# ‘JAYE’
# SAFEGUARDING ADULT REVIEW (SAR)
# EXECUTIVE SUMMARY

Contents

## 1. INTRODUCTION

1.1. This summary describes the incidents and learning emerging from an independently led Safeguarding Adult Review (SAR) commissioned by the Leicestershire & Rutland Safeguarding Adults Board (SAB). This is in relation to Jaye who was 20 years old when she was found unconscious with a ligature on Unit X whilst an inpatient detained under the Mental Health Act 1983.

1.2. Following this incident Jaye was immediately transferred to an acute hospital, where she sadly passed away 2 days later.

1.3. The Independent Author of the Safeguarding Adult Review was supported in their decision making by safeguarding leads employed by the Local Authority, Health services and the Police, who are collectively referred to in this summary as the 'Panel'.

1.4. The Panel extend their sincere and heartfelt condolences to Jaye's family.

1.5. The purpose of a SAR is to undertake a multi-agency review process which seeks to determine what relevant agencies and individuals involved might have done differently that may have prevented harm or a death from taking place. The SAR does not re-investigate or apportion blame. The objectives include establishing lessons that can be learnt from how professionals and their agencies work together.

## 2. JAYE

2.1. In undertaking this SAR, Jaye's family were invited and agreed to contribute to the review.

2.2. Jaye's parents recall with fondness a young woman with a bold personality, reflected in her choice of hairstyle and vivid, colourful clothing, but who could also be thoughtful and sensitive. Jaye is also described as being very adventurous. Her family recalled that Jaye's autism gave her amazing willpower when working towards something she really wanted. Among her many interests, one constant was that Jaye loved animals, was dedicated to her dog, and intended to pursue working with animals.

2.3. Since her childhood, Jaye had lived with serious mental health difficulties and experienced periods where she engaged in prolific self-harm. As an in-patient at a Mental Health Unit (Unit X), Jaye had insight into her needs and expressed how no one seemed to understand that she had no skills to cope and her distractions were self-harm, ligature and cutting. She also stated that she felt that Unit X staff did not fully understand her autism, and she felt she would cope better once she was in her planned longer-term placement.

2.4. However, a theme that emerged throughout this review was that that Jaye's expressed insight into her needs may have led to the assumption that Jaye had the capacity to make decisions, and agencies responding to this assumption as if an assessment had taken place.

## 3. MEDICAL HISTORY & SELF-HARMING BEHAVIOURS

3.1. During childhood Jaye had been diagnosed with Asperger's (within the Autism Spectrum Disorder [ASD]).

3.2. Jaye had been under the care of Child and Adolescent Mental Health Services (CAMHS) since she was 13 years old.

3.3. There were multiple occasions, following escalation of serious self-harming behaviours, when Jaye was admitted as a CAMHS in-patient, including for a period of time on a CAMHS Intensive Care Unit.

3.4. By the age of 15-16 years old, Jaye had a well-established pattern of self-harming incidents which reflected how traumatic she found her day-to-day living. Furthermore, it became evident that her behaviour exposed her to risk of sexual harm and there were concerns for her online safety.

3.5. It was following several attempts of serious self-harm that agencies, including the Police, appropriately referred Jaye to Children's Social Care (CSC). This was in line with legislation including the Mental Health Act 1983 and Multi-Agency Safeguarding Procedures.

3.6. During her childhood Jaye lived with her parents in Local Authority X. When she was 12 years old the family moved to Leicestershire. Jaye had been subject to a Child in Need Plan with Local Authority X's Children's Social Care and a Multi-Agency Meeting took place with Leicestershire Children's Social Care to transition these arrangements.

3.7. To progress Jaye's transition from Children's to Adult Social Care (ASC), the Children's Social Care Social Work team made multiple attempts to contact the Psychosis Intervention Early Recovery Team (PIER). PIER is a specialised service providing assessment, support, and treatment to those aged 14-64 who are experiencing psychosis for the first time. The record suggests that the future of the Social Work staff in the PIER Team was under review and the future of the team was uncertain. The agreed action was that the PIER Team (Social Care) would progress the referral into their team if the team continued to exist. Children's Social Care was advised that, if the team were to be disbanded, the PIER Team Social Worker would undertake to refer to ASC, but the records did not establish how this arrangement was to be confirmed. This resulted in a lack of evidence on the case file to determine the level of liaison with ASC and the efficacy of any subsequent contact being made from ASC requesting reports, plans, or case summaries of Children and Family Service's involvement.

