# Safeguarding Adults Review - Sophie

Lorraine Stanforth March 2023

## Contents

## Introduction:

*1.1.1* This is an Overview Report of a Safeguarding Adult Review (SAR) following the death of Sophie an 18-year-old vulnerable young woman at North Middlesex University Hospital (NMUH) 15th November 2017.

1.1.2 Section 44 of the Care Act 2014 places a statutory responsibility on Safeguarding Adult Boards' (SAB) to conduct a SAR into certain cases under certain circumstances. A SAB is required to arrange a Review where there is reasonable cause for concern about how the SAB, and its members or some other person with relevant functions involved in the case worked together and either the adult at risk died and the SAB knows or suspects that the death resulted from abuse or neglect. Or, the adult is alive, and the SAB knows or suspects that they experienced serious abuse or neglect.

1.1.3 In this case, the Enfield Safeguarding Adults Partnership in consultation with partners from the local authority, the London Borough of Haringey (LBH), North Middlesex University Hospital (NMUH) and the Metropolitan Police Service (MPS) concluded that a SAR should be conducted as the criteria under s44 was met.

## Case Summary

1.2.1 Sophie received care and support from the LBH who held social work care management responsibility for her. A SAR referral was raised 15th March 2018 by NMUH to the London Borough of Enfield (LBE), the host authority, who retained adult safeguarding responsibility as Sophie lived in the LBE area. The referral provided a short history of Sophie .

1.2.2 At 16.5 years old, Sophie left her childhood home in Northamptonshire after a breakdown in the relationship with her mother to live with a friend in London. At that time, she had a named social worker in Corby Borough Council, but her social work case was closed when she moved to London. There was no transfer arrangement made.

1.2.3 She subsequently became homeless and sought support from the LBH who initially found her to be ineligible for support her with accommodation and finances. A legal challenge was initiated on her behalf based on her health and vulnerability as a young person, and she was provided support through s20 and s17 Children Act1989. Upon attaining 18 years of age, she was moved to temporary accommodation in the LBE. LBH Children & Young People's Services transferred social work responsibility to LBH Adult Social Care (ASC) and she was subsequently supported by the LBH Young Adults service.

1.2.4 Sophie had a history of numerous hospital admissions because of her diabetes. Her final admission was in November 2017 with arterial thrombosis, signs of heart problems and diabetes.

1.2.5 There were several concerns raised that Sophie might have experienced sexual exploitation and had substance and alcohol misuse issues. She admitted to using cannabis and was frank about the amount of alcohol she consumed, which was considerably over the recommended limit for anyone with diabetes and placed her at higher risk of experiencing a hypoglycaemia attack.

1.2.6 Adult safeguarding concerns were raised to LBE followed up via a discussion with Sophie who did not see herself as vulnerable or exploited. She was also assessed to have the mental capacity to make her own decisions. None of the safeguarding concerns progressed to a s42 Care Act 2014 safeguarding enquiry.

1.2.7 Sophie received medical treatment from the paediatric diabetes team based at NMUH who raised several concerns with social care about her lifestyle and non-compliance with medication. This together with concerns about her lack of finances and access to state benefits, and the raised safeguarding concerns led to an adult social worker being assigned from LBH adult social care services.

1.2.8 From the time Sophie came to London she had a history of several London hospitals admissions with diabetic ketoacidosis. The hospitals included St. Bartholomew's, The Royal London, The Whittington, Whipps Cross University Hospital and North Middlesex University Hospital.

1.2.9 Her last hospital admission was to North Middlesex University Hospital on 10th November 2017 diagnosed with a chest infection, diabetes, and tachycardia. On 12th November 2017 she was short of breath and experienced breathing difficulties. On 15th November 2017 she went into cardiac arrest and sadly died.

1.2.10 A post-mortem was held 24th November 2017. Sophie 's death was recorded as Diabetic Ketoacidosis (DK) and treated pulmonary embolism. The reason for the post-mortem was that she was previously admitted because of two large clots in her lungs but had refused to stay in hospital. The post-mortem concluded the clots had responded positively to treatment.

## Purpose of Review

1.3.1 The purpose of this SAR is to identify where:

- lessons might be learned to improve practice with adults at risk from an analysis of the decisions and actions taken by individuals and organisations working with Sophie .
- there are examples of good practice measured by national standards that can be shared across the Safeguarding Adults Board partnership.
- procedures might have failed, and Sophie 's death gives rise to serious concerns about the way in which local professionals worked together to safeguard Sophie and;
- preventative measures might be taken in future to safeguard adults at risk

1.3.2 The terms of reference for this SAR are partly taken from a meeting held 5th July 2018 chaired by the then independent Enfield Partnership Safeguarding Adult Board chair.

1.3.3 The Review aims to be accessible to a wide audience. It will be measured against the Social Care Institute for Excellence (SCIE) and Research in Practice for Adults (RiPfA) standards and be proportionate and transparent. Above all it is intended to focus on learning and not apportion blame. The Enfield Safeguarding Partnership Board is committed to learning and sharing all SAR's in full abiding by common understanding of confidentiality by anonymising names of individuals in the published report.

1.3.4 The methodology for this SAR adopts a hybrid approach. This includes:

- Significant Incident Learning Process (SILP) exploring with practitioners why decisions and actions took place at the time of the event
- Analysis of Individual Management Reviews (IMR)
- Round table discussions
- Active engagement of practitioners and managers to learn of actions and improvement plans to prevent future safeguarding incidents
- Records of the impact of any remedial action taken following the death of Sophie

1.3.5 The Care Act 2014 allows for SAB's to conduct a SAR within 6 months of the referral. In this case there has been considerable delay due initially to the fact that the referral was sent in error to the LBH; commissioning an overview author; and latterly disruption due to the national Covid-19 pandemic. The report was commissioned in June 2020 and completed December 2020.

1.3.6 The Young Adults team were the assigned service from social care at the time of Sophie 's death. They remained in contact with the mother who was in receipt of support from her GP who had referred her for bereavement counselling.

1.3.7 It is best practice to involve service users and/or family members in the Review. This did not happen. Making Safeguarding Personal within the Care Act 2014 guidance is clear that individuals should at the minimum be asked what outcome they would like from a Review. This is now encompassed in the Enfield Safeguarding Adult Review Protocol.

1.3.8 The local authority in this case, had no dealing with the mother, and LBH had not had any further contact with the family since Sophie 's funeral. It was therefore deemed inappropriate after such a time delay to contact the family prior to the completion of the Review.

1.3.9 Thanks, are extended to all individuals and organisations for their contributions to this SAR.

1.3.10 The timeline the Review is focussed is between September 2016, when Sophie came to London and her death 15th November 2017.

## 2. Independent Management Reviews and Chronologies

2.1.1 The individual agency collation of information provides an overview of what each agency did, their decision making and how they worked in partnership to safeguard Sophie from abuse and neglect. As noted by the independent chair of the SAR Criteria meeting held 5th July 2018, the complexities of this case are compounded by the number of agencies involved.

2.1.2 The following section provides an account by each agency. Each account is followed by questions and analysis.

### Children & Young People's Service

2.2.1 There is no IMR account of Northamptonshire councils as the timeframe for this SAR starts from when Sophie left her mothers' house and moved to London.

2.2.2 Information gleaned from LBH accounts of Sophie childhood set the tone for how Sophie and her family worked with health and social care professionals.

2.2.3 The family history is that Sophie came to the United Kingdom aged 8 from Eastern Europe. She has an older sister living in Poland, and a younger sister

living with her mother. Sophie told professionals that her father committed suicide prior to her birth.

2.2.4 Throughout her short life there was continual concern about how Sophie managed her type 1 diabetes. Northamptonshire diabetes service reported to LBH, that intervention by both health and social care had little impact on Sophie 's diabetes management. It was noted that Sophie was rarely accompanied by her mother to medical appointments.

2.2.5 A referral to LBH Children & Young People's Service (CYPS) was received on 23rd September 2016 from NMUH. The concern surrounded Sophie 's poor diabetes management, gave insight into her previous medical history of diabetic coma, non-compliance with medication and living in unstable and poor hygienic surroundings.

2.2.6 A CYPS safeguarding social worker noted the following concerns:

- Sophie living with unknown male aged 24 to 26 years old
- Multi-occupancy house with unknown people
- House dirty and unhygienic
- Non-compliance with medication
- Missed health and social care appointments
- Sophie alcohol consumption of concern
- Sophie diet limited and non-nutritious
- Lack of access to money
- Sophie may be exploited to obtain finances

2.2.7 There was also uncorroborated concern that Sophie may be soliciting and that she worked at prestigious London hotels. She may also have had a job as a cleaner.

2.2.8 On 17th November 2016, a Child Sexual Exploitation (CSE) strategy meeting was held because of the concern that Sophie was staying with an unknown male. This included health, social care, and the police. A children and family assessment was initiated the next day and a Child in Need (CIN) plan formulated.

2.2.9 Sophie 's circumstances were also discussed at a Multi-Agency Sexual Exploitation (MASE) meeting on 17th December 2016. The purpose of such a meeting is aimed at preventing children and young people from being exploited, supported by professionals working together to share and understand information and intelligence in order to identify potential risks, and for agencies to use their collective resources to plan to protect children and young people.

2.2.10 A Child in Need (CIN) review was called on the 21st December 2016. It was agreed that an allocated social worker would support Sophie to further medical appointments. Safer London, a London charity working to prevent

and address gang violence, vulnerability and exploitation among young people became involved.

2.2.11 CYPS offered support to meet Sophie 's housing needs through s20 Children Act 1989, whereby the Local Authority would accommodate her. Sophie declined this offer and chose to continue her current lifestyle.

2.2.12 The Metropolitan Police ended their involvement 18th January 2017 due to lack of evidence of sexual exploitation and Sophie 's unwillingness to engage. Safer London and the Metropolitan Police both voiced concern to CYPS that Sophie was at risk of homelessness.

