London Borough of Southwark

Safeguarding Adults Review: Adult A

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HIGHLY CONFIDENTIAL

Contents

1. Introduction

1.1 Independent Author's Introduction

This Safeguarding Adults Review concerns Adult A, a man who was 45 years of age when he died at home and alone, being found a significant time after his death in a state of decomposition. A month before he had been discharged from the Maudsley Hospital, following detainment under the Mental Health Act (1983), and during that detainment he had also received treatment in Intensive Care at King's College Hospital, in respect of hyper-glycaemia resulting from insulin-dependent Type Two Diabetes.

Despite being subject to two statutory orders that required agencies to be in contact with him, (the Criminal Justice Act (2003) as a Registered Sex Offender and a Community Treatment Order under the Mental Health Act 1983), Adult A had seen no professionals since his discharge into the community to bed and breakfast accommodation on 29th August 2012; he was not registered with a GP, and this had not been identified as part of his discharge planning. How he died, or when he died shall never be known. However, I am clear, as are my colleagues who formed this Safeguarding Adults Review Panel that he should not have died in such circumstances. Those who had a duty of care towards him need to learn from this tragic situation and make changes, together, to prevent it happening again.

The purpose of this Safeguarding Adults Review is not to apportion blame, gain justice or bring individuals to account; that role is undertaken by the other processes. Rather, it is to facilitate learning and provide explanations and assurances as far as is possible to Mrs A's family, for whom his loss is the greatest.

I would like to take this opportunity to thank the agencies who have participated in this Safeguarding Adults Review for their commitment to learning and for their openness and honesty. I trust that the changes and improvements that they have already identified, together with the recommendations in this report will ensure improved safeguarding for adults in circumstances similar to those of Adult A into the future.

Dr Paul Kingston – Independent Author

September 2016

1.2 Circumstances Leading to the Safeguarding Adults Review

Adult A was born in London to parents of Nigerian heritage. He had two sisters and a brother. His parents separated in 1982, when he was 15, and he lost contact with his father, who returned to Nigeria, leaving his family living in the London Borough of Southwark. He left school soon after and reportedly had few relationships or friendships and his relationship with his mother and brother broke down after he assaulted them in December 2011.

Adult A was found dead in a decomposed state on 27th September 2012. He had been detained and admitted under the Mental Health Act (1983) at the South London & Maudsley NHS Trust since 9th May 2012, being discharged into the community on 29th August 2012. He had been discharged on a Mental Health Act (1983) Community Treatment Order with two weeks' worth of his prescribed Diabetes Type II medication (insulin). He had seen no professionals since his discharge to a hostel, his accommodation in the community, which he himself had requested from London Borough of Southwark Housing Department after he left hospital.

Adult A had been diagnosed with a Schizo-affective Disorder in 2002 and had experienced periods of detainment prior to the episode prior to his death in 2012 and had a history of criminal behaviour, including sexual assault in 2006, his conviction for which led to his name being placed on the Sex Offenders' Register.

Adult A was diagnosed with Type II Diabetes in 2008. He had a history of being non-compliant with his diabetes medication and also with his psychiatric treatment.

Adult A had not been registered with a GP practice at the time of his discharge from the Maudsley Hospital and was not in receipt of primary care services. This was not identified by professionals providing him with care, but the absence of this has been identified by the Review Panel as being the key to him falling through what should be robust system of care and support for individuals with both severe and enduring mental health diagnoses and chronic medical conditions.

Following Adult A being found dead in the hostel in which he was staying, his death was immediately referred to the Coroner and the inquest was concluded on 30th September 2014, finding the cause of Adult A's death to be:

1 a) Hyperposomalar non-ketotic coma

1 b) Diabetes Mellitis types II (insulin dependent), schizoaffective disorder

2) Natural causes to which neglect contributed

The Assistant Coroner recorded that there, '*were many failures in relation to his care and his discharge planning and his discharge follow-up'*.

These '*gross failures'* were accorded to the South London and Maudsley NHS Foundation Trust. The

Assistant Coroner recorded that, '*But for one or more of these gross failures, the deceased would not have died when he did*'.

The Assistant Coroner therefore issued a Schedule 5 of the Coroners and Justice Act (2009) Prevention of Future Deaths Report to South London and Maudsley NHS Foundation Trust and to the London Borough of Southwark, which jointly commissions mental health services with the NHS Clinical Commissioning Group.

At this point, the Coroner's concerns were raised with the Southwark Safeguarding Adults Board and a recommendation was made to the then chair to conduct a review of the care and safeguarding of Adult A. This review was agreed in October 2014.

1.3 Contact with Adult A's Family

Adult A is survived by his mother and father and three siblings. Following the decision to proceed with a Safeguarding Adults Review, the Independent Chair of the Southwark Safeguarding Adults Board wrote to both parents to explain the process and invite their participation. While neither responded, they will be contacted again following the conclusion of the Review to offer a meeting to explain the Review findings and recommendations.

2. Methodology

2.1 Membership of the Safeguarding Adults Review Panel

The Safeguarding Adults Review Panel was formed of the following members:

- Emma Mortimer (Independent Chair)
- Dr Paul Kingston (Independent Author)
- Kate Moriarty-Baker, Head of Safeguarding and Continuing Care, Southwark Clinical Commissioning Group
- Simon Rayner, Head of Mental Health, London Borough of Southwark
- Jennifer di Fabio, Inspector, Metropolitan Police
- Paul Langford, Director of Resident Services, Housing and Modernisation Department, London Borough of Southwark
- Simon Mitchell, Senior Commissioning Manager, London Borough of Southwark
- Cath Gormally, Director of Social Care, South London and Maudsley NHS Foundation Trust
- Jonathan Lillistone, Director of Commissioning, London Borough of Southwark
- Ann Hamlet, Head of Safeguarding, King's College Hospital
- John Emery, Service Manager, Safeguarding and Quality, London Borough of Southwark

2.2. Individual Management Review Authors

Individual Management Review (IMR) and chronology authors were as follows:

- Myrna Harding, South London and Maudsley NHS Foundation Trust
- Ann Hamlet, King's College Hospital
- Martin Kovats, London Borough of Southwark Housing and Modernisation

The Metropolitan Police Service provided a Brief Management Report, written by DI Di Fabio, which included a timeline of key events.

South London and Maudsley NHS Foundation Trust also provided the Review with a report in September 2016, giving further information and assurance regarding changes to systems and practice within the Trust in relation to matters identified within the Review. These are reflected in this report in Section 5 ii, Overall Conclusions.

IMR Authors attended all Review Panel Meetings.

2.3 Period for Consideration during the Review

The Review focused on the following three time periods:

1. Brief summary of the agency's involvement up to 2006 when Adult A registered with MAPPA
2. 2006 date of MAPPA registration to admission to South London and Maudsley NHS Foundation Trust in May 2012
3. Adult A's admission to South London and Maudsley NHS Foundation Trust to his body being found in September 2012

2.4 Terms of Reference

The scope of the Safeguarding Adults Review (SAR) covered the following issues:

i. Standards of practice

Each agency should review and report on its own practice with Adult A. Was this response of an acceptable and good enough standard? Did the agency's response reflect what could have reasonably been expected? Agencies should reflect on relevant professional and employment codes of conduct, relevant policies and procedures and national guidance1.

ii. Multi-agency working and information sharing

An exploration of the quality of multi-agency collaboration, including around exchange of information, standard of collaboration, extent of collaboration and follow up of did not attends. Was this response of an acceptable and good enough standard? Did the standard of multi-agency working and collaboration response reflect what could have reasonably been expected?

iii. Statutory requirements

Knowledge and use of available legislation, particularly:

- the Mental Health Act (1983)
- Mental Capacity Act (2005)
- Criminal Justice Act (2003)

Individual Management Review authors were also asked to give consideration to the following issues when compiling their reviews.

i. The interface of adult safeguarding work and criminal investigations
ii. Developing a shared understanding across local partners in regard to the consideration of neglect and organisational abuse in adult safeguarding work
iii. The interface between clinical governance and adult safeguarding work

[1] E.g.: Housing and Adult Safeguarding, Social Care Institute for Excellence 2014: http://www.scie.org.uk/publications/guides/guide53/ , Clinical Governance and Adult Safeguarding, An Integrated Process, DoH 2010: http://www.scie.org.uk/publications/guides/guide53 , Safeguarding Adults: The role of health service managers and their boards, DoH 2011: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215713/dh_125035.pdf

iv. Consideration of how the local authority (and its commissioned services) ensure it carries out its lead agency role fairly and even-handedly, when its own practice or decisions require scrutiny in an adult safeguarding process.

2.5 Legal Framework for the Safeguarding Adults Review

This Safeguarding Adults Review was commissioned prior to the enactment of the Care Act 2014, Section 44[2] of which places the requirement to conduct a Safeguarding Adults Review on a statutory basis. However, the first full Review Panel meeting was held after 1st April 2015, when the Act was enacted and therefore follows the framework set out in the Act and in the Care and Support Statutory Guidance[3].

Chapter 14, Section 166 of the March 2016 Care and Support Statutory Guidance advises that Safeguarding Adults Reviews should reflect the Six Safeguarding Adults Principles that are set out in that Guidance and which were first published in May 2011[4]. Section 5 of this report considers those principles in relation to Adult A's experience of care and support.

