RICHMOND AND WANDSWORTH SAFEGUARDING ADULTS BOARD

SAFEGUARDING ADULT REVIEW – Jasmine

2020

Independent Reviewer: Sarah Williams

Contents

1. Executive Summary

1.1. Jasmine was a 20-year-old woman, who had been known to children's services since 2013 due to safeguarding concerns arising from poorly managed diabetes and emerging mental health issues. Jasmine found it difficult to maintain positive relationships in her personal life and would often refuse help from professionals. Her history shows patterns of seeking support in managing her chronic health and conditions, but not attending follow up appointments or complying with her medical regime. She was found dead in her supported accommodation in September 2019, and although a coroner's inquest has not been held because she died of natural causes, it is believed that this was a consequence of complications relating to her diabetes.

1.2 Systems Findings

Learning Lesson 1: Transition planning

- Transition planning can be inconsistent and delayed, in particular where young people's cases are held outside the specialist disabilities service in Children's Social Care.
- The concept of transition is set out in policy and understood by specialist services but not embedded in mainstream services, resulting in a lack of joined-up planning. Adults' services expect young people to quickly adapt to the new legal framework that surrounds them as adults, leaving them bewildered by the complex network of health and care services.

Lesson 2: Self-neglect and safeguarding

- Issues of neglect of health needs and refusal to engage with services are poorly understood by practitioners within the context of self-neglect, and consequently opportunities to mitigate risks to the individual are missed.
- The impact of trauma on cognitive abilities and executive decision making is poorly understood and this limits the value of mental capacity assessments.
- Understanding of Care Act duties and mental capacity is not embedded in Children's Social Care and relevant training is generally considered specific to the Adult service. This impacts on practitioners' ability to respond to the needs of young people transitioning from Children's Social Care.

Learning Lesson 3: Cohesive services for individuals with co-morbid physical and mental health needs

- Individuals with complex needs, particularly with co-morbidity with mental health or personality disorders, receive insufficient support to navigate their treatment pathway. The limited discussion between health disciplines results in an incomplete analysis of global health needs and a lack of holistic planning.

2. Purpose of the Safeguarding Adult Review

2.1. The purpose of having a Safeguarding Adult Review (SAR) is not to re-investigate or to apportion blame, to undertake human resources duties or to establish how someone died; its purpose is:

2.1.1. To establish whether there are lessons to be learned from the circumstances of the case about the way in which local professionals and agencies work together to safeguard adults;
2.1.2. To review the effectiveness of procedures (both multi agency and those of individual organisations);
2.1.3. To inform and improve local interagency practice;
2.1.4. To improve practice by acting on learning (developing best practice);
2.1.5. To prepare or commission a summary report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action.

2.2. There is a strong focus in this report on understanding the underlying issues that informed agency and professionals' actions and what, if anything, prevented them from being able to help and protect Jasmine from harm.

3. Agencies involved in the SAR

3.1. A number of agencies were involved with Jasmine and have contributed to this review through the provision of their own management reviews or chronologies relating to the circumstances leading up to the death of Jasmine. The GP surgeries and the Housing Department provided their complete records in respect of Jasmine.

3.2. For the purpose of this report and in line with standard practice for SAR's, the agencies (below) and individuals providing information to the review are anonymised:

3.2.1. Hospital NHS Foundation Trust A (Hospital A[i]) – including Eating Disorder Service, Community Mental Health Services, Psychiatric Liaison Service and Diabetes Service
3.2.2. Hospital NHS Foundation Trust B (Hospital B[ii])
3.2.3. Hospital NHS Trust C (Hospital C[iii]) – Autistic Spectrum Disorder Service
3.2.4. Children's Social Care
3.2.5. 0-25 Social Care Services
3.2.6. Child and Adolescent Mental Health Services
3.2.7. Supported accommodation provider
3.2.8. Housing
3.2.9. General Practice Surgeries

3.3. A practitioners' meeting took place on the afternoon of 19 October 2020 to engage with front-line practitioners and line managers, and generate the qualitative data needed to inform the review process. Unfortunately, due to a number of staff members leaving, there were few attendees who had worked directly with Jasmine, and most agencies were represented by more senior managers. This has limited analysis of the enablers and barriers to good practice experienced by front-line practitioners.

3.4. A SAR review meeting took place on the afternoon of 5 November 2020, to discuss the proposed findings with managers from each of the key agencies. Additional information was also sought from individual agencies when clarification was required on a number of points.

3.5. The absence of attendees from diabetes services or the GP at either meeting meant that the actions of these services have been analysed through the documentation provided, but this could not be explored in the detail the reviewer would have wished.