2.2.13 The CYPS proposed to Sophie that she return to Northamptonshire to her family. This was not an option that Sophie wanted to pursue. An advocate from Safer London supported Sophie to contact New Horizons, a charity working with young people. The approach to New Horizons was for accommodation, but they were unable to provide accommodation as Sophie was then under 18 years old.

2.2.14 Sophie was taken to the Whittington Hospital Accident & Emergency Department on 8th February 2017 via ambulance. She exhibited aggressive behaviour towards the ambulance crew and raised concern of staff in the emergency department. She was intoxicated and her behaviour led to a psychiatry referral. Her diabetes was of concern and she was clinically unwell therefore admitted. Mental health screening was carried out with planned follow up.

2.2.15 NMUH raised further concerns with CYPS and an advocate supported a request for an assessment under the Southwark Ruling. This is a Judgement of the House of Lords in May of 2009 that sets out the responsibilities of Housing and Children's Services, in relation to 16-17-year olds who present to a Local Authority as homeless. In a nutshell it puts a statutory responsibility on Children's Services to assess if a young person is a child in need and if so, requires accommodation under s20 Children Act 1989.

2.2.16 Subsequently Sophie was offered her own accommodation but failed to collect the keys from a local estate agent. Further referrals from NMUH led Sophie to be accommodated in residential care and become a Looked After Child (LAC) on 23rd February 2017.

2.2.17 On 2nd March 2017 Sophie was admitted onto the High Dependency Unit (HDU) at Whipps Cross University Hospital. Her clinical condition was poor and due to vascular complications, she was transferred to the Royal London Hospital where she remained until later that month. Again, the key reason for her admission was poor diabetes management.

2.2.18 Liaison between the NMUH and Barts Health Trust (The Royal London) was good and information sharing about discharge plans effective.

2.2.19 Sophie remained at the Royal London following a treatment plan for intravenous medication to improve blood flow to her arm, but she refused this and was given oral medication and transferred back to NMUH adult ward following her treatment.

2.2.20 Sophie was also seen by clinical psychology at the Royal London who concluded that she was not willing to engage, reacted negatively to any kind of authority and unlikely to benefit from a psychological centre.

2.2.21 A final LAC review was held on the 16th March 2017 and her case transferred to Adult Social Care on 13th April 2017 and finally closed to CYPS on 2nd May 2017.

Issues

- Was legal included in early discussions?
- What were the thoughts of the Independent Reviewing Officer?
- Sophie was offered accommodation under s20 earlier why did she refuse? Was it the type of accommodation i.e. foster care or hostel that she refused?
- Given that the Mental Capacity Act (2005) applies to those over 16-years-old, was this considered in relation to her health care – did she lack capacity around her health care/ diabetes management? Did she have Executive Capacity?

**Adult Social Care**

2.3.1 CYPS closed the case and transferred social work responsibility to adult social care. There did not appear to be discussion about the transfer or any direct discussions with Sophie about change in service support. Sophie had at this time experienced several hospital admissions.

2.3.2 The first service from Adult Social Care to be contacted was the reablement team upon receipt of a referral from NMUH dated 28th April 2017. It is noted on LBH data base that Sophie does not manage her type 1 diabetes well, has declined counselling and psychological support. The entry notes that she has poor risk perception based on the information from health and social care histories.

2.3.3 There is however data entry of a telephone conversation between CYPS social worker and Adult Social Care (ASC) whereby CYPS said that they ceased responsibility in February 2017 and transferred social work responsibility to adult services who are awaiting allocation to an ASC social worker.

2.3.4 The Reablement Service did not become involved. Sophie neither wanted nor needed a support package, as she was able to manage daily living tasks, but lacked motivation to self-manage her medication regime. It was already noted that she refused counselling and psychological support.

2.3.5 On 5th May 2017 LBH were of the view that Sophie needed a Pathway Assessment to assess her capabilities to manage independently in her own accommodation. An appointment was made for 9th May 2017.

2.3.6 The chronology from ASC indicates that throughout May to early June 2017 Sophie repeatedly attended the Emergency Department and approached the NMUH paediatric diabetic service for support with finances.

2.3.7 ASC was currently working with Sophie , although it is confusing about who was taking the lead. The Duty Older People and Physical Disabilities, the Locality Team and the Physical Disabilities and Floating Support team were all approached about accommodation and finances. Confusion was added to by the fact that Sophie had a temporary address in Enfield, although her care and support was a Haringey responsibility.

2.3.8 Sophie was also in contact with Providence Row, a London based charity for homeless people who were assisting her with state benefit claims. There is mention also of Route to Roots another charity that supports the homeless, who supported her quest for appropriate sheltered accommodation.

2.3.9 The key referrers to social services throughout this period were the NMUH diabetic team and the Adult Safeguarding Lead Nurse. The latter requested clarification about key contacts and requested to be kept informed of changes and events.

2.3.10 A request for a discharge planning meeting was made 27th July 2017. There is a further note that on the 31st July 2017 the Matron at NMUH where Sophie was currently an inpatient requested that a proposed discharge planning meeting be convened as the concerns surrounding Sophie remained.

2.3.11 Earlier focus for ASC was on practical issues. A psychiatrist had since assessed Sophie and believed her to be at risk of exploitation. Unfortunately, Sophie was deemed medically fit for discharge and did not wish to stay in hospital. There was no legal precedent for her to do so. She was assessed to have the mental capacity to make her own decision, although hospital professionals viewed her decision making as unwise. She also did not meet the criteria for detention under the Mental Health Acts.

2.3.12 The records show that Sophie felt that services had done little to change her housing and financial situation. She is said to have agreed to psychotherapy on the basis that she would receive practical help.

2.3.13 The lead adult nurse for safeguarding at NMUH made attempts to contact professionals to hold a multi-disciplinary meeting 23rd August 2017. The focus of the meeting was to centre around Sophie 's diabetes management. The risk of non-compliance by Sophie was high, citing that early death may be an outcome should Sophie not engage in treatment plans.

2.3.14 Up until the meeting ASC had face to face contact with Sophie once on the 15th August 2017. At this meeting Sophie again focussed on practical issues and advised that she had a part time job. There was a frank discussion about the impact of shift work to her health. Sophie said that this was a temporary position and had had a successful interview for a retail post.

2.3.15 It is not recorded whether the planned multi-disciplinary meeting was discussed with Sophie , therefore it is unknown if Sophie had the opportunity to attend or make her views known.

2.3.16 The conversation centred on Sophie 's diabetes management. She accepted that this was poor and that she had difficulty coming to terms with her diagnosis and managing a long-term condition.

2.3.17 The multi-disciplinary meeting went ahead, attended by the diabetes nurse, psychologist, hospital consultant, social services. The risks Sophie continued to take, and the rapid deterioration in her health was highlighted as the overriding concern. Recommendations agreed were for a community psychologist to support her in managing her diabetes and adult social care to focus on accommodation and finances. A further meeting was planned for September 2017.

2.3.18 There was a continued pattern of missed medical appointments by Sophie . Throughout August and early September, ASC made attempts to engage with Sophie in their effort to secure accommodation and support her status and rights to housing and employment benefits.

2.3.19 Sophie moved from Northamptonshire to London without a national insurance number which made claiming state benefit in her own right challenging. There was also a question of her immigration status. She was difficult to contact, initially staying with "friends" and later when in temporary accommodation in Enfield not always contactable by phone and did not always keep appointments. Furthermore, Sophie did not always retain correspondence from official organisations, therefore evidencing eligibility for services was hampered.

2.3.20 In September 2017 there was a change of worker, and the Young Adult service took on casework responsibility. The Young Adults personal advisor requested a handover meeting; a decision was made to joint work and for a multi-disciplinary meeting between health, social care, advocacy was made for 4th October 2017.

**Issues**

- What happened to the Pathway Plan appointment 5th May 2017? Which team made this?
- Why were so many ASC teams involved and how did they link together? Which social work waiting list was Sophie on? Who was the appropriate lead team?
- Pathway Planning might have identified the growing number of agencies involved with Sophie , who were likely duplicating tasks e.g. advocacy
- There was an opportunity to undertake health and social care risk assessment as part of Pathway Planning – why did this not take place when there was a multi-agency meeting?

**Young Adult Service**

2.4.1 The Young Adults Service is designed to support young people leaving care. It meets statutory responsibilities under the Leaving Care Act 2000. Those eligible for the service must be in continuous care for 13 weeks on or after their sixteenth birthday to qualify for service. This presented a challenge for LBH to provide support to Sophie .

2.4.2 A Personal Advisor (PA) became LBH keyworker from 12th September 2017. Their role was to complete a Pathway Plan with a social worker. Initial contact was made on the 12th September via telephone. In this exchange Sophie stated that she did not want to accept supported accommodation. A planned visit was made on 19th September 2017 where agreement with Sophie was reached that the priorities were diabetes self -management and access to mental health services.

2.4.3 A professionals meeting with Sophie was held 4th October 2017 which included Sophie , the PA, diabetic nurse, and the social worker from adult social care. Sophie met the PA two days later with the Employment Engagement Manager to explore options for hairdressing training.

2.4.4 Pathway Planning commenced on 21st September 2017. The purpose of the Pathway Plan is to produce a written document that records needs, identifies actions to be taken, and resources that need to be put in place to support young people during their transition to adulthood.

2.4.5 On the 25th September, Sophie contacted the PA to advise she had lost her employment. The PA reminded her about her upcoming appointment for mental health at Chase Farm hospital, but Sophie retracts her agreement to attend. The PA duly cancels the appointment.

2.4.6 Shortly afterwards Sophie was admitted to hospital on the 27th September 2017, in relation to domestic violence. She was discharged the following day.

2.4.5 The Pathway Plan was submitted to the Pathway Manager on the 16th October 2017 aiming to secure accommodation. It was refused the following day, and the deputy Head of Service informed.

2.4.6 On 25 October 2017 an email was received from the hospital advising Sophie had not attended her weekly appointment with the Diabetic Nurse and had not been checking her blood glucose readings.