2.6 Purpose of the Safeguarding Adults Review

The purpose of a Safeguarding Adults Review is to, '*seek to determine what the relevant agencies and individuals involved in the case might have done differently that might have prevented harm and death. This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm from occurring again. Its purpose is not to hold individuals or organisations to account*'.[5]

Given the primary purpose of this review is of learning lessons, it is necessary to note the fact that it is concluding over three years since Adult A's death. It is therefore important that the Review is mindful of the application of hindsight; this comment in the Pemberton Domestic Homicide Review is applicable in any form of review, investigation or enquiry that has a scope over several years, "*We have attempted to view the case and its circumstances as it would have been seen by the individuals at the time. It would be foolhardy not to recognise that a review of this type will undoubtedly lend*

[2] Care Act 2014, HM Government http://www.legislation.gov.uk/ukpga/2014/23/part/1/crossheading/safeguarding-adults-at-risk-of-abuse-or-neglect/enacted
(accessed 26.02.16)
[3] Care and Support Statutory Guidance, HM Government, updated 24th March 2016
https://www.gov.uk/guidance/care-and-support-statutory-guidance/safeguarding
(accessed 24.03.2016)
[4] Adult Safeguarding: Statement of Government policy, DoH, May 2011
https://www.gov.uk/government/publications/adult-safeguarding-statement-of-government-policy (accessed (25.03.2016)
[5] Care and Support Statutory Guidance, HM Government, updated 24th March 2016
https://www.gov.uk/guidance/care-and-support-statutory-guidance/safeguarding
(accessed 24.03.2016)

itself to the application of hindsight and also that looking back to learn lessons often benefits from that very practice."[6]

Similarly, it is helpful to reflect on the statements contained in the Report of the Mid- Staffordshire NHS Foundation Trust Public Inquiry, led by Robert Francis QC:

"It is of course inappropriate to criticise individuals or organisations for failing to apply fully the lessons to be learned from the knowledge that is now available, and accepting in the light of that knowledge, not possessed at the relevant time, that more or earlier intervention should have occurred. It must be accepted that it is easier to recognise what should have been done at the time… There is, however, a difference between a judgment which is hindered by understandable ignorance of particular information and a judgment clouded or hindered by a failure to accord an appropriate weight to facts which were known."[7]

These principles have been borne in mind in the conduct of this review and in the writing of this Overview Report.

2.7 Confidentiality and Adult A's Right to Privacy

In order that the sensitive information that is being discussed in this review is dealt with appropriately and in accordance with information governance principles, we have decided to not use Adult A's real name and to identify him as 'Adult A'. This report has identified professionals and other individuals through job titles in order to respect the principles of confidentiality and Data Protection Act (1998).

[6] A domestic homicide review into the deaths of Julia and William Pemberton, Walker,M. McGlade, M Gamble, J. November 2008 http://www.thamesvalley.police.uk/aboutus/crprev-domabu/crprev-domabu-whatdomabu/crprev-domabu-whatdomabu-howtvp/crprev-domabu-whatdomabu-howtvp-pemberton.htm (accessed 18.02.2016)

[7] Report of the Mid-Staffordshire NHS Foundation Trust Public Inquiry Executive Summary pp23 Francis QC, Robert February 2013. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/279124/0947.pdf (accessed 24.03.2016)

3. Key events

3.1 Summary of key events prior to the period considered during the SAR (pre-2006)

24.07.1967	Adult A's date of birth
1982	Adult A's parents separated and his father left London for Nigeria
27.05.1987	Adult A, aged 19 was convicted of Actual Bodily Harm and was given a twelve month Probation Order
21.08.1987	Adult A, aged 20, was convicted of Possession of an Offensive Weapon and was imprisoned in a Detention Centre for two months
1988	Adult A, aged 21 was admitted to Guy's Hospital under the Mental Health Act (1983)
11.01.1989	Adult A was remanded to Brixton Prison on charges of Actual Bodily Harm, Wounding, Criminal Damage, Burglary and Theft. He was transferred to hospital and detained under Section 37 of the Mental Health Act (1983). He was diagnosed at this time with Paranoid Schizophrenia.
12.05.1989	Adult A was convicted of Handling Stolen Goods and was given a two year Probation Order
17.08.1992	Adult A was convicted of Possession of Drugs and received a fine.
06.01.1998	Adult A was convicted of Possession of Crack Cocaine and received a Caution.
2002	Adult A was re-diagnosed as having Schizo-affective Disorder

3.2 Summary of key events during the period considered for the SAR (2006 - 2012)

20.09.2006	Following receipt of an allegation, Adult A was charged with Section 3 of the Sexual Offences Act 2003 and was remanded into Police Custody.
19.01.2007	Adult A was convicted of a Sexual Assault on a Female and was imprisoned for three months, and placed on the Sex Offenders' Register (SOR) for 7 years. He had already served over three months while on remand, and therefore was released on the same day. The requirement to comply with the SOR notification process began on that date.
15.02.2007 – 13.12.2011	Adult A breached his SOR notification requirements on six occasions, resulting, on the last occasion with a fourteen day imprisonment.
2008	Adult A was diagnosed with Type II Diabetes
06.10.2011	Adult A sought accommodation from LB Southwark Housing Department. He was assessed as being unable to manage a tenancy without moderate support, but as there was no supported accommodation available at that time, he was offered a temporary Bed and Breakfast placement, which he declined.
08.02.2012	Adult A was convicted of Battery, following reports of an assault against his mother and brother. He was given a four week sentence, but as he had already served this on remand, he was released the following day (09.02.2012) and he sought accommodation from LB Southwark Housing Department. No supported accommodation was available and so Adult A was offered interim Bed and Breakfast accommodation, at Rose House, Lee High Road, which he accepted.
13.03.2012	The LB Southwark Housing Department Reablement Team identified a possible placement at Thamesreach, a mental health specialist supported housing provider, but this was allocated to an existing Thamesreach tenant.
27.04.2012	Adult A was seen by the LB Southwark Housing Department Reablement Team. He advised he had left the temporary Bed and Breakfast accommodation and was living on the streets. He was provided with supported accommodation by St Giles' Trust, but only lasted four days, due to his behaviour and poor hygiene.
01.05.2012	Adult A was placed by LB Southwark Housing Department at the temporary accommodation he had lived in previously, RH, Lee High Road.
14.05.2012	Adult A was admitted to Maudsley Hospital under Section 2 of the Mental Health Act (1983). This detention followed Adult A being arrested for an attempted burglary. Adult A was subsequently detained under Section 3 of the Act.
12.07.2012	Adult A's well-being was considered at a Ward Round. He was considered ready for discharge but was in need of accommodation and so discharge was delayed pending that being arranged through Care Coordinator 1. It was also agreed that he should be subject to a Community Treatment Order under the Mental Health Act (1983) and this had to be arranged.

04.08.2012	Adult A was found collapsed in a toilet on the ward. He had a very high blood glucose reading and was taken via ambulance to King's College Hospital, where he was admitted, in the early hours of 5th August to the Intensive Care Unit.
07.08.2012	Adult A was discharged from King's College Hospital and returned to the Maudsley Hospital.
13.08.2012	Adult A received his depot injection; the next was due on 27.08.2012.
14.08.2012	Adult A was seen by a duty doctor and was found to have a high BM (blood sugar reading). He was advised to attend King's College Hospital but declined.
14.08.2012	The Care Coordinator began the search for suitable accommodation for Adult A upon discharge.
18.08.2012	Adult A was seen again by the duty doctor, who expressed concern at his blood sugar levels, but Adult A refused to seek medical treatment at King's College Hospital.
23.08.2012	A Ward Round was held and Adult A's discharge was discussed again. This was not attended by Care Coordinator 1 who was on leave, and no-one was asked to stand in for him. A discharge date was set for 28.08.2012 and it was noted that he had been found accommodation in a hostel (not in supported accommodation).
24.08.2012	Adult A was seen by the Community Consultant Psychiatrist, who completed the Community Treatment Order (CTO) documentation. Adult A agreed to engage with the CTO requirements and engage with the CMHT following discharge.
27.08.2012	Adult A's depot injection was due; the records held in the South London and Maudsley NHS Foundation Trust do not state whether or not this took place.
29.08.2012	Adult A was discharged from hospital to bed and breakfast accommodation in Lambeth, a neighbouring borough.
03.09.2012	Adult A had been given this date as a discharge follow-up meeting with his Care Coordinator. He did not attend.
03.09.2012	The Care Coordinator recorded that he had contacted the Police Jigsaw Team to advise them of Adult A's discharge five days previously. This is disputed by the Jigsaw Team, which states it has no record of the call.
07.09.2012	Adult A's non-attendance at the meeting with his Care Coordinator was discussed at the Community Mental Health Team (CMHT) Multi-disciplinary Team meeting (MDT). It was decided that a letter should be sent to him with a further appointment for 12.09.2012. He was also sent a letter, providing an appointment for him to meet with the Community Consultant Psychologist on 18.09.2012.
10.09.2012	Adult A had been due his next depot injection, but did not attend.

12.09.2012	Adult A did not attend the proposed meeting with his Care Coordinator.
12.09.2012	Adult A's Care Coordinator recorded a plan to visit Adult A the following week. This did not take place.
18.09.2012	Adult A did not attend the meeting with the Community Consultant Psychologist.
24.09.2012	Adult A did not attend the appointment that the Care Coordinator had proposed on 12.09.2012.
25.09.2012	The Care Coordinator visited Adult A at home; there was no answer when he rang the doorbell. The Care Coordinator recorded that he planned to write a further letter, offering a further appointment. The Care Coordinator discussed his concern about Adult A's well-being at the multi-disciplinary team meeting, noting he had not engaged with the Community Mental Health Team (CMHT) since his discharge. It was agreed that a further letter should be sent to Adult A, offering a further appointment. Adult A's overdue depot injection was noted.
27.09.2012	Adult A was found by a maintenance worker employed by the organisation that owned Adult A's Bed and breakfast accommodation, deceased and his body decomposed.

