Croydon Safeguarding Adults Board

Safeguarding Adult Review

Natalie

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Revised by Croydon SAB Safeguarding Adults Review Panel

Final

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Contents

Introduction and Overview

This is the report of a Safeguarding Adults Review (SAR) commissioned by Croydon Safeguarding Adults Board (CSAB) under section 44 of the Care Act 2014. The SAR was set up to identify the learning following the death of Natalie. Natalie was a woman with complex health conditions who died in October 2021, shortly after her discharge from hospital following a stay of four and half months.

Natalie was living in temporary 'self-contained accommodation' provided by the housing department of Wandsworth Council. This was in the basement of a residential hotel in London Borough of Croydon. At the time of her discharge from hospital, the lift at the hotel was broken and so access was via stairs. There was no mobile phone signal or WiFi connection at her accommodation.

This accommodation became unsuitable as Natalie's mobility and health conditions deteriorated and she required frequent, often urgent, professional input. The risks of discharging Natalie to this accommodation were raised by several health and social care practitioners during her hospital stay but were not addressed. This was caused by confusion over Natalie's Ordinary Residence, shortfalls in communication, policy, and systems. Though her mobility had improved by the time she was discharged home in October 2021, the discharge planning did not take full account of all the identified risks.

Once Natalie was home, there were significant omissions in the District Nursing Plan designed to monitor her health and administer essential medication. Visits were missed, and her body was not found until sometime after her death despite several room checks. The Autopsy Report gave the cause of Natalie's death as 'complications of diabetes'. A Coroner's Inquest has been scheduled for January 2025 and two preliminary meetings have taken place.

Process of this Safeguarding Adults Review

The purpose of a SAR, set out in section 44 of the Care Act 2014, is to "identifying the lessons to be learnt from the adult's case". All members of a Safeguarding Adults Board (SAB) must co-operate with the SAR, and they must apply the lessons learned to future cases.

The SAR was commissioned under Condition 1 of section 44 of the Care Act 2014, the conditions for which are:

- an adult in the SAB's area with needs for care and support has died;
- the SAB knows or suspects that the death resulted from abuse or neglect; and
- there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult.

The Board knew or suspected that there had been abuse or neglect as Croydon Council Adult Social Care and Health made a referral to Croydon SAB for consideration for a SAR, following a section 42 Care Act 2014 adult safeguarding enquiry into the circumstances leading up to the death of Natalie. This enquiry concluded there had been organisational abuse across a range of organisations.

The Terms of Reference for this review were for the Review to consider and reflect on:

- Cross border partnership working between local authorities, ICB hospitals within ICB footprint, community nursing teams and housing providers.
- Escalation process when there are disputes across agencies.
- Responsibilities of out of borough housing departments for vulnerable adults accommodated in unregulated temporary accommodation in Croydon.
- The Discharge to Assess processes between Wandsworth Council and Croydon Council.
- Lessons to be learned around Ordinary Residence.
- Review and update quality assurance processes around the commissioning of temporary accommodation.
- Lessons to be learned around missed opportunities in relation to practices and processes.

A Panel was established to steer the progress of the SAR, to ensure adherence to the terms of reference and to assist with overcoming any obstacles to the process. The panel met virtually on 19 January 2023 and 24 April 2023. The Panel consisted of representatives from the following organisations:

- London Borough of Croydon Adult Social Care
- London Borough of Wandsworth Adult Social Care
- London Borough of Wandsworth Housing
- St George's University NHS Foundation Trust
- Community Nursing Team, Croydon Health Services
- Dunheved Hotel, London Housing Group
- Croydon Police
- London Ambulance Service
- South London and Maudsley NHS Trust
- South West London Integrated Care Board

Method

There is a range of methods for conducting a SAR and CSAB determines which method suits the case best, ensuring that it is proportionate and appropriate to the situation and makes effective use of resources. This decision was delegated to the Panel.

This SAR used a hybrid methodology, using an analysis of chronologies and Individual Management Reports submitted by each organisation. It was underpinned by principles of 'Learning Together', a validated systems methodology produced by the Social Care Institute for Excellence. The Lead Reviewer is trained and experienced in this method.

This method focuses on systems and how the different parts of it work together. It is not about blame but about learning from experience to protect vulnerable people in the future. The process was confidential, although the Lead Reviewer reserved the right to raise any issues she believed may result in harm to any individual. The professionals participating were advised to seek support from their organisations if they experience distress at any stage.

'Learning Together' avoids hindsight bias, being 'wise after the event', in order to understanding the system as it was at the time of the events by the people working within it. The analysis makes clear where hindsight is used to understand why the situation unfolded as it did and where changes may be made to avoid similar tragedies occurring.

An Independent Reviewer was commissioned to lead the process and to write the Report. She had the appropriate skills, experience, and qualifications to carry out this process and was not employed by any of the organisations involved and had no links to Croydon.

The Care Act 2014 requires that the individual and their family are involved in the SAR. In this case, the Social Worker carrying out the Safeguarding Adults Enquiry under Section 42 of the Care Act 2014 'contacted Natalie's mother by telephone on 27/10/2021, 15/11/2021 and 22/11/2021. She gave her views and desired outcomes in relation to the safeguarding concern and for the enquiry to bring agencies together and offer some accountability for what happened to her daughter. She wishes for the investigation to identify areas where the work of agencies, with vulnerable adults such as Natalie need improvement and may lead to a different outcome'.

The Lead Reviewer met virtually with Natalie's mother, twin sister, and aunt on 6th March 2023.

Following the conclusion of the involvement of the Lead Reviewer, further information was provided to Croydon SAB which determined that this Review needed to take account of. To do this, additional work was carried out on this report by members of Croydon SAB's Safeguarding Adults Review group who had no prior involvement with these matters.

Natalie

The following information was obtained primarily from a virtual meeting with Natalie's mother, twin sister, and mothers' cousin.

Natalie was 28-year-old black British female, born at St George's Hospital, one of non-identical twin sisters. The twins were different in appearance and in temperament, with Natalie described as 'loud and outgoing', very gregarious and very caring, never forgetting birthdays. She worked in a shop after leaving school, leaving home when she was around 23 years old to live with friends. She maintained close contact with her family, especially her mother, sister and mothers' cousin. Her mother and sister visited her regularly with practical help with meals and diabetes management. She was housed by Richmond and Wandsworth Borough Council when she was around 25 years old, in temporary accommodation at the Dunheved Hotel in Croydon.

Natalie's health started to deteriorate when she was 16 years old when her mother identified signs of diabetes. Natalie's father had Type 1 diabetes, so the family understood the symptoms. Natalie found this very difficult to manage due to her needle phobia and social life. Her family said 'she didn't let her condition hold her back'. Her mother and twin sister gave her a great deal of support with managing her diabetes, providing meals and help with insulin injections right up to her hospital admission in May 2021. The Covid-19 pandemic restrictions impacted severely on Natalie because of her preexisting health conditions, and therefore she was unable to have contact with her friends and wider family, although her twin sister continued to visit her.

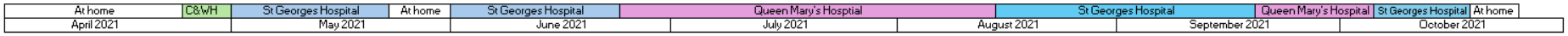
According to her medical records, Natalie had poorly controlled hypertension, heart failure (hypertensive cardiomyopathy), chronic kidney disease stage 5, chronic renal failure, insulin dependent Type 1 diabetes mellitus and diabetic retinopathy. She was open to the Dialysis Team where she received dialysis three times a week. Natalie fell in her room at Dunheved Hotel on at the end of May 2021, sustaining a leg injury causing persistent pain and impaired mobility. This resulted in admission to hospital in June 2021 for treatment.

Natalie was reporting 'new pain' at end of July 2021. A review by the surgeon indicated that there was a new fracture present in mid-August 2021. This was a new type of fracture and would not have been present in June, although there were no reports of falls or injury. The surgeon advised it could have been a simple 'twisting' injury rather than a fall. Her family believe that the other health conditions affecting Natalie arose because of not managing her diabetes well.

Natalie was discharged from hospital in mid-October 2021. Three days later she was found unresponsive in her room at Dunheved Hotel by a district nurse. She was pronounced dead by the London Ambulance Service crew who attended. The Autopsy report gave cause of death as 'complications of diabetes'.

Brief Chronology

10/01/2019	Moved to the hotel temporary accommodation
29/04/2021	Admitted to Chelsea and Westminster hospital with Diabetic Ketoacidosis
03/05/2021	Transferred to St Georges Hospital
20/05/2021	Discharged from St Georges Hospital
01/06/2021	Admitted to St Georges Hospital due to pain following a fall
09/06/2021	Transferred to ward due to anaemia
25/06/2021	Transferred to Queen Mary's Hospital
16/08/2021	Admitted to St Georges Hospital as an X-ray had shown a fracture in right leg
24/08/2021	Surgery to right leg
25/08/2021	Transferred ward
24/09/2021	Transferred to Queen Mary's Hospital
09/10/2021	Transferred ward
14/10/2021	Discharged. Returned to the hotel temporary accommodation
17/10/2021	Found deceased in hotel room



Practice issues identified in this review

Understanding of cross-border local authority duties

The first principle: putting the person first

As is explained below, a dispute arose between Croydon Council and Wandsworth Council about which was responsible for meeting her adult social care needs. When this occurs, the law is clear about what should, and should not, happen. It says

> *"The authorities must not allow the existence of the dispute to prevent, delay, interrupt or otherwise adversely affect the meeting of the needs of the adult or carer to whom the dispute relates." (Regulation 2, The Care and Support (Disputes Between Local Authorities) Regulations 2014)*

That is not what happened to Natalie.