## 4. IN-PATIENT STAYS AND DISCHARGE INTO THE COMMUNITY 2014-2016

4.1. Leicestershire Adult Social Care confirmed that their involvement with Jaye began after her admission to Unit X in August 2014.

4.2. In late September 2014, Jaye was allocated to a Social Worker who remained her Social Worker until Jaye died. During this period, the Social

Worker also offered the family support and advocacy. The work the Social Worker undertook with Jaye and her family included enabling them to develop an understanding of Jaye's autism, her needs, and aspirations for the future along with the risk she presented to herself. In addition, the close working relationship with the parents enabled a good understanding of their concerns and the impact of Jaye's self-harm incidents upon them.

4.3. Jaye's first admission as an in-patient to an Adult Mental Health unit, Unit X, was in August 2014. Jaye was subsequently admitted for in-patient mental health care on 5 occasions, totalling 12 months up to Winter 2016. During her stays on Unit X, there were 62 self-harm incidents, including ligature events.

4.4. The Panel noted Unit X only escalated 50% of the 62 self-harm events as NHS Serious Incidents. This contravened NHS England Serious Incident Reporting Guidance (2015).

4.5. The incidents were not considered for discussion with Adult Social Care to assess the requirement for an Adult Safeguarding Enquiry (Section 42 Care Act 2014 enquiry).

4.6. In addition, the Panel noted that the only record of a Section 42 enquiry occurred after Jaye's death.

4.7. During her hospital admissions, Jaye was subject to a number of restrictions, including being restricted to the Ward and placed on close observations. Ward staff became aware that Jaye was not able to recognise her own triggers and that the ward setting was not the appropriate placement for her.

4.8. In June 2015, Jaye had been formally discharged into the community and back to live with her parents, with community support and treatment being provided by the PIER Team.

4.9. From this date until early 2016, Jaye's behaviour and well-being were supported and managed by the PIER Team within the community. However, by the middle of January 2016, Jaye's mental health had started to deteriorate.

4.10. By May 2016, Jaye's attempts at self-harm escalated to the extent that she was again admitted to Unit X, as an inpatient under the appropriate provisions of the Mental Health Act 1983. Jaye and her family agreed with the attending clinicians that Jaye would remain on Unit X to enable long term accommodation suitable to her needs to be located. Jaye's Social Worker and staff on Unit X were aware that Unit X was not a suitable placement.

4.11. This final period of Jaye's inpatient admission to hospital lasted 7 months. During that time, her patient records and other documentation record her frequently stated intention to take her own life. In addition, 105 incidents occurred of which 76 incidents were either serious incidents, adverse events, prevented patient safety incidents, near misses or safeguarding concerns. However, a significant number were not reported in line with requirements of the local incident and safeguarding reporting policy and procedures.

4.12. As Jaye had an Asperger's syndrome diagnosis since she was 15 years old, she was eligible for a Care and Treatment Review (CTR) by the relevant Clinical Commissioning Group (CCG).

4.13. CCGs are required to undertake CTRs for CCG commissioned placements for individuals with a diagnosis of Learning Disability (LD) and/or ASD, including Asperger's. This is detailed within 'The Care and Treatment Review: Policy and Guidance (NHSE 2015)', commonly known as the Transforming Care Programme.

4.14. The CCG undertook Jaye's CTR as soon as they received notification from Unit X in August 2016 that Jaye was an inpatient. The CTR acknowledged that Jaye was on the waiting list for a specialist bed. There was a national shortage of specialist beds; therefore, Jaye remained on Unit X.

4.15. In early Autumn, Unit X submitted an action plan to update the CCG with the progress against the recommendations made at the August 2016 CTR. The action plan did not indicate that risk assessments, including a risk assessment that incorporated Jaye's sexual safety, had been updated. As the action plan was submitted administratively, the absence of the risk assessments being completed was not identified and reported to the CTR Chair.

4.16. It is in this context that the CTR, which took place in August 2016, became the first opportunity to understand the risks surrounding Jaye and what measures Unit X had put in place to mitigate these to ensure her safety as a patient. The CTR panel correctly identified risks in the absence of up-to-date care planning and risk assessments. The CTR panel recommendations stated they were to be completed "As Soon As Possible'' (ASAP). The recommendations did not stipulate a date for completion so the lack of a completion deadline could have been interpreted as the action not being urgent.

