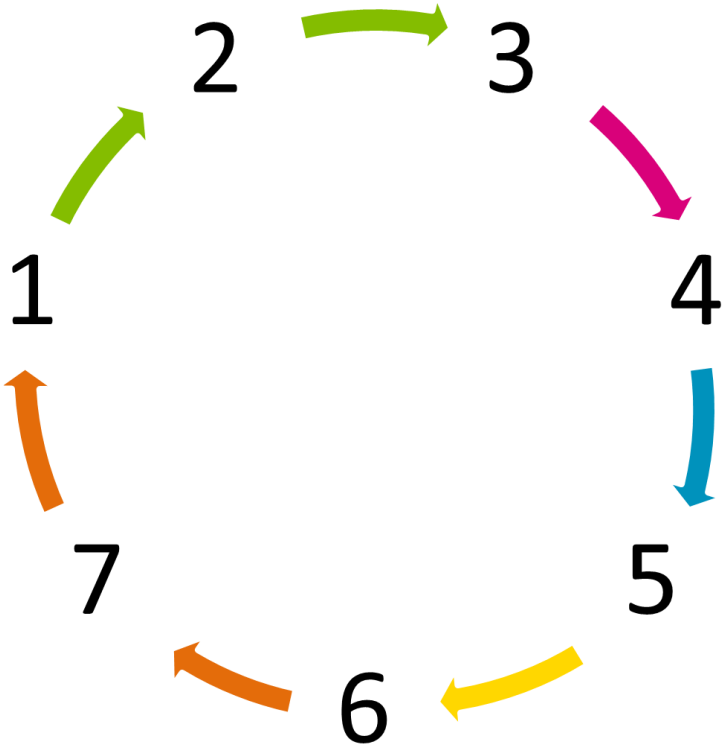


7 Minute Briefing: Diane

Safeguarding Adult Review (SAR): Diane

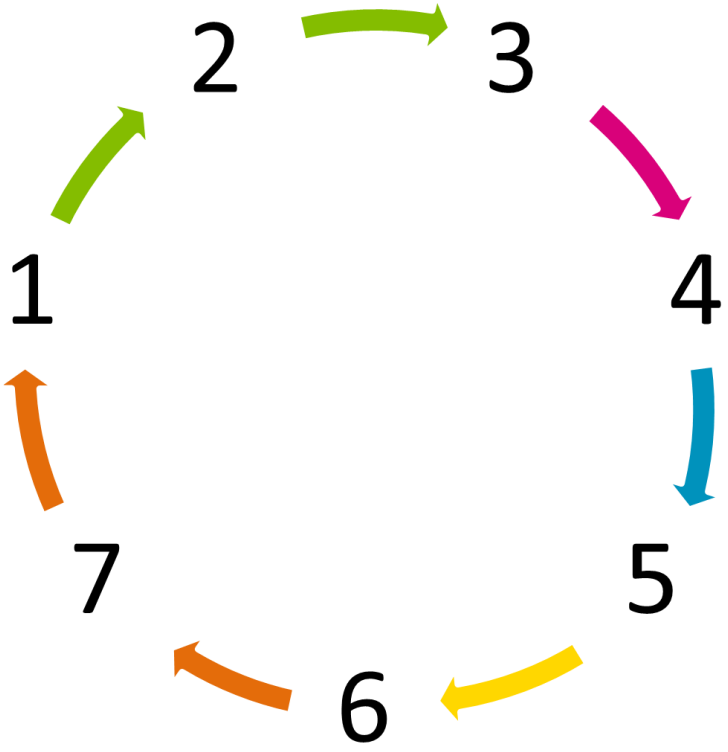
Wigan Safeguarding Adults Board

Methodology

The Adult's Independent Chair is consulted on the methodology utilised in any given SAR and mandates the approach.

The WSAB used a 'Systems Learning' approach in the review of Diane. This is a model that was introduced by the Social Care Institute for Excellence following the Munro Review of Child Protection published in 2011. This approach sets out to study the whole system and look closely at what influenced professional practice. It does this by taking account of the many factors that interact and influence individual worker's practice in a more in-depth way. The process seeks to be a collaborative process with professionals being actively involved in the review from the outset. The approach promotes reflective thinking as a system to identify the causal factors that influenced practice for which improvements can be made upon.

Background



Background

Diane was a 65-year-old lady who died as result of fire in her home. She was considered complex and was presenting to services with increasing medical needs, both physical and mental. Diane had a history of trauma and self-neglect, as well as ongoing concerns regarding self-neglect and hoarding, especially in relation to refusing care and support.

Diane had multiple referrals to mental health services, however due to being deemed to have capacity and her non-engagement, no therapeutic interventions took place. As a result, Learning Disability was never considered, and as such not diagnosed.

