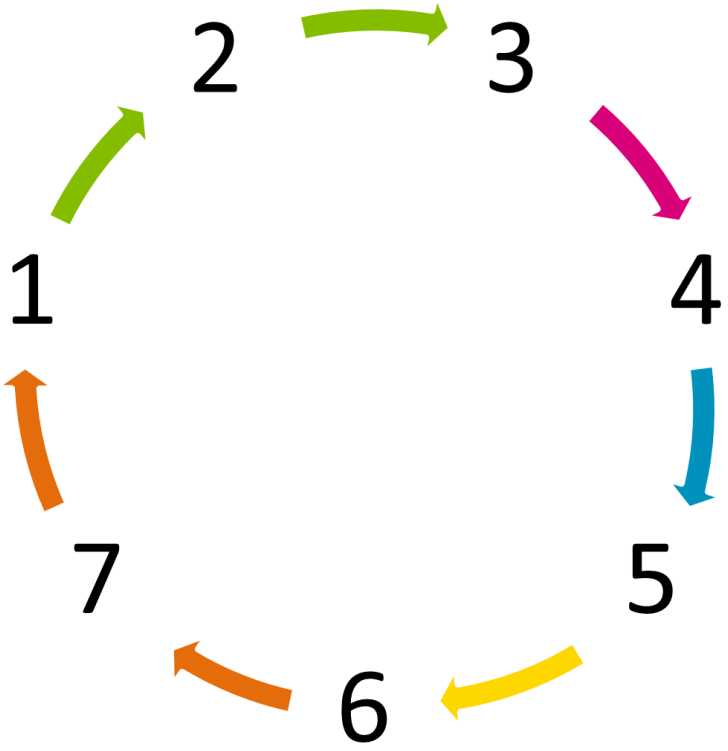
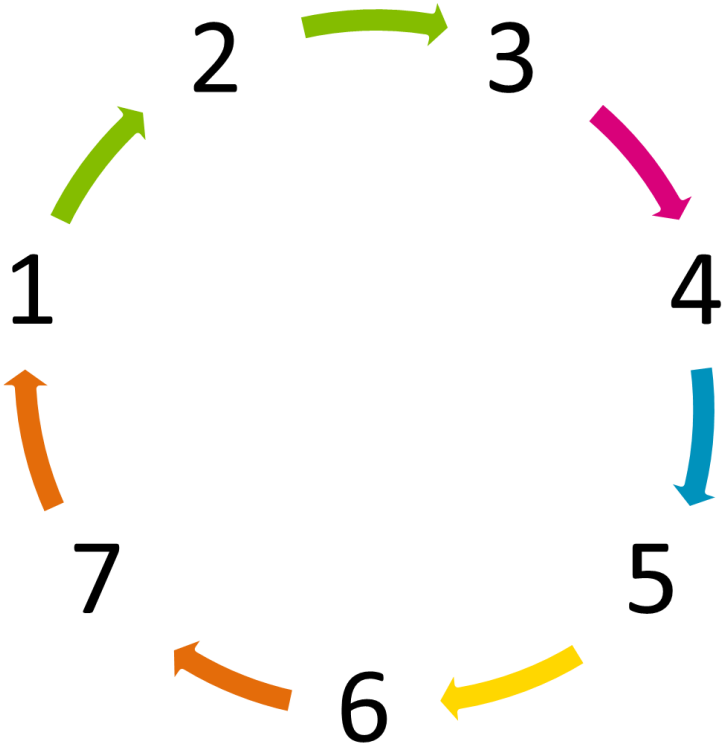


7 Minute Briefing: SAR Jayne

Safeguarding Adults Review: Jayne

Background



Background

Jayne was a middle aged lady who had a schizophrenia diagnosis and who was not receiving any treatment or prescription for this condition. She was supported by primary care for with her diagnosis of Eczema and dry skin conditions for many years, though these began worsening in 2019. There is some question as to whether Jayne was able to follow her skincare plan as prescribed. She was referred to and seen by Dermatology but disengaged when requested to increase her attendance so she could be be supported with the application of topical cream.