2.4.7 The PA explored options for Sophie to attend Open Door for counselling, which Sophie initially agrees to and works with the PA on completing the self-referment form.

2.4.8 On 31 October 2017 the PA informed health professionals that Sophie was unable to attend an induction for a six-week employability programme as she was coughing up blood due to an ongoing chest infection. Sophie was advised by health and social care to get an emergency GP appointment, which she missed and subsequently attended hospital.

2.4.9 On 2 November 2017, the PA called Sophie , she explained she had stopped coughing up blood and was still taking antibiotics prescribed for a chest infection. She told the PA she would have further medical exploration to establish whether she was asthmatic. She also told the PA that her mother wanted her to travel to Poland in respect of a family matter, which the PA advised against.

2.4.10 On 03 November 2017, Sophie made an office visit to collect an Emergency Payment Card. The same day, her mother telephoned the PA to ask for advice about Sophie 's immigration status.

2.4.11 On 13 November 2017, Sophie told the PA that when returning home from Oxford Street she experienced breathing difficulties. She had presented to NMUH on 11th November 2017 where her oxygen saturation was found to be low, and a CT scan found several blood clots on her lungs. She was prescribed oral medication and discharged on Sunday on 12 November 2017 at 8pm.

2.4.12 On 15 November 2017 health professionals contacted the Young Adults Service to inform them of Sophie 's death. The Consultant Paediatrician reported that Sophie was seen at A&E on Sunday 12 November 2017 with suspected collapsed lungs. She was not admitted and prescribed oral medication.

2.4.13 Sophie called the ambulance the morning of 15 November 2017 reporting she had breathing difficulties. The ambulance could not gain entry to her property and broke the glass to gain access. Sophie was found in bed and whilst being transported to the NMUH she collapsed. Paramedics and the Emergency Department performed CPR, but she had suffered cardiac arrest and died.

## Issues

- Good timely practice by reaching joint agreement and goals in first meeting with Sophie
- Good practice service user involvement in joint health and social care meeting
- Was domestic violence towards Sophie raised? What was the future risk of domestic violence and ways to protect herself discussed?
- When is coughing up blood seen as an emergency for a person with similar previous medical history?

**Advocacy**

2.5.1 Sophie was very well supported by advocacy. This included community for support with potential exploitation, housing officer and advocate for support with accommodation and legal advocates who championed her rights under the Children Act 1989.

**Issues**

- How are advocates included? Who agrees advocacy? Why did Sophie have so many? How did advocacy services link together?

**The Police**

2.6.1 The first contact that the Metropolitan Police had with Sophie was during an eviction process of Sophie and her friend in October 2016. This was followed later in the same month by an invitation to a Child Sexual Exploitation meeting chaired by LBH CYPS. There is no further information about this from the police chronology, however they closed their enquiry after a six-month review.

2.6.2 In February 2017 the first domestic violence concern was raised with the police. This was from Sophie ’s mother. The police made a welfare check and found no visible injuries on Sophie who did not make any allegations.

2.6.3 Two days later 24th February 2017 and again on 28th February 2017 missing person reports were made. Sophie was found safe and well on both occasions.

2.6.4 In May 2017 Sophie attended a police station to request assistance as she had locked herself out and needed her insulin.

2.6.5 On 26th September 2017, the police attended Sophie ’s property following an allegation of domestic violence. On this occasion Sophie refused to give a statement and appeared unwell. The police called for medical assistance and the London Ambulance Service (LAS) transported her to hospital, although she had told the police that she did not want help.

2.6.6 Police were again called to Sophie ’s property as neighbours reported shouting. The police attended and found Sophie alone and in a distressed state. She had drunk alcohol and exhibited worrying behaviour which

prompted the police to call the LAS. LAS diagnosed that she was in hyperglycaemic shock and was taken to hospital.

2.6.7 A final report of alleged violence against Sophie was made 10th November 2017. The police noted at the time of the alleged incident Sophie presented as vague and inconsistent in her account.

2.6.8 The alleged assault was not followed up further due to difficulty in contacting Sophie and lack of evidence.

Issues

- Was Sophie provided with any domestic violence support or information?

**General Practitioner**

2.7.1 The GP notes they were informed on the 13th March 2017, that Sophie was discharged from hospital. The GP attempted contact with CYPS and Sophie but neither returned the call.

2.7.2 On 10th October 2017 Sophie attended the surgery as a naval piercing had become infected. No wider discussion about her lifestyle and risks of infections were held.

2.7.3 On 26th October 2017 Sophie attended the surgery for a genealogical matter. There are no other visits noted.

2.7.4 The GP IMR noted that wider discussions about, non-attendance at outpatient appointments, poor diabetes management risks and stronger agency working especially between primary and secondary care would have been helpful.

**Issues**

- Good practice to establish links with social care
- Was there ever any discussion about repeat prescriptions as Sophie had a pattern of running out. Could support for links with local pharmacist be encouraged?
- What co-ordinating role might the GP play to strengthen stronger agency working?

**North Middlesex University Hospital**

2.8.1 Sophie first came to the attention of NMUH in September 2016. She presented with cold symptoms and diagnosed with hyperglycaemia (low). She had recently arrived in London and not registered with a GP. She was advised to do so, given treatment, and sent home.

2.8.2 A week later, 22nd September 2016 Sophie was admitted via ambulance in a state of high hyperglycaemia onto an adult ward as she was over 16 years old. She was seen by the safeguarding nurse who made a referral to the LBH CYPS.

2.8.3 She was assessed as 'Gillick competent' to make decisions and provide consent. Sophie was discharged from hospital.

2.8.4 Sophie had a further emergency admission 4th October 2016 resulting in her transfer to the Intensive Care Unit with diabetes ketoacidosis. Whilst in hospital discussion with Sophie was held about risky behaviours and ensuring she was now registered with a GP.

2.8.5 The NMUH contacted Kettering Hospital who were responsible for diabetic services when Sophie lived in Northamptonshire. Kettering were aware of social care involvement via LBH and that Sophie now lived out of their area. They took the decision to transfer her case to a NMUH Consultant.

2.8.6 The diabetic team held a psychosocial meeting on the 25th October and attended the safeguarding strategy meeting chaired by LBH C&YPS on the 28th October 2016.

2.8.7 An email detailing a series of agreed actions were received following the strategy meeting:

1) Social worker (SW) to contact mother
2) SW to discuss with manager
3) SW to provide Sophie with oyster card to enable monitoring by police
4) SW to provide accounts to police for monitoring purposes
5) Joint visit SW & Police
6) Instigate s47 Children Act investigation
7) Social care to alert all hospitals
8) Referral to Safer London/targeted response
9) Consider MACE referral
10) LBH to gather background information from Northamptonshire
11) Diabetic team to maintain mobile contact with Sophie

2.8.8 A review social care meeting was planned for 22nd November 2016.

2.8.9 Sophie attended her first outpatient diabetic clinic on 9th November 2016 where her lack of motivation was noted. She did not attend the next appointment scheduled for 21st November 2016.

2.8.10 Sophie was admitted via ambulance to NMUH on 23rd November 2016 with a possible urine infection.

2.8.11 A face to face meeting was held with Sophie with the Paediatric Consultant and Safeguarding Nurse. Sophie refused to give her current address. The medical team suggested that she remain in hospital until suitable

accommodation could be arranged but Sophie discharged herself against medical advice.

2.8.12 Throughout this period contact with Sophie appears to be on her terms. She contacted the Paediatric Diabetic Specialist Nursing Team and kept medical appointments in an inconsistent manner.

2.8.13 The NMUH staff, police and C&YPS were in touch with each other and shared concerns about risk. Attempts were made throughout December 2016 to hold a Child in Need meeting prior to the Christmas holidays with some success, although the college was unable to attend. It was confirmed that Sophie would stay with her mother for the holiday period. It was also noted that Sophie was likely to binge drink and had been drinking alcohol since she was 11 years old.

2.8.13 The diabetes team advised Sophie on alcohol and its risks and ensured she had information.

2.8.14 On 22nd December 2016, Sophie visited the PDSN and said that she had no insulin supply, no credit on her phone and confirmed her plan to stay with her mother. She was assisted with an emergency hospital prescription and contact was made with the GP. An appointment for the ambulatory general medical care was made which Sophie did not attend.

2.8.15 On 6th January 2017, The Whittington Hospital made contact seeking background information on Sophie for their proposed Exploitation Panel. There is no further information about this.

2.8.16 On 17th January 2017 Sophie was escorted to the NMUH diabetic outpatient clinic by her social worker. Sophie said that she was in the process of relocating and there was a conversation about the importance of engagement and compliance. Sophie also attended the clinic on the 24th January 2017 and although her diabetes management was poor overall there were small signs of improvement.

2.8.17 At this meeting Sophie talked to the nurse about sexual issues, her impending homelessness, and finances. The latter were passed onto social care. The nurse also identified that there was a need to discuss transition from children to adult services as this was a complex case and the ambition was to succeed in managing a smooth transition.

2.8.18 The nurse therefore identified three key issues for the upcoming professionals meeting:

1. Homelessness
2. Risk of Self Harm resulting in death (diabetic ketoacidosis)
3. Transition from Children in Need team to Adult Services

2.8.19 At this stage, the NMUH diabetes team and social care were not aware of the Southwark Ruling, and the overriding concern for NMUH was that no transition would take place and social care might cease once Sophie attained the age of eighteen years.

2.8.20 The one contact that Sophie appears to have maintained is with Safer London (advocacy service). At the CIN meeting it was reported that Sophie was low in mood, has admitted to self-harming and had expressed suicidal ideation.

2.8.21 In early February the NMUH diabetes clinic had face to face and telephone contact with Sophie . Sophie 's main preoccupation was around housing and finances. Sophie did still did not have a National Insurance number hampering claims for state benefit. The NMUH were supporting Sophie financially with food vouchers from the hospital fund.

