7 Learning

- Team around the Adult processes and the VIP Front Door project frequently improve outcomes for individuals and should have been considered.
- There should have been better documentation around capacity and JN's understanding of the risks associated with her behaviours.
- Guidance for non-medical professionals on the actions that they should take in relation to suicidal ideation would be helpful in promoting consistent access to services.
- Where there is a history of non-engagement, professionals should be alert to the potential for the escalation of untreated illnesses. The identification of supportive friends or family can be helpful in engaging with reluctant clients.
- Mandatory management oversight of case closure in Adult Social Care can ensure that clients who choose not to engage are supported in the best way possible for an appropriate time period.
- The observation of a period of stability and consultation with other agencies prior to the closure of a case is likely to lead to better client outcomes.
- Effective case coordination and the enhanced ability to escalate where necessary is likely to ensure that a client has the best outcome possible and provides opportunities for professionals to work together in a co-ordinated approach.

6 Further Findings

The participants at the learning review felt that, in retrospect, the formation of a Team Around the Adult may have proven beneficial in creating clearer communication and cooperation between agencies, as well as identified self-neglect. JN was adamant that she did not want the situation discussed with her husband, however participants felt more effort could have been made to employ JN's friends in the cause. Concern was also raised that no agency escalated JN's lack of engagement until just before her death.

5 Findings – Working in Isolation

The learning review raised concerns on the lack of effective case coordination. For example, colleagues from Psychological Medicines and the TPA were not aware of each other's involvement with JN until the review. Furthermore, both the TPA keyworker and social worker closed JN's cases around the same time without consulting each other. The learning review found that although both decisions were justified within the remit of their organisations, if they had consulted each other a different decision may have been made regarding withdrawing their service engagement. The review also found that the Adult Social Care worker did not raise the closing of JN's case during supervision sessions and as such the decision was not subject to management approval or peer review. Throughout this period the Direct Payment team at ASC had oversight of JN, but JN would not engage with them despite repeated attempts.

Links:

Response to physical health concerns for non-professional staff

MAARS Process

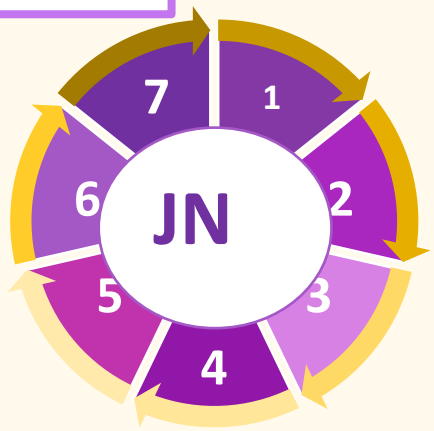
https://www.turning-point.co.uk/

Self-Neglect Strategy & Guidance

Escalation Policy

1 Background

JN was a Manchester resident who died in 2019 due to Ketoacidosis, alcohol related liver disease and cardio myopathy. Although JN's case did not meet the SAR criteria, questions raised by the family prompted a learning review which provided valuable insights.



4 Communication and Documentation Process

A number of agencies were involved in providing support to JN and there were examples of good practice by all as well as inter-agency working to engage with JN. However, there was little overall coordination, which resulted in some agencies not being aware of the role of others in supporting her. JN reported to ASC she was having suicidal thoughts. JN's GP did subsequently make contact to address this issue, but JN declined the appointment as it conflicted with her detox session. As part of the learning review, some Health professionals felt concern over sharing information on JN with other agencies if there was no legal requirement. It was also noted that most of the professionals involved with JN were reliant on communicating with her on the phone, rather than making physical visits which may have provided more information in to her wellbeing or actively encouraged participation in services. Although several agencies deemed JN to have capacity and have awareness of the risks of her lifestyle choices, this was rarely formally documented. The above is indicative of some of agencies 'working in isolation' and not sharing information when working with JN.

2 Context and Initial Treatment

JN was a corporate professional, mother and wife who had historically been a perpetrator in several domestic abuse incidents and had served a short prison sentence for drunk driving. Whilst on holiday in 2015, JN became ill and injured to the extent that her mobility was severely reduced. JN's relationship with her husband became dysfunctional so a decision was made for her to move out of the family home to private accommodation. She subsequently became reliant on benefits and began to misuse alcohol which resulted in accidents in the home. JN also reported being threatened by her husband's family to the police.

JN was offered a range of services to support her needs, including those offered by Adult Social Care (ASC), TPA and Psychological Medicines. Collectively these should have allowed her to continue to live independently. JN was deemed to have capacity, and the ability to make her own choices on how she led her life

3 Further Treatment

In March 2019 JN was scheduled to attend a two-week detox session. After instances of JN claiming to not feel well enough to attend or over-sleeping, JN finally attended and completed the course. However, this set a precedent for further non-engagement from JN with services. JN chose not to complete her detox after-care plan and claimed she felt well enough to continue on her own. Her case was closed to the TPA, but by June, JN had started drinking excessive amounts of alcohol again. JN's GP denied a request from her for a prescription of sedatives due to it being potentially dangerous. Apart from this, JN continued to not engage with services or attend appointments. Most of the contact between JN and services was made by phone. In mid-August 2019, JN told a pathfinder keyworker that there was blood in both her vomit and stool. She was told to seek medical assistance. This was the last professional contact JN received before passing away. Given JN's known non-engagement in services it would have been reasonable to have reported JN's relapse into significant alcohol consumption and ill health as a safeguarding concern, but this did not happen.

7 Minute Briefing

Safeguarding Adults in Stockport