4. Findings

4.1 Primary care services

4.1.1 Adult A was not registered with a GP practice when he was admitted to the Maudsley Hospital in May 2012, but this was not identified on his admission, nor on discharge. Similarly, when Adult A was admitted to King's College Hospital while still detained at the Maudsley Hospital in August 2012, this information was not identified because the NHS Spine that had been checked by administrative staff in the Accident and Emergency Department, as is usual practice, had recorded Adult A as being registered with a practice from which he had been removed some years previously.

4.2 London Borough of Southwark Housing Department

4.2.1 The London Borough of Southwark Housing Department had been providing a service to Adult A for many years. Adult A had initially received support around his accommodation in October 2011. Prior to that, he had lived as a child with his parents who were Local Authority tenants

4.2.2 The LB Southwark Housing Department advised the SAR that Adult A had received support from the Reablement Service when he sought housing advice in January 2012. The Review Panel heard that the Reablement Service within the Housing Department is a team in the Department that works with people who have been accepted by the Housing Options section of the Department as an individual with an entitlement to accommodation under the Housing Act (1996). The Panel was informed that the Reablement Service would ideally support Adult A in achieving the accommodation that best suited his needs.

4.2.3 When Adult A approached the Homelessness Service in October 2011, he was referred to the Reablement Service. He was seen by Reablement Officer 1 within 48 hours of receipt of that referral, which met the standard as required by procedure. Reablement Officer 1 conducted an assessment of Adult A's needs and a risk assessment. The Review Panel heard from LB Southwark Housing Department that both assessments were solely based on information provided by Adult A himself and were not therefore necessarily evidence-based. This was described as usual practice, but in fact, the IMR Author identified that this was contrary to the practice required in the Reablement Service Procedures Manual.

4.2.4. While risk assessments are necessarily a dynamic process, the Reablement Service procedures require management approval once the initial assessment is completed; not thereafter and there is no requirement that they subsequently be updated. This meant that while significant changes occurred in Adult A's situation after the completion of the first assessment on 6th October 2011, such as him reporting that he had been living on the streets in April 2012, and being convicted of battery in January 2012, the original risk assessment was not changed.

4.2.5 The Review Panel was advised that Adult A's Needs and Risk Assessments were also not updated when the Reablement Service became aware in August 2012 that his name was on

the Sex Offender's Register and therefore this information did not change the decisions about where he would live.

4.2.6 LB Southwark Housing Department advised the Review Panel that the assessment of Adult A's needs was incorrect. The section detailing 'offending history' had not been completed; his mental health diagnosis was recorded incorrectly as being '*schizophrenia'* rather than '*Schizo-affective Disorder'*. Adult A's independent living skills were assessed as being '*independent with moderate support'*, noting his isolation and self-reported inability to clean.

4.2.7 The Risk Assessment was also significantly inaccurate. It stated that Adult A had no history of violent behaviour, with the '*risk of harming others'* section being graded as zero. This was not true.

4.2.8 The output of the Reablement Service Risk Assessment was a Risk Management Plan. This reportedly stated that Adult A would be '*at risk if he lost his accommodation due to his schizophrenia'*. The Risk Management Plan stated that Adult A should receive '*suitable and appropriate*' accommodation, and that he would be supported by the Reablement Officer, and his Care Coordinator. Despite this recommendation, he was offered Bed and Breakfast accommodation and no further contact was made by the Reablement Service until February 2012, following his release from prison.

4.2.9 It was noted in discussion at the Review Panel meeting that although recommendations were routinely made by the Reablement Service regarding individuals' housing needs, the Housing Options Team were under considerable pressure at this this time, with few resources available to meet a high level of need and therefore, often it was not possible to act on the recommendations of the Reablement Service.

4.2.10 This is illustrated further by the fact that the Reablement Team recommended in February 2012, following Adult A's release from prison that he be housed in accommodation with other single males and '*away from any families'*. However, he was housed in Bed and Breakfast accommodation, with other families in the same accommodation.

4.2.11 Adult A's accommodation was cancelled by the LB Southwark Temporary Accommodation Team on 23rd March 2012, with this due to come into effect on 25th March. This followed his non-payment of rent, despite Adult A claiming Housing Benefit. Reablement Officer 1 had already been concerned about Adult A's budgeting skills and his ability to manage his money and had contacted his Care Coordinator on 13th March 2012 asking for this support. There is no record of any response being received.

4.2.12 Although his accommodation had been cancelled, Adult A continued to stay in this tenancy until at least 8th April, up until when he was recorded as signing into the accommodation. However, on 27th April, he visited the Reablement Service and advised that he was sleeping on the streets and the Reablement Officer he saw was concerned at his appearance, contacting the Community Mental Health Team to express concerns. Reablement Officer 1 also organised a tenancy for Adult A in supported accommodation provided by a charity providing support to individuals with needs such as Adult A. Adult A's behaviours and his poor hygiene meant that he only stayed in that accommodation for four days before being asked to leave and he was placed back in the Bed and Breakfast accommodation he lived in during February and March.

4.2.13 Reablement Officer 1 contacted the Community Mental Health Team by telephone and email, expressing further concern about Adult A's well-being, but received no response, other than being advised on 23rd May that Adult A had been detained under the Mental Act (1983) and admitted to hospital on 9th May. Reablement Officer 1 sought further information on 11th July 2012, and was responded to on 14th August, at which point the Care Coordinator informed Reablement Officer 1 that Adult A was about to be discharged, provided a copy of his risk assessment (dated 8th August 2011, a year previously) and for the first time therefore was given information that showed that Adult A was a Registered Sex Offender. The Reablement Service was subsequently advised that Adult A had a prospective discharge date of 28th August and the Community Mental Health Team requested accommodation be sought. There was no appropriate supported housing available. On 28th August, Adult A attended the Housing Office and was allocated Bed and Breakfast accommodation with further appointments being provided for 6th and 9th September, but he did not attend these. Reablement Officer 1 tried to contact Adult A on 14th September, but received no response.

4.2.14 The Panel was advised that the LB Southwark Housing Department had been working corporately to a whole-authority approach to working with vulnerable people and families, including those with long-term mental health conditions. The aim of the approach is described as: '*To coordinate a multi-agency, multi-disciplinary approach, focussing on early intervention to prevent individuals and families with multiple needs drawing on high cost social care across the local public sector'*[8].

4.2.15 This has been launched as a pilot with successful results being reported to in March 2016. The Safeguarding Adults Review was highly impressed with the project and supports this approach.

4.3 King's College Hospital NHS Foundation Trust

4.3.1 King's College Hospital NHS Foundation Trust is an acute NHS Trust. Adult A was taken to Emergency Department and was subsequently admitted to the Intensive Care Unit of the hospital in the early hours of 5th August 2012 with excessively high blood sugars; he was hyper-glycaemic. Adult A was reportedly confused and very unwell. Adult A remained detained under Section 3 of the Mental Health Act (1983) and so was accompanied at all time by a Registered Mental Health Nurse.

4.3.2 King's College Hospital advised the Review Panel that when Adult A was admitted to the Emergency Department, usual practice was followed and the receptionist checked the NHS spine for GP details; this showed that Adult A had a GP listed against his name and so, this GP was recorded in his records in the hospital as being Adult A's GP, and this surgery was sent his discharge notes etc. Following Adult A's death, it was clarified that Adult A had not been registered with a GP.

4.2.3 Adult A was treated with insulin and his condition improved and on 7th August (his second full day in King's College Hospital), he was seen at the Ward Round and a decision was made to increase his insulin intake in order that he could be returned to the Maudsley Hospital. At the same time, he was seen by a Diabetes Nurse who provided education about

[8] LB Southwark, 'Multi agency working project update' - Report to COT, March 2016

management of his diabetes. This included insulin administration, safe storage of insulin and insulin injection sites, prevention of a repeat of his acute hyper-glycaemic episode and when to seek professional help.

4.3.4 The Hospital did not undertake an assessment of Adult A's capacity to make decisions in relation to his health under the Mental Capacity Act (2005).

4.3.5 The Review Panel heard that the Diabetic Nurse assessed that Adult A would need support from community District Nurses when discharged from Maudsley Hospital, with follow-up by his GP.

4.3.6 Adult A was discharged back to the Maudsley Hospital on the same day, 7th August 2012. The Diabetes Nurse sought to speak with Adult A's Care Coordinator following his discharge on three occasions, but could not contact him. The Nurse therefore spoke with another member of staff and agreed that the Maudsley Hospital would provide a named contact they could access and also that Adult A would be returned to King's College Hospital for further diabetes education prior to his discharge from the mental health hospital. This did not happen.

4.4 South London and Maudsley NHS Foundation Trust

4.4.1 South London and Maudsley NHS Foundation Trust provides the widest range of NHS mental health services in the UK. Adult A received services from the Community Mental Health Team and also was an in-patient at the Maudsley Hospital.

4.4.2 The Review Panel was informed that Adult A was detained under the Mental Health Act (1983) on at least 15 occasions following his initial diagnosis of schizophrenia in 1989. The Trust advised that, '*Between admissions Adult A was under the care of community mental health teams (CMHTs) in the area. Though he had some more stable periods, it was in generally difficult to offer treatment with any consistency since Adult A had a history of disengaging from services, stopping his medication and going missing from his address for weeks or months at a time'*.