2.8.22 On the 7th February 2017, Sophie was admitted to the Whittington and NMUH advised the social worker to contact the named Whittington safeguarding nurse and doctor to arrange a Discharge Planning Meeting.

2.8.23 When she left the Whittington Sophie told the NMUH nurse that she was staying with a 25-year-old male friend, but this was a temporary stop gap. She contacted the team again for additional food vouchers and expressed her reluctance to return to Northamptonshire as Haringey CYPS were advocating. Sophie was also receiving accommodation help from New Horizon, which was inappropriate for her needs as she needed somewhere stable to store her insulin, and the support from New Horizon was transient.

2.8.24 On the 19th February 2017 Sophie was again admitted to the NMUH with high hyperglycaemia, she discharged herself the following day.

2.8.25 Sophie was unwell with a chest infection but attended her dietician appointment on the 21st February 2017 and was seen jointly with the NMUH diabetic nurse. She said that through legal support Haringey had provided her with accommodation. She had spent the night of the 20th in the NMUH Emergency Department with a friend who had needed treatment and she acted as a translator.

2.8.26 Sophie showed signs of distress on the 22nd February 2017, her throat and body were swelling which might have been a reaction to antibiotics prescribed for her chest infection. On advice she attended the Emergency Department for her own health needs.

2.8.27 At this time, Sophie was placed in semi-independent accommodation in LB Waltham Forest commissioned by LB Haringey and signed her own s20 Children Act form to become a Looked After Child. The NMUH offered joint diabetes training with the service managing the accommodation but unfortunately Sophie left this accommodation and was reported missing. She

was later found to be an inpatient on the High Dependency Unit of Whipps Cross University Hospital.

2.8.28 Throughout March 2017 the NMUH diabetes nurse liaised with LB Haringey social care and the Royal London Hospital team and maintained a handle on Sophie 's health and welfare.

2.8.29 The NMUH were also made aware by LB Haringey of the complications due to Ordinary Residence and duty of care responsibilities. The issue outlined in the Southwark Ruling also came to the fore.

2.8.30 Throughout April 2017 NMUH liaised extensively with Haringey social services, the Royal London Hospital and the homeless team attached to the Royal London. Sophie also initiated contact with NMUH diabetes team and maintained contact with the Safer London advocate. LB Haringey C&YPS were the main conduit of information to NMUH but this came to a halt as Sophie was transferred to Adult Social Care (ASC).

2.8.31 A Discharge Planning Meeting proposed by the Royal London Hospital was communicated to NMUH safeguarding nurse. In the event, this did not take place as there was no social work availability and Sophie was transferred home.

2.8.32 Sophie was provided with a 2-week temporary accommodation by LB Haringey, and the Royal London Hospital made a referral for community nursing. Route to Root were also providing housing advocacy support.

2.8.33 On 11th May 2017, Sophie attended NMUH on an unplanned visit to the PDSN. She checked on the dates for her upcoming appointments and said that she had sufficient food and money. She also told the nurse that she had no family, friends, or money and nothing to live for. Despite voicing these thoughts, she presented in high spirits.

2.8.34 A referral was made to cardiology and Sophie was discussed in Multi-Disciplinary Team Meetings primarily about her engagement with services and suitability for an insulin pump assessment.

2.8.35 Sophie continued a pattern of non-attendance for outpatient appointments but made unplanned visits every few days to the diabetic clinic to speak with the diabetic nurses.

2.8.36 1st June 2017 Sophie made an unplanned visit and was clearly unwell. She admitted to drinking for four days and said she was vomiting. She was persuaded to attend the Emergency Department but again refused to stay. The NMUH contacted LB Haringey ASC and was informed there was no allocated social worker, but she had a housing support officer in the re-engagement service. The PDSN continued to support Sophie with food vouchers and made attempts to reinstate her oyster travel card.

2.8.37 The following day Sophie made a further unplanned visit and disclosed that she had been offered work as a prostitute but declined. A male friend had given Sophie a £600 iPhone and Sophie said that he did not want anything in return.

2.8.38 The PDSN continued to contact social care and discussed disclosures with Safer London. The housing support worker contacted the diabetes safeguarding nurse to confirm that an appointment had been made with Sophie .

2.8.39 The PDSN was concerned about the lack of formal meetings to share information and work with partners in social care. It was noted that following the final Child In Need meeting and the transfer to Adult Services that no meetings were convened. A concern shared by Safer London.

2.8.40 The diabetes team arranged a professionals meeting 13th June 2017 attended by the Paediatric Diabetic Consultant, PDSN, Safer London. The LBH housing support worker sent apologies and emailed an update, and the Child Sexual Exploitation Team advised that they were no longer involved as Sophie was now an adult.

2.8.41 The meeting noted high health risks to Sophie described by the Consultant as life threatening, and significant concerns for her well-being. A safeguarding referral was already in progress with the LB Enfield Multi-Agency Safeguarding Hub via the hospital social work team.

2.8.42 Sophie was admitted to NMUH 16th June 2017 diagnosed diabetes ketoacidosis and severe sepsis leading to infective endocarditis. Whilst Sophie was an inpatient a referral was made to Barnet, Enfield & Haringey Mental Health Trust Consultant Psychiatrist who agreed the mental health team would work with Sophie . Further unfruitful attempts were made to discuss with ASC.

2.8.43 Sophie made a further unplanned visit to the PDSN Frank discussion was held with Sophie about her recent serious hospital admission which was interrupted by a telephone call to her. The nurse noted that her demeanour changed, and she became anxious. She told the PDSN it was a male who had lent her money.

2.8.44 A professionals meeting was held the same day 20th June 2017. The outcome of the meeting was for an allocated ASC social worker to undertake a s9 Care Act 2014 wellbeing assessment.

2.8.45 Due to her heart condition Sophie was referred to the Royal London Hospital. Sophie spoke to the PDSN about her anxiety surrounding the heart concern and requested to see the psychologist.

2.8.46 On 22nd June 2017 Sophie was assessed by the mental health team. She was also seen by LB Enfield MASH team following up on the safeguarding concern.

2.8.47 The social work responsibility for Sophie was unclear for health partners. The NMUH is situated in Edmonton, therefore under agreed protocols and now embedded in Care Act 2014 guidance, if a safeguarding referral is made the host local authority are the lead agency and hold responsibility for the safeguarding enquiry. Edmonton is situated in the London Borough of Enfield, and regardless of adult social work care management or other social work involvement, Enfield was the responsible agency for safeguarding.

2.8.48 In this instance Sophie also had a temporary Enfield address but had been placed by LB Haringey, therefore Haringey remained responsible for adult social care arrangements except for adult safeguarding as she was not ordinarily an Enfield resident.

2.8.49 The safeguarding referral was closed. NMUH staff were not part of this decision making.

2.8.50 NMUH diabetic team liaised with the Royal London Hospital to ensure continuity of support for Sophie . She was transferred back to NMUH on 20th July 2017 from the Royal London Hospital.

2.8.51 Whilst an inpatient Sophie was seen by mental health services and also assessed for an insulin pump. She re-engaged with the Safer London worker and her challenge for continued support under the Children Acts provided her with a status of 'Qualifying Child'. At this time, she became known to the LBH Young Adult Service, managed by the CYPS.

2.8.52 Despite a night-time altercation involving Sophie 's friends, she remained on the ward until 1st August 2017 and had begun to engage with mental health services. Unfortunately, she could not be persuaded to remain on the ward and was medically fit and deemed to have the mental capacity to make her own decisions and discharged.

2.8.53 Once Sophie left the ward a pattern of non-attendance for outpatient appointments returned. A week later Sophie presented to the Emergency Department with back pain, blood in her urine and was diagnosed with a urine infection. She did not contact the diabetes team until 16th August 2017 as she had run out of medication.

2.8.54 A hospital led professional meeting was held 23rd August 2017 and transfer of social work responsibility from LB Haringey to LB Enfield was mooted.

2.8.55 Sophie showed symptoms of pain in her leg and was referred to the Emergency Department as it was suspected she had Deep Vein Thrombosis. She missed her Doppler Ultrasound appointment which would have assisted

in detecting any abnormality in the blood flow of her limbs. She also missed her Diabetic Annual Review on the 4th September 2017.

2.8.56 On 6th September 2017 a follow up professionals meeting was held. This was attended by diabetes team, mental health team and the young adults' team. It was reported that Sophie had no recourse to public funds which effectively put strain on building a rapport with the young adult team who were unable to financially support her.

2.8.57 On 26th September 2017 Sophie was again admitted to NMUH following an alleged assault with high blood pressure and back pain.

2.8.58 Whilst on the ward Sophie requested psychology input. The PDSN liaised with the mental health team and made an appointment for October. Mental Health Crisis intervention details were given to Sophie . Liaison was also made with Young Adults. The risks to Sophie from self-harm due to her non-compliance was noted to be high.

2.8.59 Sophie was discharged 29th September 2017 but readmitted the following day via ambulance as she had a productive cough, short of breath and in a hypoglycaemia state. She was verbally and physically aggressive towards staff.

2.8.60 Sophie was discharged on the 3rd October 2017 with agreement for follow up the next day which she attended but left prior to being seen. She kept her appointment with mental health services on the 13th October 2017.

2.8.61 A further professional meeting was held on the 4th October 2017 and one of the actions was for the Young Adult Team to support Sophie to all future medical appointments.

2.8.62 Despite reporting coughing up blood on the 6th October 2017 Sophie remained relatively well and attended her outpatient appointment on the 11th October 2017. She presented as more positive in mood and had a job interview. She also attended the mental health appointment on the 13th October 2017 but left as she felt uncomfortable with other people in the waiting area.

2.8.63 Sophie missed her 2nd diabetes annual review and was contacted by NMUH. She was unwell with a chest infection, attended the Emergency Department and prescribed antibiotics.

2.8.64 Sophie missed her cardiology outpatient appointment on the 24th October 2017. She spoke with the PDSN on 31st October 2017 as she was again coughing up blood and advised to seek medical attention. This was her third chest infection in a relatively short time.