Ordinary Residence disputes in context

Local authorities have a wide range of powers and duties in relation to their residents. Establishing which local authority has a responsibility toward a person is, in most cases, straightforward, and it will be the local authority where the person lives and which they may pay Council Tax to. If we go elsewhere temporarily, such as being on holiday, the local authority where we ordinarily live will retain its responsibilities to us. If we move elsewhere permanently, those responsibilities transfer to the local authority where we are now living.

However, there are some instances where a person may be living in a settled situation in one local authority, and a local authority elsewhere has duties to that person. Two common examples of this are:

- **Where a person has been placed in temporary accommodation by local authority A in the area of local authority B.** Local authority A will retain their duties in regard to housing matters. Local authority B will be responsible for other matters, such as rubbish collection, parking issues, and adult social care issues.
- **Where adult social care services have arranged one of a particular type of accommodation in another local authority's area.** If Local authority A arranges for a person to live in the area of local authority B in either a care home, accommodation in a shared lives scheme, or in supported living accommodation, then section 39 of the Care Act 2014 says that the person remains "ordinarily resident" in local authority A, and they retain responsibility for most adult social care duties to that person. A notable exception to this is that adult safeguarding duties under section 42 Care Act 2014 fall to the local authority where the person physically is, not the one where they are ordinarily resident.

Natalie's experience

Natalie had been placed by Wandsworth Council in temporary accommodation in Croydon. Though the accommodation was 'temporary' in term of housing law, it was a settled situation and she had no alternative accommodation. When she moved, she became "ordinarily

resident" in Croydon. This meant that Wandsworth Council retained responsibility for her regarding housing matters, but other issues, such as adult social care matters, were for Croydon Council to respond to.

When Natalie was discharged from hospital in May 2021, she needed adult social care services. Croydon Council, correctly, arranged for those.

During Natalie's stay in hospitals following her admission in June 2021, the hospitals first approached Croydon Council to discuss the possibility of Nataile needing adult social care services when she would be discharged. When the Croydon Council staff dealing with the matter this time around learned that Wandsworth Council had arranged her accommodation they incorrectly, as she was not living in a type of accommodation that section 39 Care Act 2014 applied to, concluded that she was not ordinarily resident in Croydon and told the hospitals to direct their queries to Wandsworth Council. When the hospitals did this, Wandsworth Council correctly told the hospitals that adult social care matters regarding Natalie were for Croydon Council to deal with.

It is not unheard of for a dispute to arise between local authorities about where a person is ordinarily resident. There are statutory regulations that set out what they should do when this happens, The Care and Support (Disputes Between Local Authorities) Regulations 2014. One of the things that they are required to do is to communicate with each other. Neither Wandsworth Council nor Croydon Council met this requirement. They put the hospitals in the impossible position of trying to resolve the matter by going to-and-fro from one local authority to the other.

Those regulations also say that "the authorities must not allow the existence of the dispute to prevent, delay, interrupt or otherwise adversely affect the meeting of the needs of the adult or carer to whom the dispute relates", and it is clear from the regulations that until the dispute was resolved that Croydon Council should have ensured that Nataile's care and support needs were met.

This error on Croydon Council's part did not have a material effect by the time Natalie was discharged from hospital in October 2021, as at that point the hospital staff working with her had formed the view that there was no role for adult social care at that time. They had discussed with her having some social care support service at home, which she declined, so no referral was made to adult social care services in either local authority. A referral was made to community health services for support with managing her diabetes.

However, it is clear from the records of the hospitals that the confusion over this during her stay was a source of frustration for the staff trying to make arrangements for when she would be discharged and it looked likely that there would be a need for adult social care services, and it was a source of disappointment and frustration for Natalie who said she felt let down by social services.

Ordinary residence matters can be complex to deal with, and it is likely that a student social worker, such as was working with Natalie, would find themselves out of their depth dealing with them. But they should be able to get advice and guidance on this from their colleagues or supervisors so that they get things right, and that did not happen in this instance. The information from the Croydon Council team involved does not identify why this was the case, but it does say that the team have revised their processes in relation to ordinary residence issues, which suggests that there was some deficiency in the processes in place during Natalie's stay in hospitals between June 2021 and October 2021.

Suitability of housing

When Wandsworth Council placed Natalie in the temporary accommodation in January 2019, it appears that it was suitable for her. However, her needs changed and as a result the housing became unsuitable for her.

This was clearly the case by 15/06/2021, which is when a Student Occupational Therapist at St George's Hospital sent a housing risk assessment to the Student Social Worker at Croydon Council who was working with Natalie.

Croydon Council reached the view that this was not a matter for them to deal with as they had at this point reached the view, erroneously, that Natalie was ordinarily resident in Wandsworth and so. They were correct that the housing issue was not a matter for them to deal with, but they reached this view for the wrong reason, thinking it was to do with ordinary residence and adult social care responsibilities, when it was actually in relation to housing duties which clearly remained with Wandsworth Council.

As a result, Croydon Council forwarded the OT's risk assessment to Wandsworth Council's hospital discharge team in their adult social care department. This led to a period of back and forth between the adult social care teams in the two local authorities. What neither did was to send the OT's risk assessment to Wandsworth Council's Housing Department. The information provided to this review from the Housing Department says that the first they knew of concerns about the suitability of the accommodation was on 23/07/2021 when Wandsworth adult social care alerted them to Natalie being in hospital and there were concerns that there was no WiFi at the property. Either the full range of concerns that the OT had did not reach the housing department or, if they did, they were not fully understood.

From then until the time Natalie was discharged in October there was correspondence between the Housing Department and those in the hospitals dealing with preparations for Natalie's discharge. This proved ineffective. The stumbling block was that the Housing Department asked for a range of information, including a discharge summary. The hospital staff found themselves unable to meet this request, as the discharge summary wouldn't be written until the point of discharge, or even sometime shortly after. As a result, the hospital staff sat on the request for further information until after Natalie was discharged, by which time the window of opportunity to resolve the housing issue before she was discharged had gone.

By asking for a discharge summary in advance of the discharge the Housing Department, inadvertently, undermined the chances of them getting the information they needed when they needed it. By not challenging the Housing Department to accept the information that was reasonably available at the time and to leave the matter of the discharge summary till later, those in the hospital arranging for Natalie's discharge missed an opportunity to get to a resolution.

The cumulative impact of these issues is illustrated by an email sent in August 2021 from a member of staff in adult social care services in Wandsworth to a member of staff at St George's Hospital which included "rehousing is a long process and cannot be carried out while a patient is in an acute bed and can safely return". She was not safe to return to that accommodation. The information that this was the case was available, but it was either not seen or not understood by those who needed to know this.

Application of the Mental Capacity Act 2005

Issues to do with application of the Mental Capacity Act 2005 are challenging to review after the fact in a review such as this one. Reasons for this include:

- Application of the Act is in relation to a decision being made at a specific moment in time. It can be difficult to reconstruct in retrospect what the understanding there was at that specific moment in time among those involved in applying the Act.
- The underlying approach of the Act is that the lightest touch reasonable should be taken. For instance, if there is no need to question whether a person lacks the mental capacity to make a particular decision, then the question of assessing their mental capacity does not arise. There will be little or no footprint of that decision in the records, so it can be difficult to get a full understanding of what happened. For the purposes of a review such as this one, it can be difficult to distinguish between a situation where there was a well-made decision that there was no need to do any work under the Act, and one where the Act should have been applied but either it was not considered or there was a flawed decision not to do so.

There were times when people considered whether Natalie had the mental capacity to make certain decisions. The issues that led people to ask these questions always involved one or more of the following:

- A concern that she was experiencing depression to a degree that it impaired her decision making on a range of issues.
- That her phobia about needles was impeding her ability to decide what health care she should have.
- That she was at risk of self-neglect, which may have indicated some difficulties with making or seeing through decisions.

In most instances, it was concluded that either there was no need to go ahead with an assessment of Natalies mental capacity as it was evident that she could make the decision that was facing her at the time, or it was assessed that she did have the mental capacity to make the decision involved.

This was not always the case. There was an instance in 2018 in which it was decided that she lacked the mental capacity to make a decision about her insulin treatment, and so this treatment was given as it was determined that this was in her best interest. In June 2021, the Diabetic Specialist Nursing Team working with her recorded “I have a feeling that [Natalie] does not fully understand the severity of her condition which has been a long standing problem.”