4. Research questions

4.1. The following research questions were identified in the terms of reference set by the Safeguarding Adults Board:

4.1.1. How well do practitioners support people with complex life histories to manage chronic conditions?

4.1.2. What could be learnt about how practitioners worked together during transition process from Children to Adult services?

5. Description of Jasmine

5.1. Jasmine described herself as a lonely person, who struggled to maintain friendships and had a difficult relationship with her mother. She said that she was an only child and did not have a relationship with her father. She was Black British of Caribbean decent, and it is possible that a Euro-centric view of ideal body shapes contributed to her negative body image. Jasmine experienced a number of adverse childhood experiences that resulted in significant trauma and are likely to have impacted on her ability to sustain positive relationships. She did not like professionals coming into and out of her life and could be private about her health issues.

5.2. Jasmine had a diagnosis of emotionally unstable personality disorder, eating disorder and possibly autistic spectrum disorder, and experienced periods of depression. She was diagnosed with insulin dependent diabetes mellitus at the age of four, and also experienced irritable bowel syndrome, diabetic retinopathy and diabetic ketoacidosis. She had multiple admissions to Accident and Emergency and the acute hospital wards due to poor adherence to her insulin regime. Jasmine reported that this poor concordance was due to forgetfulness and not wanting to gain weight. All professionals working with Jasmine were consistently of the view that she had capacity to take decisions in respect of her health, treatment and welfare.

5.3. Immediately prior to Jasmine's death, professionals reported that she seemed positive and motivated, both in respect of her health and her personal life. She was relieved to have been diagnosed with "diabulimia", a rare form of eating disorder where Type 1 diabetics misuse insulin to control their weight, and was keen to engage with the proposed treatment programme. She was settled in her accommodation, had obtained a new job, planned to enrol in college and went to stay with a friend for a few days. Jasmine's relationship with her mother had also

improved, and her mother had supported her by attending an appointment at the Eating Disorder Service.

5.4. Unfortunately, it has not been possible to speak to Jasmine's mother during the course of this review as she has not responded to offers of a meeting, although she will be invited to comment on the report.

6. Narrative chronology

6.1. Jasmine had been known to children's services since 2013, in response to safeguarding concerns arising from poorly managed diabetes and emerging mental health issues. Her diabetes had been well-managed as a child, but from the age of 11 she had multiple admissions to hospital. She was subject to a child protection plan between 2016 to 2017 as a consequence of physical abuse by her mother. A referral was made for Jasmine to transfer to adult services in May 2017, 4 days before her 18th birthday. It is unclear why transition planning did not start earlier. When the transitions panel considered Jasmine's case, a plan was made for the Child and Adolescent Mental Health transition worker and Jasmine's outreach worker to continue to support her post-18, while a care assessment was carried out. Jasmine was transferred to the 0-25 service of the Council's social care, which supports young people with care and support needs up to their 25th birthday.

6.2. On 30 November 2017, Jasmine's case was closed to the 0-25 Service because she had capacity and was refusing either a care assessment or any service from the local authority. Repeated efforts had been made to engage her in the assessment by both the outreach worker and social worker from the 0-25 service.

6.3. After transitioning to adult mental health services, Jasmine had multiple psychiatric and acute general hospital admissions due to difficulties managing her diabetes. During Jasmine's admission to the mental health assessment suite of Hospital A in January 2018, she admitted to suicidal ideations and that she sometimes did not use her insulin as a way of self-harm.

6.4. A safeguarding referral was made to the local authority in March 2018 by her college, where she was a student, regarding self-neglect as Jasmine was not managing her physical health conditions. This was not progressed as her mother was seen as a protective factor, despite Jasmine's family history demonstrating that her mother had struggled to effectively support the management of her health conditions and that their relationship was volatile.

6.5. Jasmine was re-referred to the Community Mental Health Team in September 2018 whereupon she was allocated to a care coordinator and began seeing the team psychologist. She was subsequently referred to the specialist Autistic Spectrum Disorder service in Hospital A for further assessment. However, due to an administrative error which delayed funding, Jasmine had not been assessed by the time she died.

6.6. Jasmine was evicted from her first supported accommodation due to rent arrears and behavioural issues in January 2019. The Council offered Jasmine further supported accommodation, to develop her life skills and support her to become ready for independent accommodation. A risk assessment was sent to the

accommodation provider, including information about Jasmine's mental health and diabetes.

6.7. In March 2019, Jasmine again attended Accident and Emergency due to poorly controlled diabetes and diabetic ketoacidosis. She was jointly reviewed by Hospital A's Liaison Psychiatry Service and her care coordinator and referred to the Eating Disorder Service, with a green zoning in respect of her level of risk. This meant that she had to proactively opt-in to receive a service and the timescales for Jasmine's assessment and intervention were longer than a higher risk rating would have provided. Jasmine was also referred to the Family Therapy Clinic.