4.17. In early Autumn 2016, whilst on Unit X, Jaye was subject to frequent intermittent observations and was found to have ligatured and was unconscious. This was correctly recorded as a Serious Incident (SI) with the completion date to be completed and reported to the SI Lead by mid-Autumn. The Serious Incident Lead requested the report in mid-Winter. By the time of the incident that led to Jaye's death in Mid-Winter 2016, this report was still outstanding. The learning from this SI may have greatly contributed toward decision making prior to home leave during the Winter of 2016. It is noted that further ligature attempts had taken place at the end during the lead up to home leave.

4.18. In late Autumn 2016 Jaye was assessed by an out of area specialist unit that could provide a bed suitable for her needs. A bed was not immediately available. However, funding was progressed by the CCG with a placement being secured and confirmed with a bed being available from January 2017.

## 5. DECISION TO ALLOW HOME LEAVE WINTER 2016

5.1. When considering the events that preceded Jaye's final home leave, it was found that Jaye was clear on her wishes and had been heard. Jaye was clear that she felt that Speech and Language Therapy Services understood her needs well and helped Jaye to try and develop ways, so that her needs could be shared with others involved in her care and treatment. Jaye and her named nurse completed the reduction of observation plan together in the Winter 2016 and it was captured within a large and colourful A3 personalised plan folder displayed on the wall in her room along with a countdown list of key dates and observation levels. The goals recorded were to reduce observation levels in order to have leave with family and abstain from self-harm incidents during the week.

5.2. However, the Panel considered the home leave plan was not comprehensive enough and there were too many gaps. The family had also made increased efforts to also feed in their concerns, after the plan had been formed. They were not given the opportunity earlier, to help formulate the plan.

5.3. The Panel also noted that the home leave plan had not yet been agreed by the Multi- Disciplinary Team and that the statutory home leave form was not signed.

5.4. The overall conclusion by the Panel is that the assessment of risk throughout Jaye's final stay in hospital, but particularly prior to her family leave, was inadequate and non-compliant with the expected standards. In light of this information, the Panel concluded that the planned home leave was not formulated in the best interests of Jaye, or her family.

5.5. Furthermore, Jaye's return to Unit X from home leave did not indicate that that potential risks were again properly considered when she returned or when risk information was shared.

## 6. RECOMMENDATIONS

- Recommendation 1
  Leicestershire & Rutland SAB should seek assurance that seamless transitional care arrangements for children to adult services incorporate the views of the person receiving care, that they consent to family involvement and, where this is given, reflect family inclusion.

- Recommendation 2
  Leicestershire & Rutland SAB should commission a review of available guidance and receive assurance that this reflects the various Independent Mental Capacity Advocates (IMCA) and advocacy services in the area, and that it is readily accessible by family members so that they can be aware of details of how and when challenge and/or escalation can be independently advocated within the Multi-Disciplinary Teams (MDT).

- Recommendation 3
  Where a person living with an Autistic Spectrum Disorder has complex mental health needs, records should reflect the MDT agreement on an identified named professional within the MDT who is best placed to coordinate care and be a key point of contact with other professionals and families, with whom they can share concerns or emerging risk factors. This named professional should be able to undertake appropriate advocacy and challenge, escalating concerns through the relevant routes. The named professional should be reflected within case records, supervision discussions and also clearly documented in the hospital passport when a person is admitted to hospital.

- Recommendation 4
  Leicestershire & Rutland SAB should commission a project group to steer current work on policies and procedures and training related to Mental Capacity Assessment (MCA) and develop an MCA Toolkit that can be adopted across all agencies. This will provide guidance to professionals working with people with learning difficulties and/or autism to plan for important moments in their lives to ensure assessments are undertaken and repeated appropriately and in line with prescribed timescales.

- Recommendation 5
  Leicestershire & Rutland SAB should commission a project group to determine how frontline staff are to be supported to confidently identify, record, refer and share appropriate safeguarding information. This activity should include specific reference to consideration of adult sexual safety and harm reduction and clear guidance on mental capacity. Where this is identified as a concern, assessment and referral should be through the pathway defined within the Historical Abuse Flowchart. Referrals related to adults through this pathway are to be monitored so the Leicestershire & Rutland SAB is assured this approach is embedded in practice.