4.4.3 Adult A was admitted to the Maudsley Hospital on 14th May 2012 under Section 2 of the Mental Health Act (1983) after being arrested for attempted burglary.

4.4.4 During the admission he was restarted on depot antipsychotic medication and an oral mood Stabiliser and had an assessment by the ward Occupational Therapist. He was found to have the functional skills required to live independently in the community. The assessment also concluded that his ability to function was dependent on his maintaining a stable mental state and engagement with CMHT services.

4.4.5 Adult A's mental health improved and he was considered to be ready for discharge at a Ward Round on 12th July 2012, but accommodation had yet to be identified.

4.4.6 On 4th August 2012, Adult A collapsed in a hyper-glycaemic state and was admitted to the Intensive Care Unit of King's College Hospital. On his return to the Maudsley Hospital he was seen by a dietician. A Discharge Care Programme Approach meeting was held on 9th August and Adult A's Care Coordinator attended. It was agreed at this meeting that he was ready for

discharge but arrangements for accommodation and a Mental Health Act (1983) Community Treatment Order needed to be put in place.

4.4.7 Adult A was seen by the duty doctor on the ward on 14th August 2012 and was again found to have a high BM (blood glucose reading). He was advised to go to King's College Hospital for treatment but he declined. This was repeated on 18th August. On both occasions appropriate consideration was given to Adult A's capacity to make a decision.

4.4.8 A final discharge Ward Round was held on 23rd August but not attended by any members of the Community Mental Health Team as Adult A's Care Coordinator was on leave. A discharge date was set for 28th August 2012, as Bed & Breakfast accommodation had been found for him.

4.4.9 The Community Consultant Psychiatrist met with Adult A on 24th August and completed his Community Treatment Order (CTO) papers. Consideration was not given to the Mental Capacity Act (2005) in discussing Adult A's consent to the Order or to his prescribed medication.

4.4.10 The last noted depot medication that Adult A received was on 13th August and he was due another depot on 27th August, directly before his discharge, but there was no record made of this having taken place. Adult A was discharged from hospital on 29th August 2012 to temporary, unsupported accommodation in Bed and Breakfast accommodation in Lambeth. He was discharged with his diabetes and psychiatric medication for a fortnight in a bag. These were: Piportal depot 100mg fortnightly, Sodium Valproate MR 2G daily, Zopicolne 3.75 mg OD and Novomix 30 (insulin) 40 units mane and 40 units pm.

4.4.11 Adult A's Care Coordinator was on annual leave at the time of discharge but he was offered a seven day follow up appointment with a duty worker on 3rd September and when he did not attend this appointment, discussion took place at the Community Mental Health Team Multi-disciplinary Team Meeting on 7th September, resulting in a letter being sent, offering an appointment to meet with Adult A's Care Coordinator on 12th September. A further letter was sent inviting him to meet the Community Consultant Psychiatrist on 18th September.

4.4.12 Adult A did not attend for his depot medication on 10th September or his planned appointments on 12th and 18th September 2012. On 12th September Adult A's Care Coordinator recorded that he would, '*make an attempt to visit'* Adult A at his home. This visit did not take place. A further letter was sent to Adult A inviting him to meet his Care Coordinator on 24th September 2012. Adult A's Care Coordinator reportedly visited his home on 25th September but did not see him, (Adult A was undoubtedly deceased by this point). A further plan was made to write to Adult A again, but he was found deceased and decomposed on 27th September.

4.5 Metropolitan Police Service Jigsaw Team (Lewisham)

4.5.1 Adult A was known to the Metropolitan police and had a number of previous criminal convictions prior to his sexual offences index offence in 2007. These are detailed in the chronology set out in Section 3 of this report.

4.5.2 Adult A was convicted of sexual assault against a female in January 2007 and was sentenced to three months imprisonment and was subsequently subject to the Sexual Offenders

Register for a period of seven years. When he was subject to the Sexual Offences Register, (SOR), Adult A was required to comply with the notification requirements. The Metropolitan Police advised the Review that these would have commenced once he was released from custody, and his seven years would have commenced from the date he completed his initial notification. Adult A was managed as a Level 1 Sex offender medium risk as per his Risk Matrix 2000. As per standard operating procedures monthly intelligence checks were to be completed along with at least one home visit a year.

4.5.3 Following his sentence Adult A was released from custody on 19/01/2007. He completed his initial notification on the 15/02/2007 and it was at this point that his management under Southwark Jigsaw commenced. Adult A was arrested on a number of occasions for failing to to complete his notification by the 21/01/2007 he was therefore arrested for this breach.

4.5.4 The Metropolitan Police advised the Review that during the majority of the time that Adult A was on the SOR he was managed by Southwark Jigsaw and was not managed by Lewisham Jigsaw until 09/02/2012 when he completed his initial release from Custody and registered an address in Lewisham.

4.5.5 Sections 325 to 327 of the Criminal Justice Act 2003 and Part 2 of the Sexual Offences Act 2003 places a duty on the Responsible Authorities who are Police, Probation and Prison Services, to risk assess and manage the risks posed by specified sexual and violent offenders in a way which best protects the public from serious harm. This is known as the Multi-Agency Public Protection Arrangements (MAPPA). MAPPA is also made up of 'duty to co-operate' agencies (as defined under S.325 (6) Criminal Justice Act). This group will normally consist of further representatives from Local Housing Authorities, Health Authorities, Social Services, Local Education Authorities, Electronic monitoring service providers, Primary Care Trusts, and/or National Health Service Trusts and since July 2011 it also includes the UK Borders Agency.

4.5.6 JIGSAW is a section of each London Borough's team responsible for supervising those on the SOR.
There are three levels of management:
Level 1 – ordinary single agency management (that relevant to Adult A)
Level 2 – active multi agency management
Level 3 - active multi agency management requiring ongoing senior management supervision and use of specialist resources.

4.5.7 There is also a Central JIGSAW Team in the Metropolitan Police Service (MPS). Central Jigsaw manages MPS policy on MAPPA and quality assures compliance and offender management across the MPS. The unit also produces performance data to the London MAPPA Strategic Management Board (SMB), Borough crime managers and Area Commanders to highlight areas of risk and good practice.

4.5.7 Adult A attended Lewisham Police Station on 09/02/2012 and completed his notification giving his address as the Bed and Breakfast in which he had been placed in Lewisham, SE13.

4.5.8 JIGSAW officers visited Adult A at his address on 20/03/2012 to complete an unannounced home visit. There was no reply. A further unannounced visit was completed on 17/04/2012 and there was again no reply despite repeated knocking.

4.5.9 The Metropolitan Police informed the Review that on 14/05/2012 Police were contacted by the Maudsley Hospital and notified that Adult A had been admitted to the Maudsley on 09/05/2012. The Hospital advised that Adult A had initially provided false details upon his admittance. The Maudsley Hospital staff advised that they were aware that he was subject to the Sexual Offences Register and were aware of his risk assessment at that time.

4.5.10 On 18/05/12 Adult A's Offender Manager contacted the Maudsley for an update. The Officer was advised Adult A had been detained under the Mental Health Act (1983).

4.5.11 On 21/06/2012 the Maudsley Hospital informed Police that Adult A was having unescorted leave for a few hours, and he had failed to return. They had subsequently reported him as missing. Adult A had reportedly returned on 23/06/2012.

4.5.12 On 13/07/12 the Maudsley Hospital contacted Adult A's Offender Manager and advised that Adult A's leave had been increased. The Offender Manager, who enquired what the long term plan was for Adult A was informed that he would be placed in supported accommodation. In this conversation, it was reportedly discussed that it would be the Maudsley's responsibility to find suitable accommodation for Adult A. Adult A's Care Coordinator assured the officer that they would keep JIGSAW up to date of any progress or should any incidents unfold that would affect his management.

4.5.13 The Metropolitan Police Review Panel member explained that the Police were therefore surprised to be told on 27/09/12 that Adult A had already been discharged to Bed and Breakfast accommodation. The Review Panel member explained that the Police would have expected to have been part of the discussion and planning around the most suitable placement for someone presenting with the level of risk that had been identified by the JIGSAW team.

4.5.13 The address that Adult A was discharged to was in a neighbouring borough, Lambeth. Due to Police having not been made aware by the Maudsley Hospital or Adult A's Care Coordinator of his discharge, Lewisham Jigsaw had not advised their counterparts in Lambeth. Adult A had also failed to complete his notification requirements upon his discharge. The review Panel was told that had Police known that he had been discharged this would have been pursued. Further, it wold have been standard practice to arrange to meet him at his address, discuss risks and remind him of his responsibilities resulting from his SOR status.

4.5.14 The Police advised the Review that no form of contact, including home visits had been made at Adult A's discharged address and there was no advance request to police, to check the suitability of the discharge address, to assist in his future management. Had Police been made aware that he had been discharged the JIGSAW Team in the Borough where he was located, they would have completed an initial visit upon him moving to the address. Police would have also completed intelligence checks. In addition, the review was told that in this situation Police would expect to have been informed of Adult A's discharge in advance so that an appropriate Risk Management Plan could be devised, incorporating liaison with the Maudsley Hospital and Adult A's Care Coordinator, establishing his on-going care plan and future management with a view to minimising any potential risks.

5. Conclusions and Analysis

Key themes identified during the Review considered in relation to the six Safeguarding Adults principles

As required by the Care Act 2014 Care and Support Statutory Guidance, the practice of all agencies in respect of Adult A is considered in this report against each of the six Safeguarding Adults Principles[9].