6.8. In June 2019, Jasmine requested to be moved from the supported accommodation provider through her solicitor, reporting that ongoing noise by other tenants was detrimental to her mental health. Although she sought to be treated as a care leaver, Jasmine had never been looked after and was not eligible for a service. However, the social worker made a referral for a Care Act assessment, having properly identified that she appeared to have a need for care and support. Unfortunately, because of staffing shortages, Jasmine was placed on a waiting list for allocation of an adult social worker to undertake the care assessment, and this had not been progressed by the point of her death.

6.9. On 25 June 2019, Jasmine was seen for a discharge review by the Community Mental Health Team specialty doctor and care coordinator. She was waiting for an appointment with the Eating Disorder Service and Family Therapy clinic at this time, but these services were not invited to attend the meeting. She was assessed to have no evidence of severe mental illness and presented with low risk to herself and others. Jasmine's care plan was communicated to the GP which also indicated that Jasmine had been engaging with psychological assessment input. The role of the care coordinator ended when the Community Mental Health Team closed Jasmine's case.

6.10. Jasmine confirmed she wanted to engage with the Eating Disorder Service and attended her appointment for an initial assessment in July 2019 with her mother. This was a constructive meeting, where Jasmine and her mother shared information about her medical and personal history. Jasmine returned for her follow up appointment at the Eating Disorder Service the next week, although her mother could not attend. The assessment report was discussed with Jasmine and information provided regarding the process of day unit admission and the need for joint working with her diabetic team to ensure that there was a clear routine, monitoring regime and an agreed meal plan.

6.11. The Eating Disorder Service told Jasmine that they would need to jointly work with her diabetes service, and she expressed her preference to work with Hospital B. As she was not open to the diabetic service due to previous non-attendances, Jasmine's GP was asked to complete a referral to the Hospital B's diabetic service. Following her assessment by the Eating Disorder Service, Jasmine's risk rating was zoned amber, resulting in a reduced timescale for her intervention to start.

6.12. Jasmine was last seen by her GP on 5 August 2019. She was offered appointments with both Hospital A and Hospital B's diabetic clinics in August and September, but she did not attend. Both the Family Therapy Clinic and Eating Disorder Service made repeated efforts to contact Jasmine in August, telephoning her and leaving

messages and writing letters requesting that she contact the service within two weeks to progress the treatment plan. However, Jasmine had previously reported that she struggled to manage her finances and often did not have credit on her mobile to call professionals. The positive changes that she had made in her personal life, in particular obtaining a job and applying for college, would have conflicted with the very intensive Eating Disorder Service treatment programme, which would have required her to attend a day service every weekday. Because they did not receive a response, the Family Therapy clinic discharged Jasmine from their services, unaware that by point of discharge, Jasmine had died. The Eating Disorder Service wrote a personalised letter to encourage Jasmine to engage.

6.13. At the end of August 2019, Jasmine's accommodation provider reviewed her risk assessment, rating her as high risk, and updated her safety plan. During a telephone conversation with her key worker on 10 September 2019, Jasmine advised that she was going to stay with a friend from 11 to 14 September 2019. The key worker had no concerns about Jasmine's presentation, she was in good spirits.

6.14. On 14 September 2019, a staff member from Jasmine's supported accommodation found that Jasmine's door was unlocked. On entering the flat to check on Jasmine's welfare, the staff member found her unconscious and unresponsive. She called emergency services and attempted resuscitation, but on arrival the ambulance officers confirmed that Jasmine had been dead for some time.

7. Analysis

7.1. Overall, the quality of the service Jasmine received from the professional network was of a good quality, with examples of outstanding practice. In the months preceding her death, the thoughtful, personalised multidisciplinary approach of the Eating Disorder Service was a particular exemplar of best practice. There is no evidence that her death was a consequence of a failure by any specific service. Each service assessed and treated Jasmine in accordance with their protocols and complied with national standards. However, there were gaps between services, which meant professional response to Jasmine's needs was not always cohesive.

8. Learning Lesson 1: Transition planning is not embedded in mainstream services

8.1. Analysis of practice

8.1.1. In addition to the transitions provisions in the Care Act 2014, both the special needs provision in the Children and Families Act 2014 and the leaving care provisions in the Children Act 1989 provide for continuous service from social care for young people with complex needs, up the age of 25. The Government recognises that a 'cliff-edge' at 18 is detrimental to this cohort of young people.

