Natalie

What Happened?

- When she was 25 years old she was housed in temporary accommodation by Wandsworth Council's Housing Department.
- In the six months or so before she died she spent most of that time in hospital. She was admitted with a leg fracture following a fall. Her complex health needs meant discharge was delayed several times.
- She was discharged home with a plan for community nurses to support her with insulin injections four times a day.
- Three days after discharge Natalie was found in her room at Dunheved Hotel by a district nurse unresponsive.

Natalie

Natalie was 28 years old, black British female and one of a non-identical twin. The twins were different in both appearance and temperament with Natalie being described as 'loud and outgoing', 'very gregarious and caring'.

She worked in a shop after leaving school, leaving home when she was around 23 to live with friends but maintained close contact with her family. At 16 Natalie's health started to deteriorate when her mother identified signs of diabetes which her father had but her mother said she didn't let her condition hold her back. She was also open to the Dialysis Team where she received dialysis three times per week. From 25 she was housed by the bi borough Richmond & Wandsworth (Wandsworth Housing) in temporary accommodation at the Dunheved Hotel in Croydon.

Natalie's family have engaged with the SAR process from the beginning wanting there to be learning from this review.

Learning Identified by the Review

Multi Agency/Single Agency issues

- Impact of cross-border local authority duties on discharge planning.
- Information about the unsuitability of Natalie's accommodation did not get to the right place.
- Impact of understanding of the Care Act 2014 on discharge planning.
- Application of the Mental Capacity Act 2005.
- Hotel not aware of where she was, both when she was in the hospital and when she had fallen in her room.
- District Nurses missed visits.

Multi-Agency Learning

1. Ordinary Residence
2. Information Sharing
3. Multi-agency understanding of application of the Care Act.
4. Application of the Mental Capacity Act 2005.

Good Practice Identified by the Review

- There was a good hospital discharge in May 2021 using the Discharge to Assess process.
- Planning for Natilie's discharge started in a timely way, with risks being raised, just two weeks after her second admission in the period the SAR reviewed.
- In June and October 2021, attempts were made by some practitioners to represent Natalie's view about the risks to her safety from return to temporary accommodation.
- There is evidence of some good communication between practitioners, teams and agencies.
- A comprehensive Section 42 Enquiry Report was completed following the incident.
- There has been work by the hospital ward and discharge teams since Natalie died to share the learning about what happened and make changes to avoid something similar happening again.

Recommendations

1) For Croydon Safeguarding Adults Board to seek assurance from the Adult Social Care and Health Directorate of Croydon Council of what it has done to:

   - ensure all of its staff whose work involves dealing with such matters have a sufficient understanding of Ordinary Residence issues in general, and specifically in relation to people with care and support needs placed in Croydon by a housing department of another local authority; and

   - assure itself that the work being done across ASC&H is correctly applying he requirements on it in regard to Ordinary Residence.

2) For Croydon Safeguarding Adults Board to share the learning from this review about application of the Mental Capacity Act 2005 with any organisation in Croydon that it deems may benefit from it.

3) For Croydon Safeguarding Adults Board to share the learning from this review about application of the Care Act 2014 with any organisation in Croydon that it deems may benefit from it.

4) For Croydon Safeguarding Adults Board to consider what, if any, evidence it may seek from the organisations in Croydon involved in this review, any organisation that is a member of Croydon SAB, or any other organisations in Croydon that it consider relevant to do so, about their application of learning points (2) and (3) above.

5) For Croydon Safeguarding Adults Board to consider whether to share the learning from this review regarding any local authority or NHS service in other areas with the Safeguarding Adults Board(s) for those areas.

A Tool for Reflective Discussions

Theory and Context: Questions to consider

- How can I / we use the learning from this Safeguarding Adults Review to build my professional or theoretical knowledge?
- What have I / we learned from this Safeguarding Adults Review that I / we can apply to a similar situation in the future?
- What have I / we learned in general from this Safeguarding Adults Review?

Preparation: Questions to consider

- What could I / we do if we faced a similar situation in future?
- What can I / we do now to prepare ourselves for dealing in future with the issue identified in the learning from this Safeguarding Adults Review?
- What do I / we need from others to help prepare to deal with such issues? What can I / we do to make that happen?
- What can I / we offer others to help them to prepare to deal with such issues?

Full Report can be found by clicking here