Her lack of self-care / self-neglect led to deterioration of her physical health. Jayne had an admission to hospital in March 21 in which she received intensive care treatment due to low blood sugars, not eating (she had previously been diagnosed with diabetes, though this was later ruled out following biochemistry investigations that did not support diabetes as a diagnosis) and severe weight loss. This followed two in patient episodes in the preceding year in which she presented with signs of self neglect. She was flagged by health professionals as potential self neglect within all of these hospital admissions .

In the March admission there were further concerns regarding her welfare from numerous agencies, and her mother disclosed to professionals potential sexual abuse, this issue became the focal point of section 42 enquiries whilst an in-patient; she was interviewed by police at this point and was deemed by officers to be lucid and with capacity. The interview resulted in Jayne stating there were no issues and that she

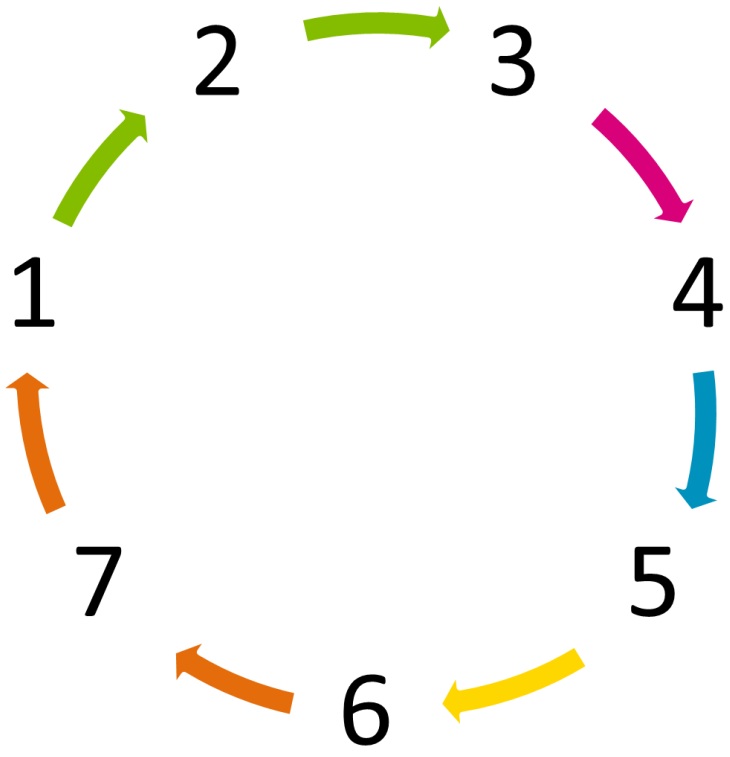
didn't want to pursue any criminal investigation. Therefore both the police recorded incident and safeguarding enquiry were closed.

Jayne was discharged home with no onward support having turned down social care following improvement in her physical function. Additionally although a referral to Community Mental Health Team was made whilst within the discharge to assess providers care, they were not informed by them when Jayne returned home, neither was this followed up. As a result Jayne was not seen by any agency between her discharge and consequent re-admission with deteriorating physical health in October, where she died with a diagnosis of Stevens - Johnson Syndrome.

There appears to have been no offers of support regarding the informal care that Jayne's mother was providing, she reported struggling with this throughout this time period.

The system did not recognise or respond to a repeating pattern of poor-self care / self-neglect leading to physical deterioration and in patient admissions, exacerbated by inconsistent take up of community service offers. Whilst it's not possible to know what the impact taking a self-neglect approach with Jayne would have yielded, the panel concluded that in future cases the system should improve it's ability to both identify and manage similar cases through this lens, incorporating support for informal carers / family members within that pathway.