There will be instances when making a determination about whether there is a need to carry out a mental capacity assessment or not, the carrying out of a mental capacity assessment, or the making of a best interest decision will be straightforward. The complexities of this work often arise in those cases where one or more of these decisions is marginal. It appears that may have been the case with Natalie. Indications of this include:

- Different professionals involved appear to have reached different conclusions based on what appears to have been similar information and / or similar circumstances. This can reasonably happen.

- The nature of the decisions Natalie was facing, and the judgements that those working with her had to make, touched on some facets of work under the Mental Capacity Act that are known to be challenging. In particular, they involved
    - Finely balanced decisions when applying the test in s3(1)(c) Mental Capacity Act 2005, about whether Natalie was able to use and weigh the relevant information to make a decision. Issues such as her needle phobia could have had an impact on this issue, but it can be difficult to determine to what extent such an issue is having an impact on a person's ability to make a decision.
    - Whether Natalie was able in the moment to give a convincing account of the decision she was making, but was not taking into account her inability to see through the actions she was describing that she would take. This issue is sometimes referred to as "executive capacity", and it has been recognised that the framework of the Mental Capacity Act 2005 is not well-designed to deal with situations where this is an issue.

Given the challenges already noted of there being limited information in the records provided to the review, for what can be reasonable grounds, it is not possible to say with any certainty here whether this was reasonable or not in the instances considered within this review. However, as there is, for the same reason, equally insufficient evidence to rule out their relevance it is reasonable for this Review to consider what learning there may be on this issue.

Planning for discharge from hospital on 14th October 2021

Involving Natalie's family

During this review, organisations that worked with Natalie told us that sometimes she put limits on them involving her family in the work they were doing. However, she was keeping in contact with them herself. For example, on the day she was discharged from hospital she telephoned her mother and messaged her sister to let them know she was being discharged.

Because the services working with Natalie could not have direct contact with family members, it made it difficult for them to involve them in work they were doing with Natalie, such as her discharge planning, for instance.

Often, adult social care would be able to liaise between people with care and support needs and with their families, particularly where the person has put some restrictions on that contact. It is often possible to find a way to address any concerns someone has about the services working with them having contact with their families. But as there was no such involvement in this instance, for the reasons noted above, this didn't happen.

The decision not to refer to adult social care

Natalie had made use of services arranged by adult social care following her discharge from hospital in May 2021. When she was discharged from hospital in October 2021, the view taken was that there was no need for services arranged by adult social care, so there was no referral made to them.

The information received by this review shows that the issue about whether Natalie may need support from services arranged by adult social care was clearly dynamic, as views changed over time. And it was finely balanced. This can be seen by comparing the indications in the information received for this review that point toward there being a need for adult social care involvement, and those that point away from this.

Indicators pointing toward the need for adult social care involvement:

- In June 2021, the therapy team working with her at St George's Hospital recorded that Natalie said that prior to her fall which led to her admission to hospital she was just staying in her room and she did not go outside. She said she would like to do more things but that she would need help to do so. She said care workers came to prepare her breakfast, check her medication, helped with washing and dressing, and then left. The therapist noted that Natalie's hair was unkempt and the therapist queries whether Nataile had been experiencing long-term self-neglect.
- A "Discharge to Assess" referral in June 2021 identified a number of risk factors: Risk of self-neglect and malnutrition due to low mood, and restrictive environment; Risk of falls due to reduced mobility and within current accommodation nil phone signal and unable to alert emergency service; and Risk of readmission due to temporary accommodation currently placed in
- In July 2021, a social worker from Wandsworth's adult social care services spoke to Natalie on the phone. The record of the discussion shows that there were provisional plans for Natalie to have a package of care at home when she is discharged to assist

with washing, dressing and shopping. The social worker asked the hospital discharge team to send a "Discharge to Assess" referral to adult social care services in Croydon.

- On the 12/08/2021, there was a discussion between Natalie and the medical team in charge of her care at that time. The record of this discussion says that Natalie said she had no fixed discharge destination as she did not think it was safe to return to her accommodation as it was in a basement and she had no phone signal there. She said she had not had any direct contact with social services and she felt they were not communicating with her.
- On 06/09/2021 the discharge coordination team made a "discharge to assess" referral to adult social care services in Croydon. Adult social care services in Croydon said they were not the relevant local authority and that they referral needs to be sent to Wandsworth. On 07/09/2021 the discharge coordination team contacted adult social care services in Wandsworth, who told them that Croydon was the relevant local authority. It is not obvious from the information received for this review that Natalie's needs significantly changed between these events and when she was discharged, which would suggest that if a referral to adult social care was appropriate on the 06/09/2021 and 07/09/2021 of October, it would have still been appropriate on 14/10/2021.
- On 09/09/2021 the nursing team caring for her at the time notes that Natalie sometimes was not eating well or was declining meals which made it harder to administer her insulin due to risks of hypoglycaemia.
- On two occasions, Croydon Council adult social care set up adult social care services, both times to offer support to Natalie following discharge from hospital. The first was in May 2021. The second was in August 2021, though Natalie did not actually receive these services as the planned discharge did not go ahead, but Croydon Council were not told this and so carried on arranging the services in good faith. In both instances, this was done under the discretionary power local authorities have under section 19(3) Care Act 2014 to set up urgently needed services to meet care and support needs in advance of a section 9 Care Act 2014 assessment. This is normal practice under the "Discharge to Assess" (or "D2A") arrangements, which are governed by the "Hospital discharge and community support" statutory guidance. Under these arrangements, it is typical for someone to be discharged from hospital with services put in place to meet the care and support needs they are understood to have, and for a section 9 Care Act assessment to take place once they have returned home, to definitively establish what care and support needs they have. Neither Wandsworth or Croydon councils reached the point of completing a section 9 Care Act 2014 needs assessment for Natalie, so we do not have that definitive statement, but she had appearance of care and support needs on two occasions that led to Croydon Council using its section 19(3) Care Act 2014 powers, and it is not obvious that here situation was markedly different at the time she was discharged from hospital on October 2021 than on those occasions.
- There were several referrals made to either Croydon or Wandsworth adult social care services from the hospitals where Natalie received care and treatment. These included information about Natalie's mental well-being, risks of self-neglect and environmental risks. These were all reasonable matters to bring to the attention of a local authority. None of them were resolved at the time she was discharged from hospital in October 2021, which would suggest that it would also have been reasonable at that time to bring them to the attention of a local authority.

Indicators pointing away from the need for adult social care involvement:

- On October 2021 a review by a dietitian included the information that Natalie "Liked cooked breakfast. At the hostel has food stores. Meals mainly ready meals - microwaved. Family visit and may help with shopping. Has problems with phone reception at the hostel - often misses calls."
- At a learning event following Natalie's death held by the hospital ward that had been caring for her before her discharge it was noted that at the point of discharge, Natalie was mobilising safely with elbow crutches and was able to use the stairs safely. She was independent with her "activities of daily living". A package of care was not arranged and therefore a D2A was not sent prior to her most recent discharge. It was noted that she was offered a once-a-day package of care for shopping and food preparation, but she declined this and said she would manage.
- On 13/10/2021 Natalie was seen by a physiotherapist. The record of this by the physiotherapist says "Patient currently mobilising safely with EC's (elbow crutches) due to ongoing pain and she is able to complete stairs safely as per assessment on 13/10/21. Patient is independent with ADLs ("Activities of daily living") and PADLs ("Personal activities of daily living") and has nil concerns managing with this at home. Patient to be visited multiple times daily by DNs who will be able to flag any safety concerns."

Clarity of language and meaning

It was unclear to this review what was meant, in the record of the review by a dietician, of "At the hostel has food stores". Notwithstanding that the accommodation was a hotel rather than a hostel, the phrase appears ambiguous. It is unclear whether what was meant was

- There are facilities to store food there.
- She has a store of food there.
- There are food shops there.

This review has not seen evidence which shows what was the intended meaning, nor evidence of what others who were involved in the discharge planning understood this to mean. We can only note that different people may have understood this differently from one another. If anyone understood this to mean something different from the actual material circumstances that Natalie was in, it could have led to decisions being made on a flawed basis.

The understanding of the role of adult social care

The evidence this review has seen about the decision not to make a referral to adult social care, irrespective of whether that would have been to Croydon Council or Wandsworth Council, hinged on whether there was a need for adult social care to arrange for social care services who would provide practical support to Natalie once she returned home. This suggests that there may have been an incomplete understanding of the role of adult social care.

The process set out in Part 1 of the Care Act 2014, which is the principle legislation that local authority adult social care services work under, is that before a local authority makes arrangements for meeting a person's care and support needs that they will undertake an assessment under section 9 Care Act 2014 to determine whether a person has care and support

needs and, if so, what those needs are. However, the purpose of such an assessment is not only to help with making a determination what services a person may need the local authority to arrange for them.

