Safeguarding Adults Review
Executive Summary
Julie

2024
City of York Safeguarding Adults Board

Independent Reviewer: Rachael Sharp

1. Introduction

This executive report covers a summary of the findings and recommendations of the Safeguarding Adult Review, undertaken on behalf of the City of York Safeguarding Adults Board (CYSAB) relating to the death of an adult in the city in 2022 (referred to as Julie throughout this report to preserve her anonymity).

The CYSAB received a referral for Julie in February 2023 from City of York Adult Social Care. The Safeguarding Adults Review subgroup met on the 11th of July 2023 and 3rd October 2023 to discuss the referral; a decision was concluded that the criteria for a Safeguarding Adult Review as determined by section 44 of the Care Act 2014 was met.

There had been a delay in the review commencing, however initial scoping and learning was completed, and immediate learning implemented. It was agreed due to the delay that a rapid review would be undertaken by an independent author which would include a practitioner learning event with an outcome of a presentation and executive summary produced that could be used a learning document for agencies.

2. Background

Julie died following a long history of anorexia, mental health, alcohol substance use and self-neglect. She resided in the City of York in private rented accommodation which towards the end of life did not meet her needs, she was unable to leave the property due to her reduced mobility and health. She was known to several services throughout her life for her physical, mental health and social care needs. Julie had periods of time in hospital and rehabilitation establishments due to ongoing self-neglect, support was offered but often declined leading to her becoming hidden, this was further impacted by the Covid Pandemic. In July 2022 her family called the emergency services due to weight loss and a decline in her physical health, she was admitted to

the Intensive Care Unit and diagnosed with being underweight and malnutrition, she sadly died in hospital.

3. Key Lines of Enquiry

- What were the implications of the Covid Pandemic and lockdown periods on providing and supporting Julie? (including visits, assessments, placements, housing)
- How did agencies work together?
    - with following up appointments or nonattendance/ engagement?
    - to recognise and respond to safeguarding including exploitation/ self-neglect?
    - to communicate and share information on concerns/risks?
- What assessments were undertaken and how did these involve other agencies? (were Julie and her family aware of her 117 entitlement, the offer of a carers assessments and safeguarding plan)
- How was the Mental Capacity Act 2005 considered and applied if appropriate by agencies working with Julie?
- What were Julie's housing and mobility needs? (considering referrals in a timely manner, reasonable adjustments, length of time taken)
- What good and strong practice took place during this period?
    - What learning has already been undertaken as a result of this review?

4. Family Involvement

Julie was supported by family members including a sister, brothers, son and a niece and nephew. CYSAB have made several attempts to contact family members but unfortunately have not been successful, therefore at the time of writing this report there has been no family engagement in formulating this review.

5. Methodology

To undertake the review, a number of agencies were asked to provide information during a specific scoping period, being March 2020 up until Julie's

death. Chronologies were obtained and formulated into a combined chronology to produce a timeline and identify key episodes. The CYSAB agreed key lines of enquiry and a practitioner event was held. The practitioner event involved agencies that had engaged with Julie, reviewing involvement; identifying good practice; individual agency and system learning.

6. Findings

- **Professional Curiosity**

  A need for professional curiosity featured throughout this review. Agencies involved with Julie often accepted information at face value during telephone conversations and assessments, without exploring or confirming information that Julie was providing. Given previous assessments of lacking mental capacity to make decisions this should have been considered. There were periods of time that Julie was not seen in person to ensure information was substantiated. Agencies would have benefited in confirming and clarifying the information provided by Julie in a tenacious capacity given the information available of a history of mental health, substance misuse and eating disorder.

- **Application of the Mental Capacity Act 2005**

  Julie had a history of enduring mental health alongside an eating disorder and substance misuse. Although mental capacity should be presumed there would have been enough information to be curious about her mental capacity to make complex decisions. Although Julie was able to articulate what she was able to do, this was not followed up with her actions, therefore raising concern about her executive functioning.