Diane was admitted to a mental health ward and subsequently discharged to supported accommodation where improved outcomes were noted by professionals, however Diane's wishes to return to her own home were facilitated as per making safeguarding personal legislation, although there was acknowledgment of concerns from professionals. Outcomes deteriorated again for Diane despite lots of professional involvement and evidence of excellent practice.

The main themes of the review are:

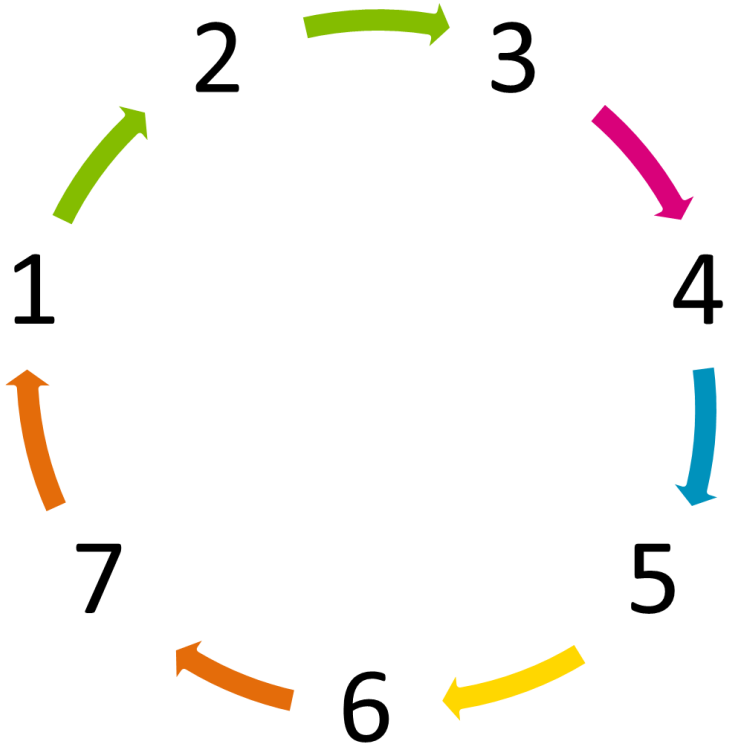
- Fire Risk
- Self-Neglect
- Learning disability
- Trauma

The main learning themes from the review are captured within Key Lines of Enquiry and in this case include:

1. Fire Risk Assessment
2. Self-Neglect Pathway
    a. Learning Disability
    b. Reasonable Adjustments
    c. Trauma
3. Good Practice

Learning points were identified through the case review, highlighting areas of learning and improvement.

1. Fire Risk Assessment



Fire Risk Assessment

The existing pathway for GMFRS referral of fire risk assessment into Adult Social Care resulted in the information relating to an identified risk of fire can be recorded within case notes and be hidden from a person's summary. Checks with GMFRS are completed as standard in the hoarding pathway due to the environmental risk but not necessarily on the self-neglect pathway; in Diane's case the previous fire only came to light when undertaking a deep dive of records.

Making a difference:

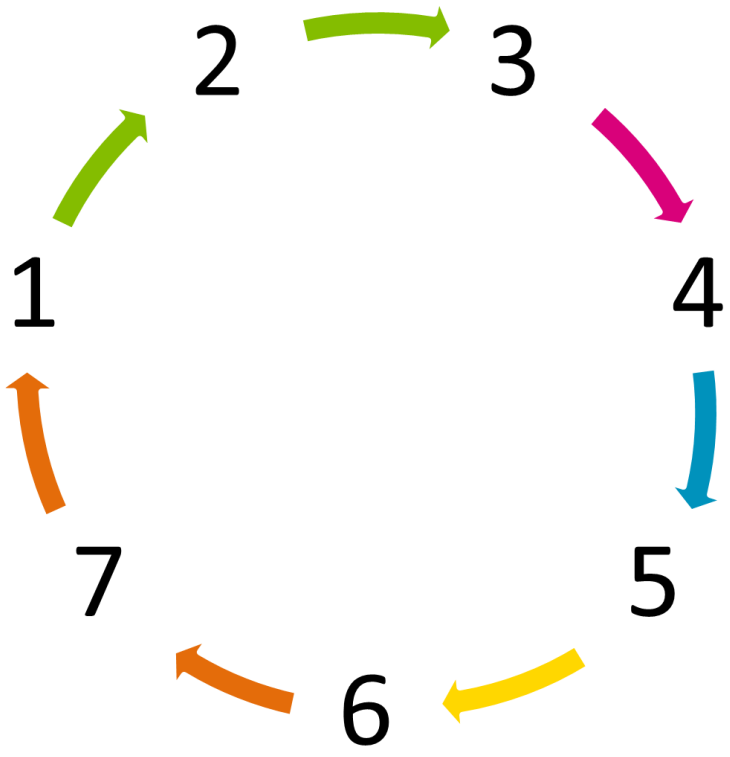
> Referral pathway from GMFRS to Adult Social Care for individuals assessed as being a fire risk are in place; WSAB Business Unit to quality assure the pathway ensuring that individuals are effectively protected via explicit reference to the fire risk within care plans and assessments