Not all agencies' contact with Adult A can be reflected in all six areas, and so, particularly in respect of Primary Care Services, King's College Hospital NHS Foundation Trust and the Metropolitan Police, principles have been considered only where relevant.

5.1 *Empowerment* – People being supported and encouraged to make their own decisions and informed consent.

5.1.1 Primary Care Services

Adult A was not registered with a GP, and this was not identified by his Care Coordinator or others responsible for his discharge into the community. One result was that Adult A was not empowered to manage his medication and own physical and mental health needs personally as had been appropriately intended and anticipated by the Diabetes Nurse in King's College Hospital. The direct impact of this was that Adult A was unable to cope with managing his own care and support needs and this was identified by HM Coroner as an element of his cause of death.

5.1.2 LB Southwark Housing Department

LB Southwark Housing Department conducted a process of assessment by the Reablement Officer in the Reablement Service that was highly-person-centred and focused on the individual's view. This was good practice.

5.1.3 King's College Hospital NHS Foundation Trust

King's College Hospital NHS Foundation Trust provided Adult A with a very brief, acute medical intervention. However, the fact that Adult A was provided with Diabetes education just 48 hours after his admission with acute illness and while under Section 3 of the Mental Health Act (1983), was not person-centred, because it did not consider his ability to understand, absorb and then execute the information he was being given. The fact that an assessment under the Mental Capacity Act (2005) was not considered necessary in relation to his ability to make relevant decisions about his own healthcare

[9] Care and Support Statutory Guidance, para 14.13, DoH March 2016

did not enable him to understand the education and therefore make relevant decisions about his own health needs.

5.1.4 South London and Maudsley NHS Foundation Trust

South London and Maudsley NHS Foundation Trust provided Adult A with the majority of his care and support in the period under review. Adult A was treated under Section 3 of the Mental Health Act (1983) while an in-patient at the Maudsley Hospital and had been receiving a service from the Community Mental Health Team prior to his admission. He was discharged from the Hospital on 29th August 2012, under the statutory provisions of a Community Treatment Order and this was intended to be supervised through the Community Mental Health Team.

Adult A was a man of Nigerian heritage. The Review has found no reference in the records or submissions, however, to indicate that his culture and ethnicity were considered as part of the assessment of his needs or the planning of his discharge and his recovery. The Review did not identify an inclusive approach to Adult A as a black man or recognition of the individual needs or considerations that should inform culturally sensitive practice.

Several significant decisions were taken in relation to Adult A's life during his period of hospitalisation, relating to his arrangements for accommodation and so forth on discharge and significantly in respect of his physical health. Adult A had been acutely unwell and admitted to the Intensive Care Unit of King's College Hospital on 4th August 2012, being discharged back to the Maudsley Hospital on 7th August. Adult A was unwell again with very high BM (blood sugar) readings the following week, on 14th August 2012 and again on 18th August 2012. Adult A was advised to go to King's College Hospital but he declined on both occasions.

The records show that Adult A's capacity to make this decision was considered on both dates. However, given the fact that he had been critically ill with the same medical concern only a week before, it would be improved practice to carefully record the reasons for deciding that Adult A had capacity to make that decision, describing the way in which the risks had been explained to him and exploring the reasons behind his decision. This is absent from the recordings and is an area of learning for the Hospital.

Good practice in respect of supporting an individual assessed as having capacity who is making an unwise decision, requires that the following are addressed[10]:

1. *Does the individual have all the relevant information needed to make the decision?*
2. *If there is a choice of options, has information been provided on the alternatives?*
3. *Have the communication needs of the individual been taken into account? The information needs to be presented in a way that is easier for them to understand.*
4. *Have different communication methods been explored, including obtaining professional or carer support?*
5. *Consider the risks and benefits, including describing the consequences of making a decision, and making no decision.*

[10] Social Care Institute for Excellence Mental Capacity Act Resource http://www.scie.org.uk/publications/mca/decision-making/index.asp Accessed 9th March 2016

This lack of reference in the care and support of Adult A to the requirements and the ethos of the Mental Capacity Act (2005) is addressed in a review recommendation.

Similarly, the Trust did not provide the Review Panel with information or assurance about Adult A's access to:

1. advocacy, in particular, an Independent Mental Health Advocate (IMHA);
2. to information that explained his rights;
3. to Adult A's involvement in his own care planning

These are requirements of the Mental Health Act (2007) and indicate missed opportunities in working with Adult A in managing his own risks, being able to express his own views, have the opportunity to weigh up the options open to him and develop his own decision-making skills.

The Care Quality Commission, (CQC) published its fourth annual report on its statutory monitoring of the use of the Mental Health Act in 2012- 2013[11], therefore during the time period under review. That report notes that, '*there was no improvement in evidence of patients' rights being explained to them. In the last two years we have not seen adequate evidence of discussions with patients about their rights*'. This was clearly an area requiring development in many mental health trusts. It should be made clear, that this report is a thematic analysis of all CQC visits and inspections concerning application of the Mental Health Act in 2012-13 (a total of 1,502 visits) and the comment does not relate specifically to the Maudsley Hospital.

Whilst being aware of the length of time that has elapsed since 2012 and the conclusion of this Review, it is important that assurance is provided to the Safeguarding Adults Board that significant improvements have been made in this area. For this reason, a recommendation is made, asking that assurance is provided by the Trust that it has reinforced the importance of this approach within its internal structures. This will be in line with the Making Safeguarding Personal approach espoused by the Care Act 2014 and subsequent statutory guidance. Approaches to involving users of services begin with an organisation's culture and the messages disseminated by its leaders. This area of learning is addressed in one of the Review recommendations.

5.2 Prevention – It is better to take action before harm occurs.

5.2.1 Primary Care Services

The result of Adult A not being registered with a GP practice was that when he was discharged into the community recovering from an acute mental health admission and a period of time being seriously physically unwell , the pivotal role undertaken by community GP practices was absent and he therefore slipped through the safety net that GP practices provide. The Review Panel considers that this is a key lesson in this Review.

[11] Monitoring the Mental Health Act in 2012/13; CQC
https://www.cqc.org.uk/sites/default/files/documents/cqc_mentalhealth_2012_13_07_update.pdf

5.2.2 LB Southwark Housing Department

LB Southwark Housing Department staff, particularly Reablement Officer 1 were focused on Adult A's needs, and the action taken by Reablement Officer 1 on 13th March 2012 to seek support from Adult A's Care Coordinator in relation to his ability to budget and pay his rent was good preventative practice.

Regrettably, the custom and practice in relation to assessment and risk assessments not being updated meant that real risk was not identified or recorded.

Similarly, by having an assessment process that is entirely person-led, clear risks are potentially not addressed, multi-agency information is not shared and the risk assessment is incomplete. This was clearly the case in relation to the Reablement Team's understanding of Adult A's history of violence and his registration as a convicted Sex Offender and furthermore the service had an incorrect recording of his mental health diagnosis. However, it is important to be clear that it was the Care Coordinator's duty to advise the Reablement Officer about Adult A being registered as Sex Offender.

5.2.3 King's College Hospital

King's College Hospital's contact with Adult A was limited. However, as is discussed above, the lack of any form of capacity assessment relating to Adult A's ability to make decisions regarding his diabetes education meant that it was not possible to either support him in managing his own health needs, or alternatively seek support for him. While it would have been the Care Coordinator's duty to arrange for community healthcare support for Adult A and not King's College Hospital's, had that capacity assessment been undertaken and be found that he was not able to make the relevant decisions regarding his diabetes care, this would have given the Diabetes Nurse greater evidence on which to base their evident concerns. That practitioner had identified that Adult A had not understood what was required and had sought an individual with accountability for Adult A at the Maudsley Hospital with a view to preventing harm to him. The framework of the Mental Capacity Act (2005) would have provided a much clearer basis for setting out their concerns.

5.2.4 South London and Maudsley NHS Foundation Trust

This report has already considered the Trust's approach to risk assessment and information sharing; clearly if this had been achieved as it should have, harm should have been prevented. The same principle applies in relation to the Trust's decision to communicate with Adult A following his discharge by letter. This decision was not only made by his Care Coordinator, but was endorsed by his psychiatrist and the CMHT Multi-disciplinary Team Meeting (MDT) held on 7th September 2012. Had the Trust had sought to communicate with Adult A in a way which met his own well-known and well-documented communication and engagement needs, (he had a long history of non-engagement) he may have attended the appointments that were arranged for him on 3rd September 2012, (appointment with his Care Coordinator), 12th September 2012, (appointment with Care Coordinator), 18th

September 2012, (appointment with Psychiatrist) and 24th September 2012 (appointment with Care Coordinator). On all these occasions, the Trust sent Adult A a letter, inviting him to an appointment and on one occasion, (12th September), Adult A's Care Coordinator recorded that he would '*attempt*' to visit him the following week. The use of the word '*attempt*' illustrates a lack of urgency or concern that was entirely disproportionate to the risks and the duties. This passive approach inevitably failed to engage Adult A and was inappropriate, given his level of need, the risks to him and others and to the statutory responsibility held by the Trust in respect of his Community Treatment Order.

5.3 Proportionality – The least intrusive response appropriate to the risk presented.

5.3.1 LB Southwark Housing Department

LB Housing Department's response to Adult A's needs and the level of risk towards himself and also towards others was regrettably not proportionate to his requirements because both were based on inaccurate and inadequate information and were not changed or updated as new information about Adult A's level of need and the increasing level of risk to him and to others became known.

