7-minute Learning Summary

Safeguarding Adults Review – Sophie

Richmond and Wandsworth Safeguarding Adults Board

Case Summary

Sophie was a young woman who had been in care from the age of 14. This review covers the period of her care from transition to adults services at the age of 18 through to her death at 19 when she was living in a residential setting in Richmond.

From her teenage years, Sophie suffered from mental health problems and at a young age received a diagnosis of bipolar affective disorder and depression and atypical autism. Sophie had a history of self-harming and it was well known that she found change particularly challenging. She had difficulty in expressing her feelings and displayed disproportionate behavioural responses to interruptions in routine or stressful situations. After an initial settling in period at the care home, Sophie flourished, her self-esteem and confidence grew. She started volunteering and developed strong friendships with the other residents. Profound unilateral changes were made to the way care was delivered in the home during January 2016 and the staff group changed dramatically. Residents and families raised concerns with the Care Quality Commission (CQC), who liaised with the local council. Over the next few weeks, Sophie became more unsettled, her friends were either moved out of the home, or were admitted to hospital. Sophie remained in the home with only one other resident. In May 2016, she took her own life.

Lessons

1. The importance of ***better joint working*** between agencies and the role of placing authority's in maintaining an active and ongoing relationship with service users, providers and partners to have a clear picture of changing needs of service users.
2. In ***transitions,*** all agencies need to work together to effectively support and protect vulnerable young adults.
3. The lack of a systematic multi-disciplinary individualised ***risk management strategy*** for resident's places them at unnecessary risk. Situations will inevitably arise that trigger crisis, if these are not explicitly discussed then are less likely to be responded to in a timely and appropriate way; in a worst-case scenario, they can be inadvertently made worse in the way they are handled
4. The absence of safeguards preventing unilateral change in provider's delivery systems, allows providers to make changes based on organisational needs at the expense of person centred care. This needs to be addressed ***contractually*** to avoid it happening.
5. Effective multiagency ***person-centred transition planning*** is essential to help young people and their families prepare for adulthood and should support relapse prevention and crisis contingency planning.
6. The lack of a ***comprehensive care plan*** that covers all aspects of a resident's needs for when they are both well and in relapse, can result in their vulnerability being increased due to inappropriate decisions being made and or left to chance.
7. When delivered appropriately a ***person-centred care plan*** offers young people the best opportunity and chance to function to their full potential. Operating in an environment where care delivery is devolved adult social care must ensure that the care plan is clear and providers are held accountable for its delivery.

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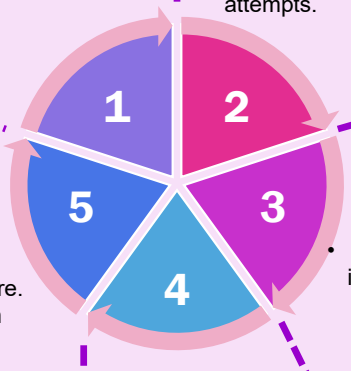
Safeguarding Adults Review Sophie

Multi-agency working in the context of out of borough placements and working with young people in transitions

- The Adult Mental Health team liaised with the provider to arrange the placement. There was no account taken of the fact that Sophie was just 18 years and vulnerable.
- The Leaving Care Team was involved with Sophie and supported her during the move. There was no contact between the placing Council and the receiving mental health trust to advise them of Sophie's move into their service.
- Each agency (Leaving Care Team, Mental Health Trust and placing council) undertook their activities in isolation from one another.

Working together to protect individual residents to predict and manage personal crisis

- At different stages in her life, Sophie experienced relapses of illness, including 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. The Mental Health Trust has now developed crisis collaborative plans that cover predictable risks.
- It was predictable that any move would be difficult and challenging for Sophie. Despite this, there was no multiagency plan about how the information should be shared and how she would be supported during the move. When Sophie displayed distress at the prospect of a move, there was no multi-agency plan on how to mitigate these risks.
- The multi-agency network was focused on the organizational safeguarding concerns but did not consider how moving residents would impact on their mental health. Other residents experienced crises during this period, two of whom were admitted to hospital following suicide attempts.



Person-centred care for adults in a placement

- The quality of care provided to Sophie when she was under 18 was good: her needs were well documented by Children's Social Care.
- The Leaving Care Team worked with Sophie to develop a comprehensive Pathway Plan, tailored to her needs including vocational work and Recovery College.
- Sophie moved to an adult care home without visiting it before moving in.
- There was no continuity of contact from professionals who knew Sophie during the first month of her placement, other than her Leaving Care Professional Advisor.
- There was no contact between agencies to build a picture of Sophie's progress and wellbeing through transition.
- There was no care plan which could have provided a reference point to include all aspects of her care.
- The benefits of a CPA approach were not fully utilised through the development of a shared plan to support Sophie and the agencies that supported her to deliver comprehensive and coordinated care.
- Sophie was not involved in the decision to move and neither was this discussed with the agencies who worked closely with her and knew her well. The placement review officer spoke with her parents, against her previously expressed wishes, and at no point was an advocate offered to her to help her better communicate her wishes and needs.
- The lack of communication between the provider, mental health trust care coordinator, Leaving Care PA and placement review officer meant that insight and knowledge about Sophie within the system was not maximised.

Contractual safeguards to prevent unilateral service decisions being made by a provider

- Changes made by the provider resulted in profound changes to the nature of care delivery. Neither the proposal to make changes nor the actual changes in care delivery were communicated to placing authorities, nor did any consultation take place about the potential impact on residents.
- Residents and families were unaware of changes being proposed. These changes resulted in the provider not being able to deliver on their service offer to the placing authorities. Only when complaints were made to the CQC did the host and placing authorities become aware of the changes.
- Placement agreements (contracts) are silent on what should happen when a provider changes its model.

Personalised care planning that reflects the precariousness and complexity for adults with mental illness

- During her time at the care home Sophie experienced times of stability and achievement as well as times of emotional adversity.
- At time the provider undertook activities which amounted to a deprivation of liberty by crushing Sophie's medication and ensuring she was always accompanied when she left the home. These decisions were made out of concern for Sophie's wellbeing but without her explicit consent or involvement.
- When the staff in the home were seriously concerned about Sophie's mental state a phone call was made to the emergency team who advised that she be taken into hospital; this was misunderstood, and she remained in the home.