8.1.2. In 2018, the Safeguarding Adults Board undertook a Safeguarding Adults Review in respect of Sophie, a 19-year-old care leaver who took her own life in a residential placement.[1] The authors reported:

> "*Much knowledge exists around transition illustrating how difficult this period of time is for all young people… there appears to be no attempt to work with those young adults for whom the transition is easily predictable to be severely challenging, and likely to fail, if they are not provided with more support than would otherwise be the norm. The challenges for adult social care services are for it to be truly person centred, responding to the needs of those clients who very vulnerable. Vulnerable young people who come into the care of adult social care requires them to work in a sophisticated way, working extremely closely with transition services, family and others to support the client through this difficult change, whilst respecting and working within the legal framework for adults. This is likely to mean a different style of service provision and possibly closer oversight of the care being delivered than would be usual for other adults. The alternative is a very sharp, abrupt loss of support for young adults at a time when they might need it most."*

8.1.3. There are strong parallels between Jasmine's case and the case of Sophie in respect of the challenges in providing effective transition pathways, which are reflected in a large number of Safeguarding Adult Reviews nationally, and it is important to consider why these problems continue to arise to enable real changes to be made to systems to prevent future tragedies.

Delay in transition

8.1.4. The Council has a 0-25 team for children and younger adults with disabilities, to facilitate transition in accordance with their duties under the Care Act 2014. The purpose of this is to ensure that planning for young people's transition to adult services takes place well in advance of their 18th birthday, and that they receive continuity in respect of the social workers involved in their care.

8.1.5. Due to the concerns around physical abuse as a child, Jasmine's case was open to a child protection team, as opposed to the Children with Disabilities Service. Children's Social Care did not transfer the case to the 0-25 team or make a referral for a care assessment as Jasmine approached 18, despite her significant health and mental health needs indicating that she was likely to have care and support needs as an adult.

8.1.6. Children's Social Care advised that their usual practice would have been to transfer a young person's case to the 0-25 service at the age of 15, if they were not already held by the service. However, it was acknowledged that it was not uncommon for this transfer to be overlooked in cases held by mainstream Children's Social Care. Social workers are often very good at dealing with immediate risks, but can struggle to balance this with long-term planning. There is also a misunderstanding in respect of the

[1] SAR authored by Mary Burkett and Eliot Sullivan-Smith, dated 23 April 2018

thresholds for a care assessment as an adult, as social workers often believe that this is much higher than the threshold for a child in need assessment.

8.1.7. To address this, a case tracker has already been introduced to capture and plan for the young people who may need to transition to adult services. Currently this is manually updated, but work is underway to enable this information to be parsed from multiagency records. A review of the 0-25 service has also recently been undertaken and the service has been divided into a 0-17 team and an 18-25 team, to ensure that social workers hold the necessary skills set to comply with the different legal frameworks for children and adults. It is planned that once the new arrangements are embedded, an audit will be undertaken using the Preparations for and Transitions to Adulthood audit tool, although this is an audit of services rather than an analysis of the effectiveness of transitions in individual cases.

Relationship building

8.1.8. It is essential that the social workers in the 18-25 team are provided with tools and resources to support them to provide close oversight of the care plan and services that young people transitioning to adults require. Consistent, nuanced direct work is required to secure the trust and engagement of the young person.

8.1.9. In Jasmine's case, the delay in transition planning was a missed opportunity, because thoughtful care planning over a number of years would have resulted in a detailed care plan being completed in advance of Jasmine's 18th birthday, and any necessary resources being in place immediately. Jasmine would have had an opportunity to build up relationships with the professionals who would be involved in her case as an adult, which is something she had identified as being important to her, core to the principles of Making Safeguarding Personal. Having a new cohort of professionals introduced at the age she gained agency over her own decision making may have contributed to her disengagement from some services.

8.1.10. However, once this oversight was identified, Jasmine was immediately referred to the Council's transition panel, and there was no delay in her case being considered. The panel took the decision to extend allocation of the outreach worker, with whom Jasmine had formed a positive relationship, and she worked closely with the allocated adult social worker to help him to understand Jasmine's needs and support transfer of the relationship. Ideally, allocation of the outreach worker would have been further extended, until Jasmine engaged with the adult social worker. She had explicitly asked to continue working with this individual, engaged with her regularly – although not consistently – and demonstrated trust.

8.1.11. Child and Adolescent Mental Health Services had also appointed a transition worker to support Jasmine's transfer from children's to adult mental health services. The purpose of this role was to help Jasmine to navigate the complex mental health system and support her across all

realms of her life. This support was effective and thoughtful. The 0-25 service manager noted during the review that this was a highly valued resource, with a motivated and skilled officer in the post. Although Jasmine disengaged from the service in 2017, the same worker was reallocated in 2018 after Jasmine was admitted to hospital. This decision was person-centred, so Jasmine engaged well with the transition worker. Regrettably, this post is currently vacant, and consideration is being given to how to resource this going forward.