## 7. DEVELOPMENTS THAT HAVE TAKEN PLACE SINCE JAYE'S DEATH

7.1. Throughout the review, the Panel noted that a number of significant improvements have been implemented following Jaye's death. These include:

- Unit X have made progress in the development of an Autistic Spectrum Disorder (ASD) strategy, which aspires to meet all the recommendations in the Autism Act 2009.

- Unit X have made progress in the development of face-to-face bespoke ASD training for frontline staff to access.

- An ASD briefing sheet has been completed and disseminated within Unit X so that all staff will be reminded of best practice requirements and learning from this review when an individual with ASD is admitted to the ward. This is aimed to ensure that, when staff are caring for an individual with ASD, they are reminded to seek advice on how to manage their environment to make the

patient's experience less stressful. The aim of this activity is to ensure that care plans are adapted to meet their unique ASD needs.

- MCA training is being refreshed by Unit X to reflect the learning from this review. This includes the key message that, if a patient (formal or informal) is making or considering making unwise decisions, staff should not assume they have capacity. Instead, they need to assess to see if they have capacity, and this may need to be done on a number of occasions during their stay. Staff are also being encouraged to access training on MCA and ASD, so they are more informed.

- Unit X are piloting a sexual harm reduction programme and staff are receiving communications to support their recognition that, when a patient is vulnerable and is at risk of being sexually harmed, they are to "think safeguarding" and obtain advice from the Unit X Safeguarding Team.

- Unit X have also revised their supervision policy and approach so that it clearly reflects a review of case management and recording to enable critical reflection and professional empathy.

- The Serious Incident Reporting Framework has implemented a tracker system to ensure that all reviews are undertaken within prescribed timescales. It also ensures that there is a review of frequent incidents to identify if any further action is required.

- Care and Treatment Review (CTR) Chairs have been reminded to ensure actions are recorded with clear timescales; managers have been reminded of the importance of early referral to the CTR process and the CTR process is now being audited.

- Unit X will ensure that all staff have received the Autism strategy and supporting guidance.

- Safeguarding leads from Adult and Children's services now meet on a 3-monthly basis to establish a clear line of communication to assist working relationships between Adult and Children's services to ensure smooth transition planning and, where necessary, resolve any emerging issues.

7.2. These developments were shared with Jaye's Mum and Dad who advised Jaye wanted to be sure that professionals would have a better understanding of how to care for a patient who had both mental health needs and a diagnosis of ASD. They advised that they felt reassured and noted that Jaye would agree "that steps have been taken based on what issues were identified, and what needed to change as part of the review and how this had been addressed across partners".

## 8. CONCLUSION

8.1. This review highlighted the lack of bed availability at a national level for young women with ASD and complex mental health needs, particularly for beds in highly specialist units that have so few beds. The review also

recognised the complex challenges faced by practitioners who support those with mental health needs, ASD and/or learning difficulties. This is particularly the case when a lack of suitable placement makes worse those challenges as the person struggles to manage when inevitable changes are delayed, and they struggle to adjust to the pace of change or lose hope that it will happen.

8.2. There was evidence within the review that highlighted the need to consider if ASD patients require reasonable adjustments to ensure ward life does not cause sensory overload and re-traumatisation due to over-stimulation within the ward environment. Jaye tried to communicate her needs to ward staff to support their consideration of reasonable adjustments and her efforts were not consistently recognised. Although some ward staff advocated on Jaye's behalf and escalated concerns shared by Jaye's family, this review highlights the need for an agreed key worker or IMCA to advocate on an individual's with ASD behalf so that decisions and care management plans reflect their voice and experience.

8.3. This review reminds us that, if a person is making or considering making unwise decisions, we should not assume they have capacity to make decisions. Instead, we need to assess the individual to see if they have capacity, and this may need to be done on a number of occasions during our contact with them.

8.4. In relation to sexual safety, the review also reminded us that safeguarding vulnerable people requires us to be confident in recognising when capacity needs to be assessed. A referral should be made where someone who is vulnerable may be at risk of sexual harm, so their safeguarding needs can be addressed. Recording those assessments enables us to evidence that we have made informed decisions that incorporates their voice or the voice of their family, when making best interest decisions. The review also highlighted the importance of timely referral to the Care and Treatment Review (CTR) process, at the earliest opportunity, to ensure capacity, needs, vulnerability and safety are holistically considered in the coordination and ongoing provision of patient care.