2.8.65 On 4th November 2017 Sophie had been drinking with friends and had not taken her insulin. She was admitted to hospital but refused to stay or consent to treatment. She was discharged the following day.

2.8.66 She attended her diabetic outpatient clinic on the 8th November 2017 but had been at the hospital translating for a friend and was distracted in the clinic. It was likely that she was experiencing some degree of hypoglycaemia but insisted upon leaving.

2.8.67 Sophie had further bouts of chest infections and was prescribed antibiotics. She was further readmitted to NMUH via ambulance on the 12th November 2017 and refused to stay. Blood clots on her lungs were diagnosed.

2.8.68 On the 13th November 2017 she attended the diabetic outpatient clinic. On the 15th November 2017 she attended the Emergency Department in cardiac arrest and sadly died.

**Issues**

- Good practice to attend social care meetings
- At what age can a patient discharge themselves?
- Service and especially the PDSN showed good consistency and took a proactive stance in attempting to work in partnership with other agencies
- Service user engagement from diabetic team was strong
- Good practice to offer training by the diabetic team to housing
- Good identification of the need for a smooth transition to adult services
- Could the flow to Emergency from outpatient departments be smoother?

**Whittington Health**

2.9.1 The Haringey Safeguarding Children Nurse works in partnership with the LBH CYPS. They recorded six attendances by Sophie to hospital Emergency Departments and admissions to NMUH, Whipps Cross University Hospital and St. Bartholomew's Hospital between September 2016 and June 2017.

2.9.2 Attendance at the Child Sexual Exploitation meeting and health and nursing professional meetings were all recorded and detailed the concerns raised by all health professionals. Additionally, there are recordings of information sharing between health, social care and the police via referrals and multi-disciplinary team meetings.

2.9.3 There were several named safeguarding/liaison nurses across several different health providers who had either direct involvement with Sophie or shared information about her poorly controlled diabetes, chaotic lifestyle, and alcohol consumption. The deterioration in Sophie 's health and risks associated with possible sexual exploitation were all recorded on Rio (health database) and therefore accessible to all health professionals with appropriate log in qualifications.

2.9.4 As with the local authority CYPS, the named safeguarding children nurses ceased their involvement when Sophie became an adult. The exception to this was the Paediatric Diabetic team who planned to work with Sophie until she was 19 years old as agreed policy, and whom Sophie continued to make unplanned visits to.

**Issues**

- Is there a Risk Matrix when a child/young adult noting the number of times that they come to the attention of safeguarding nurses within a short period?
- What training on self-neglect by young people is there for clinicians?
- What links are made with CYPS social care of high-risk young people with health conditions?

**Barts Health NHS Trust**

2.10.1 Barts Health NHS Trust covers several hospitals including The Royal London and Whipps Cross University Hospital (WX) that this account covers. As mentioned in other accounts Sophie had an emergency admission to WX on 2nd March 2017 and placed in the High Dependency Unit (HDU).

2.10.2 The account provides a history of Sophie poor diabetes management, binge drinking and non-compliance with medication. The team liaised with the hostel manager (LB Waltham Forest) where Sophie was admitted from to gather background information.

2.10.3 Once she was stable, the HDU team planned on Sophie being transferred to a general ward, which Sophie objected to and was insisting on returning to her accommodation. The HDU ward team made a referral to the North East London Foundation Trust (see below) to assess Sophie 's decision making capacity.

2.10.4 On 5th March 2017, a critical care transfer was made to the Royal London Hospital. Throughout this time, there was regular contact with the social worker.

2.10.5 On 6th March 2017, despite her health condition Sophie "disappeared" from the ward for cigarettes. At one time, she left the ward for a considerable period and the police were informed.

2.10.6 Sophie had an episode of hypoglycaemia and offered food which she rejected. Another patient informed the nursing staff that she had seen Sophie inject herself with insulin which had the effect of dropping her blood sugar level.

2.10.7 An insulin pen was removed, and nursing staff ensured she had no further opportunity to self-administer insulin. Her behaviour was discussed at a multi-disciplinary ward meeting.

2.10.8 Sophie requested a trial period to self-management of her diabetes. She was also offered smoking cessation sessions as this also impacted on her vascular fitness.

2.10.9 On 15th March 2017, Sophie left the ward against medical advice and continued to exhibit risky behaviour. Staff gave frank advice about these risks which appear to have little impact or change her behaviour.

2.10.10 The ward was provided with some background from NMUH, WXUH, and had limited contact with the social worker. Sophie continued to cause concern about the impact her behaviour had on her health, long term prognosis and her level of understanding the risks. A referral was made to the psychology department who assessed Sophie on 21st March 2017.

2.10.11 The IMR notes that Sophie was referred due to compliance around diabetes and not agreeing to infusion treatment that will ultimately save her thumb. Main purpose of today's assessment to (i) establish rapport (ii) understand nature of diabetes and reluctance around infusion.

2.10.12 The ward continued to have concerns about how much time Sophie spent off the ward and her blood sugars not being managed. The ward took the decision to lock the insulin in the Controlled Drugs cabinet.

2.10.13 The psychologist discussed with the medical team, the difference between telling someone the risks of not having a treatment and assessing their understanding of what they have been told. It was agreed they may need to re-visit this.

2.10 12 The psychologist gathered Sophie 's background and there is a note of a lawyer pursuing extension of s20 Children Act 1989. Sophie 's troublesome family history is noted and long-standing involvement of social services.

2.10.13 The psychologist also noted that Sophie was under the care of the paediatrics diabetes team and that there had been discussions with Sophie about transitioning to adult healthcare. At Sophie 's request it was agreed that she would not transition until she was 19 years old.

2.10.14 Sophie said that in her experience the more gradual approach to compliance taken by paediatrics was preferable to adult healthcare. Sophie told the psychologist that she had previously received psychological support but had not attended all the planned sessions. She also said that she did not want to go too deep into her life experiences and that she did not like talking about her emotions.

2.10.15 Sophie spoke about the family history of mental illness and said that she did not want to be like them. She denied a history of deliberate self-harm but acknowledged that not taking her insulin may be akin to passive deliberate self-harm. She admitted to binge drinking but denied taking any recreational drugs.

2.10.16 Sophie told the psychologist that she was resentful of her diabetes diagnosis, and of being told by professionals of the need to be compliant. Sophie said that she understood the risks to her health and that she had improved, and only had one hospital admission in the past seven months.

2.10.17 Sophie was not challenged on her account and the psychologist spent time building a rapport with her.

2.10.18 Sophie did not accept any responsibility for her current vascular condition and spoke about seeking medical compensation and expressed resentment toward previous clinicians.

2.10.19 The psychologist concluded, "Sophie does have capacity around her diabetes treatment and care. She understands the consequences of not having treatment and not taking her insulin, she is clear that she does want the treatment but there needs to be a degree of negotiation with her."

2.10.20 An assessment of Sophie 's mental health was also made by the psychologist and quoted in full in section 4 Diabetes and Young People.

2.10.21 The psychologist helpfully provided the ward with a plan on how to work with Sophie .

- Engagement - we need to negotiate treatments with Sophie . Communication is the most important thing, and she is someone that we need to think about from a paediatric service perspective. If we fail to make treatments flexible to her needs she will struggle to comply, and it is our responsibility to ensure that we work with her.
- Avoid consultant rotations - she is someone who needs to build a relationship with one doctor, and this will also avoid conflicting messages and clear and transparent working.
- Clarity - be clear what she has to comply to: 6, 10, 12 hours of infusion? Have some agreement with her on the time of day e.g. waking up early in the morning, or having it through the night?
- Negotiating time with friends visiting and prioritising treatments.
- Aware of the consequences of her
- Make awareness of her actions and decisions
- Sophie ward confinement and making exceptions
- Provide flexible options for cigarette breaks
- Distraction and ward entertainment

2.10.22 The psychologist noted that Sophie will need ongoing work around her long-term approach to diabetes, stable housing, and emotion management. A flexible approach to care is the most important aspect of enabling her to engage with what is a very restrictive treatment regime.

2.10.23 Sophie was given a transfusion for her arm. She was also reviewed by Endocrine and confirmed her treatment and waiting for a pump. She did not want her current insulin medication changed.

2.10.24 Throughout her time on the ward, Sophie showed little engagement with staff, at times she was disrespectful and angry, shouted and threw objects. She continued her sessions with the psychologist whilst on the ward, who had contacted the social worker for further background information.

2.10.25 Sophie is described as difficult to manage on the ward but has been compliant with transfusion. The psychologist notes that Sophie does not take responsibility for her actions, denies feeling depressed or wanting to self-harm and is most likely working with the team as she is afraid of losing her thumb although there is a risk of discharging herself against medical advice.

2.10.26 The LB Tower Hamlets, Royal London Hospital Homeless Team began to support Sophie . They made a referral to Route to Roots, for benefit advice and support to make an application. Sophie was adamant that she did not want to return to Northampton where her chances of housing was better. Sophie gave permission for Route to Roots to speak with her mother, who Sophie said has refused for Sophie to return home.

2.10.27 There was agreement with the medical team that Sophie would not be discharged until her housing situation was settled. Sophie said that she did not want to live with her mother or in a hostel, but she is anxious about living alone and worried about how she will cope.

2.10.28 The Homeless Team, Route to Roots, solicitor DR and the Complex Discharge Team worked on the outstanding issues related to finance, housing, immigration. They implemented a plan to secure Sophie a legal footing to be supported as a Qualifying Child, until her 21st birthday. Contingency plans were made for a Judicial Review in relation to housing with specialist lawyers.

2.10.29 By early May 2017, the above team in consultation with Sophie and her mother secured housing and state benefits.

2.10.30 Discharge plans included follow up at clinic and referral to community nursing. Clinicians reviewed Sophie prior to her discharge. Sophie was escorted to her accommodation in LB Enfield funded by LB Haringey by Route to Roots.