The Care and Support statutory guidance, at paragraph 6.2, says

> *"The assessment process starts from when local authorities begin to collect information about the person, and will be an integral part of the person's journey through the care and support system as their needs change. It should not just be seen as a gateway to care and support, but should be a critical intervention in its own right, which can help people to understand their situation and the needs they have, to reduce or delay the onset of greater needs, and to access support when they require it. It can also help people to understand their strengths and capabilities, and the support available to them in the community and through other networks and services."*

It goes on to say, at paragraph 6.10, that

> *"An assessment must seek to establish the total extent of needs before the local authority considers the person's eligibility for care and support and what types of care and support can help to meet those needs. This must include looking at the impact of the adult's needs on their wellbeing and whether meeting these needs will help the adult achieve their desired outcomes. The assessment process also provides the opportunity for local authorities to take a holistic view of the person's needs in the context of their wider support network. Local authorities must consider how the adult, their support network and the wider community can contribute towards meeting the outcomes the person wants to achieve."*

It is relevant to Natalie's circumstances to note that the meaning of "care and support needs" in the Care Act 2014 is not limited to matters that a local authority may arrange services to meet. Section 22 Care Act 2014 is clear that there are some care and support needs that should be met by NHS services, rather than a local authority's adult social care services, and section 23 Care Act 2014 is clear that there are some care and support needs that should be met by a local authority housing department, that than a local authority's adult social care services.

But those provisions only relate to the local authority's duty to meet care and support needs that meet the eligibility criteria in section 13 Care Act 2014. It does not affect the local authority's section 9 Care Act duty to assess those care and support needs.

The relevance of self-neglect to the role of the local authority

As noted above, there were concerns that Natalie may have been neglecting herself. This can have a significant bearing on the role of the adult social care services of a local authority. Where it appears to a local authority that an adult may have needs for care and support, section 9 Care Act 2014 places that local authority under a duty to assess those care and support needs. However, if a person does not want to take up the offer of that assessment, section 11(1) Care Act 2014 says that discharges the local authority's duty to assess. Natalie appears to have been in that position when she turned down the offer of a package of care.

However, section 11(2) Care Act 2014 says there are two circumstances where people are prevented from refusing an assessment of their care and support needs. The first is people who

lack the mental capacity to decide whether to accept or refuse the offer of an assessment of their care and support needs. It seems likely that this would not have applied to Natalie. The second is people who do have the mental capacity to make that decision, but the local authority believes they are experiencing, or are at risk of, abuse or neglect. For this purpose, the meaning of abuse or neglect is as defined in paragraph 14.17 of the Care and Support statutory guidance, which includes self-neglect.

In addition, circumstances in which section 9 and section 11(2)(b) Care Act apply are likely also to meet criteria (a) and (b) in section 42(1) Care Act. That is to say, there would be reasonable cause to suspect that an adult has care and support needs and is experiencing, or is at risk of, abuse or neglect, which includes self-neglect. The document "Understanding what constitutes a safeguarding concern and how to support effective outcomes" published by the Local Government Association and the Association of Directors of Adult Social Services says that circumstances that meet these criteria should lead to a referral of an adult safeguarding concern to the relevant local authority.

The local authority that receives such a referral will need to consider whether the criteria in section 42(1) (a), (b), and (c) Care Act 2014 are met. If they are, then the local authority must ensure that there is an adult safeguarding enquiry. This decision includes the additional test of whether there is reasonable cause to suspect that the adult is unable to protect themselves from that abuse or neglect because of their care and support needs. In addition, self-neglect is the only form of abuse or neglect that the Care and Support statutory guidance gives local authorities discretion about whether there will be an adult safeguarding enquiry or not, even if all three criteria in section 41(1) Care Act 2014 are met.

The Care and Support statutory guidance makes clear that these decisions are for local authorities to make. Paragraph 14.199 of the Care and Support statutory guidance says

> *"It is not for front line staff to second-guess the outcome of an enquiry in deciding whether or nor to share their concerns."*

As Natalie was an adult with care and support needs, and there were concerns that she was at risk of self-neglect, then

- There should have been a referral to the relevant local authority. Notwithstanding that they incorrectly may not have thought so at the time, that was Croydon Council.
- Had that referral been made, then on receipt of that referral Croydon Council should have
    - Recognised it was under a duty to carry out a section 9 Care Act 2014 assessment of Natalie's care and support needs, and that if she refused that assessment then it would need to proceed in the face of her objection as it appeared that she was at risk of self-neglect; and
    - Considered whether there needed to be an adult safeguarding enquiry under s42 Care Act 2014.

There would be no need to delay referring an adult safeguarding concern until the point of discharge, so this referral should have been made as soon as possible once it was recognised that Natalie was at risk of self-neglect.

Though this review has not seen evidence that would allow for a determination either way, it is acknowledged that there is at least a possibility that, consciously or not, the frustrating position that the hospital staff had found themselves in for several months, with neither Wandsworth Council nor Croydon Council taking responsibility for the adult social care arrangements for Natalie, and neither doing what they are required to do when there is such a dispute, could have had an impact on decision making about whether to make a referral to adult social care.

District Nursing Service

Information provided to this review by Croydon Health Services said they received a referral on 13/10/2021 for the Community Nursing Team to visit four times a day to administer insulin. It also noted that the Diabetic Nurse would be involved on discharge to give advice and support around ongoing diabetic management.

District Nurses tried to contact the ward to see what time Natalie was being discharged so they could let the Out of Hours Team Community Nursing Team (OOH) know. They did not get a response so the day team referred to OOH and requested they visit on the evening of the 14th of October 2021.

At 19:15 on 14/10/2021 the OOH team contacted Natalie by telephone to ask what time she would be at home so they could visit. She said she was still at dialysis and awaiting transport so was not sure.

At 21:50 on 14/10/2021 the OOH team contacted Natalie who said her insulin had been administered whilst she was at the hospital and her blood glucose level was 12mmol/ litre She said she would require visits the next day as planned.

At 09:30 on 15/10/2021 the Community Nursing Team visited Natalie and carried out their first assessment. Clinical observations were taken and were within normal limits. Natalie's blood glucose level which was 7.2 mmol/litre and insulin was administered. They visited again at 17:00 and got no answer.

At 09:46 on 16/10/2021, the Community Nursing team attempted to visit Natalie but there was no answer from her at the door or on her phone. They asked the hotel staff to force entry into the room. They got entry at 10:40 and found the room to be empty. At 16:40 they visited again and got no reply.

At 10:40am on 17/10/2021, the Community nursing visited at 10:40am and got no answer. They asked for the hotel staff to open the door to Natalie's room, where they discovered Natalie's body.

Croydon Health Services NHS Trust carried out a Serious Incident Investigation, and that established that some bookings for visits had not been added to the community nursing work diary. That investigation found that the information on the referral from the main community nursing team to the Out of House team was vague and could be interpreted as being for a one-off visit whereas it was meant to be a continual booking. This led to some visits not occurring as intended.

The investigation also found that CHS's 'no reply' guidance' was only followed partially in that the police were never contacted and attempts were only made on one occasion to contact Natalie's next of kin.

Consideration of protected characteristics

This review considered the nine protected characteristics set out in section 149 of the Equality Act 2010. These are age, disability including learning disability, gender reassignment, marriage and civil partnerships, pregnancy and maternity, ethnicity, religion and belief, sex and sexual orientation. The review found no evidence of there been relevant issues in regard to these characteristics, except in relation to age.

Natalie was 28 years old and her need for frequent interventions on discharge to manage her health conditions was unusual for her age group in comparison to older people, for whom systems are in place routinely for complex discharges.

Paragraph 6.30 of the Care and Support statutory guidance says "The local authority must involve the person being assessed in the process as they are best placed to judge their own wellbeing."

Several practitioners took note of Natalie's views and tried to get them acted upon over several months, although no action was ever taken due to systems and communications failures. Natalie would have been aware that her housing options were very limited, and it is clear that she became increasingly resigned to returning to Dunheved, without even the pendant alarm which had been suggested to her.

Impact of Covid-19 Pandemic

The Pandemic had a major impact on health and care services between March 2020 to December 2021 and beyond. Whilst many of the social restrictions were being eased in October 2021, when Natalie was being discharged, inpatient numbers and waiting lists were still very high. Hospitals were under intense pressure and few services in the community were operating normally. It is not surprising that Natalie's discharge became a priority as soon as she was medically fit for discharge, particularly as her stay had been protracted.

Discharge was a priority for all patients who no longer required medical treatment. Remaining in hospital carried risk of hospital acquired infection, particularly but not only Covid, as well as risk of deconditioning and the impact on her broader wellbeing.

The pandemic affected everyone in the UK and many people experienced significant problems due to social restrictions. Natalie's family said that Natalie found lockdown particularly difficult in terms of isolation and loneliness.

There is little doubt that the social restrictions and depleted workforces created by the pandemic created massive difficulties in terms of delivering safe services. Other SARs attest to situations where this had a detrimental effect on an individual's health e.g., Mrs E from Portsmouth (Appendix 8)

Good practice identified by this Review

The Discharge to Assess process was used to facilitate Natalie's first discharge in May 2021 effectively.

Planning for Natalie's discharge started in a timely way, with risks being raised, just 2 weeks after second admission.

Attempts were made by some practitioners to represent Natalie's view about the risks to her safety from return to temporary accommodation by hospital practitioners in June and October 2021.

There is evidence of some good communication between practitioners, teams, and agencies.

A comprehensive Section 42 Enquiry Report was completed following the incident.