  During her hospital admissions and rehabilitation, she was subject to Deprivation of Liberty Safeguards (DoLS) which would have been determined by an assessment which concluded as lacking capacity to make decisions about being deprived of her liberty. There should have been a review of this deprivation as she continued to be rehabilitated, there was no information or notification to the local authority that she normally resided that she was subject to DoLS, she left the rehabilitation establishment over a bank holiday

weekend which resulted in assessments being undertaken in urgent circumstances. This did not allow enough time for discharge planning and ensuring appropriate support was in place.

Julie had family members that supported her including her sister and brothers. During the review it was identified that Julie would not be tried posthumously but an offence would be recorded against Julie for producing and possession with intent of a Class B drug, alongside other individuals known to her. Julie did express concern about her charges and court appearance to professionals she would have benefited from support from an independent advocate.

- **Complexity of Need**

  The review highlighted that Julie had a number of complex needs including, physical health, mental health, history of trauma, eating disorder, housing, substance misuse and safeguarding concerns. Agencies worked in isolation and did not consider the person needs holistically. When assessing individuals with multi complex needs, practitioners need to ensure that they do not work in isolation and ensure assessments, care planning and reviews are holistic.

  The need to consider the interface between her complexity of needs, mental capacity to make decisions including the fluctuation of mental and physical health would have required a comprehensive assessment of her care and support needs with a collaborative approach with specialist agencies.

- **Information Sharing**

  The review highlighted that although information was gathered by agencies this was done in isolation and not shared in a timely and proportionate manner. The sharing of information with all agencies would have enabled a holistic overview of Julie's care and support needs.

  The involvement and referrals to a number of agencies made it difficult to have oversight of the number of appointments that were not attended and a clear picture of the day-to-day routine of Julie. An example of this, was

information provided by Julie that her sister was undertaking her shopping, however given the distance of travel and Covid Lockdown arrangements this would have been difficult.

Several referrals had also been made to various physical health specialist services, given her complexity and mobility needs this needed further exploration. If information had been shared about her circumstances reasonable adjustments could have been made to support attendance at these appointments to enable her to address her physical health needs.

This review highlighted that when discharge information was completed it was not always shared with all agencies involved, this was particularly evident when discharged to an out of area placement. When completing discharge letters consideration is needed on a case-by-case basis who the information needs to be shared with and that is contains holistic information. In this instance it led to her own GP not having information about her hospital discharge and rehabilitation plan.

The involvement of family members within the assessment and discharge planning was not considered and there was no identification or recognition of informal carers. This was a missed opportunity to ensure that adequate support was in place and contextual information was gathered to form assessments and care planning. It is not recorded that her informal carers had been offered a carer assessment.

- **Did Not Attend (DNA)**

  The review highlighted numerous DNA with all agencies, it highlighted no consideration of the individuals' circumstances to attend, reasonable adjustment considerations, information sharing with other agencies and several discharges without applying professional curiosity.

  Julie was also being assessed for her housing needs due to reduced mobility, towards the end of her life she was unable to leave her flat, there had been no

support in place to facilitate her attending appointments, this led to did not attends and the discharge from services without consideration of her accessibility needs.

- **Funding Arrangements**

  It was clear throughout this review that the person and agencies were unsure of the funding available to support the care provided. There was confusion between NHS Continuing Health Care funding, S117 of the Mental Health Act 1983, and self-funding. Julie would refuse support offered as part of her care and support needs assessment, believing that she would have been required to contribute to the cost of her care, if agencies and Julie had been aware of the funding available, support may have been more readily accepted.
  There needs to be awareness of the different funding streams available and consideration of a marker/ indicator that would support agencies when assessing for care and support needs and how this will be funded.