2.10.31 Liaison was maintained with NMUH and LBH social worker throughout her Royal London stay. The IMR also notes that Sophie needs safeguarding, but it does not elaborate on this.

2.10.32 The IMR notes the main concern and risk for Sophie was her non-compliance with diabetes management.

Issues

- Appropriate referral to psychology and clear reason for referral
- Good multi-disciplinary team sharing of information
- Outstanding psychology assessment
- Excellent partnership working by thorough complex discharge planning. Partnership working at its best between health, advocacy, clinicians, legal, psychology, and Sophie
- Holistic approach to health and care support was evident throughout

**North East London Foundation Trust**

2.11.1 The Trust had limited contact with Sophie on the 4th March 2017 following a referral from the HDU at Whipps Cross University Hospital. The referral noted that Sophie was admitted in Diabetic Ketoacidosis and still unwell but wanted to discharge herself.

2.11.2 The HDU wanted to ensure that a) Sophie was not experiencing any mental health issues and b) that she had the mental capacity to make decisions. The HDU were satisfied that Sophie was clinically well enough for a step down to a general ward, but not for discharge.

2.11.3 Sophie gave a coherent account to the North East London Foundation Trust (NELFT) doctor of why she was in hospital and of her own diabetes management which led to her admission. She told the NELFT doctor that her self-management had led to 35 similar hospital admissions, but these were when she lived in Northamptonshire. She said that she smoked 20 cigarettes a day, did not take recreational drugs and occasionally drank. She knew why she was feeling unwell and had called the ambulance herself.

2.11.4 The background information given to the NELFT doctor was that Sophie was living in a hostel and was known to social services and currently had a social worker. The NELFT doctor spoke with the hostel staff where Sophie was living, primarily to allay Sophie 's fears that her belongings would be stolen if she remained in hospital.

2.11.5 The NELFT doctor was able to gain a good family history. He noted that Sophie had an older married sister living in Poland, a younger sister living with her mother and that her own father had hung himself when he was 21 years old.

2.11.6 She expressed antipathy towards her mother for perceived favouring of her younger sister and for lying to her about her father's death who she was led to believe died in a car accident. Her grandmother had disclosed his suicide to her.

2.11.7 Sophie denied any intentional self-harm or being motivated to punish her mother by not taking her insulin. She said that she was lazy, did not like needles or the glucose testing regime. She did not express any suicidal ideation, delusional episodes and through a mental health assessment the NELFT doctor concluded that she did not have any mental health concerns.

2.11.8 The HDU doctor requested support for a Mental Capacity Assessment and the NELFT doctor established that Sophie showed understanding and knowledge about her situation and did not show any signs of cognitive impairment.

2.11.9 The NELFT doctor discussed his assessment with a Great Ormond Street Hospital on call CAMHS Registrar. The outcome of this visit was that there was no further action to be taken by the NELFT as the HDU were able to undertake their own Mental Capacity Assessment should they assess the need.

**Issues**

- What records were available to NELFT to test the patient account?
- Good practice to consult with GOSH Registrar

**Safeguarding Adults**

2.12.1 There were three safeguarding concerns raised with the LBE Multi-Agency Safeguarding Hub (MASH). The first by the specialist paediatric nurse based at NMUH on 12th June 2017. It detailed Sophie 's poor diabetes management, her non-compliance and poor diet, the fact that she continually had little to no access to money, yet she had a new iPhone, she was generally unable to manage independently and keep herself safe.

2.12.2 Contact was made with Sophie on 15th June 2017 by the MASH. For Sophie her presenting problem was that she had no money. The MASH worker confirmed her address, what professionals she was in contact with and sought consent from Sophie to speak with other professionals about her circumstances.

2.12.3 MASH confirmed that Safer London, Housing, paediatric diabetes services were all supporting Sophie . MASH made plans for a home visit and discussion about possible sexual exploitation where her safety could be better assessed. At this stage MASH did not view Sophie in immediate

danger and confirmed involvement of other professionals and booked appointments.

2.12.4 MASH were informed on 19th June 2017 that Sophie was readmitted to NMUH because of her diabetes. A telephone conference call was made between MASH, Hospital Consultant, Specialist Diabetes Nurse, Safer London advocate and Housing Support Officer.

2.12.5 The conference established the current situation and the risks that Sophie took in relation to her diabetes management and her apparent lack of understanding about the impact her lifestyle and non-compliance had on her health. The risk that Sophie placed herself in by meeting with males in their 20's and 30's she met on the internet who she admitted to borrowing money from. Additionally, links were made with her difficult childhood experiences and her attitude to risk and self.

2.12.6 Plans were made to undertake a Mental Capacity Assessment, a s9 Care Act (2014) Assessment for Care and Support and to provide Sophie with information and advice on keeping safe and who to contact. The provision of ongoing support to access education and diabetes management was part of the planning. It is not known whether the plans were implemented.

2.12.7 A ward visit to Sophie 22nd June 2017 was made. Discussion centred around her diabetes management, accommodation, and finances. Sophie showed a tendency to put all her current difficulties on finances and housing.

2.12.8 Frank and open questioning of sexual exploitation were asked by the social workers who shared the safeguarding concern with Sophie. Her response was that she was able to protect herself and told the team about a proposal put to her at a party to work as a prostitute. Sophie had declined to become involved and had no further dealings with the people involved. She acknowledged her own responsibility in managing her diabetes but believed it was more difficult to do so because of her housing situation. She requested an insulin pump rather than be reliant on injecting her insulin as she did not like needles.

2.12.9 From this contact the MASH concluded that Sophie had capacity to make her own decisions. She showed understanding of information sharing and consent and expressed that she wanted the safeguarding concern closed. The main outcome she wanted was for an insulin pump, access to finance and better accommodation.

2.12.10 The second safeguarding concern came from the NHS 111 service on 31st August 2017. The NHS 111 handler said that Sophie had not followed up her heart valve outpatient appointment due to lack of finances and that she had several health concerns and was reluctant to attend hospital as she was fearful of losing her job. A clinician from the 111 service had spoken to Sophie .

2.11.11 On 4th September 2017, the MASH team discussed the 111-safeguarding referral with Sophie by telephone. Sophie said that she was independent and did not have care and support needs. She also however said that she was waiting for a psychiatric appointment and acknowledged that she may need psychological support.

2.12.12 The MASH worker advised her to contact her GP. The decision was made that Sophie did not meet the three-stage test for safeguarding services as MASH concurred with Sophie 's view that she did not have care and support needs and was not experiencing or at risk of abuse and neglect.

2.12.13 The third safeguarding concern received by the MASH 27th September 2017 came via a Police Merlin report. This detailed an incident of domestic violence whereby Sophie 's boyfriend had allegedly punched her in the face.

2.12.14 Sophie declined to press charges and refused for an ambulance to be called. The police however called an ambulance and paramedics advised hospital attendance due to her raised blood sugar levels. Sophie admitted that she had not taken her medication.

2.12.15 On this occasion MASH were unable to contact Sophie direct. They discussed the Merlin referral with LBH Young Adult Service who were aware of the incident. MASH closed the safeguarding episode down as were satisfied that matters were in hand.

2.12.16 A further police Merlin report was received on 4th November 2017. Police attended Sophie 's property following a report of shouting from her address. She was found alone but presented in need of medical attention and an ambulance was called.

2.12.17 The London Ambulance Service attended to Sophie and she was conveyed to North Middlesex University Hospital having gone into hyperglycaemic shock.

Issues

- Good practice to see Sophie at home for a domestic violence concern
- There was timely safeguarding action
- Collation of pattern of referrals might be made that pinpointed domestic violence when reviewing and decision making about safeguarding
- There was an opportunity for LBH under s42 – 'causing others to make enquiries' and LBE having a quality assurance oversight role.
- It should be remembered that the adult does not need to be in receipt of care and support from the local authority but where there is an identified need this is sufficient for meeting the 3-stage test for adult safeguarding.

## Section Three: Analysis

3.1.1 This Review is challenged by the sheer number of agencies involved with Sophie . For the agencies where information is available, all produced chronologies but few provided independent management commentary. Where these were available, they were a valuable tool to measure how much reflection and learning had already taken place.

3.1.2 It would be helpful for IMR authors to be provided with practice guidance on completing the IMR to meet the terms of reference to support learning and organizational discussion.

3.1.3 The chronologies all painted the same picture of a young women who had experienced a difficult childhood and whose life experiences and long-term condition rendered her vulnerable.

3.1.4 Within some organizations, there were different services and teams all working with Sophie on reoccurring issues of risk identified by all the professionals she had contact with. There was however no overall strategic joint plan for everyone to work towards. Sophie should have been at the centre of plans where her voice could be heard.

3.1.5 Statutory services in social care, housing, health providers in hospital and mental health trusts, emergency services via the police and ambulance, third sector and voluntary organisations providing advocacy all agreed that Sophie needed a stable home and ongoing emotional and practical support to accept and manage her diabetes. She also needed support to live safely and independently. How this might be achieved through a detailed shared plan agreed with Sophie and all partners was unavailable.

3.1.6 All the agencies were **responsive** to Sophie . What was lacking was a **strategic** approach to bring all the agencies together in a **methodical** and **consistent** manner keeping Sophie ’s wishes, values, understanding and thoughts central to decision making and action. There were missed opportunities to do this.

3.1.7 Sophie was adept at seeking out agencies and eliciting their help and had learnt to be so because of her difficult childhood and adolescence but did not always want to accept what was on offer and the limitations and constraints agencies worked within.

## Engagement

3.2.1 Positive attempts were made to engage with Sophie , but engagement was difficult as Sophie did not always keep appointments and it appears was not always forthcoming with facts. Time to build up a rapport was also more difficult for some agencies than others. This is particularly difficult for clinical services, as noted by the NMUH Paediatric Diabetes Team and colleagues in a meeting held with the reviewer 3rd November 2020.

