh.nhs.uk/our-services/find-service/neurology-and-neurosurgery/neuropsychiatry/functional-neurological-disorder-fnd-rehabilitation-service