> PMMD to ensure the common understanding of this risk marker with provider services to ensure the risk marker is not detrimental to securing placement or provision

> The Self-Neglect Pathway is being updated with reference to fire risk / assessment and clarity on steps to address safety planning. This will be evidenced through the WSAB Quality Assurance Framework

> GMFRS are promoting a borough wide training offer across Health and Social Care to ensure a wider set of eyes and ears are confident in understanding / undertaking fire risk assessments and highlighting / referring them into supportive processes

2. Self-Neglect Pathway



The self-neglect pathway provides an earlier opportunity for identifying risks across a multi-agency information sharing process, and put in place a multi-disciplinary approach to those risks. This includes risks relating to non-engagement / capacity / impact of un-diagnosed LD. The self-neglect pathway was not in place at the time of the fatal fire. On reflection the review panel felt that is likely that Diane had an un-diagnosed learning disability which could impact on her ability to perform self-

care and engage positively with services. The identification of this would have led to reasonable adjustments being made by services in their expectations whilst care planning.

Making a difference:

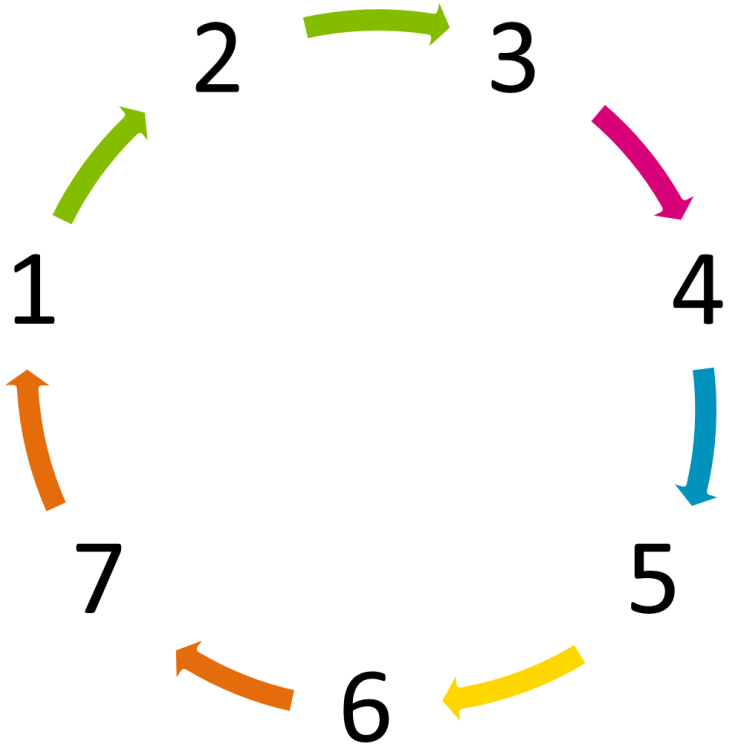
> The Self-neglect Delivery Group to develop and implement a Performance and Quality Assurance Framework to demonstrate effectiveness in identifying and managing non-engagement, using trauma informed practice to identify the cause of non-engagement (for example cognitive ability / un-diagnosed Learning Disability)

> Review the Self-Neglect Policy and Pathway to ensure a resilience and trauma informed perspective and language is clear and ensure any workforce development activity focuses on this element of practice

> There is a practice guidance tool to aid practitioners in a trauma informed response to perceived non-engagement which will be shared across the partnership via the Learning and Quality Assurance Subgroup Delivery Plan

> Consideration to Housing Status to refer into specialist hoarding professional within housing services and to inform wider housing standards programme of work within private rental sector in the borough