8.1.12. These roles, though effective at the time, were relatively short-term and did not provide the continuity that would have better supported Jasmine to engage with adult services.

8.1.13. The Board also need to consider how services embed the specific needs of young people transitioning into wider adult services. Unfortunately, despite general agreement about the importance of effective transitional care, a scoping review of research found that there is a paucity of evidence to inform best practice about both the process of and what constitutes effective transitional care for young people with complex health needs.[2] A transitional equivalent of a 'team around the child' – multi-disciplinary team meetings is likely to assist.

8.1.14. By way of example, the Eating Disorder Service has recently secured funding for a FREED Champion for 16–25-year-olds with a first episode of anorexia nervosa. This aims to overcome barriers to early treatment by providing a highly coordinated, specialist care package.

Policies to support practice

8.1.15. Importantly, at the time of Jasmine's death in 2019, the Council's transition policy had not been comprehensively updated to reflect the changes introduced by the Care Act 2014, and the draft policy was never signed off. This may have contributed to the poor understanding of the transitions process, particularly for services that have fewer cases which fall within this framework. A Care Act compliant policy is being drafted, and it is essential that this is finalised and rolled out across both Children's Social Care and Adult Social Care to embed understanding of the transition process.

8.1.16. Children's and Adolescent Mental Health Services has also now drafted a new transitions policy to secure a smooth transfer from children's to adults' mental health services at 18, supported by an adult transition improvement plan. This includes a requirement that a referral should be sent for a care assessment in respect of any young people not currently open to Children's Social Care. These policies need to be cohesive and consistent, and drafted to strengthen partnership working.

[2] "Models of transitional care for young people with complex health needs: a scoping review", R Watson, J R Parr, C Joyce, C May, A S Le Couteur, Child Care Health Dev November 2011

8.2. System findings

8.2.1. Transition planning can be inconsistent and delayed, in particular where young people's cases are held outside the specialist disabilities service in Children's Social Care.

8.2.2. The concept of transition is set out in policy and understood by specialist services but not embedded in mainstream services, resulting in a lack of joined-up planning. Adults' services expect young people to quickly adapt to the new legal framework that surrounds them as adults, leaving them bewildered by the complex network of health and care services.

8.3. Recommendations

8.3.1. The transitions policies for the Council and Children's and Adolescent Mental Health Services must be aligned to each other, finalised, and rolled out to staff across the agencies, with training to embed knowledge. An equivalent policy for wider health services should also be introduced, to support the transition for young people in respect of their physical health needs.

8.3.2. A multi-agency case audit across Children's Social Care, Education, Children's and Adolescent Mental Health Services, Health Services and Youth Offending Services should be undertaken to assess whether the current tracker is properly capturing the cohort of children who require transition planning, and the quality of those transitions. This should include an audit of compliance with statutory timescales for assessments and the quality of supervision, including those who are not currently open to the 0-25 service.

8.3.3. All agencies to consider how best to adapt current operational models to encourage practitioners to routinely make reasonable adjustments so that service delivery is designed to better support young people transitioning to adulthood successfully access mainstream adult services. Workflows should allow for longer term engagement and repeat visits. These should also aim to reduce the number of new professionals introduced to hard-to-reach young people as they transition to adult services, to reduce the risk of disengagement, and ensure the staff working with this cohort have specialist training in engagement with young people. Good practice requires that a lead professional should be allocated to take responsibility for coordinating services and supporting the young person's engagement, even where the case is not open to social care.

9. Learning Lesson 2: Self-neglect and safeguarding

9.1. After she turned 18, Jasmine was repeatedly offered an assessment in respect of her care and support needs, but refused to engage with the assessment or accept any services. She was assessed as having capacity to take this decision, and consequently her case was closed to the 0-25 service in November 2017. However, section 11(2) of the Care Act 2014 imposes an enduring obligation on the Council

to complete a needs assessment if there is concern that the adult might be at risk of abuse or neglect, including self-neglect.