Practitioners were deeply distressed by the events and tragic outcome of this case, and it is to the credit of the organisations involved that they have acted individually and together to understand and learn from it. Reviews have been conducted and many resulting actions have been completed or initiated, including a reflection session with the Ward team facilitated by the Adult Safeguarding Team on the 04/07/2022.

Learning

Learning identified by agencies involved in this review

In the information provided to this Review, several of the agencies involved shared learning that they had identified for themselves and the actions they had taken or intended to take.

Croydon Health Services

The processes for booking home visits by community nurses and for handover were not as robust as they could have been, and no relevant formal Standard Operating Procedures (SOP) existed within the community services. CSH has now revised its "No Reply" guidance has now been strengthened with a SOP, and this is incorporated into the Managing Missed Appointments procedure, which covers 'Was Not Brought', 'Did Not Attend' and 'No Access' scenarios. There has been development of a SOP for handover and booking process between District Nurses and the OOH service

Croydon Council Adult Social Care

The "Out of Borough" team deal with discharges of Croydon residents from hospitals outside of Croydon. They have reviewed their discharge planning processes with regards to Ordinary Residence issues, in light of the learning following Natalie's death. This includes a requirement for situations where there is uncertainty over where a person is ordinarily resident to be discussed with the Team Manager.

South London and Maudsley NHS Foundation Trust

They have

- Introduced a safeguarding flag on their patient record system to highlight potential safeguarding concerns.
- Added a Mental Capacity Assessment Form to the recording system to highlight mental capacity concerns.

St George's University Hospitals NHS Foundation Trust

MCA related:

- MCA training at Level 1 or 2 is mandatory for clinical staff, this via bespoke e-Learning package.
- MCA Level 3 pilot training was trialled in 2022, with extensive work pre LPS. This being reviewed and redesigned in 2024 training plans.
- Safeguarding team staff are sponsored to undertake BIA training and then released to undertake assessments and work towards conscious competence.

- Reminder of use of the Ad Hoc MCA assessment recording form is on the landing page of the mandatory learning.

Discharge

- MADE events (multi-agency discharge events) are held regularly during times of high acuity with all Local Authority and community partners.
- Discharge processes: in 2023, the Trust moved away from 'Red to Green' (days when a patient was or was not receiving care that could only be provided in an acute hospital) and to Criteria to Reside in line with national guidance.
- A Transfer of Care (discharge team) has been created, a centrally based team responsible for supporting clinical areas with safe, timely discharge. They are a central point of contact and specialism where a discharge may require additional input and escalation.
- D2A referral forms have been redesigned in collaboration with system partners across South West London.
- Early notification forms are now in use, these are similar to the previously used Section 2 notices.

Safeguarding Training

- Self-neglect forms part of face-to-face Safeguarding training.
- In 2024, a Safeguarding Conference was held with the theme of Transitional Safeguarding. This focus enables / prompt staff to consider presenting needs for younger people and extend curiosity. The sessions will be uploaded to the virtual learning hub to support ongoing learning and development.

Learning identified by this review

Cross-border local authority duties and ordinary residence

The two local authorities made errors regarding the issue of Natalie's ordinary residence. This caused confusion for them and for the hospital discharge teams which hindered the discharge planning for Natalie.

London Borough of Croydon

- London Borough of Croydon changed its stance on whether Natalie was ordinarily resident in its area. Twice they accepted that she was and arranged care services for her. This was the correct application of The Care and Support (Ordinary Residence) (Specified Accommodation) Regulations 2014. However, both times they subsequently reversed that decision and asserted, incorrectly, that Natalie was ordinarily resident in Wandsworth, so Wandsworth Council had responsibility for adult social care arrangements for Natalie. When they asserted that Natalie was not ordinarily resident in Croydon, London Borough of Croydon were wrong.
- The Care and Support statutory guidance requires local authorities to work together to resolve a dispute over ordinary residence. Croydon knew it was in a dispute with Wandsworth, but it did not do this.
- Where there is uncertainty over ordinary residence the Care and Support statutory guidance says the local authority should meet the individual's needs first, and then resolve the question of ordinary residence subsequently.

London Borough of Wandsworth

- The Care and Support statutory guidance requires local authorities to work together to resolve a dispute over ordinary residence. Wandsworth knew it was in a dispute with Croydon, but it did not do this.

Ensuring the suitability of Natalie's housing

Information was known about Natalie's housing situation that would have allowed a view to be taken about its suitability, but the people who needed this information did not have it when they needed it.

- Wandsworth Council's Housing Department asked for details of the issues about Natalie's housing situation to be emailed to them. But they made this request to adult social care in Croydon, who were not the ones with the concerns. Croydon adult social care asked the Occupational Therapy service at St Georges Hospital for these concerns to be put in an email, which was done, but by then Croydon adult social care had formed the view that Natalie was ordinarily resident in Wandsworth. They passed the OT's report

to Wandsworth adult social care. Wandsworth's housing department did not receive it. It had all the information they needed to reach a view about her housing situation.

- In the absence of the OT report, Wandsworth's housing department made several requests for the information they needed. Unfortunately, they asked for this to include a discharge summary. A discharge summary can only be produced at the time of discharge as it is a snapshot of that moment in time. The housing department needed information in advance of discharge, so that they could take a view whether they needed to make different arrangements for Natalie's housing. They made the request in good faith. Those that they made the request to tried to respond to it in good faith. Nobody recognised the implication that because they had asked for the discharge summary, the housing department would not get the information when they needed it.
- The temporary accommodation provider was unaware of Natalie's hospital admissions and stays, despite having a process for residents to sign in. It was not clear to this review that Wandsworth's housing department was aware that the accommodation provider did not know Natalie had been in hospital for an extended period

Mental Capacity

The Mental Capacity Act 2005 requires there to be a presumption of capacity. However, that presumption should be tested, by way of assessment of a person's mental capacity to make a decision when there are grounds for doing so. This did happen on occasion with Natalie, but there are times when a formal assessment of her capacity should have been done but this did not happen.

Where the issue of her mental capacity to make a decision was explored, the records this review have seen do not demonstrate that the following issues were addressed fully:

- The person carrying out the assessment of capacity being clear in their own mind in advance of the assessment what the "relevant information" was for the decision being made;
- The impact that Natalie's needle phobia had on her ability to use and weigh the relevant information for decisions where that was a factor;
- The evidence that while she could describe actions she may plan to take, there was a history of her not following through on those actions, which may have indicated some issue around executive capacity.

Understanding of the Care Act 2014

- There was a conflation between the issue of whether Natalie needed social care services put in place when she returned home in October 2021, and whether she had care and support needs, which is a broader concept.
- There were ongoing concerns about the risk of self-neglect by Natalie. These should have been seen as adult safeguarding concerns, but this did not happen.

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
    a. 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
    b. 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.

Appendix A: Fuller chronology

This appendix is not exhaustive but is intended to give a sufficient level of detail to underpin the analysis, learning and recommendations in this report.

The report anonymises the individual members of staff involved, but where someone had sustained involvement with Natalie and it is useful to understand the sequence of that involvement, an identifier is used.

Date	Event	Response
10/12/2020	Natalie's GP in Clapham wrote to Wandsworth Council Adult Social Care asking that she be assisted to register with a GP in Croydon.	Wandsworth Council Adult Social Care replied to say that the GP will need to contact Croydon Council regarding this.
16/12/2020	Natalie's GP in Clapham wrote to Croydon Council Adult Social Care asking that she be assisted to register with a GP in Croydon.	A duty worker made a telephone call to Natalie on 22/12/2020. She explained her health conditions. She said she was independent with daily living activities. She said she was attending the dialysis clinic the next day and would as their assistance to register with a local GP. LB Croydon Adult Social Care ended their involvement that same day.
29/04/2021	Natalie was admitted to the Chelsea and Westminster hospital. She was treated for Diabetic Ketoacidosis.	
03/05/2021	Natalie was transferred to St Georges Hospital. She was experiencing diabetic ketoacidosis, acute confusion and right leg deep vein thrombosis	

20/05/2021	Discharge referral from St Georges Hospital received by LB Croydon Adult Social Care. Information on the referral includes "At high risk of self-neglect. Needs encouragement to engage in personal care. T1DM insulin dependent, multiple admission related to poor diabetic control so needs prompting to eat regularly."	Discussion with named nurse, who confirmed Natalie was discharged the evening before. A package of care was set up with two care visits per day, with a s9 Care Act assessment planned. The case note includes a comment from the Team Manager "This patient was placed in Croydon by Wandsworth Housing in Jan 2020, it's over a year I have to assume she is now ordinary resident in Croydon."
22/05/2021	An Advanced Practitioner in LB Croydon's Disability Service completed a LIFE service assessment can care plan. She notes that there is a need for a Care Act assessment to be completed by the Out of Borough team, and that the care package can be reduced to one visit per day. The case note includes some goals Natalie has identified: "To register with a GP more locally; To have medication put into blister packs , I currently have a lot of medication and this can be confusing; For medication to be delivered if possible; To have OT input to assess environment, possible perching stool / shower chair other aids that maybe beneficial; Referral to Physio re mobility; Referral for benefit check to ensure that Natalie is in receipt of the correct benefits, currently in receipt of UC, but maybe entitled to PI; OT to make suggestions regarding elevation of leg to help swelling"	Case is allocated on 24/05/2024 to LBC SW1
01/06/2021	Natalie came to St Georges Hospital because of pain she was experiencing following a fall the day before. When the paramedics arrived at her home to take her for dialysis she was unable to transfer from bed to wheelchair due to pain. X-rays were taken but no fracture was seen.	
03/06/2021	Natalie moved to another ward at St Georges Hospital.	
09/06/2021	Natalie moved to another ward in the hospital	
09/06/2021	LBC SW1 telephone Natalie with the aim of arranging a date and time to visit to carry out a Care Act assessment of need. Natalie told LBC SW1 that she was in hospital following a fall.	LBC SW1 contacted the ward and discussed Natalie's situation. She left her contact details so she could be involved in discharge planning.