Review Themes



The main themes of the review are:

- Self-Neglect,
- Mental Capacity
- Safeguarding Processes

Other themes that have an impact on this case are:

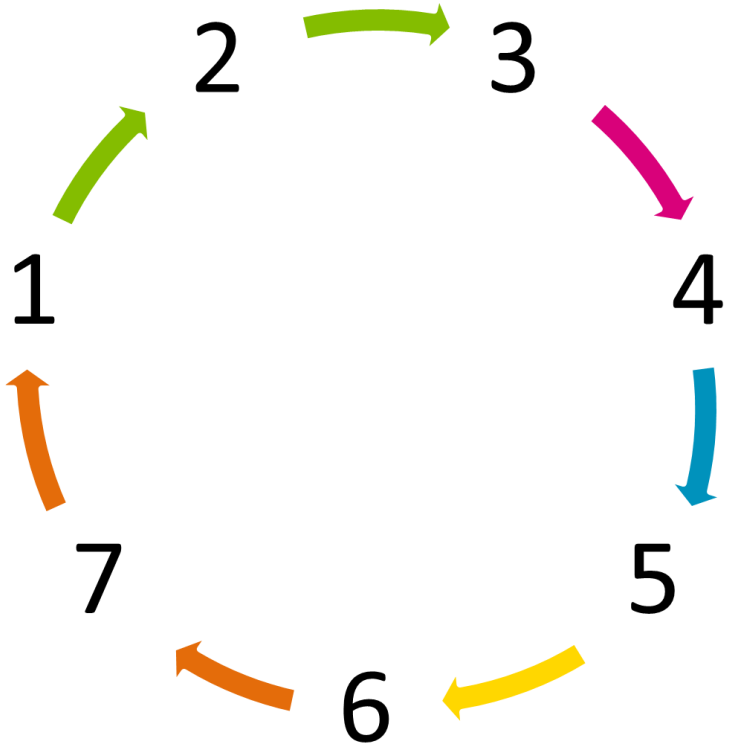
- **Covid-19 and resulting lack of face-to-face assessment**

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

1. Self-Neglect
    i. Mental Capacity and Executive Functioning
    ii. Safeguarding Processes
    iii. Perceived Non-Engagement
2. Community Services
    i. Mental Health
    ii. Adult Social Care
    iii. GP
    iv. Community Matron
3. Informal Carer
4. Quality of Safeguarding Referrals

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

1. Self-Neglect



- **Mental Capacity / Executive Functioning**

Jayne's mental capacity was assessed at multiple points providing an overview of fluctuating capacity. It is unclear to what extent this was caused by inconsistency in taking prescribed medication. It is also unclear to what extent this impacted on Jayne's ability to care for herself, as she was presenting with concerns for self-neglect and this was recognised by health professionals. Capacity in relation to self-neglect was never assessed, including executive functioning. Recording of assumed capacity decision making was also absent from social care records.

Physical health took precedence in relation to capacity assessment.

- **Self Neglect and Safeguarding Processes**

Self-neglect was documented within health records in March on admission to hospital, however safeguarding alerts and safeguarding response at the time focused on another safeguarding matter regarding disclosure of potential sexual assault rather than self-neglect..

Therefore safeguarding alerts raised with Adult Social Care regarding self-neglect were not progressed to Section 42 enquiry as a result of the individual being admitted to hospital *and the perception that the reported risk is removed as a result). As a result any concerns regarding self-neglect were not made to

the community discharge service provider where Jayne went for assessment prior to returning home. The focus was on functional independence.

Consideration to the risk of self-neglect following discharge was required, particularly where previous concerns were logged for self-neglect and poor self care. This occurred twice for Jayne, previously, in the year before the March admission. The panel considered that the cycle of discharge and re-admission (with concerns of self-neglect) was not considered.

On inspection of Jayne's social care case records regarding historic in- patient stays and by the then hospital social work team (Better at Home), it was noted that some safeguarding concerns were incorrectly recorded on forms outside of the Section 42 process, and there wasn't consistency in the recording of the category of abuse, meaning that combined risk and concerns in relation to self-neglect were not obviously apparent on Jayne's record and therefore to professionals dealing with the onward care of Jayne from discharge to community and on re-admission episodes.