Policies to support practice

9.2. The Council's adult services had a Self-neglect and Hoarding Staff Guidance in place at the time of Jasmine's death. This adopts the SCIE definition of self -neglect as follows:

"2.3 Braye et al (2001) as set out in the SCIE guidance 'Self-neglect policy and practice: research messages for managers,' suggests the following definition for self-neglect:

- *lack of self-care: neglect of personal hygiene, nutrition, hydration and/or health, thereby endangering safety and wellbeing, and/or*
- *lack of care of one's environment: squalor and hoarding; and/or*
- *refusal of services that would mitigate risk of harm."*

9.3. The policy further sets out:

"*3.1 The Statutory Guidance to the Care Act 2014 states that self-neglect may be an adult safeguarding issue, but that concerns about self-neglect should not automatically be dealt with under Safeguarding Adults Procedures. Decisions should be made on a case by case basis. Very often other supportive action, such as signposting to universal services or an assessment of care needs by the local authority may be more appropriate and should usually be attempted first…*

3.3 Where an adult at risk of self-neglect has mental capacity, but refuses a needs assessment, the local authority must undertake an assessment so far as possible and document this. It should continue to keep in contact with the adult and carry out an assessment if the adult changes their mind, and asks them to do so."

9.4. The Council's policy is comprehensive and fit for purpose, and clearly set out how a person-centred approach should be taken. It recognises that it is important for staff and manager to be supported to manage these cases balancing the person's right to self-determination with the risks they expose themselves to. A vulnerable adults multi-agency panel is well established across the safeguarding partnership, with referrals received from most agencies.

9.5. However, there may be a tendency for practitioners to think about self-neglect in the context of personal hygiene or hoarding, as opposed to medical self-neglect and there is no indication from the records that consideration was given to how this policy applied to Jasmine. Jasmine's poor concordance with her diabetes regime and refusal of services that would mitigate harm were not seen in the context of a safeguarding issue, despite a safeguarding referral being received from her college guidance councillor in 2018, explicitly raising concern about self-neglect.

9.6. The cohort of social workers in the 0-25 service have a children's social care background. Efforts to appoint social workers with broader experience, for example, adult specialists or those from a mental health background have only resulted in a few temporary locum appointments, which has hindered the cross-pollination of

experience. It is unclear to what extent the training and policies that support the Adult Social Care department have been provided to the 0-25 service, and whether this knowledge has become embedded in their practice.

Mental capacity and assessment of care and support needs

9.7. Social workers did revisit the issue of a Care Act assessment with Jasmine on a number of occasions, which was good practice. There are case notes in both care and health files recording that Jasmine's capacity to take decisions in respect of her care needs and health was considered at points where she refused a service, and professionals were consistently of the view that she had capacity in respect of all decision making. However, the impact of trauma on adolescent brain development and an individual's cognition and decision-making ability is well recognised and this should have been explicitly considered in Jasmine's mental capacity assessments. Where necessary, advice or cooperation should have been sought from other professionals working with Jasmine, to ensure that this issue was explored in a nuanced way.

9.8. Additionally, there is no record that a care assessment was progressed as far as it could be, in accordance with the self-neglect policy. Presentation to the multi-agency panel may have assisted practitioners to identify more effective ways to engage with Jasmine, or additional resources that may have been useful. This would also have ensured that health professionals were more alive to this safeguarding issue when assessing Jasmine's risk rating to determine her priority level for services.

9.9. This is consistent with the findings of a thematic review of Safeguarding Adult Reviews (SARs) by Professors Suzy Braye and Michael Preston-Shoot commissioned by the London Safeguarding Adult Board.[3] This found that when considering mental capacity in cases of self-neglect, reviews are critical of how practitioners have responded to the challenges of engagement, often taking at face value and leaving unexplored a person's reluctance to engage. Reliance on the notion of lifestyle choices came in for particular criticism.

9.10. Following the referral from Jasmine's solicitor in June 2019, seeking rehousing and support for Jasmine, the care leaving service properly identified that Jasmine may require a care assessment and referred the case to the 0-25 Service for assessment. It is unfortunate that at the point of Jasmine's death, staffing shortages within the service meant that it had not been possible to allocate the case for assessment. It is possible, though by no means certain, that Jasmine would have engaged at that point with an assessment, having made the initial approach for further support herself.

9.11. Again, it is important to draw from the lessons from the Board's SAR in respect of Sophie:

"An important part of effective mental health care is the assessment of risk and development of crisis and contingency plans that seek to understand signs and symptoms of relapse, and to predict and prevent relapse and personal crisis. At different stages in her life Sophie experienced relapses of illness, including

[3] https://www.local.gov.uk/analysis-safeguarding-adult-reviews-april-2017-march-2019

paranoia, anxiety, and depression; which she exhibited through challenging behaviours, and acts of self-harm. Despite this risk management plans to both minimise the way unavoidable change/challenges were presented and discussed with her, or how she could be best supported in a crisis, were not developed."

9.12. In Jasmine's case, a risk management plan was developed by the care co-ordinator and accommodation provider to support Jasmine to manage risks in respect of her mental health and diabetes. However, had Jasmine been presented to the multi-agency panel, this could have been a more comprehensive, multi-disciplinary plan, utilising the tools and resources available to the partnership.

