NOTTINGHAMSHIRE SAFEGUARDING ADULTS BOARD

silp™ Significant Incident Learning Process

OVERVIEW REPORT – EXECUTIVE SUMMARY

SAFEGUARDING ADULTS REVIEW

SIGNIFICANT INCIDENT LEARNING PROCESS

Adult H

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1. Introduction

1.1. Adult H is a confident young person who lives with her mother and siblings. Adult H has a diagnosis of Spina Bifida and Hydrocephalus. She has close relationships with her mother and sister, who have provided support to her to remain within the family home over the years, although this support is now provided by professionals at Adult H's request.

1.2. A safeguarding adults referral was made by the Ambulance Service and also Hospital 1 after Adult H had been found by her family with severe burns indicative of urine burns. A strategy meeting was held during which Adult H was described as having 14% skin loss and chronic wounds. After an extended period in hospital Adult H returned home with a significant package of care.

1.3. Adult H's consistent desire to return home and be as independent as possible have been respected. There is no evidence she lacks capacity and the police had no legal grounds to pursue an investigation and the council, similarly had no legal power to prevent her from returning home.

2. Summary of the Facts

Adult H

2.1 At school, H made some good friendships and largely managed her own self care. Her attendance was very poor. In Year 9 it was only 3.2%, in Year 10 17.5% and in Year 11 with a multi-agency approach and support it increased to 62%. She did make progress academically as her attendance increased, although she had missed some fundamental building blocks of learning throughout her education. Upon leaving school she had a reading age which was 4 years behind her chronological age.

2.2 At college H was always well presented, clean and happy to be in the same class as her sister. Her sister took care of some of her support needs, including her personal care and getting her around as a wheel chair user. Her sister made sure H had something to eat and drink and supported her to and from transport. Overall, H always seemed happy to be at college and would have a joke with everyone in her sessions. Staff have described H as a pleasure to work with and support.

3. Themes

3.1 The following have been highlighted as themes within this review :

- Transitions
- Non-engagement
- Support
- Capacity & Choice
- Invisibility/Preventability
- Previous Safeguarding Adult Reviews

4. Good Practice

4.1 There were elements of practice which made a difference in this case and there is equal learning to be derived from these as from the shortcomings in practice. Of the utmost importance in cases where there is a high level of non-engagement, persistence is often the only way to make those inroads, however, small they may be. The Education Welfare Officer involved prior to the scoping period was certainly an example of this, and was even described as 'dogged' in the face of the challenges they faced in relation to non-engagement. Good inter agency working is evidenced between the Education Welfare Officer and the School Nurse.

4.2 The work undertaken with Adult H to ensure she was supported in college should also be recognised. Grouping her with her sister to provide that support seemed significant and the college managed to keep her engaged and applied to her work. It is not known if this had a negative impact on her sister.

4.3 When Adult H arrived in the emergency department multi-agency working was evident alongside treatment being provided in a timely way with decisions being made in her best interests. However, as she regained capacity she became less compliant with treatment. Whist this presented professionals with dilemmas, her views were respected and care and treatment were provided within the parameters of compliance. There was good information sharing between this hospital and the GP regarding missed appointments prior to the incident. It is documented that the GP made an unannounced home visit, which is also good practice.

4.4 During her stay in Hospital 2 this theme continued. Professionals used a variety of strategies to keep H engaged and persisted in the face of high level non-engagement to deliver a high standard of treatment, to which H responded well. Having the longer stay here, the strategy of taking time, establishing relationships and building rapport described by research as so crucial in self-neglect cases had an important impact here. The multi-agency approach to discharge planning and the levels of commitment and persistence that have been put into implementing that plan by all those involved has been considerable. H's wishes and feelings have been prioritised throughout.

5. Improvements Already Implemented

5.1 The developments of most relevance to this review are the development of the new Transitions Team, the establishment of non-attendance policies in respect of missed medical appointments, Think Family meetings in the GP surgery and the regular meetings held by occupational therapists.

6. Conclusions and Lessons Learned

6.1 There is little doubt that the approach taken by services involved with H as a child set the blueprint for interventions beginning at the start of her adult life. During her transition to adult services, the issue of extensive lack of attendance for medical appointments received insufficient focus. This was largely due to a poorly organised transition process during which inter-agency working was minimal, with a lack of clarity around who should take the lead role.