Following a disclosure from Jayne's mother regarding a suspected sexual assault on Jayne, within the March admission, the safeguarding enquiry focus was in relation to this. Following person centred intervention and support from the hospital based IDVA team, when Police spoke to Jayne whilst an inpatient , she refuted any offences had taken place, therefore both the ongoing safeguarding enquiry and police log was closed. Moreover, the social worker dealing with discharge was working in silo to the social worker dealing with the safeguarding concerns. This resulted in a discharge focused on assessment of functional independence and did not consider any wider social and safeguarding risks.

Self-neglect concerns whilst a hospital in-patient and through mental health assessments could have been raised under the self-neglect pathway. Further learning regarding use of mental health legacy records on historic case management systems was noted (at the time the new mental health provider was using both a legacy system which would have contained previous information on individuals and their own case management system, this has since been resolved and all legacy records have been migrated onto new system).

- **Perceived Non-Engagement**

Jayne declined assessment for support in the community, reporting that she can manage and didn't have any problems with her mental health or with alcohol use. If the history of self-neglect and poor self-care had been considered then it may have been apparent that there was non-engagement taking place and therefore identification of potential ongoing risk on discharge. The repeated declining of support was not recognised over the longer term as a self-neglect trend linking back to a missed opportunity to consider self neglect from an executive functioning perspective.

Making a difference:

> To address the lack of safeguarding response to the risk of self neglect, the Self Neglect Policy and Pathway, it's recording / case management system and training products should be reviewed to reflect the learning in this case, namely

- Social care professionals must clearly document decision making rationale when capacity has been considered and assumed (i.e. when there are no indications for lack of capacity and so capacity is assumed).

- Revise the self-neglect policy and pathway ensuring that the requirement to refer self-neglect concerns into the Section 42 process is made explicit, and that practitioners can more easily identify and contextualise historic information or previous safeguarding episodes

- Revise the self-neglect policy, toolkit and training inputs for social care to include how practitioners can recognise signs of self-neglect from long-term trends and functional/executive capacity theme

- Update Social Care Mosaic case management system to automatically flag repeat safeguarding alerts

- Refresher training to be undertaken for the front door in relation to recording all reported safeguarding concerns as a safeguarding alert so that safeguarding trends can be identified more readily on an individuals case management record, together with a case management system amendment to highlight alerts that duplicate reports of the same incident

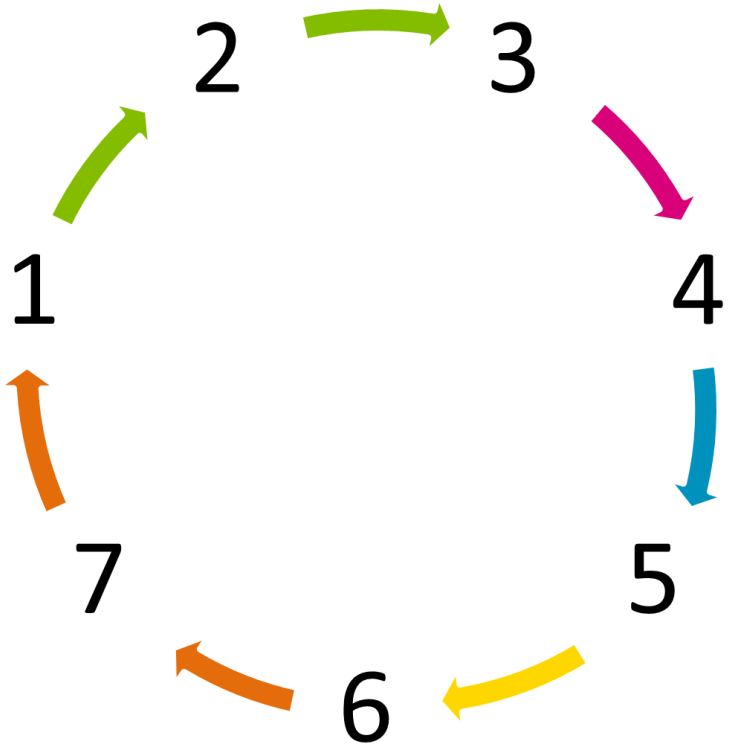
- Within self-neglect cases a trauma informed approach is required, especially If perceived non-engagement is suspected. WSAB have training and guidance resources available for this topic and ongoing work to embed this into practice and roll out across the partnership. This will need to include the Self neglect policy and pathway.