10/06/2021	Natalie was reviewed by the Diabetic Specialist Nursing Team. In their assessment they noted ""“I have a feeling Natalie does not fully understand the severity of her condition which has been a long standing problem”	
14/06/2021	LBC SW1 spoke to SGH OT1 about the OT's "concerns regarding the current property and that it was not suitable to meet Natalie's needs. She has DVT in one leg and attends dialysis 3 times a week and SGH OT1 reported that the accommodation is impacting her health and that it is likely if she is discharged back there she will be readmitted to the hospital. Natalie will require adaptations to the property such as grab rails etc"	LBC SW1 telephoned Natalie to discuss her housing situation. She "confirmed that she had been placed there by Wandsworth LA. I asked Natalie how she managed in the current property, the accommodation is in the basement which does cause some difficulties and a ground floor would be more suitable for her needs. She gave consent to contact Wandsworth to discuss her housing needs." LBC SW1 contacted LB Wandsworth Adult Social Care who said they had no record of Natalie, and gave LBC SW1 contact details for Wandsworth's housing department.
15/06/2021	LBC SW1 contacted Wandsworth's housing department. They asked for details of the issues to be emailed to them.	LBC SW1 spoke to SGH OT1 and asked for the issues regarding Natalie's housing situation to be emailed to her. The case note includes "SGH OT1 will email me and copy in the new OT as she will be leaving SGH on Thursday. They have concerns regarding the discharge destination and that there is a risk of Natalie being hospitalised due to the environment. I asked SGH OT1 if she could email me with the details of this. SGH OT1 will email this today."

15/06/2021	SGH OT1 sent an email with their concerns about Natalie's housing situation. This included "is a high risk of falls as has difficulty mobilising within a restricted space and inability to complete stairs independently. She had a fall at home which lead to this particular admission. The current property cannot be adapted to support Natalie's independence and safety as it is temporary accommodation. Community OT are unable to install adaptive equipment such as grab rails to assist with mobilising and safe transferring e.g. on and off toilet/in and out of chair. Natalie's most recent admission could have been prevented if adaptive equipment was installed within the flat by community team. There are no pull cords/fall sensors and current accommodation is not suitable to install fall prevention devices such as a pendent alarm."	
16/06/2021	A referral was made to a rehab ward at Queen Mary's Hospital for rehabilitation to improve mobility and independence	
17/06/2021	LBC SW1 telephone SGH OT1. She said that the housing needs are the responsibility of Wandsworth Council to meet. The case note includes "an email would be sent to Wandsworth regarding the housing needs for Natalie with contact details for the OT team."	
17/06/2021	LBC SW1 wrote an email to Wandsworth Adult Social Care's Discharge to Assess team: "Please find a referral for your team regarding Natalie Lindsay. Natalie was placed in temporary accommodation in Croydon by Wandsworth and is known to your authority. On the 20th May Natalie was discharged from hospital and a package of care was put in place to support the discharge. There has been a further admission to hospital and the OT have raised concerns regarding the discharge destination of her temporary accommodation as it does not meet her needs. The OT have recommended that Natalie be provided more suitable accommodation to prevent readmission to hospital and to support her care needs and that discharge to the current accommodation places Natalie at risk of further admissions. Croydon will not be providing a further package of care for Natalie and will require support from Wandsworth to secure appropriate accommodation and for her care and support needs to be met."	An email was received by LBC SW1 from Wandsworth's ASC Hospital Discharge team on 18/06/2021 saying they had not yet received the D2A referral for Natalie and they would contact the hospital.

20/06/2021	Natalie was seen by the Liaison Psychiatry team. They recommended that she be referred by her GP to a local Improving Access to Psychological Therapies team.	
21/06/2021	The ward raised a concern that Natalie would not have an "exit strategy" at the end of her rehabilitation stay, because of her unsuitable accommodation. A Discharge to Assess referral was made for pathway 2A, requesting an interim placement post rehabilitation. This was sent to Wandsworth adult social care.	
22/06/2021	LB Croydon Adult Social Care received a notification of discharge from St Georges Hospital. The information on this included "Pre: low mood, reduced motivation / volition. Current: Requires AO1 to encourage to engage in ADLS. Continues to display low mood, reduced motivation during therapy sessions ... She acknowledges that she has periods of being low at times which she attributed to hospitalisation and physical health problems ... Risks of deliberate self harm or suicide is considered low. There is a risk of inadvertent harm due to poor concordance with her insulin regime ... Risk of self neglect and malnutrition due to low mood, and restrictive environment. Risk of falls due to reduced mob and within current accom nil phone signal and unable to alert emergency service. Risk of readmission due to temporary accommodation currently placed in."	
22/06/2021	LBC SW1 emailed Wandsworth ASC to see if anyone had been allocated to work with Natalie.	
24/06/2021	LBC SW1 telephoned Wandsworth ASC to see if anyone had been allocated to work with Natalie. They were told Wandsworth had the referral and were triaging it.	
24/06/2021	LBC Croydon Adult Social Care received a withdrawal of discharge notification from St Georges Hospital	
25/06/2021	Natalie was transferred to Queen Mary's Hospital	

30/06/2021	LBC SW1 had a telephone call from the person at Wandsworth Council they spoke to on 24/06/2021 who said they had not received a referral for Natalie, and they queried why LB Croydon would not continue with the care arrangements following discharge. The case note includes that LBC SW1 "advised this was due to Natalie not being ordinary residence of Croydon and was placed by Wandsworth. [Wandsworth worker] told me that she will discuss with [a] discharge coordinator as this has not yet been flagged at LOS meetings and they will require a new D2A as now in rehab at Queen Mary's and OT may determine that she is able to return to the accommodation."	
01/07/2021	LB Croydon Adult Social Care received a notification of discharge from St Georges Hospital. This included the same information about low mood and risk of self neglect as on the notification received on 22/06/2021. In addition, it included "Following this short rehab stay pt requires interim accommodation until long term housing issue sorted, she would ideally benefit from interim accom which is located on ground floor or with working lift access in situ due to difficulty completing stairs due to pain, reduced strength, fatigue and low mood. She would also benefit from visitor access or ability to leave accommodation to access community. Pt is agreeable to returning home if she is better able to complete stairs independently post rehab as last resort however likely due to restrictive environment and repetitive cycle leading to admissions alternative accommodation required. Pt would be safe between care calls, can operate call bell and could be placed in side room. Pt is aware client group likely older however feels interim placement would be best scenario as doesn't feel she would cope on discharge to current accommodation and be readmitted … Pt functional ability and mental health has deteriorated within the past few months and the accommodation is no longer appropriate … is a high risk of falls as has difficulty mobilising within a restricted space and inability to complete stairs independently. She had a fall at home which lead to this particular admission … The current property cannot be adapted to support Natalie's independence and safety as it is temporary accommodation. Community OT are unable to install adaptive	

	equipment such as grab rails to assist with mobilising and safe transferring e.g. on and off toilet/in and out of chair. Natalie's most recent admission could have been prevented if adaptive equipment was installed within the flat by community team. There are no pull cords/fall sensors and current accommodation is not suitable to install fall prevention devices such as a pendent alarm. There is no signal to current accommodation which restricts pt from being able to contact emergency services , friends and family."	
01/07/2021	LBC SW1 sent an email to St George's Hospital Discharge team to tell them that the D2A referral should be sent to Wandsworth Council Adult Social Care	
06/07/2021	LB Croydon Adult Social Care received a notification of discharge from St Georges Hospital. This included the same information about low mood, self-neglect and environmental risks as the discharge notification received on 01/07/2021.	
08/07/2021	Queen Mary Hospital discharge team sent a D2A referral to Wandsworth Adult Social Care	
13/07/2021	Email from Wandsworth Adult Social Care's Hospital Discharge Team to Queen Mary Hospital's discharge team, saying the are seeking advice on ordinary residence for Natalie	LBC SW1 was CCd in on this email. She forwarded it to her supervisor asking "Would we continue to support Natalie as POC was accepted on first discharge?"
13/07/2021	Email from LBC SW1 to Wandsworth ASC and St Mary's Hospital's discharge teams. It includes "Natalie is placed in temporary accommodation by Wandsworth in Croydon. The care provided initially was to support Natalie following discharge from hospital. The OT team have advised that the current accommodation is unsuitable to meet Natalie's needs and places her at risk of further admissions. We are unable to support Natalie with her accommodation or further packages of care as she is not an ordinary resident of Croydon and would require support from Wandsworth to source suitable accommodation."	
19/07/2021	Email from Wandsworth Adult Social Care's Hospital Discharge Team to Queen Mary Hospital's discharge team, saying that the referral should be sent to Croydon as she is resident there	