6.2 At every stage, the system seemed disabled by the family's non-engagement. The introduction of 'DNA' or non-attendance policies across Nottinghamshire hospitals failed to have any impact in respect of non-engagement which continued after their introduction in 2009. There were individuals who tried to escalate their concerns about how this may have been impacting on H, but this process of referral/escalation failed to produce any discernible results.

6.3 The GP held information which was not 'unlocked' by inter-agency working or discussion. Agencies saw the GP as the central hub for information and a valuable learning point emerged within this review. It was discussed that a GP would need a reason to share information, either with other health professionals, or across agencies such as education or social care. This had not been fully appreciated by all those involved, meaning there was a perception that some information was being acted on by the GP when this was not the case.

6.4 Professionals have reflected that greater curiosity and assessment may have achieved improvements in terms of how the case developed. There was less recording of H's voice than would be expected and she was rarely spoken to without her mother by some agencies, but professionals were listening and responding to her expressed wish for autonomy. The lack of curiosity prevailed around the times of transition and the first safeguarding referral, when more work with H and her family would have led to a better understanding of how to extend or improve on service provision. It cannot be said with any certainty that this would have prevented H from becoming lost to services, but nevertheless these were missed opportunities to build relationships and encourage H and her family to place higher priority on ensuring her health needs were met.

6.5 There were times when there may have been some benefit from assessing H's capacity more regularly, although these pre-dated the scoping period. Professionals have debated during this review whether H had become depressed as a result of the relationship breakdown. Of greatest significance for Adult H would have been an agency who could have reached her during her period of 'invisibility'. H's mother was successful in evading professional contact in the form of the school 'NEETs' (Young Person Not in Education, Employment or Training) visit and contact with the GP surgery. It is impossible to say whether the adult community nursing team may have uncovered the reality of H's situation via their assessment process.

6.6 From the point of the second safeguarding referral to the end of the scoping period, the responses were timely, appropriate and sensitive, with capacity being assessed and re-assessed in the light of changing circumstances. Relationships have been built over time, despite this having not been easy in many instances. There is now reason to be optimistic that agencies have developed the mechanisms to work together following this tragic occurrence to recognise at an early stage if H is likely to relapse and it is hoped, to take appropriate action.

7. Recommendations

Recommendation 1

Nottinghamshire Safeguarding Adults Board should review the measures that are in place to ensure families of young people transferring to adult services are offered a carers assessment where appropriate.

Recommendation 2

Nottinghamshire Safeguarding Adults Board should introduce a multi-agency Self-Neglect policy. In developing this it should consider the evidence base in favour of the role of a lead professional, timely and appropriate capacity assessments and multi-agency arrangements for shared/single assessment process.

Recommendation 3

Nottinghamshire Safeguarding Adults Board should produce a multi-agency escalation policy. Links could be made to that of the Nottinghamshire Safeguarding Children Board in this regard.

Recommendation 4

Nottinghamshire Safeguarding Adults Board incorporate the issue of working in the context of service refusal into its current multi-agency training offerings and the competency framework. The Board should seek assurance from relevant agencies regarding the advice and / or guidance staff receive as to what is required of them when working with service refusal.

Recommendation 5

Nottinghamshire Safeguarding Adults Board should share the learning from this review with the Nottinghamshire Safeguarding Children Board. This should ideally involve some workshop activity to highlight important areas of learning.

Recommendation 6

Nottinghamshire Safeguarding Adults Board should make arrangements to disseminate key messages from this review as widely as possible, including:-

- Persistence in re-referring cases
- The right person to do a capacity assessment
- Understanding the absence of adult DNA policy and the particular need to share concern around 16 year olds with complex health needs
- The importance of speaking to service users alone and not in the presence of potential perpetrators or those exerting influence & encouraging use of advocacy
- The tensions between what actions practitioners expect to see taken & the limitations of guidance and the legislative framework on self-neglect eg police not pursuing a prosecution where there were no legal grounds to do so.

APPENDIX A

Nottinghamshire Safeguarding Adults Board

CASE REVIEW

TERMS OF REFERENCE & PROJECT PLAN

SUBJECT: Adult H

Version 2: 29.06.2016

1. Introduction:

1.1 This Learning Review is commissioned by Nottinghamshire Safeguarding Adults Board in response to concerns around missed opportunities to engage with Adult H and her family both in her childhood and early adulthood.

1.2 A safeguarding adults referral was made in relation to possible neglect of Adult H by East Midlands Ambulance Service after she had been found with severe burns indicative of urine burns. Adult H has a diagnosis of Spina Bifida and Hydrocephalus. A strategy meeting was held during which Adult H was described as having 70% burns form the chest downwards and multiple pressure sores. After an extended period in the Intensive Therapy Unit Adult H returned home on a significant care package.