>Establish robust mechanisms between Adult Social Care Locality Team and Hospital teams (Transfer of Care Hub) regarding safeguarding enquiries including ensuring that safeguarding alerts are inappropriately closed not closed on in-patient transitions from community to hospital

>Greater Manchester Mental Health Trust to develop a specific self-neglect training package incorporating the need to ensure that staff are clear regarding referrals into local pathways for in-patients

> Greater Manchester Mental Health Trust to ensure case management legacy issue is rectified to ensure professionals have access to all pertinent current and historical records

2. Community Services



Community Services

- **Mental Health**

Whilst in the discharge to assess service within the March in-patient admission, a referral to Community Mental Health Team was made for follow up in the community. However the team were not informed by the discharge to assess service that Jayne had returned home, nor was this followed up by them post discharge. Jayne was therefore not seen in community by Mental Health Services may have provided insight into how she was coping on at home.

During this in patient stay she was administered anti-psychotic medication to assist with her treatment, this should have automatically resulted in a community follow up by appropriate primary care services and regarding any changes required from the having being administered anti-psychotic medication as in-patient. This did not take place in her own home, rather through liaison with the discharge to assess service; therefore there was no assessment of any changes to mental health medication in her own home environment. The panel considered that therefore it was not known how she was managing in consideration to her history of schizophrenia, despite her medical records detailing delirium and catatonic episodes on admissions, and the impact of this on her ability to care for herself.

- **Adult Social Care**

There was no commissioned package of care in place to support Jayne in community, an assessment was offered (a Supported Self-Assessment was not completed as Jayne reported that she was fine and did not require one). This was offered in the March discharge to assess period of care, supported by the fact that she was positively assessed for functional independence. The social worker spoke to Jayne's mother, who disagreed and reported that Jayne had mental health needs and expressed that she needed support; information and advice was provided.

- **Mental Capacity**

Jayne's mental capacity was assessed at multiple points providing an overview of fluctuating capacity. It is unclear to what extent this was caused by inconsistency in taking prescribed medication. It is also unclear to what extent this impacted on her ability to care for herself, as she was presenting with concerns for self-neglect and this was recognised by health professionals. Capacity in relation to self-neglect was never assessed.

Physical health took precedence in relation to capacity assessment.

- **Community Matron**

Follow up care in community by the Community Matron was documented on the Discharge to Assess (D2A) referral following discharge from the admission to hospital in October 2020; however, the service noted that it was referral made in error , noting as mental health referrals had already been made, notes document that this was appropriate given this was the presenting issue.

- **Alcohol Misuse**

Whilst there is reference within GP records to increased alcohol use and Jayne was prescribed Thiamine to reduce the impact of alcohol, there appeared to be little evidence to support this assumption. Jayne herself consistently denied heavy drinking whilst complaining of weight loss, dizziness and reduced overall functioning. Whilst the panel noted the GP phone call made above, conversations with both mum and brother were undertaken regarding this review. They stated that whilst Jayne did drink occasionally she would not have had the either the financial responses to support a dependent habit.