9.13. System Finding

9.13.1. Issues of neglect of health needs and refusal to engage with services are poorly understood by practitioners within the context of self-neglect, and consequently opportunities to mitigate risks to the individual are missed.

9.13.2. The impact of trauma on cognitive abilities and executive decision making is poorly understood and this limits the value of mental capacity assessments.

9.13.3. Understanding of Care Act duties and mental capacity is not embedded in Children's Social Care and relevant training is generally considered specific to the Adult service. This impacts on practitioners' ability to respond to the needs of young people transitioning from Children's Social Care.

9.14. Recommendations

9.14.1. The Safeguarding Adults Board need to undertake work with front-line staff to understand how best to improve legal literacy in respect of the issue of medical self-neglect. This should explore whether Wandsworth's practitioners are overwilling to accept decisions to refuse assessments or services, without balancing respect for autonomy against proportionate risk reduction.

9.14.2. Multi-agency networks need to be used more widely to holistically assess capacity in complex areas such as the impact of trauma on cognition. Use of the Vulnerable Adults Multi-Agency Panel should be promoted across the partnership, to raise awareness with staff about this valuable risk management tool.

9.14.3. Training in relevant areas, such as Care Act duties, trauma and adolescent brain development, mental health and mental capacity should be joined-up between children's and adults' services, with practitioners from both areas attending training together. This will ensure a shared understanding of thresholds and responsibilities, and provide opportunities for professional networks to develop which can only strengthen working relationships across teams.

10. Learning Lesson 3: Cohesive services for individuals with co-morbid physical and mental health needs

10.1. The service Jasmine received in respect of her mental health and in particular, her diabetes, was marked by repeated discharges from services, which acted in a siloed way. Some of these relate to discharge from emergency services, her decision to attend different health care providers, her non-attendance at appointments, or the service transferring her care to another service, after another potential diagnosis was identified. In general, clear plans were in place in respect of Jasmine's treatment pathway and the transfers were well managed objectively.

10.2. Jasmine's experiences of trauma and limited social support are likely to have significantly impacted on her ability to navigate the array of appointments and services she needed to consistently engage with to safely manage her multiple health conditions. While frequent transfers maybe an inevitability for an individual with complex and emerging needs, there are two key practice issues.

Dichotomy between physical and mental health treatment

10.3. With the exception of the Eating Disorder Service, Jasmine's diabetes and mental health were generally treated as separate conditions, by services that acted independently of each other. However, the two were inextricably linked. Jasmine's diabetes, the pain she suffered through ketosis, repeated hospital admissions and daily injections would have impacted on her mental health and depression. Her depression will have impacted on her motivation to attend appointments and comply with her medical regime.

10.4. A multi-disciplinary health approach may have facilitated better treatment of Jasmine's holistic needs. Meetings between Jasmine's treating physical and mental health teams at key points of her care pathway would have promoted understanding of the interactions between her conditions and may have enabled issues such as her eating disorder or possible autistic traits to be identified more quickly.

10.5. It is unfortunate that although she was referred for an assessment to establish whether she was on the autistic spectrum in January 2019, funding for this was not agreed until June 2019 and Jasmine was on a 12-month long waiting list at the point she died. Professionals agreed that it would have assisted their understanding of Jasmine's needs and most effective ways to communicate and engage with her, had this possible diagnosis been confirmed or ruled out. Additionally, delays of this nature may have increased the likelihood of Jasmine disengaging from services when eventually offered a service, as her initial motivation to engage waned.

10.6. At the point that the Psychiatric Liaison Service referred Jasmine to the Eating Disorder Service, they zoned Jasmine as a green level risk, meaning that she had a lower priority for a service. It is unclear whether they had considered the more immediate risk from her mismanaged diabetes as well as the longer-term risk arising from her eating disorder. The impact of a mental health issue upon a physical health problem (and vice versa) can often be underestimated by professionals. The recent pilot that the Eating Disorder Service was involved with in respect of Type 1 diabetes and disordered eating that brings together diabetes and mental health care under one team presents as an ideal joined-up approach between mental and physical health services.

Disjointed transfer between health services

10.7. At most of Jasmine's transitions between services, the first service would discharge her immediately upon making a referral, without waiting to see whether she would engage with the new service, or whether they would accept her following assessment. This cycle of transfer and closure is likely to have exacerbated Jasmine's feelings of mistrust towards new professionals. A more person-centred and trauma-informed approach may have supported professionals to recognise the tension between Jasmine's wish to be healthy and her struggle to attend appointments.