1.3 Adult H's consistent desire to return home and be as independent as possible have been respected. There is no evidence she lacks capacity and the police have not pursued an investigation and the council would have no legal power to prevent her from returning home.

1.4 Nottinghamshire Safeguarding Adults Board is keen to establish how information sharing could have been improved to result in earlier intervention in Adult H's life. The Board has also noted similarities with previous reviews undertaken both by the NSAB and nationally and wants to explore whether practice has changed and lessons learned.

2. Legal Framework:

2.1 The Care Act 2014 states that Safeguarding Adults Boards (SABs) must arrange a Safeguarding Adults Review (SAR) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult. SABs must also arrange a SAR if an adult in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect.

In addition to the above SABs might select cases for either of the reasons noted in the statutory guidance:

1. Where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults
2. To explore examples of good practice where this is likely to identify lessons that can be applied to future cases.

2.2 The purpose of the SAR is to promote effective learning and improvement action to prevent future deaths or serious harm occurring again. The aim is that lessons can be learned from the case and for those lessons to be applied to future cases to prevent similar harm re-occurring.

3. Methodology:

3.1 This Case Review will be conducted using the Significant Incident Learning Process (SILP) methodology, which reflects on multi-agency work systemically and aims to answer the question why things happened. Importantly it recognises good practice and strengths that

can be built on, as well as things that need to be done differently to encourage improvements. The SILP learning model engages frontline practitioners and their managers in the review of the case, focussing on why those involved acted in a certain way at that time. It is a collaborative and analytical process which combines written Agency Reports with Learning Events.

3.2 This model is based on the expectation that Case Reviews are conducted in a way that recognises the complex circumstances in which professionals work together and seeks to understand practice from the viewpoint of the individuals and organisations involved at the time, rather than using hindsight.

3.3 The SILP model of review adheres to the principles of;

- Proportionality
- Learning from good practice
- Active engagement of practitioners
- Engagement with families
- Systems methodology

4. Scope of Case Review:

4.1 Subject Adult H:

4.2 Scoping period:

August 2013 (Adult H's 18th birthday) to January 2016 (date Adult H was discharged from hospital)

4.3 In addition agencies are asked to provide a brief background of any significant events and safeguarding issues in respect of Adult H, including a summary of historical missed appointments and an account of her preparation for transition. This will include any significant event that falls outside the timeframe if agencies consider that it would add value and learning to the review.

5. Agency Reports:

5.1 Agency Reports will be requested from all agencies involved with the care and support of Adult H

Agency list not listed due to confidentiality.

6. Areas for consideration:

6.1 Please summarise the approach that was taken to Adult H's historical missed appointments/non-compliance?

6.2 Please critically evaluate the arrangements for transition between children's and adult services, taking into account 4.2 above in terms of preparation for transition.

6.3 Could communication and information sharing have been improved post transition in light of Adult H's continued pattern of missed appointments/non-compliance?

6.4 How well was the family supported to support a young adult moving to independence?

6.5 What was the professional view of Adult H's understanding? What impact did this have on service provision?

6.6 How visible was Adult H to any agency from early June up to her admission to hospital in August 2015?

6.7 Identify examples of good practice, both single and multi-agency.

7. Engagement with the family

7.1 A key element of SILP is engagement with family members, in order that their views can be sought and integrated into the Review and the learning. NSAB has already informed the family that this Review is being undertaken. The independent lead reviewer will follow up by making contact with Adult H, who will be consulted on the terms of reference for the review.

7.2 Further contact will be made to invite Adult H to participate in the form of a home visit, interview, correspondence or telephone conversation prior to the Learning Event. Adult H's contribution will be woven into the text of the Overview Report and she will be given feedback at the end of the process.

8. Timetable for Case Review:

Scoping Meeting	21 June 2016
Letters to Agencies	1 July 2016
Agency Report Authors' Briefing	18 July at 10.45am
Engagement with family	Begin July 2016 once authorised
Agency Reports submitted to NSAB	16 September 2016
Agency Reports quality assured by chair	16-21 September 2016
Agency Reports distributed	21 September 2016
Learning Event	28 September 2016
First draft of Overview Report to NSAB	21 October 2016
Recall Event	3 November 2016
Second draft of Overview Report to NSAB	9 November 2016
Presentation to NSAB Sub Group	17 November 2016