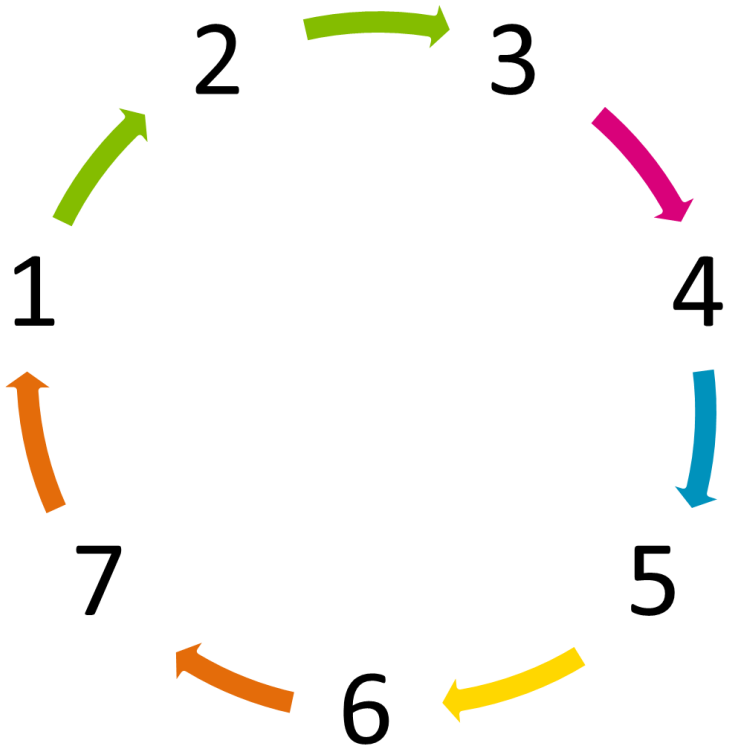
Making a difference:

> Revise the Self-Neglect policy to explicitly reference the role of primary care in referring to Section 42 and to receive WSAB self-neglect training that challenges the concept of 'life choices' in regard to functioning/executive capacity

> WSAB Self-Neglect subgroup to quality assure the self-neglect pathway under the revised policy, examining the practical application of professional curiosity, face-to-face assessment and referral into community support pathways

> GMMH to provide assurance to WSAB Learning and Quality Assurance Subgroup that discharge policies are followed and patients are appropriately seen in community

3. Informal Carer



Informal Carer

Jayne's mother was providing informal care regarding and the panel noted that she raised concerns that she wasn't able to manage on multiple occasions. Jayne's mother was recorded Next of Kin but was not considered or recorded as a carer on Adult Social Care's Case Management records.

Based on Jayne's mother asking for help, referrals were recorded as being made to Adult Social Care for assessment of Jayne but are not present in Adult Social Care records. As such no formal assessment of need for Jayne and her mother either for her own needs or as an informal carer took place. There were multiple occasions when Jayne was offered an assessment but declined whilst self-reporting to be

managing, and as she was deemed to have capacity, her refusals were accepted, and this resulted in any needs of Jayne's mother being overlooked.

Jayne was not seen by Adult Social Care, in part due to Covid-19 restrictions at the time; whilst its probable that a face to face visit may have triggered social workers to consider self-neglect and any unmet care needs if they had seen Jayne in her home environment, this did not occur.