5.3.2 South London and Maudsley NHS Foundation Trust

Adult A advised his Reablement Officer in the LB Southwark Housing Department that he considered that he was at risk from his own mental health condition. This was perceptive. However, he was also at risk from his physical health difficulties and others were at risk from his offending and violent and sexually harmful behaviour.

The Trust did not undertake a robust or timely assessment of risk in relation to Adult A's vulnerabilities and this was compounded by a lack of sharing of that assessment across partner agencies. This is illustrated by the fact that the Care Coordinator provided the Housing Department with a copy of an out of date by a year risk assessment just before Adult A was discharged into the community. This meant that the risk assessment was essentially of no use and harmful to Adult A because it did not detail his risks or any means of addressing those. Similarly, although the risk assessment did detail Adult A's status as a Registered Sex Offender, providing that information to the Housing Department approximately a year after they had begun providing him with accommodation was a clear breach of their duties and put others in Adult A's accommodation at risk of harm.

The Maudsley Hospital did not share information about Adult A's risk to others with King's College Hospital when he was admitted and therefore potentially placed staff and other patients at King's College Hospital at risk.

The Trust advised the Review Panel that, '*The community consultant psychiatrist met with Adult A on 24.08.2012 and completed his Community Treatment Order (CTO) Mental Health*

Act papers. At this assessment, Adult A is reported to have presented as pleasant, mildly perplexed and paranoid. He had some residual symptoms with a grandiose flavour. Adult A felt that medication had helped stabilise his mood and that he was almost back to his normal self. He agreed to the conditions of his CTO to accept medication and engage with his CMHT'. There is no record of Adult A's capacity to make this decision in line with the requirement of the Mental Capacity Act (2005), despite previous capacity assessments having been undertaken with regard to his medication by ward staff on previous occasions. This meant that his discharge plans, such as they were, were predicated on a decision that the Trust did not know that Adult A was able to make or carry through.

5.3.3 Metropolitan Police Service Jigsaw Team (Lewisham)

The Jigsaw Team's role was to manage the risk that Adult A's behaviour posed to the public. The Team performed its duties as required until Adult A was detained under the Mental Health Act in May 2012. The Team was unable to carry out that role after that date because it was not advised, as it should have been, that Adult A was discharged into the community on 29th August 2012.

5.4 Protection – Support and representation for those in greatest need.

5.4.1 LB Southwark Housing Department

The Review Panel heard that one of the significant challenges in the Borough is the lack of suitable accommodation for individuals with mental health needs. The Review Panel was advised that even if Adult A had been assessed thoroughly and the true level of risk identified correctly, he would still have been placed in Bed and Breakfast accommodation, because there was no other alternative. Adult A had complex needs, affecting his physical, mental, social and financial wellbeing.
The Review was advised that this challenge is a commissioning priority that is being addressed. However, Recommendation 1 asks that the LB Southwark Housing Department provide assurance to the Safeguarding Adults Board in this matter.

5.4.2 King's College Hospital NHS Foundation Trust

King's College Hospital clearly cared well for Adult A in his acutely unwell state. However, the provision of Diabetes Education 48 hours after his admission to Intensive Care and while he was detained under the Mental Health Act (1983) did not achieve the protection that the education was clearly intended to achieve.

The Review Panel heard that the Diabetes Nurse had understood that Adult A had not absorbed the information he needed and therefore followed up the concern with the Maudsley Hospital after he had returned there on discharge from King's. The Diabetes Nurse demonstrated good practice in their clear adherence to the duty of care they had towards Adult A.

5.4.3 South London and Maudsley NHS Foundation Trust

HM Coroner has already established that South London and Maudsley NHS Foundation Trust had failed in a number of areas of support and care towards Adult A. These meant that Adult A was not protected by that NHS Trust. The Trust, largely through the Community Mental Health Team was not robust in its care and support of Adult A, or of others who may have been at risk from his behaviour. This is illustrated as follows:

i. The Trust exercised poor, largely non-existent communication with partners, particularly in relation to Adult A's needs regarding housing, the level of risk to which he was vulnerable and that which he posed to others, together with the complexity of his physical health needs;

ii. Adult A's diabetic needs were not addressed following his discharge from King's College Hospital on 7th August 2012. Despite being advised that Adult A would need community support in managing his physical health and a GP follow-up and that he needed further education in managing his diabetes at King's, he was discharged with two week's prescription of insulin, and no further physical healthcare support organised. The NHS Diabetes Information Report, Commissioning Mental Health and Diabetes Services (2011) states that, '*Mental health disorders can pose significant barriers to diabetes care and therefore mental health stability is vital for good self-care*[12]'. This learning is highlighted in the Review recommendations.

iii. Adult A's discharge plans were woefully inadequate, with little reference or consideration of his essential mental and physical health needs, means by which he would maintain or indeed improve his mental health and no consideration of his wider needs, aspirations and well-being. His Care Programme Approach (CPA) Discharge Planning meeting was held on 9th August 2012. It was not updated prior to his discharge form the Maudsley Hospital, despite a period of three weeks elapsing and Adult A's physical health condition continuing to be unstable. The Jigsaw Team that managed Adult A's registration as a Sex Offender was not contacted, consulted or informed about the discharge plan. The Mental Health Act (1983) Code of Practice (2008) states that its Purpose Principle is that, '*Decisions under the Act must be taken with a view to minimising the undesirable effects of mental disorder, by maximising the safety and wellbeing (mental and physical) of patients, promoting their recovery and protecting other people from harm'*[13]. This principle was not adhered to in Adult A's case.

iv. Adult A's Care Coordinator was on annual leave when Adult A was discharged from his detainment on 29th August and his role was covered by a duty worker from his team. The Assistant Coroner was of the view that this person was equally responsible for the lack of

[12] Commissioning Diabetes and Mental Health Services, NHS Diabetes, June 2011 https://www.diabetes.org.uk/Documents/nhs-diabetes/commissioning/commissioning-guide-diabetes-mental-health-0611.pdf

[13] Mental Health Act (1983) Code of Practice 2008 http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_087073.pdf (Note: this Code of Practice was updated and re-issued on 15th January 2015)

effective discharge planning and after-care. This Review has found, however that Adult A's Care Coordinator had responsibility for Adult A's discharge planning and should have undertaken the work that enabled Adult A to have a safe discharge that met his needs and supported him in the community. This should also then have been managed by his supervisor. The inadequacy of the discharge plan should have been picked up by someone in a supervisory role. The duty Care Coordinator should, however have seen how lacking the plans for Adult A were and they had a professional duty to raise this concern with the ward and escalate as necessary.

v. As noted above, the Trust lacked rigour in its attempts to engage with Adult A following his discharge, simply writing letters and repeating this when inevitably these were unsuccessful in gaining his engagement. It seems that the risk of Adult A failing to engage after his discharge from the Maudsley Hospital, which was high and well-evidenced had not been considered and no contingencies were established to address that significant risk.

vi. Adult A was not registered with a GP. It is highly surprising that the Trust did not know this, particularly given Adult A's detention under the Mental Health Act (1983) and his discharge with a Community Treatment Order. The absence of Adult A being registered with a GP meant that his long-term mental health needs were not planned for. In addition, Adult A's diabetic healthcare needs were not considered in relation to his discharge into the community. The Dietician that saw Adult A on the ward had made an assumption that he had a GP, recording on 20th August that it was, *'likely that Adult A would benefit from further education on diabetes and its management. This could be done via his GP Practice*'. Additionally, other agencies which assumed Adult A had a GP, also assumed that this person would coordinate Adult A's care and support; this did not happen because that person did not exist.

5.4.4 Metropolitan Police Service Jigsaw Team (Lewisham)

Adult A was discharged on 29th August, a month before the Jigsaw Team was given this information. The Police had not been informed or consulted and a duty was therefore breached in respect of the Criminal Justice Act (2003). The Jigsaw Team was therefore unable to perform their role in protecting the public from a Registered Sex Offender.

The Review Panel was advised that had the Jigsaw Team known of the discharge date, they would have undertaken the following tasks:

i. Intelligence checks regarding address prior to discharge, and physical check of property to ensure that it is suitable considering index offence.
ii. Notify and liaise with the Borough where the proposed address is situated.
iii. Liaise with Mental Health re on going care plan and potential risk and management of Mental Health
iv. Review of RM2K. (risk assessment)
v. Review of Risk Management Plan to reflect discharge into community.
vi. Liaise with Mental Health to ascertain if this matter should be referred to MAPPA prior to discharge for multi -agency discussion.
vii. Ensure that Adult A had completed his notification upon discharge within three (3) days. If this was not completed Police would have looked to initiate breach proceedings.
viii. Home visit upon discharge.

ix. Consideration for any disclosures, if applicable, to manage any potential risks posed by offender.

None of this happened.

5.5 Partnership – Local solutions through services working with each other and their communities.

5.5.1 LB Southwark Housing Department

As noted above, Adult A had complex needs; he had a severe and enduring mental health condition, Schizo-affective Disorder, a chronic physical condition, Type ii Diabetes, and a history of offending. For individuals such as Adult A, these needs typically '*interact*' resulting in multiple problems at the same time; this was the case for Adult A.

Clearly, people with complex needs require care from more than one service to address these and services must work in partnership to meet those needs. LB Southwark Housing Department did not work in partnership with other services, not because it did not wish to do so, but because it was not able to do so. There is evidence of Reablement Officer 1 seeking contact with Adult A's Care Coordinator or his Care Coordinator, appropriately highlighting risks around his financial management and as his mental health deteriorated, around their concerns for his well-being. This was all good practice, but it seems was largely ignored by his Care Coordinator.