3.2.2 At this meeting held at their request, the team stressed how often Sophie came to the clinic, even when not an appointment day. She became familiar with reception staff and nurses within the team whom it appeared to them was a substitute family for Sophie .

3.2.3 Colleagues from the Mental Health Trust contributed that when Sophie was an inpatient it was easier to engage with her. Ward visits were easier to facilitate as they were not dependent upon Sophie attending clinic. This situation had supported the Royal London Hospital psychologist to have a more positive working relationship.

3.2.4 Some professionals noted that other agencies were involved and there was a danger that this led to thinking that the other involved agency was actively engaged with Sophie and therefore she was safe.

3.2.5 There may have been an inclination to ‘close the case’ promptly partly because Sophie was difficult to engage rather than consider what other avenues might be explored to encourage better outcomes. It was important to consider how continued help could happen by discussion and negotiation rather than just closing the case.

3.2.6 Good practice was to include Sophie in meetings and agree actions with her. This echoes the guidance of psychologists and psychiatrists across organisations.

3.2.7 There was good practice by some professionals who were consistent and proactive in working with Sophie and in their attempts to work in partnership with others. Engaging with partners to provide a consistent approach to Sophie was not straightforward and hampered by the changing teams and personnel. The one agency that was consistent throughout was the Paediatric Diabetes Team and the one that notably built up the best rapport.

3.2.8 The need to engage was recognised by all organizations, and there was at times frustration in lack of progress. Plans to engage with Sophie emphasised negotiation which was not always easy when weighing up safety and safeguarding issues with individual autonomy.

3.2.9 When weighing up personal autonomy and professional duty of care there is no ready-made formula. It cannot be said that professionals neglected their duty of care to Sophie , but they could have worked better together to weigh up options with her.

**Referrals**

3.3.1 Referrals to other agencies were appropriate but should not be the end of involvement. There is a need to ensure that the agency receiving the referral is fully cognisant of the urgency and impact of the risk on the vulnerable person. It is also the responsibility of the receiving agency to speak with referrers to ensure that they are fully equipped with the facts and that they have understood nuances within the referral. It was particularly important in this case, that referrals were discussed as the number of professionals increased, and Sophie 's risky behaviour continued. Knowing who was doing what and why would have helped to avoid duplication and strengthen partnership working.

3.3.2 Some social care referrals led to an initial response and were not accepted as Sophie was either not seen as eligible or did not engage with the service. There was no feedback to the referrer causing delay to safeguard Sophie .

3.3.3 In some instances, eligibility was misunderstood and inconsistent within the same organisation. There also needed to be an understanding of legal guidance and statutory obligations.

3.3.4 There was little clarity over 'Ordinary Residence' and Transition and transfer of social work case responsibility. Equally for social care there may have been some misunderstanding about where paediatric and adult orientated health services change and effect follow up.

3.3.5 When fact finding a safeguarding concern, it is essential that practitioners review all known information and look at patterns of concern. Above all, they need to exchange information with other professionals. There were several police reports and a history of children and family's involvement that might have warranted greater attention. The professional who knew Sophie best and had the most consistent rapport with her were not approached for further background information in the fact-finding stage of some safeguarding episodes.

**Risk**

3.4.1 As Sophie was difficult to engage and her actions evidenced her poor adherence to medication regime, there was a danger that risks were compartmentalised. Whilst there might be better qualified expertise to manage types of risks, seeing another agency as responsible for managing risk strictly along policy and protocol lines leaves the vulnerable person still exposed to that risk if there is no assurance that other party is dealing with it.

3.4.2 The lack of engagement with Sophie might have prompted professionals to undertake a joint risk assessment. There was a distinct lack of a risk management plan that allowed for shared input, changing needs and input from Sophie .

3.4.3 Throughout all the chronologies there was good consensus at identifying risks. What is not clearly documented throughout is what Sophie viewed as risk. In this case all the professionals agreed, but that does not mean that their agreement could have been formulated into actions that would have safeguarded Sophie as she very much had her own views on risk. Sophie needed to be part of risk management planning.

3.4.4 Organisations worked hard to ensure that Sophie 's immediate support needs were met in terms of accommodation, finances, medication, clinical treatment but there was no ongoing risk strategy to involve Sophie in the decision making. The high-level risks were identified, and the increased health risk well documented with worst possible outcome identified. Within hospital settings there was good, shared understanding of risk, unfortunately this did not translate well between different organisations.

3.4.5 The tension between safety and personal choice may have led to professional paralysis, there was no evidence of strategies to try to find a balance. For example, Sophie discharged herself from hospitals and legal remedies were sought. She was appropriately screened for mental illness and mental capacity under the associated Acts which were perceived as the only option available to prevent her leaving hospital.

3.4.6 Discharging herself from hospital against medical advice was a pattern of behaviour repeated across several hospitals. This was known high risk behaviour but there was no multi-agency strategy to mitigate against the risk.

There were no recorded conversations with her mother or approach to legal services to look at options. Neither was there any clear documentation about why Sophie behaved in this way. Drilling down into her behaviour might have enabled practitioners to work together to persuade Sophie not to take such action.

3.4.7 Despite evidence of mounting risks, Sophie ’s refusal of services was respected. Even when she was a minor, and there was a s17 Child in Need assessment and plan, Sophie chose not to be accommodated by the local authority, who were later challenged by advocates, so Sophie became a Looked After Child.

3.4.8 Whilst respecting Sophie ’s autonomy it may have been possible to consider what was behind her decisions and explore issues with her. This was undertaken by the Barts Health Trust but there were constraints in continuing work once she was discharged and out of area. Where Sophie ’s decisions placed her at significant risks conversations were held with her, but they were framed within parameters of mental health and managing her diabetes better.

3.4.9 Sophie did not have presenting mental illness and had the capacity to make decisions, this however should not be an automatic response to no further action.

**Mental Capacity**

3.5.1 Sophie experienced traumatic events that might have impacted on her development. Young adults with a history of trauma are vulnerable to getting "stuck" developmentally, or to growing more slowly and/or unevenly than otherwise.

3.5.2 Because of her circumstances Sophie may have struggled with shifts in complexity of thinking that typically occur in young adulthood. She may have struggled with the expectations and demands of modern life in part because she was hampered by thinking capacities that are more typical in some ways of adolescence and younger ages.

3.5.3 When under the CYPS, Sophie was assessed as Gillick competent and chose to refuse treatments and had a pattern of discharging herself from hospital. A ruling by Lord Donaldson held that,

“If a Gillick competent child refuses medical examination or treatment then the law does allow a person with parental responsibility to consent in their place.” (2015).

It is not known if Sophie ’s mother was spoken with about consent to treatment but up until the age of 18 years, she still held parental responsibility.

3.5.6 It should also be noted that there are ongoing legal arguments surrounding this issue and that at the time Sophie came to London she was over the age of 16 years and subject to the Mental Capacity Act 2005.

3.5.7 Understanding that mental capacity is crucial at all stages of safeguarding adults’ procedures as it provides a framework for decision making to balance independence and protection, was understood by professionals working with Sophie but some professionals were not confident in their assessment skills. There is also a need to ensure that young people are assessed under the lawful framework when they reach 16 years.

3.5.8 Mental capacity assessments were undertaken to test Sophie ’s understanding around her medical care and diabetes management and whether she understood the associated risks should she decide to discharge herself against medical advice. They all concluded that Sophie had the mental capacity to make decisions. These focussed on the specific issue of discharge from hospital. Mental capacity assessments were also made when Sophie refused treatment.

3.5.9 There may have been occasions where Sophie had fluctuating capacity when she was admitted in ketoacidosis and emergency treatment was provided. The police on one occasion did not comply with Sophie ’s wishes to be seen by medical staff and called for emergency assistance from London Ambulance Service anyway.

3.5.10 This case starkly exposes the limitations of the law. It is one thing to provide emergency treatment and compel a person to receive it as an inpatient whilst they might be temporarily incapacitated. But aside from treatment of a mental illness, there is only a modest prospect of enforcing the regular daily treatment should the adult patient actively refuse to comply, whether they have capacity or not.

3.5.11 Consideration of executive capacity might have been made. This refers to the ability to carry out decisions and intentions, especially in relation to one’s own welfare. Sophie did not have an impairment of the brain but did appear incapable of acting to support her own welfare. There is no legal framework for executive capacity, built on his work of self-neglect Michael Preston-Shoot, the leading authority on ‘Executive Capacity’ identified that it is best practice

to consider ‘executive capacity’ in addition to mental capacity when working with people who are at risk of self-neglect.

3.5.12 Preston-Shoot (2019) states that the combination of Decisional Capacity (Ability to retain, understand and weigh up) + Executive Capacity (Ability to implement) leads to Capacity.

3.5.13 When working with Sophie , practitioners lawfully applied the Mental Capacity Act (2005) and what was good is that there was not an over reliance on other professional or historical mental capacity assessments, they were time specific to a particular issue. What was not taken into consideration was that Sophie ’s decision making difficulties. Whilst in theory mental capacity was good, in practice it lacked the forensic analysis to see Sophie in context and take account of her real-world behaviour.

3.5.14 Both the risk and mental capacity assessments failed to factor in how Sophie beliefs and experiences shaped her decision making. Furthermore, whilst balancing choice professionals were too accepting of Sophie ’s lifestyle choices. Respecting Sophie rights to make unwise decisions failed to consider her dignity or flag up the need to escalate the situation. Acceding to choice and determining capacity should not compound vulnerability.

**Partnership Working**

3.6.1 Partnership working did not work as well as it might have. There was a need to enhance Sophie ’s involvement, in keeping with **making safeguarding personal**. Joint working to secure outcomes in a safety plan tailored to what might enhance Sophie ’s choice and control around safety, risks, wellbeing, and her relationships. Some attempts were made to trust Sophie to manage her medication whilst in hospital, but unfortunately this was unsuccessful.

3.6.2 Looking to explore interface arrangements that might have supported Sophie was dependent upon good information-sharing and effective joint planning. There were limited agreed strategies for how to engage with Sophie It was known that in her case when she did what she wanted she placed herself at harm.