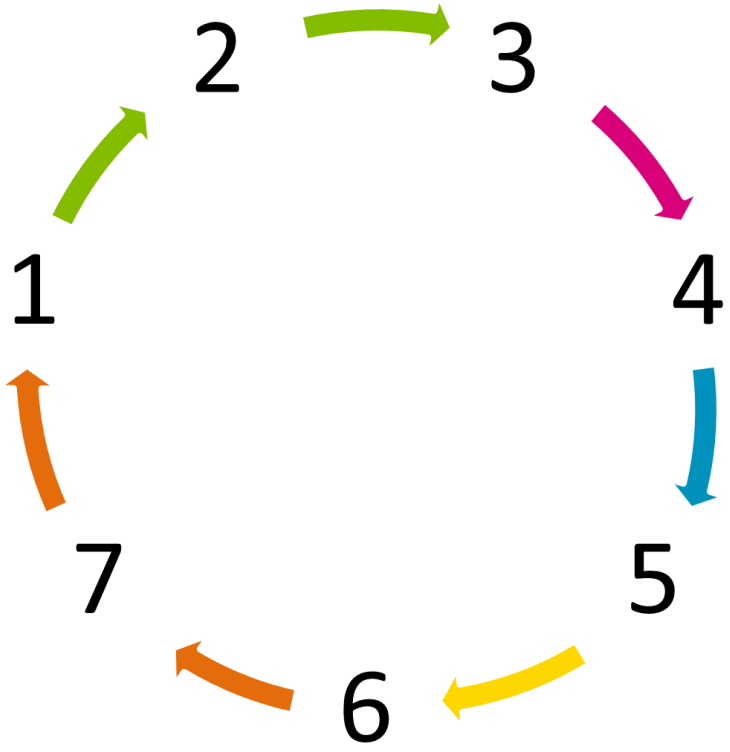
As a result, Jayne's mother was not offered support regarding her support for Jayne and not as as an informal carer. This in all likelihood exacerbated Jayne's poor self-care leading to a cycle of hospital re-admissions.

Making a difference:

> Establish a process within both self-neglect referrals and cases that ensures any caring responsibilities are clearly logged with appropriate offers of support also captured and outcomes captured

> Offer to support informal carers when no formal assessment of need takes place for the individual (or does take place but all needs are being met by the informal carer)

4. Quality of Safeguarding Referrals



Quality of Safeguarding Referrals

North West Ambulance Service raised a safeguarding for self-neglect following transporting Jayne to hospital resulting in the March 2021 admission. The category of abuse was recorded as self-neglect, however the information contained within the detail of the alert did not point to self-neglect. This resulted in triage by adult social care front door closing the alert as No Further Action as they were satisfied that there were no ongoing concerns in relation to the specific details provided. **Safeguarding concerns have to include the contextual information that causes concern, not just the details of the incident leading to the referral.**

Making a difference:

> Rewording of the online safeguarding referral form to be explicit regarding reporting the contextual details of concern, not just details of the incident

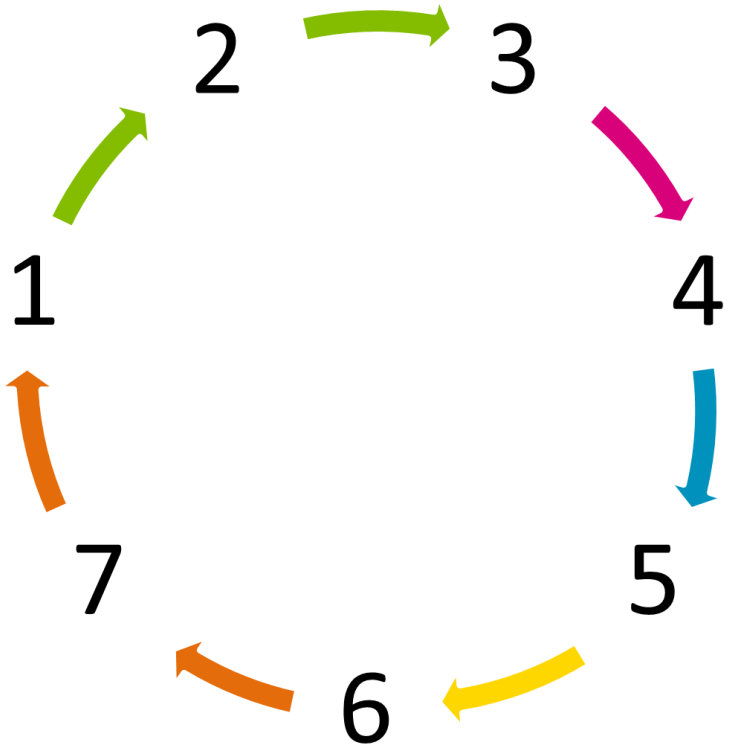
> WSAB Business Unit to develop guidelines for the quality of referrals to safeguarding, including the contextual information required