- **Covid Pandemic**

  It is important to note that the scoping of the key events of this review occurred at the start of the Covid Pandemic and during the first official lockdown of the country. The pandemic presented significant challenges to adult safeguarding law and practice, local authorities were underprepared and struggled to undertake key functions as did all partners and agencies. It must be noted that the Coronavirus Act 2020 included scope of widespread suspension of key duties under adult social care legislation, which resulted in concerns that adults who required care and support were not having their needs met. Coronavirus Act 2020

  It must be noted significant change occurred in the delivery of services during this period including the increase of remote working and remote assessments and care planning, those classed as vulnerable shielding, including the health and social care workforce.

  Although it is noted that there does not appear to be any direct impact from the Covid Pandemic in this review, it was critical that this was considered in

the context of that period of time as it will have had a wider contextual impact.timeline-coronavirus-lockdown-december-2021

- **Recommendations**

  A need for professional curiosity featured throughout this review, to be Professional curious is where a practitioner explores and proactively tries to understand what is happening within a family or for an individual, rather than making assumptions or taking a single source of information and accepting it at face value. City of York Safeguarding Adults Board and its partners should consider how to raise awareness of practitioners testing out assumptions, considering information and seeing past the obvious when working with individuals with complex needs.

  To raise awareness of the legal framework of Deprivation of Liberty Safeguards including application, removal and sharing of information.

  When assessing capacity under the MCA 2005 recognising that a person may demonstrate awareness into an issue in assessment and plan but not be able to execute the plan in the real-life situation. CYSAB to consider how to support practitioners in understanding Executive Functioning with individuals who have complex cognitive abilities.

  To ensure the consideration of the use of advocacy when assessing, planning and working with individuals with safeguarding, cognitive impairment and complex needs.

  The review highlighted this individual had a number of complex needs including, physical health, mental health, history of trauma, eating disorder, housing, substance misuse, safeguarding concerns. Agencies worked in isolation and did not consider the person needs holistically. When assessing individuals with multi complex needs, practitioners need to ensure that they do not work in isolation and ensure assessments, care planning and reviews are holistic.

Agencies to ensure consideration of how to work effectively together to support people who have complex needs and ongoing trauma. This includes how to best support individuals with accessing appropriate services.
The review highlighted that information was not shared effectively between agencies, which resulted in agencies not having accurate, proportionate and timely information to assess need and implement care and intervention. Professionals must all agree the best method of case communication in complex cases.

CYSAB to consider raising awareness of the necessity to share proportionate and timely information sharing to provide agencies with the confidence to do so. Consider promoting the NYSAB One Minute Guide on Information Sharing.

This review highlighted that when discharge information was completed it was not always shared with agencies that had been involved with the individual, especially when a discharge is to an out of area placement. When completing discharge letters to consider on a case-by-case basis who the information needs to be shared with and that is contains holistic information.

Throughout this review it highlighted numerous DNA with all agencies, it highlighted no consideration of the individuals' circumstances to attend, reasonable adjustment considerations, information sharing with other agencies and a number of discharges without applying professional curiosity.

CYSAB to consider guidance on how to support the partnership managing individuals with complex needs who regularly do not attend appointments/ visits/ assessments.

To raise awareness amongst agencies of ensuring that reasonable adjustments have been considered. Reasonable adjustments are a way of making small changes to remove the barriers for someone with a disability to access care. There is a legal duty under the Equality Act 2010 for anyone with a disability.

To raise awareness of the Reasonable Adjustment Digital Flag

There needs to be awareness of the different funding streams available and consideration of a marker/ indicator that would support agencies when assessing for care and support needs and how this will be funded.

7. Acknowledgements

Thanks goes to the independent Author, Rachael Sharpe for undertaking this review and to all the agencies who participated in providing information and engaged in considering the findings.

8. Next Steps

This executive summary and recommendations were considered at the City of York Safeguarding Adults Board (CYSAB) extraordinary meeting 28th January 2025 and approved. Associated actions were also considered by the CYSAB in order to implement the recommendations. These actions will be progressed by the CYSAB SAR Subgroup and may become part of thematic action planning related to existing and future SARs.