Learning On One Page (LOOP)

Derbyshire Safeguarding Adult Board (DSAB) Safeguarding Adults Review (SAR24B) Karolina – December 2024

Background/circumstances leading to the Review

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

Derbyshire Safeguarding Adults Board carried out a Safeguarding Adult Review (SAR) following the death of Karolina, an Eastern European woman in her 20's who died in October 2022. Whilst being conveyed to a mental health bed Karolina collapsed in the secure patient transport outside her mother's home. She was attended to by a bystander for immediate life support and subsequently by paramedics but sadly she later died in Hospital.

Karolina moved several times between Cheshire, Derbyshire, and Eastern Europe within the timeframe of the SAR. She had a diagnosis of paranoid schizophrenia and there were a number of professionals involved who were supporting her with a deterioration of mental health resulting in significant self-neglect. She was also cared for by her Mum when Karolina lived in Derbyshire. Karolina had four Mental Health Act assessments in the timeframe of this review as well as inpatient admissions. She spent at least 4 months out of the last year of her life in hospital.

What did not go so well?

- There were missed opportunities for agencies to come together to explore their full understanding of what was happening and to establish a shared understanding of risk.
- Professionals needed to have more robust and detailed conversations with Karolina's mother to understand the full circumstances and how to access help and support. Factors that acted as a barrier to communication included the fact that English was not a first language for Karolina and her Mother, leading to a lack of understanding of past experiences of mental health care in Eastern Europe, and expectations and arrangements of mental health care in the UK.
- When Karolina had a Mental Health Act assessment and required a bed there were delays. This is not a unique challenge to Derbyshire and there are ongoing oversight processes to manage these issues.
- Except for the time that Karolina spent in hospital, the access that services had to monitor Karolina's physical health was limited.
- There was a record of historical domestic abuse and the possibility of exploitation. These wider issues did not feed into any future process. This is relevant because at times when she was very unwell, she was living with the same partner and risk and vulnerability relating to him was not considered.

Good practice

- Karolina's engagement with services was sporadic and she moved between Derbyshire, Cheshire, and Eastern Europe on a regular basis. There was good practice of cross border information sharing on some occasions where practitioners shared and sought information.
- There was positive cross boundary working to facilitate an assessment by Karolina's consultant, and subsequent arrangements to conduct a Mental Health Act assessment and to identify a bed.
- There were some occasions when an interpreter was used, and this was documented to have a positive effect on Karolina's wellbeing.

Key Learning Themes

- Cross boundary and multi-agency working
- Person-centered care planning and professional curiosity
- Legal literacy
- Language and cultural barrier
- Bed challenges and processes.
- Professional supervision and escalation
- Physical health management

Six recommendations were made in this SAR under four key themes:

- Multi-Agency working
- Carer's assessments
- Mental Health Act assessments for people who self-neglect
- Cultural competency

DSAB recommendations

- The DSAB Policy and Procedures subgroup will develop and disseminate practice guidance in relation to mental health discharge planning arrangements.
- The DSAB will strengthen communication and seek assurance that agencies are aware of the process for carers assessments; how to identify need and how to refer.
- The DSAB Performance and Improvement subgroup will seek assurance in relation to Mental Health Act assessments for people who self neglect, in particular in relation to decision making and actions taken when beds are not available.
- Derby and Derbyshire ICB will share the learning from this SAR with private mental health bed providers in Derbyshire.
- The DSAB will ensure that the cultural competence guidance is available on its website and undertake a communications exercise to ensure that front line staff have access to this information.
- The DSAB's Performance and Improvement subgroup will seek assurance from partner agencies that professional interpreters are utilised at significant points of any provision of care and support.