5.5.2 South London and Maudsley Foundation NHS Trust

As has been highlighted earlier in this report, the Review Panel concurred with the view of HM Assistant Coroner; Adult A was not well-served by the South London and Maudsley NHS Trust. The Trust's areas for development are set out clearly earlier in this report, and the limitations in terms of its partnership working quite clear. However, for completeness it is important to state that the Review heard that the Trust did not attempt to work in partnership with other agencies.

This is evidenced by the lack of response to the Reablement Officer's request for support around budgeting for Adult A and the seemingly reluctant sharing of an out of date risk assessment with the Housing Department as Adult A was due for discharge.

The Trust should have had a duty to work in close partnership with the Metropolitan Police Jigsaw Team (Lewisham), given Adult A's registration as a Sex Offender. This did not happen. Adult A's Care Coordinator recorded that he had been contacted by a Jigsaw Police Officer on 24th September, and that he had advised the Officer that Adult A had been discharged from the Maudsley Hospital. The Metropolitan Police dispute this account and states that the first knowledge the Jigsaw Team had of Adult A having been discharged was when he was found deceased on 27th September 2012. On the balance of probabilities, it seems likely that the Police account is correct; the Care Coordinator having not been seen to have performed well in this case. However, regardless of whether the conversation was on 24th or 27th September, Adult A was discharged on 29th August, a month earlier and the Jigsaw Team had not been informed or consulted and therefore a statutory duty had been breached.

5.5.3 Metropolitan Police Jigsaw Team (Lewisham)

The Jigsaw Team was aware that Adult A had been detained under the Mental Health Act (1983), being informed by the Maudsley Hospital on 9th May 2012. Between May 2012 and September, when Adult A was found deceased, the Jigsaw Team was in regular contact with staff on the ward at the Maudsley Hospital and were appropriately informed when Adult A was on leave. The communication from the South London and Maudsley Foundation NHS Trust seems to have broken down at the point at which it was Adult A's Care Coordinator's responsibility to arrange Adult A's discharge and establish safe and appropriate support in the community. Therefore, although the Jigsaw Team and the Hospital Ward liaised effectively, at the point at which real partnership working was vital, the principle was not adhered to.

5.6 Accountability – Accountability and transparency in delivering safeguarding.

5.6.1 LB Southwark Housing Department

The Review Panel heard evidence that the recording of actions taken in the Housing Reablement Service were of a good and thorough standard; this enabled the Service to provide HM Coroner with robust evidence in Adult A's inquest.

While the needs and risk assessments were appropriately approved by a manager, this was at an early stage of the two assessments and therefore no further oversight of the Service's input, activity or decision-making was provided.

It was not possible for the Review Panel to know when Adult A actually left his bed and Breakfast tenancy in March 2012, because the recording system was inadequate at that time. However, the Review Panel heard that LB Southwark introduced an Electronic Data Management System in 2013, and this had enabled more accurate recording.

The Independent Author wishes to highlight the importance of the level and standard of training and development Reablement Team staff receive about:

i. Mental health conditions and the potential impact of these on individuals' functioning and capacity to make relevant decisions in line with the requirements of the Mental Capacity Act (2005)
ii. Risk assessment and risk management

Research has shown that those who are homeless, or at risk of homelessness, are much more likely to experience mental distress. Further, Homeless Link reported in 2010[14] that 7 out of 10 of clients had mental health needs and a third of those lacked the support they needed to address their mental health needs. On this basis it is likely that a significant number of people seen by the Reablement Service will have some form of mental health difficulty and therefore that cohort of staff need to be skilled in understanding the implications of these difficulties and be in a position to conduct robust, evidence-based, multi-disciplinary risk assessments.

[14] Department of Health, Closing the Gap: Priorities for essential change in mental health, January 2014

5.6.2 South London and Maudsley NHS Trust

The Trust was commissioned by Southwark NHS CCG with a Section 75 of the NHS Act 2006 partnership arrangement with the London Borough of Southwark to provide health and social care community mental health services. This has now been dissolved. However, at the time the Trust was therefore accountable in its actions to both, yet did not advise either that Adult A had been found deceased, or that its actions were under scrutiny by the Coroner's office. This was only discovered when the Assistant Coroner issued the Schedule 5 Prevention of Future Deaths Notice. It is important to note that had this situation occurred after the enactment of the Care Act (2014), there would be an expectation that the Trust should not only inform its commissioners, but also refer for a Section 44 Safeguarding Adults Review.

Maudsley Hospital Ward staff show good accountability in their standard of recording, which has made the chronology produced for this Review highly accessible.

Recording by Adult A's Care Coordinator, however is reportedly of a poor standard and is largely absent, reflecting either a lack of recording, or a lack of action; the latter is likely given the reports provided to the Review. As noted previously, the way in which care and support was provided to Adult A by the Trust was not supported by the statutory Mental Health Act Code of Practice or the Mental Capacity Act Code of Practice.

It is not the place of this Review to consider or discuss in detail the actions of individual members of staff in any agency; the Review has sought take a systemic perspective on the experience of Adult A. However, there are questions about the performance of Adult A's Care Coordinator and furthermore, how this has been addressed. The Trust advised the Review Panel that, '*It was reported in some staff interviews that Adult A's CMHT care co-ordinator had been underperforming in his role prior to his redeployment to the generic CMHT [in 2010], particularly with regard to time management and updating documentation. However, his new manager within the generic CMHT stated that the care co-ordinators' previous performance issues had not been handed over*'. This approach to performance management is of concern, but also is the fact that this Review has identified a range of performance concerns that reveal breaches in legal and regulatory duties. Most of these were the responsibility of his Care Coordinator, yet it seems that his supervisor was unaware, with the Trust stating that, '*no performance concerns were documented in the available supervision records since 2009 until Adult A's death in September 2012'.* The Assistant Coroner noted that Adult A's Care Coordinator and his manager had different understandings of the regularity of his supervision, indicating a somewhat loose approach to this vital process. As Lord Laming stated in his report of the Victoria Climbie Inquiry*, 'Supervision is the cornerstone of good ……practice and should be seen to operate effectively at all levels of the organisation'*[15]. Responsibility for the legal breaches, the poor approach to discharge planning and a general lack of interest and care in Adult A as a person, all of which have been identified in this review, cannot be the sole responsibility of Adult A's Care Coordinator.

[15] The Victoria Climbie Inquiry, Lord Laming, 2003
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/273183/5730.pdf

6. Overall findings

6.1 Partnership working

The Care Quality Commission comments in its report of its statutory monitoring of the Mental Health Act in 2012-2013[16] that, '*There are clear, recurring themes that come out of our findings. All parts of the health and care system need to work together [*the Independent Author's emphasis*] to make the changes that are urgently needed and, in most cases, required as a minimum by the Mental Health Act and the accompanying Code of Practice*'. This view is supported by the findings in this Review and many others; it is vital that agencies proactively work together to support individuals with needs such as Adult A.

It must be emphasised that this report is cited for a wider reference purpose, and it did not focus on the South London and Maudsley NHS Foundation Trust in its findings.

6.2 Registration with a GP

This Review has already focused on the significance of registration with a GP Practice and how the lack of this in Adult A's circumstance was pivotal. The Trust has advised the Review Panel that it has worked with care in this area, stating that,

'*The Trust can confirm that the admissions and discharge checklists require admin staff to check registration and if not to ask clinical staff to support with this. Though this process is not clearly set out in any policy document, this has been the usual practice across the in-patient areas, albeit not in any systematic way. The newly formed Acute Clinical Academic Group (CAG) will be developing a standardised system via EPJS, as it is noted that currently each ward does have systems in place but they are not the same across the Acute Pathway.*

The wards issue discharge notification forms within 24hrs of the patient's discharge which highlight that the patient needs a GP, a care co-ordinator and also the discharge medication, including who is going to be prescribing the medication with an additional section for recording a brief summary, discharge plan, and comments. It is now routine practice in community teams to monitor whether service users are registered with a GP by monthly performance monitoring.

The Trust would like to assure the panel that it is committed to follow this through. This has now been handed over to the new Acute CAG as a matter of priority, to develop standard processes and a check list for, not only noting whether patient is registered on the system, but for ensuring the GP registration is active'.

The Review has been assured by this response from the Trust, but would like to take this opportunity to ensure the learning and improvement is embedded. To this end, the Review wishes to emphasise the importance of this matter by asking that the Trust Acute Clinical Academic Group (CAG)'s task in developing standard processes and a check list for, not only noting whether patient is registered on the system, but for ensuring the GP registration is active. This forms a recommendation and is a matter of priority.

[16] Monitoring the Mental Health Act in 2012/13, CQC

Similarly, the Review is assured by the other areas of response given by the Trust, but asks that lessons learnt are disseminated wider than the Psychosis Clinical Academic Group. The Review considers that the lessons are relevant across all services working with adults with care and support needs, and are therefore relevant to the entire Trust.

Similarly, lessons learned by the Trust regarding use of the Disclosure and Barring Service and the referral to the Nursing Midwifery Council should be shared across all staffing teams. This would allow for a standardised approach to such matters, which is vital in terms of organisational transparency and accountability.

6.3 Dignity and Person-Centred Services

Adult A was described by the Assistant Coroner as being '*challenging'* to work with and this is acknowledged by all agencies. Indeed this, together with his mental health status, his ethnicity, his registration as a sex offender and his lack of family contact all placed him as being marginalised and hard to reach. His behaviours may well have led to him being labelled, non-overtly, as being what was described in Felicity Stockwell's research as the 'Unpopular Patient[17]'; the person that no professional will explicitly state is '*difficult*', but who is felt to be so and therefore receives a psychological label that may, subliminally influence the type and standard of care they receive.