3. Good Practice



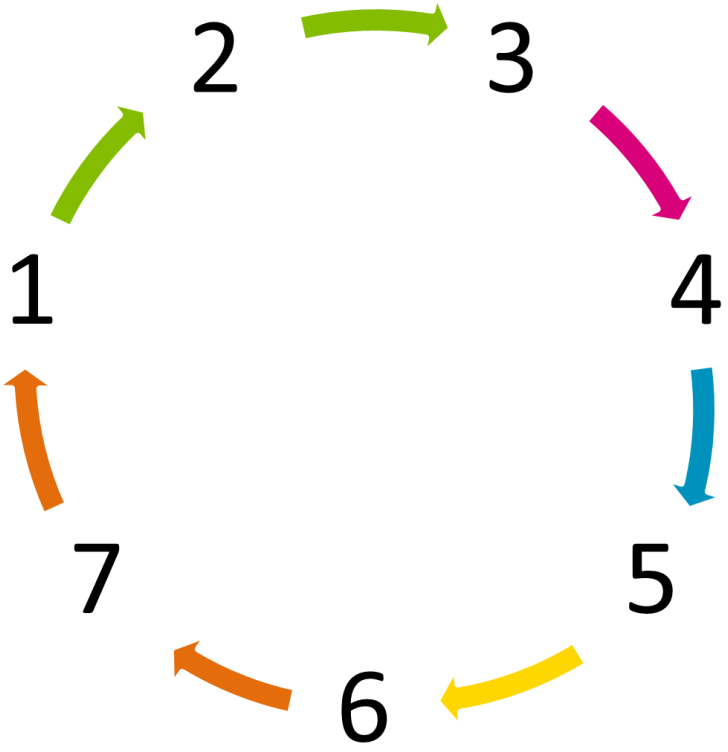
Good Practice

- Good practice was demonstrated in the coordinated multi-disciplinary safe discharge from an admission to hospital that led to positive outcomes for Diane

- Adult Social Care were commended by Coroners Court for going above and beyond in their efforts to support Diane

- Adult Social Care commended the Care Home provider for their joint working and going above and beyond expectations to support Diane, as well as supportive mechanisms in place for staff

Practitioner Questions to Consider



Practitioner questions to consider

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1. ***Have you checked for diagnosed LD with the LD register?***

2. ***Has consideration been made to undiagnosed LD if mental capacity assessment results in the person having capacity, particularly when there are multiple referrals / concerns relating to mental health and / or the individual is older and less likely to have been diagnosed as a child?***

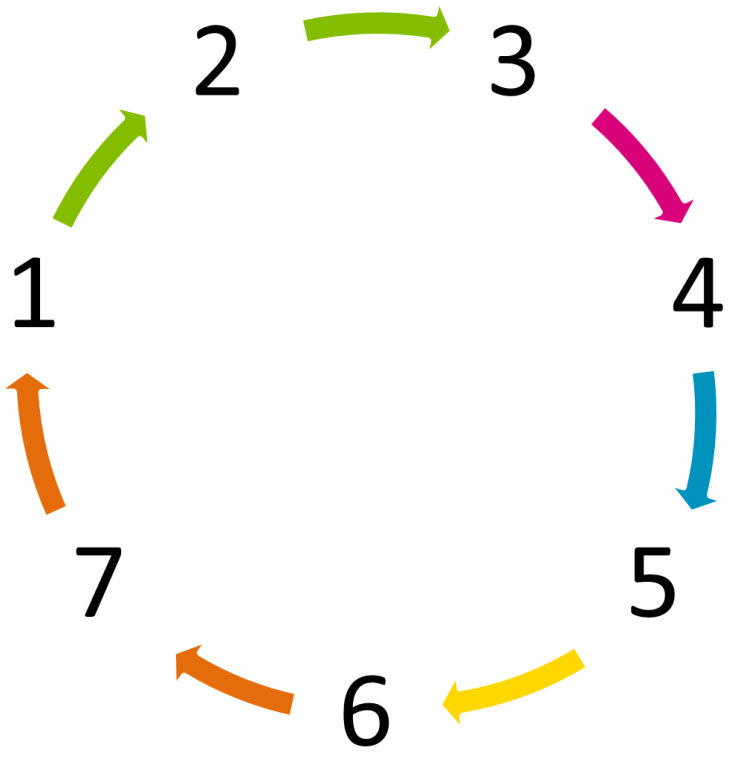
3. ***If there is no LD diagnosis and considerations have been made for undiagnosed LD, have you taken appropriate steps to refer your client?***

4. ***Have you considered the impact of past trauma, including childhood, on an individual's current presentation issues and willingness to engage?***

5. ***Have you considered different presentations of self-neglect? For example, medical self-neglect and environmental self-neglect***

6. ***Has a Fire Home Risk Assessment been completed in relation to concerns regarding self-neglect / hoarding?***

Want to learn more?



Trauma and Resilience Training:

WSAB Training Brochure 2021 (wigan.gov.uk)

Trauma Informed Response to Perceived Non-Engagement Guide:

Understanding non engagement with services (wigansafeguardingadults.org)

Wigan Adult Social Care Self-Neglect Guidance (Policy and Toolkit):

Wigan policy and procedure (wigansafeguardingadults.org)

WSAB Self-Neglect Lunch and Learn:

WSAB Training Brochure 2021 (wigan.gov.uk)

LD Register / Referral Guidance:

Wigan contact: Kimberley Watts - kimberley.watts1@nhs.net

WSAB Training Brochure:

WSAB Training Brochure 2021 (wigan.gov.uk)