21/07/2021	Queen Mary Hospital discharge team sent a D2A referral to Croydon Adult Social Care. This included the same information about low mood, self-neglect and environmental risks as the discharge notification received on 01/07/2021.	
21/07/2021	A social worker in Croydon's Out of Borough Hospital Discharge Team wrote to Wandsworth and St Mary's hospital discharge teams to say Natalie's needs are housing related and any housing and any care arrangements are for Wandsworth to deal with.	
21/07/2021	A social worker in Croydon's Out of Borough Hospital Discharge Team telephoned a hospital OT. Case note includes the OT saying that Natalie "had said she will consider going to current accommodation while Wandsworth arrange long term accommodation. I advised I spoke to client today and she informed me that she mobilise with crutches and the basement accommodation in Croydon will be detrimental to her health as she fell the last time she was there, which led to her hospital re admission. Emma said she will go in the ward tomorrow to speak to client and update me with the outcome."	
21/07/2021	Email from a discharge coordinator at St Mary's hospital to members of Croydon and Wandsworth's hospital discharge teams: "Natalie has been ready for discharge since 7/7/21. Her D2A has been rejected by Croydon and Wandsworth LA trying to put responsibility at each other. Ms Lindsey is happy to go back to her previous accommodation in Croydon and she can mobilise on the stairs. Please can Wandsworth or Croydon LA decide on Ms Lindsey discharge plan."	
22/07/2021	Duty social worker in Croydon's Out of Borough team recorded: "I called Natalie to find out if client has had conversation with OT. She informed me she is at dialysis at st Georges all day today and will be returning to the ward later. She advised she will call tomorrow when she speaks to OT. She further stated that she does not want to go to the hazard in Croydon and hope they do not force her to go back there."	
23/07/2021	St Mary's hospital discharge team spoke to a duty worker in Croydon's Out of Borough team asking for the once a day care package to be restarted. The duty worker told them to approach Wandsworth Council on this.	

29/07/2021	Discussed at ward MDT, discharged from OT/PT. Can use the stairs independently	
23/07/2021	A LB Wandsworth Senior Social Worker told LB Wandsworth Housing Department that Natalie was in hospital. LB Wandsworth received a letter from adult social care which raised concerns about the lack of WiFi in the accommodation.	LB Wandsworth Housing Department replied asking for dates of admission and planned discharge, medical information including the discharge summary and risk assessment, and details of the concerns in relation to the temporary accommodation, so that this can be assessed by the council's medical advisor.
31/07/2021	Wandsworth Social Worker spoke on the phone with Natalie. The social worker advised that at the moment there is no alternative accommodation options available and that if Natalie was to go back to the hotel room for the present a care plan and pendant alarm could be provided to support her. Natalie advised she still does not want to go back to the hotel but that she feels like she doesn't have any other options. The social worker suggested having support to complete a shop once a week as well. Natalie was agreeable to this. "Plan as per SW entry on iClip: ... Ward to send D2A to Croydon SS for POC for once daily care call and once a week shopping call. Referral for pendant/ watch alarm"	
03/08/2021	Email from an assistant team manger of Wandsworth's hospital discharge team to ward where Natalie was includes "I have checked with management and we will not be providing a package of care and if she needs one you will need to approach Croydon. Based off therapy feedback she is improving and can complete stairs so she can return to her accommodation. If she would like housing to move her she will need to contact them and deal with this once she is home, rehousing is a long process and cannot be carried out while a patient is in an acute bed and can safely return."	
04/08/2021	LB Croydon Adult Social Care recevied a notification of discharge from St Georges Hospital. This included the same information about low mood, self-neglect and environmental risks as the discharge notification received on 01/07/2021.	

04/08/2021	A case note records a decision by LB Croydon to put care in place starting the next day for Natalie, and to then address the dispute with Wandsworth about ordinary residence. The case note includes "Liaise with Wandsworth SSD re taking responsibility for this case during the 6 week period review and handover to Croydon if Natalie's intention is to become ordinary resident in Croydon."	
06/08/2021	D2A withdrawn, Natalie requiring increasing analgesia and had a possible ongoing infection	
09/08/2021	The social care service provider sent an email to LB Croydon's Out of Borough team saying "This is to inform you that the carer attends Natalie's home all weekend and she's not home."	
12/08/2021	Natalie had a discussion with the medical team regarding discharge. Natalie reports no fixed discharge destination – does not feel it is safe to return to the basement she was previously living in as there is no phone signal, so she doesn't get notifications about upcoming appts. Has not had any direct contact with social services – feels they are not communicating with her. Does not know the details of her social worker. Has been in contact with her mother but reports there is nowhere to stay. Reports Wandsworth council placed her in the basement accommodation in Croydon – has been there for 2 years	
16/08/2021	At a scheduled appointment with the fracture clinic, Natalie reported worsening pain and that she was struggling to weight bear. An X-ray found a previously undiagnosed fracture. Natalie was admitted to St George's hospital.	
20/08/2021	A member of staff working on duty in LB Croydon's Out of Borough team sent an email to the managers of that team saying "Not sure if a Senior has been in contact with Wandsworth as there are no further notes to suggest otherwise. Last duty notes recorded below." The notes below included "Liaise with Wandsworth SSD re taking responsibility for this case during the 6 week period review and handover to Croydon if Natalie's intention is to become ordinary resident in Croydon."	One of the people this was emailed to forwards the email to the Service Manager and Head of Service, with a covering note which says "Please see email below, client is a Wandsworth resident but somehow LBC have put in PoC since early August 2021. Please advise whether we should allocate for Part B or refer to Wandsworth to take responsibility?"

23/08/2021	LB Croydon Adult Social Care allocate a new worker, a Senior Health and Wellbeing Officer (LBC SHWO 1) to work with Natalie. She spoke with Natalie on the telephone. Natalie told her that she was in St George's Hospital and was due to have surgery today on her foot. She said she had been in hospital for about a month. LBC SWHO established that the care that was restarted on 05/08/2021 had been cancelled after three days as Natalie was not at home. However, that service had not been recorded on the Council's LAS system, and there had been no follow up by LB Croydon to establish why she was not at home or where she was.	
24/08/2021	LBC SHWO1 spoke to a nurse on the ward Natalie was in. She had her surgery yesterday. The case note includes "I advised when client is ready for discharge Wandsworth will need to be notified to source alternative accommodation and arrange care for client. I advised Croydon should not be sent a D2A as client is not a Croydon resident."	
24/08/2021	LBC SHWO1 wrote a note when closing the workflow on the Contact record of the hospital discharge referral of 21/07/2021. This includes Natalie "was provisionally placed in Croydon by Wandsworth Council therefore she is a Wandsworth resident. Closed to OOB nfa required."	
25/08/2021	Natalie transferred to St Georges Hospital.	
01/09/2021	LB Wandsworth Housing Officer asked LB Wandsworth adult social care for an update on Natalie's situation. They said they had contacted Queen Mary Hospital, who said she was at St Georges, and contacted St Georges who said they were unaware of her.	
03/09/2021	LB Croydon Adult Social Care received a notification of discharge from St Georges Hospital. This identifies the presenting need as rehabilitation in a bed-based facility. It includes "Known to social services who for almost 2 years according to pt. Pt unhappy with accommodation as is in a basement of hotel and is unable to climb stairs at present and often the lifts do not work ... Previously patient was living in a basement room in a hotel which has stairs while waiting for social services to rehouse her. The patient reports that often the lifts do not work and there fore would not be able to access the room at present due to her reduced mobility requiring Ao2 and a gutter frame to step transfer from bed to chair"	A note is added to the Contact record on 09/09/2021 when this workstream is ended. This includes "the hospital have been advised to Refer to Wandsworth LA who placed Natalie in the borough and they have picked this up. Closed to OOB Team –NFA."