The approach of the South London and Maudsley Foundation NHS Trust seems to have lacked a focus on Adult A as a person, and a person with fears, wishes, hopes and aspirations. The reasons for this attitude are not clear, but indicate far more than the poor practice of one individual. The Assistant Coroner commented in her report that, '*the caring element of the Care Coordinator role was missing'.* This is true, and there is a sense that absence has pervaded this entire review. It is emphasised, it seems, by the Care Coordinator's record on 12th September 2012, when Adult A had been out of contact with the Trust for fourteen days, that he would '*attempt*' to visit Adult A the following week; the lack of proactivity is stark and points to the possible absence of dignity afforded to Adult A.

The Royal College of Nursing states that, '*Dignity is concerned with how people feel, think and behave in relation to the worth or value of themselves and others. To treat someone with dignity is to treat them as being of worth, in a way that is respectful of them as valued individuals'*[18]. This review has found that Adult A was not treated with dignity or as someone of worth and as value as a person. This conclusion forms the final recommendation from this Review, that the South London and Maudsley NHS Trust should undertake an exercise to remind their staff, particularly those in Community Mental Health Teams of the importance of focusing on the person as an individual and treating them with dignity in <u>all</u> their interactions with patients.

[17] The Unpopular Patient, Felicity Stockwell, Royal College of Nursing, 1972

[18] Defending Dignity: Challenges and Opportunities for Nursing, Royal College of Nursing, 2008

7. Developments since 2012

The Review has been very aware, as highlighted at the start of this report, that some considerable time has elapsed since Adult A's death. Changes have taken place, particularly within two of the key agencies with whom Adult A had contact; South London and Maudsley NHS Foundation Trust and LB Southwark Housing Department. These are set out below.

7.1 LB Southwark Housing Department

As noted earlier in this report, the Local Authority and NHS CCG have led a pilot aiming to:

i. '*Coordinate a multi-agency, multi-disciplinary approach, focussing on early intervention to prevent individuals and families with multiple needs drawing on high cost social care across the local public sector.*
ii. *Provide a person-centred approach for the coordination of council services, voluntary support groups and community services to deliver better outcomes for the clients, the council and our partners.*
iii. *Explore alternative interventions that can be delivered through the voluntary sector and community health services.*
iv. *Identify how the project team's interventions and methods impact on the mental wellbeing of the clients with chaotic lifestyles and provide the evidence base for determining whether a multi-agency working approach can contribute to reducing costs and managing resources more effectively in the medium to long term'*[19].

This is a significant area of development that is intended to address a number of the challenges identified in this review. It has been welcomed by the Review Chair and Author.

7.2 South London and Maudsley NHS Foundation Trust

This SAR report has highlighted the fact that the South London and Maudsley NHS Foundation Trust provided an additional report to the Review in September 2016, setting out its learning, commitment to development as a result of that learning in relation to Adult A's death and its improvement activity. This report provided extensive assurance to the Review.

The report highlights a range of acknowledgments and developments that are welcomed by the Review Chair and Author. These include:

i. An explicit statement that the lessons from Adult A's experience are understood and addressed within the Trust;
ii. That this strategic acknowledgement and understanding must also be replicated operationally across the Trust;
iii. That the Trust was not as attentive as it should have been to its role and responsibility in relation to Adult A's safety and day to day care and support needs following discharge;
iv. That communicating with people with needs such as Adult A solely by letter is counter-productive;

[19] Multi-agency Working Team Update, LB Southwark COT Report, March 2016

v. That performance management of individual staff is particularly essential in managing a service providing care to people with complex needs;
vi. That concerns about individual staff members' performance need to be routinely addressed and where concerns remain and harm is experienced, early referrals to the Disclosure and Barring Service (DBS) and any regulatory body is undertaken;
vii. That discharge to the community from a detainment under the Mental Health Act (1983) is a statutory responsibility, best achieved across a multi-agency partnership and the opportunity to ensure that people such as Adult A are able to manage their own risks is fundamental to the rehabilitation process.

The South London and Maudsley NHS Foundation Trust noted that a CQUIN[20] for the Trust and a Key Performance Indicator (KPI) is a seven day *face-to-face* follow-up meeting with those patients discharged into the community. This is a significant change that addresses one of the core concerns of this Review.

This Review has highlighted an essential area of learning as being about the need for people in circumstances such as Adult A to have confirmed registration with a GP Practice and also, more importantly, to ensure this is active. The Trust has assured the Review that this concern has been addressed and that a revised system is in place that would address the matter of a patient not being currently registered with a GP practice. This is significant and important, and therefore forms a SAR recommendation, asking for assurance that this requirement extends to ensuring registration with a GP is not simply in place, but also active . Organisations should have a standard processes and a check list for, not only noting whether patient is registered on the system, but also for ensuring the GP registration is active.

The Trust has suggested that it has developed its approach to being a learning organisation over recent years and since Adult A's death. This is welcomed, but it is recommended that the South London & Maudsley NHS Foundation Trust consider how its learning in this case can be disseminated across the whole organisation and it can evidence that this has taken place.

8. Conclusion

All Review Panel members expressed sadness and concern at the way in which Adult A died and wish to give their sincere condolences to his family.

This Review has identified learning for all agencies supporting adults with care and support needs in Southwark, not just those organisations that have participated in this review. For that reason, the SAR Independent Chair and Author has asked that that the generic learning identified in this report be considered across the multi-agency partnership.

Dr Paul Kingston
September 2016

[20] CQUIN - Commissioning for Quality and Innovation Indicator https://www.england.nhs.uk/wp-content/uploads/2016/03/cquin-guidance-16-17-v3.pdf

9. Recommendations

No.	Recommendation	Agency(ies)	Performance measures	Outcomes for individuals experiencing or at risk of abuse and neglect	Target completion date	RAG rating	Comments
1	The LB Southwark Housing Department should provide assurance to the Safeguarding Adults Board about its progress in relation to commissioning suitable accommodation for individuals with complex mental health conditions.	LB Southwark					
2	All relevant staff in LB Southwark Housing Department and specifically in the Reablement Service should receive training in relation to assessment of needs, assessment and management of risk and understanding mental health.	LB Southwark					
3	King's College Hospital NHS Foundation Trust should remind staff of the need to conduct capacity assessments where there is a concern that an individual may not have the capacity to make relevant decisions about their own health. This reminder should be in line with the requirements of the Mental Capacity Act (2005).	King's College Hospital NHS Foundation Trust					

No.	Recommendation	Agency(ies)	Performance measures	Outcomes for individuals experiencing or at risk of abuse and neglect	Target completion date	RAG rating	Comments
4	South London and Maudsley NHS Foundation Trust should work with King's College Hospital NHS Foundation Trust to develop a clear care pathway, with explicit points of information exchange, including those relating to key points of contact for patients detained under the Mental Health Act (1983) who are admitted to King's College Hospital.	South London and Maudsley NHS Foundation Trust with King's College Hospital NHS Foundation Trust					
5	South London and Maudsley NHS Foundation Trust should work with King's College Hospital NHS Foundation Trust to strengthen existing relationships and structures, such as Mental Health Interface Meetings. The two trusts should consider development of a discharge planning pathway specifically related to patients from South London and Maudsley NHS Trust with severe and enduring mental health conditions who also have diagnoses of Diabetes Type I or II.	South London and Maudsley NHS Foundation Trust with King's College Hospital NHS Foundation Trust					
6	South London and Maudsley NHS Foundation Trust should provide assurance to the Safeguarding Adults Board in Southwark that patients detained under the	South London and Maudsley NHS Foundation Trust					

No.	Recommendation	Agency(ies)	Performance measures	Outcomes for individuals experiencing or at risk of abuse and neglect	Target completion date	RAG rating	Comments
	provisions of the Mental Health Acts (1983 & 2007) have access to and are encouraged to use advocacy.						
7	South London and Maudsley NHS Foundation Trust should provide assurance to the Safeguarding Adults Board in Southwark that patients detained under the provisions of the Mental Health Acts (1983 & 2007) have access to information about their rights, ability to challenge decisions, request a tribunal and inform their discharge care plan.	South London and Maudsley NHS Foundation Trust					
8	The Southwark Safeguarding Adults Board should provide guidance to statutory agencies about their information handling responsibilities in respect of safeguarding risk, including sharing of information, accurate and consistent management of information and appropriate sharing of that information.	Southwark Safeguarding Adults Board					
9	South London and Maudsley NHS Trust should undertake an exercise to remind their	South London and Maudsley					

No.	Recommendation	Agency(ies)	Performance measures	Outcomes for individuals experiencing or at risk of abuse and neglect	Target completion date	RAG rating	Comments
	staff, including those in Community Mental Health Teams of the importance of focusing on the person as an individual and treating them with dignity in all their interactions with patients.	NHS Foundation Trust					
10	The South London and Maudsley NHS Trust new Acute CAG should develop as a matter of priority a system for not only noting whether patient is registered on the system, but for ensuring the GP registration is active.	South London and Maudsley NHS Foundation Trust				`	
11	The South London and Maudsley NHS Trust should provide an assurance that the organisation understands its responsibilities in relation to the Disclosure and Barring Service and the Nursing and Midwifery Council.	South London and Maudsley NHS Foundation Trust					
12	The Southwark Safeguarding Adults Board should ensure that lessons learned from situations such as this are disseminated across the whole Trust.	Southwark Safeguarding Adults Board					