10.8. The actions of the diabetes service at both hospitals, when Jasmine failed to attend appointments in August and September 2019 clearly reflects the limitations of this pattern of closing cases quickly. Rather than viewing her approach through the Eating Disorder Service as an opportunity to reengage with a hard to reach young person whose diabetes mismanagement was resulting in serious harm, the diabetes services focussed on her previous history of disengagement, and immediately closed her case upon non-attendance. This is understandable in a time of enormous pressure on resources – the time of specialist clinicians is extremely valuable, and missed appointments are a poor use of those resources. However, there is no record that either service tried to call Jasmine or engage with her in a manner that would be more appropriate for her age and mental health.

10.9. The approach of the Eating Disorder Service, which is accustomed to working with hard to reach patients, of making contact not just by letter, but following this up by telephone was good practice, and appears to have resulted in Jasmine being motivated (albeit inconsistently) to make appointments with other services to move her treatment forward.

10.10. However, use could have been made of other members of Jasmine's professional network, in particular her GP, who was managing Jasmine's diabetes in the community, requiring regular face-to-face contact. This could have been a valuable pathway to reengage with Jasmine. It is not clear whether the 'did not attend' letters sent by services to the GP resulted in any additional action or efforts to engage with Jasmine.

10.11. The transition worker provided by Children's and Adolescent Mental Health Services to support Jasmine to transition from children's to adults' services presented as an invaluable resource. There is clear evidence that Jasmine utilised this relationship to attempt to access an array of support that she required.

10.12. As an adult, Jasmine's care coordinator through the Community Mental Health Team had the role of coordinating the range of health and mental health services involved with Jasmine, advocating on her behalf in respect of further services she required such as accommodation and supporting her to engage with these services. The care coordinator was conscientious and considered Jasmine's care holistically. However, the Community Mental Health Team discharged Jasmine in late June 2019, which ended the role of the care coordinator.

10.13. This may have been premature in light of Jasmine's history of disengaging from new services. Although the referral to the Eating Disorder Service had been made, it was

unclear whether she would be offered a service, or whether she would engage with this if offered. Given the Jasmine had found the care coordinator's support helpful, it may have been beneficial for this role to continue until Jasmine was fully engaged with the Eating Disorder Service. In any event, the Eating Disorder Service and Family Therapy Clinic should have been invited to the discharge review to ensure that all relevant information was effectively shared, and to facilitate a holistic discussion of her needs. In particular, this would have ensured that these services were aware of the delayed referral for an assessment of whether Jasmine had autistic spectrum traits, which may have led to greater perseverance or a different approach to secure her engagement with the respective services.

10.14. Ideally, for people with co-morbid mental and physical health conditions, there would be a role equivalent to that of the care coordinator who would continue to support the individual across all areas of their health needs, even when an individual service has ended. This would be of particular benefit for young people who are unaccustomed to navigating the complexities of the adult health system and need additional support to engage.

10.15. System finding

10.15.1. Individuals with complex needs, particularly with co-morbidity with mental health or personality disorders, receive insufficient support to navigate their treatment pathway. The limited discussion between health disciplines results in an incomplete analysis of global health needs and a lack of holistic planning.

10.16. Recommendations

10.16.1. The Board to review how partners can improve liaison with high-risk individuals with complex needs to proactively support them to navigate the complex health and care systems, assist with engagement and reduce the likelihood of failed appointments.

10.16.2. Partners to develop a 'hard to reach' policy, setting out a multi-agency approach to effectively risk assess hard to reach individuals and identify how best to deliver any additional support they require. This should be linked to the Equality Act duties, so that where it is likely that individuals will find it harder to keep appointments because of a protected characteristic (i.e. disability or age), services understand the onus is on them to make reasonable adjustments in line with their professional duty of care.

10.16.3. The Board to seek assurance from health partners that they have clear policies in place for multi-disciplinary cooperation in cases where individuals have co-morbid mental and physical health problems, to facilitate holistic planning and risk management. Evidence should be sought that these policies are driving positive change to practice and patient outcomes.

11. Appendix: list of documents considered in SAR

11.1. Combined chronology
11.2. Root Cause Analysis report by Hospital A dated 6 January 2020
11.3. GP records from Jasmine's current and previous GP Surgeries
11.4. Housing file
11.5. Chronology, Internal Management Review and risk assessments from supported accommodation provider
11.6. Safeguarding Adult Review (Sophie) dated 23 April 2018
11.7. Child an Adolescent draft Adult Transition Protocol Policy and Improvement Plan
11.8. Preparing for Adulthood – Guide to Transitions (Council)
11.9. Department of Adult Social Services - Self-neglect and Hoarding Staff Guidance (Council)

[i] St George's Hospital
[ii] Chelsea and Westminster
[iii] SLaM