> WSAB Business Unit to develop a workforce development offer in relation to the quality of safeguarding referral

> Quality assurance and monitoring of quality of referral to safeguarding to be developed in the WSAB Quality Assurance Framework

> WSAB Business Unit to facilitate a partnership quality of safeguarding referrals audit to the local authority

Questions to consider



1. ***Do you feel empowered to complete an assessment of capacity in your professional role?***

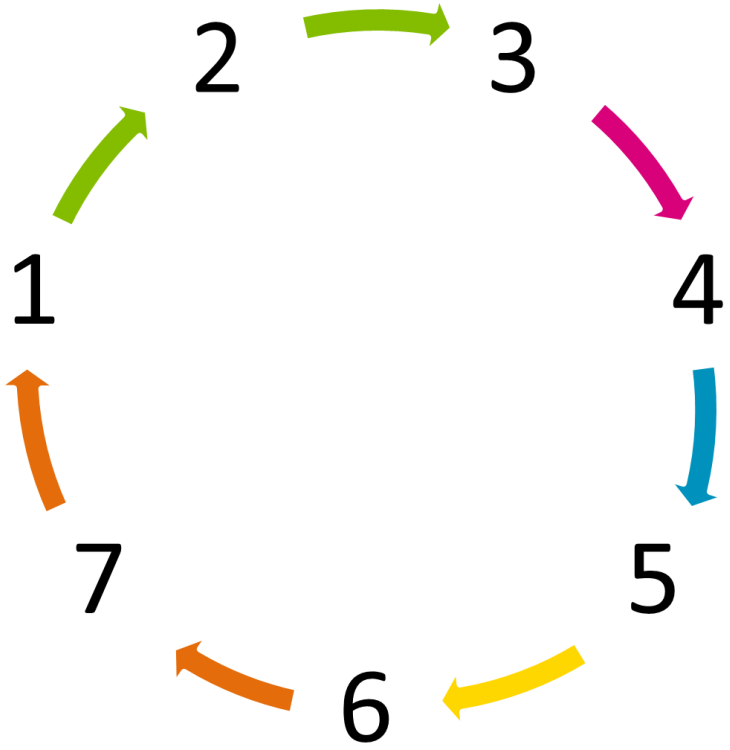
2. ***Do you feel empowered to apply professional curiosity to a scenario where there are concerns raised to suggest that an individual isn't coping despite them self-reporting that they are 'fine'?***

3. ***Have you included the reasons why you are concerned for an individual within any safeguarding alert raised?***

4. ***Is there clarity in your case notes regarding who a safeguarding referral was made to? - Is this an internal safeguarding notification or an external safeguarding referral to the local authority?***

5. ***What actions do you take to prevent being desensitized to neglect conditions in areas of higher deprivation?***

Want to learn more?



Perceived Non-Engagement Guidance:

Understanding non engagement with services (wigansafeguardingadults.org)

Self-Neglect Policy and Toolkit:

self neglect guidance (wigansafeguardingadults.org)

Self neglect criteria fact sheet (wigansafeguardingadults.org)

Further reading:

Wernicke–Korsakoff syndrome | Alzheimer's Society (alzheimers.org.uk)

Family Q SCR - Overview Report - Telford & Wrekin Safeguarding Children Board

Evidenced Led Practice:

Suspected neurological conditions: recognition and referral (nice.org.uk)

Overview | Alcohol-use disorders: diagnosis and management of physical complications | Guidance | NICE

Overview | Coexisting severe mental illness and substance misuse | Quality standards | NICE

Wigan and Leigh Carers Centre:

Wigan and Leigh Carers Centre (wlcccarers.com)

WSAB Lunch and Learn Sessions:

WSAB Learning and Development Brochure 2022/23 (wigan.gov.uk)

WSAB Training:

WSAB Learning and Development Brochure 2022/23 (wigan.gov.uk)