Sophie – Safeguarding Adult Review

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Before we start

New way of training be patient with each other ☺

Power point will be used so sometimes you won't see me, but I will appear every so often to make sure you are all ok

Please keep your camera on it really helps to engage. I will mute everyone, but unmute a certain points for questions

We will be using group work in 'break out rooms' to give you the chance to chat and discuss topics, cases etc.

Use the 'Chat' facility if you have any questions. This is on the bottom of your screen.

Please don't press 'leave' until the end of the session

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Ground Rules

- Be respectful to each other- what we say, what we write.
- Maintain confidentiality- please do not record the session
- The issue of Safeguarding Adults is a sensitive subject. If you feel you need to leave the room, please send me a message via chat
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  The trainer will be available, after the session, if you would like to contact them and talk to them about anything which has caused you upset or distress.

When do we conduct a SAR?

- An adult at risk dies (including death by suicide) and abuse or neglect is known or suspected to be a factor in their death; or
- An adult has sustained a potentially life-threatening injury through abuse, neglect, serious sexual abuse or sustained serious and permanent impairment of health or development through abuse or neglect;
- **and one of the following:**
  - Where procedures may have failed, and the case gives rise to serious concerns about the way in which local professionals and/or services worked together to safeguard adults at risk;
  - Serious or apparently systematic abuse that takes place in an institution or when multiple abusers are involved. Such reviews are likely to be more complex, on a larger scale and may require more time;
  - Where circumstances give rise to serious public concern or adverse media interest in relation to an adult/adults at risk
- ***Their purpose is to learning from what went wrong/could be improved and to share that learning to improve practice and outcomes.***

What SARs are we considering?

- Sophie – London Borough of Enfield – Self-Neglect, Sexual Exploitation, Domestic Abuse, Substance and Alcohol Misuse, Insecure Housing, Access to Finances
- Sophie attended a diabetic outpatient clinic on 8/11/17. It was noted she appeared distracted. In hindsight, it is believed she might have been experiencing some degree of hypoglycaemia.
- Sophie was admitted to hospital on 10/11/17 with a chest infection, diabetes and tachycardia. She was discharged.
- She was readmitted to hospital on the 12/11/17 as she was short of breath and experiencing breathing difficulties. She was prescribed anti-biotics and refused to stay in hospital.
- She went to the ED on the 15/11/17 in cardiac arrest and sadly died.
- The post-mortem recorded Sophie's death as Diabetic Ketoacidosis.

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Sophie

- Sophie was originally from Poland, but moved to the UK with her mother when she was very young. She said that her father committed suicide.
- There is no information from Northamptonshire as the dates for the review were for after Sophie's move to London.
- There was continuous concern for how Sophie managed her diabetes, and how it had been managed while she was a child. Intervention by health and social care had little impact on this.
- Sophie was rarely accompanied to medical appointments by her mother.
- Referrals from North Middlesex University Hospital to Children and Young Persons Services (C&YPS) detailed a history of non-compliance with medication, unstable and poor living conditions and a diabetic coma.

Sophie (2)

- Attempts were made to understand Sophie's history around sexual exploitation, but Sophie would not engage so these were closed.
- Sophie was offered accommodation, but didn't collect the keys from the estate agent.
- There was also at least one mental health assessment and psychology assessments. The Psychology assessment concluded that Sophie was not willing to engage and reacted negatively to any king of authority – so she would be unlikely to benefit their support.
- When care was transferred from C&YPS to Adult Social Care (ASC) there was no discussion about transfer between the services. There was no evidence of the change being discussed with Sophie.
- ASC records indicated that she did not manage her diabetes well, had declined support and counselling and *"has poor risk perception based on the information from health and social care histories"*.

Sophie (3)

- Lead Nurse for Adult Safeguarding attempted to hold an MDT to discuss Sophie's diabetes management.
- Sophie was focussed on practical issues. She needed to work and recognised her diabetes management was not good. It was discussed that her shift work was not good for her, she said she was trying to get another job.
- Sophie moved to London without her NI number, this made claiming benefits difficult. ASC agreed to try to support her with this. Psychology agreed to try to support her with her health care.
- Sophie continued to miss appointments with health and social care. As she lived with different friends from time to time, agencies found her difficult to contact.
- She received support from the Young Adults Service, who found her employment support and a Personal Assistant. Although she continued to miss some health appointments.

Sophie – Analysis - Planning

- It was not always clear who was leading her support as an adult. She had contact with a number of adult teams, and she also lived in Enfield, whilst receiving support from Haringey. Sophie would also still approach paediatric diabetic services too. Sophie was in contact with a number of charities seeking to support her with homelessness and finances.
- There were MDT's held to try to create wrap-around support. However, there was no overall joint plan that all agencies involved were working towards.
- There was no joint risk assessment or risk management plan between agencies – despite shared and ongoing concerns about her diabetes management.
- There was no transition planning. Sophie wasn't even communicated directly through the move from children's to adult's services.
- There was no legal advice sought around remedies and concerns about her unwise decisions and the risks around these. There was *"paralysis"* around safety v choice.

Sophie (2) – Self-Neglect

- There were referrals to safeguarding around Child Sexual Exploitation and to the MARAC.
- However, her self-neglect was never considered a safeguarding issue and this was not considered in any panel discussions. Adults that are deemed to have capacity to make decisions about their care can still self-neglect and be fall within adult safeguarding.
- Refusal of services, missing appointments, poor medication management and a chaotic lifestyle were all considered in isolation. They were not considered as a pattern of self-neglect and a consistent pattern of behaviour.
- Understanding the *"whole person"* and their history can be important in understanding the reasons behind their behaviour. Not all agencies knew this.
- Workers that did had the best engagement. Sophie would share sensitive information with them and would make unplanned visits to seek support.
- There was no information shared by agencies on what was important to Sophie and her aspirations.

Sophie – Analysis (3) – Sophie's decisions

- Whilst there were assessments of Sophie's mental capacity around decisions about her care and discharge, there was never consideration of her "*executive capacity*".
- Sophie's attitude to risk was never considered, or the impact of her experiences. Assessments didn't consider Sophie's behaviour in the real world.
- Focus on the impact of the substance and alcohol use on Sophie's diabetes management. Not in understanding her experiences of abuse, the impact on her mental health, and whether this led to the substance and alcohol use.
- More could have been done for new agencies to understand Sophie's needs, risks, history and complexity – when referrals are made.
  - This includes new agencies asking question, but also
  - Existing agencies supporting their involvement and introduction to Sophie.

Key Points

- There was no strategic joint working.
  - No joint risk assessment or risk management plan
- No transition plan.
- There was good work by individuals within their own specialisms. Workers were concerned about Sophie's wellbeing.
- There was not recognition of Sophie's experience of abuse and the impact on her behaviour, or how this would affect her choices.
- There was not consideration of her experiences on her decision making, risk assessment and executive capacity.
- It was not recognised as an issue of self-neglect and no concerns were raised. (Barnsley's Safeguarding Adults Board Guidance)

Resources

- Barnsley Safeguarding Adults Board Self-Neglect and Hoarding Policies
- Mental Capacity Act E-Learning
- Decision Support Tool (this is the tool that can support people to pass on high quality safeguarding concerns)
- Further BSAB Training

- Please note, these tools are Barnsley specific; however, I would expect most local authority areas to have similar tools in their own areas.

Thank you for attending

Please don't forget to log onto POD to complete an evaluation form and download your certificate of attendance.

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