



Bedford Borough and Central Bedfordshire Safeguarding Adults Board

An Addendum to the Safeguarding Adults Review Case
A for the period of 29 December 2016 to 28 July 2017.

Bedford Borough and Central Bedfordshire Safeguarding Adult Board have agreed to publish this addendum to the Safeguarding Adults Review into the death of Miss A. This is in the light of the Board becoming aware of a significant difference in view between the family of Miss A and the Independent Report Author on a particular issue – that of whether Miss A was given 48 hours notice to vacate her placement at Pathway House.

The Board at its meeting on 28th March 2018 accepted the SAR report, its findings and recommendations but qualified that approval in relation to this issue. The Board resolved that it fully accepted the report by Miss A's parents that Miss A had telephoned them on 13 July to say that a member of staff had told her she had 48 hours notice to leave Pathway House. The Board considered that, whether or not this was a formal issue of notice, the impact on Miss A would have been profound and would have had a significant impact on her state of mind in the period that followed.

The report author in considering the matter concluded that Miss A had not been given 48 hours notice and that this was in fact a recognition that a 28 day notice period was coming to an end.

Section (13.32) states:

While it was not the case that she (Miss A) was given 48 hours' notice to leave the placement – a 28 day notice period was coming to its conclusion - it is clear is that she considered that she had and that there was a lack of coordinated planning involving all relevant parties, including her parents, to safeguard her at this time. Given her assessment of high functioning autism, this can only have exacerbated both the stress she felt and her behaviour.

The Board heard the details of the matter as recorded contemporaneously by Miss A's mother. Miss A's mother documented a phone call from Miss A on 13th July in a distressed state to say she was being evicted on Friday. Miss A's mother's record also references her subsequent telephone conversation with a person she believed to be the manager of Pathway House, who, she recalls told her that if no placement was found, Miss A would be discharged into the hands of the police who would have to find her a place of safety. Miss A's mother reports that she then made contact with the Care Coordinator at the Sussex Partnership NHS Foundation Trust and the Care Quality Commission raising concerns about what she had been told.

The family also made reference to the Section 42 Enquiry, undertaken from July to November 2016 which considered the events leading up to Miss A's death. It had concluded:

Milton Park have effectively given Miss A notice that she is to leave. In the absence of any suitable accommodation she will be evicted into the care of the police. Our interpretation of this approach is based on our discussion with Milton Park staff. It seems that whilst this would appear an extreme measure they considered it the only

way to force the hand on the AMHP by evicting her into the care of the police and prompting them to use police powers under S136 MHA.

The Board agreed with the view of the family that Ms A was informed that she had been given notice on 13th July 2016, that the notice came without warning and without a new placement having been found. The Board agreed with the family that informing Miss A her placement was to end in 48 hours without a new placement being confirmed, would have impacted significantly on the anxiety and stress levels of Miss A potentially influencing the high risk behaviour which preceded her death just two weeks later.

The Board agreed with the family that the report writer had not fully taken this information into account when he concluded that a 48 hour notice period had not been given and therefore may not have given sufficient weight to the impact that this would have had on Miss A's mental wellbeing and subsequent high-risk behaviour.

The Board will consider whether any additional actions should be added to either the single agency or multi-agency action plans arising from the Report Recommendations to take account of the issue highlighted in this addendum.