06/09/2021	A member of staff in LB Croydon's Out of Borough team spoke to St George's Hospital's discharge team "to advise Natalie is known to Wandsworth . Hospital Discharge Coordinator to request Wandsworth SW to call Duty. Placed by Wandsworth a year ago , currently in temp accommodation in Croydon."	
07/09/2021	Discharge co-ordinator spoke to Wandsworth and they advised patient is under Croydon.	
08/09/2021	Discharge co-ordinator spoke with Ronald Gibson House who were reviewing the D2A. RGH then declined the D2A reporting RGH was note suitable for Natalie's needs	
09/09/2021	Nursing Team noted that sometimes she doesn't eat well or declines meals which makes it slightly harder to give insulin due to risks of hypoglycaemia. Natalie was declining heparin injections on the ward. It was explained to her that the team need to ensure the DVT is treated and that the INR is in the therapeutic range to prevent any complications such as Pulmonary Embolism (PE) which could be fatal. Natalie did not want the injections as she reported they are painful and cause bruising. She was assessed as having capacity to make this decision and she understood the risks with non-complying.	
09/09/2021	A member of staff working on duty in LB Croydon's Out of Borough team contacted the hospital discharge team to check that the D2A referral had been sent to Wandsworth. They confirmed it had been.	
10/09/2021	The medical team had a further conversation with her about the injections. The team went through the potential complications and explained that the DVT if not treated can cause worsening leg pain, chronic leg insufficiency, the clot can dislodge and travel to her lungs, resulting in a PE which can be fatal and she may die. Natalie understood this information, she was able to retain the information, weight it up and made a decision saying she still did not want to go ahead with the injections. She was assessed as having capacity at this moment in time to make this decision.	
13/09/2021	Referred back to Queen Marys Hospital.	

24/09/2021	Notes remotely reviewed by Queen Marys Hospital. As Natalie was assessed to be safe on stairs with Elbow Crutches the referral was closed and Natalie transferred to Queen Marys Hospital.	
27/09/2021	Natalie reported that she would like to go home however thinks she will need to stay at in hospital for 2 weeks to achieve goals. Independent on stairs, physiotherapist reported D2A sent	
30/09/2021	Email from Senior Physiotherapist (STG SP1) to an Assistant Service Manager in Wandsworth Social Services Hospital Team (LBW ASM1) requesting update on alternative accommodation. Email includes "Croydon are categorically saying they will not accept the patent back to the temporary accommodation. I know St Georges had several conversations with Wandsworth who informed them that the patient will go back. Please can you direct us to whether you will escalate this to Croydon social services as we are not getting anywhere? Or whether Wandsworth are going to look for alternative accommodation?"	There is a further email from STG SP1 to LBW SM1, apparently in response to one from here which hasn't been provided, which includes "Natalie informs me she is not aware she has a housing officer as she has not spoken to anyone since moving in 2 years ago. Natalie wants to go back to this accommodation as does not want to be "wasting" a hospital bed. Natalie was previously homeless prior to all of this. I have asked Natlie to contact Wandsworth housing – Not entirely sure how successful this will be? Who provides the care in this instance? Natalie did have a OD POC for a short period of time prior to admission. As Natalie has health needs (dialysis) we can unfortunately not go the homeless shelter route. I presume we cannot attain an interim bed whilst this gets sorted?" STG SP1's notes of a plan are 1) LBW SM1 is going to contact housing to establish if the accommodation is still available. 2) I will establish if Natalie has keys. 3) I will liaise with OT - Does patient actually need OD care? This was previously provided by Croydon but may not be needed now as patient is independent on the ward.

		4) Patient consents, aim discharge home this week. Refer on to Croydon's equivalent of the discharge team. 5) Inform Croydon of discharge and they need to highlight risks, if any, that are evidence to suggest should not return home (Only if patient require OD POC)
30/09/2021	Email from LBW ASM1 to a Housing Officer (LBW HO1) asking if Natalie accommodation is still available	LBW HO1 replies confirming that the accommodation is still available, and asks for an up-to-date list of medication that Natalie is taking, so this can be reviewed by the council's medical advisor.
01/10/2021	Email from STG SP1 to LBW HO1 and LBW ASM1 which includes "do you need any other information? Functionally Natalie remains the same and is happy to go back to the temporary accommodation as long as she is still on the radar for new accommodation. Natalie is ready to leave hospital and has been for quite a while so your help would be great"	
01/10/2021	Email from STG SP1 to LBW HO1 and LBW ASM1 which includes "I have attached medication list however will send the D2A and medical summary over next week"	
01/01/2013	LBW HO1 received a call from a nurse at Queen Mary hospital saying that Natalie was ready for discharge and required different temporary accommodation as the current provision was not suitable.	
05/10/2021	Email from LBW ASM1 to LBW HO1 asking if the medical information was provided	LBW HO1 replies saying "I have not received the information and we require this information urgently to enable the Medical adviser to comment prior to her being provided with temporary accommodation."
06/10/2021	Email from LBW ASM1 to hospital discharge team "STG SP1 asked if this [providing medical information to LBW HO1] could be done last week in his absence and housing is her only very small barrier. She does not need a POC so cannot support further from a hospital team. Who is leading on providing this information to housing?"	

07/10/2021	A physiotherapist in the STAR team had a discussion with LBW ASM1, who advised that Natalie does not have a true allocated social worker, however assistant service manager was involved with discharge planning from QMH. STAR also raised concerns regarding no signal in her basement room which led to her not being able to call the ambulance on her last admission from home and subsequently was only taken to hospital when dialysis transport found her. STAR was provided with LBW HO1's contact details to correspond regarding signal concerns for patients with health conditions.	
08/10/2021	Email from the physiotherapist in the STAR team to LBW HO1. This includes "She is reporting she has no signal in her basement room of which led to her being unable to call 999. This is a temporary accommodation for the patient. She is in poor health and has dialysis x3 weekly and feels extremely anxious of not being able to call for help. Currently she is using crutches following her fracture tibia. If possible to be in ground floor room this would enable a quicker d/c from hospital as we are currently working on increasing confidence with stairs in order for Natalie to access her room."	
09/10/2021	Natalie was transferred to St Georges Hospital	
11/10/2021	LBW HO1 replied to the physiotherapists email of 08/10/2021 and asked for up-to-date medical information as she said this had not yet been provided.	
12/10/2021	LBW HO1 received a summary of Natalie's medication and passed this to the council's medical assessor	LBW HO1 replied asking for a discharge summary including diagnosis, prognosis details of medication; Care plan; Contact details of those who will be supporting her in the community; and confirmation whether or not a referral has been made to Adult Social Care and what was the outcome.
12/10/2021	The physiotherapist replied to LBW HO1, attaching medical notes, and saying Natalie was now at St Georges Hospital	
12/10/2021	Reviewed by a Dietician.Review record includes "Liked cooked breakfast. At the hostel has food stores. Meals mainly ready meals - microwaved. Family visit and may help with shopping. Has problems with phone	

	reception at the hostel - often misses calls - may be best to be seen on HD (Haemodialysis) post discharge. Plan: 1. Encouraged with diet and to discuss food provision with family for discharge 2. Will need to try to take meals when insulin given 3. Likely diet will be inadequate for micronutrients post discharge - to continue on Renavit 4. Continue on breakfast vouchers whilst inpatient and finding these useful Review post discharge<1/12 or weekly whilst inpatient"	
13/10/2021	Seen by Physiotherapy, managed stairs safely with 1 elbow crutch	
14/10/2021	Physiotherapist summarised her function and plan for discharge: Patient currently mobilising safely with EC's (elbow crutches) due to ongoing pain and she is able to complete stairs safely as per assessment on 13/10/21. Patient is independent with ADLs and PADLs and has nil concerns managing with this at home. Patient to be visited multiple times daily by DNs who will be able to flag any safety concerns.	
14/10/2021	Natalie was discharged home that evening following being at dialysis that day. A referral was made to the District Nurses for four visits a day (three on days when she is at dialysis) for assistance with insulin administration.	
14/10/2021	Out-of-hours community nursing team contacted Natalie to find out when she would be at home for them to visit. At 19:15 she told them she was still at dialysis. At 21.50 she told them her insulin had been administered at hospital that evening. She said her blood glucose level was 12mmol/ litre, and that she would require visits the next day as planned.	
15/10/2021	The community nursing visited at 09.30 and carried out their initial assessment and administered insulin. Clinical observation taken and her blood glucose level was 7.2 mmol/litre. They visited again at 17.00 and got no answer.	

16/10/2021	At 09:47 Community Nursing team attempted to visit Natalie but there was no access. The team contacted Croydon Health Services to see if Natalie had been admitted and then called St Georges Hospital to see if she had been readmitted there. The staff also attempted to contact Natalie on her mobile number. Once the staff established that Natalie had not been readmitted, the Senior Manager advised staff to go back to the hotel and ask the staff to force entry into the room. They got entry at 10:40 and found the room to be empty. At 16:40 they visited again and got no reply.	
16/10/2021	When Natalie did not attend dialysis, the dialysis team visited her at home but got no answer	
17/10/2021	Community nursing visited at 10:40am and got no answer. They asked for the hotel staff to open the door to Natalie's room, where they discovered Natalie's body.	
18/01/2021	LB Wandsworth Housing Dept contacted St George's Safeguarding Team after learning of Natalie's death. They asked when she was discharged, noting they had not been made aware of this, and that they had not received the care plan and discharge summary that they had asked for.	St George's Safeguarding Team replied saying that they had planned to send those documents to LB Wandsworth Housing that morning. They ask "were these documents highighted as essential for discharge?" LBW HO1 replied saying "We were awaiting the medical information in relation to the client so that the council's Medical Adviser could make recommendations in relation to suitable housing as it appeared on the document submitted that she was not suitable for general needs housing."
21/09/2021	A member of St Georges Hospital's Safeguarding team emailed LB Croydon and LB Wandsworth adult social care to tell them of Natalie's death.	