3.6.3 There were some barriers to overcome to ensure effective partnership working. One of these was understanding about the remit and responsibilities of partner agencies. Understanding how decisions were made and why in different organisations, and the constraints that they work under, might have assisted understanding, and facilitate better partnership working.

3.6.4 In this case, time and other resources in some instances were used to lever action that one organisation felt would provide better outcomes for Sophie but were not accepted by the referred to agency as it was not within their remit.

3.6.5 It is important that professionals use appropriate formal processes to challenge other professionals if they are concerned about their decision making. The first step is to talk with each other and check with their respective line management about providing helpful and supportive information, whilst ensuring that the safety of the vulnerable person remains paramount.

3.6.6 Advocacy was available to Sophie and there was good practice by inviting advocates to meetings by some agencies. Non-confrontational discussions through management lines might have strengthened better partnership working rather than involvement of adversaries wasting resources and creating a possible negative response to collegiate decision making.

3.6.7 Working through legal challenges to ensure Sophie 's immigration status and secure her National Insurance number earlier by good information sharing would have been helpful.

3.6.8 Practitioners held various meetings to facilitate information sharing. Initially these were statutory meetings under the Children Acts, health policy practice Multi-Disciplinary Team and psycho-social meetings, there was no adult social care initiated statutory multi-agency meetings.

3.6.9 There was good information sharing emanating from some meetings with some agreed actions, and the NMUH initiated conversations with social care and health colleagues to keep practitioners updated, as did the Royal London. There was a gap however in assessing the impact of risk on agreed actions by systematically reviewing them with Sophie .

3.6.10 Transition planning was a missed opportunity for all the organisations to meet with Sophie to plan her future, which would have included safeguarding.

**Safeguarding**

3.7.1 Working with adults who do have capacity to make decisions, albeit perceived as unwise ones by professionals is still a safeguarding matter, where that person is at risk of abuse and/or neglect. This includes self-neglect.

3.7.2 There are several mechanisms to support safeguarding. A referral was made to the Child Sexual Exploitation meeting and consideration for a referral to the Multi-Agency Sexual Exploitation (MASE) and to the Multi-Agency Risk

Assessment Conference (MARAC), these however were focussed on specific types of risk. A multi-agency Complex Needs or High-Risk Panel may also have been in existence but not considered.

3.7.3 Good practice was noted by the inclusion of health, social care, and advocates to some meetings. It is also noted that Hospital Consultants worked across specialisms and across paediatric and adult services to support safeguarding plans.

3.7.4 There was no panel managing complex Self Neglect. This may not have changed the outcome but may have changed the focus if self-neglect is accepted as a multi-agency challenge that requires close networking with all partners and not the predominant domain of one agency.

3.7.5 The link between Deliberate Self Harm and Self-Neglect was made by the Royal London psychologist and is an area that requires more in-depth exploration.

**Self-Neglect**

3.8.1 Refusal of services, missing appointments and poor medication adherence were all signs of self-neglect and were treated in isolation rather than used as an opportunity to assess an unfolding pattern of behaviour. What was needed was a sensible risk appraisal to examine why Ms. SOPHIE continued to make unwise decisions and lifestyle choices.

3.8.2 Self-neglect often involves an interplay between mental, physical, social, and environmental factors. There is no clear point at which lifestyle patterns become self-neglect. Key triggers include disability, poverty, lack of physical space within the home.

3.8.3 There is no single operational definition of self-neglect however, the Care Act (2014) makes clear it comes within safeguarding if the individual concerned has care and support needs and is unable to protect him or herself from neglect. The Department of Health (2016) defines self-neglect as, '… a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding'.

3.8.4 Good practice when working with people that show signs of self-neglect (Self-neglect policy and practice: key research messages, SCIE, 2015) provides a helpful guide for practitioners. These include:

- ✓ Taking time to build a rapport

- ✓ Trying to find the 'whole' person through their history
- ✓ Engaging with their network and people who may know best why they are self-neglecting
- ✓ Working at the individual's own pace – there may be moments of motivation
- ✓ Offering choice and having respect
- ✓ Ensuring an understanding of mental capacity in respect of the person's self-care decisions
- ✓ Being honest and open and transparent about risk and options
- ✓ Having in-depth understanding of legal mandates
- ✓ Utilising creative and flexible interventions
- ✓ Engaging in effective multi-agency working to ensure inter-disciplinary and specialist perspectives, and co-ordination of work towards shared goals

3.8.5 Known facts about Sophie 's early history:

- Sophie was a migrant child whose first language was not English
- She came to the UK aged 8 years
- Her father committed suicide prior to her birth
- She had an older and younger sibling who have different fathers
- Family finances were stretched
- Sophie had a poor relationship with her mother
- She had an allocated children social worker when living in the family home
- She attended paediatric outpatient appointments unaccompanied
- She drank alcohol from an early age
- She left home at an early age (16-17 years old) with no clear objective to work, study, or train

3.8.6 Vulnerabilities identified by London organisations

- Made friends with older males
- Lived in unhygienic multi-occupancy households with unknown males
- Evicted for non-payment of rent
- No appropriate housing
- Poor self-management of long-term condition
- Concerns over possible sexual exploitation
- Attended Emergency Department due to non-compliance of medication
- Admitted to several London hospitals for poor adherence to medical needs
- No steady income

- Seeks out agencies to support her in practical ways
- Has poor diet and drinks alcohol to excess
- Has some insight into poor medication management
- Difficult to engage
- Expresses suicidal ideation
- Poor cardiovascular fitness
- Poor circulatory fitness
- Access to resources limited by immigration status/NI eligibility
- Victim of domestic violence

3.8.7 Understanding the 'whole' person in this case was piecemeal. Mapping out Sophie 's history and linking her behaviour in terms of self-neglect was indicated by the NELFT doctor and followed up by the Royal London psychologist. Information was shared within organisations, but these factors and relevance were not always fully explored and worked with.

3.8.8 Building a rapport seemed the most positive with the PDSN from NMUH. Sophie made unplanned visits and disclosed sensitive information to her. Time constraints, role and responsibility created barriers for this working relationship to develop along the lines that Braye et al suggest. The PDSN advocated to continue to support Sophie and highlighted that progress was slow but that improvements in engagement could be seen.

3.8.9 Providing choice and control was difficult in this case as it was unclear what she wanted. Accommodation was offered including privately rented housing, but Sophie did not collect the keys. She disliked hostel living and the concept of becoming a Looked After Child, but in the end signed her own s20 paperwork. Sophie needed her National Insurance card to make benefit claims, but this did not appear to prevent her from enrolling on college courses or take part time jobs.

3.8.10 The one area within Sophie 's reach to control was her medication regime. She asserted her control by being non-compliant, knowing that the outcome would be detrimental to her health and understood according to the NELFT assessment that this could mean death. A longitudinal study at the Radcliffe[1] has evidenced that, "poor control in adolescence relates to the physiological changes of puberty; however, problems of adherence to treatment regimens and attendance at outpatient visits suggest that psychological factors are also important."

3.8.11 Decisions were by and large made for Sophie with best intentions. Organisations were working within budgets and available resources, but it

[1] Radcliffe – Oxford University Hospital NHS Foundation Trust

was not possible to understand from the chronologies and IMR what Sophie ’s views, goals and aspirations were other than noting possible careers.

3.8.12 Advice and information were given to Sophie , and there was evidence of frank and open discussions with her. She attended the dietetic outpatient appointments and was aware of the effects of alcohol on her condition. Her cognitive skills were not impaired, but this did not mean that she was psychologically ready to change her lifestyle or was able to do so without a supportive and caring personal network.

3.8.13 For effective intervention in managing self-neglect, there needs to be effective multi-agency working with scope for creative and flexible interventions. Braye et al concluded from their research of Safeguarding Adult Reviews related to self-neglect: “Convening practitioners who could contribute a range of disciplinary perspectives to self-neglect proved to be a powerful tool in practice. Collaboration was often highly effective on the ground, with examples of strong engagement between adult social care, medical and health practitioners, the police, housing, environmental health, voluntary organisations and many others to develop shared understandings of a given situation, which could then inform the interventions selected as priorities. Case conferences, team discussions, multi-agency risk panels and other ways of convening partners were generally experienced as positive in confirming a sense of direction in an individual case, and in agreeing where the most appropriate focus should be placed, and by which agency.”

3.8.14 In creating a safeguarding structure for self-neglect Braye’s research advocates a strategic framework encompassing:

- a clear location for strategic responsibility for self-neglect
- shared understandings of how self-neglect might be defined
- joined-up systems to ensure coordination between agencies
- time allocations that allow for longer-term supportive involvement
- data collection on self-neglect referrals and outcomes
- training and practice development around the ethical challenges, legal options and skills involved in working with adults who self-neglect.

3.8.15 Concerns that Sophie did not have the ability to decide about her safety and reasonable belief that she could suffer serious harm, because she was self-neglecting and her inability to take reasonable actions to keep herself safe could have led to a focussed multi-agency safeguarding plan if there had been better partnership working on self-neglect. What was missing was:

- Guidance – multi-agency consensus for managing self-neglect
- Clarity over the interface with safeguarding

- Acceptance that mental capacity assessment alone is insufficient
- Challenges over service-related factors – time, resources, guidance, eligibility
- Appraisal of mental capacity and refusal of help
- Application of executive capacity when working with self-neglect

3.8.16 Failure to escalate Ms. SOPHIE 's self-neglect was hampered by the lack of a strategically endorsed multi-agency approach for people with complex needs who self-neglect, cutting across health, social care, and housing, supporting operational staff to take creative solutions and actions, jointly monitoring progress, sharing challenges, and celebrating success.

**Safeguarding and Domestic abuse**

3.9.1 Professional practice tended to focus on the pathology of Sophie 's health rather than also considering their underlying causes. Substance/alcohol abuse and mental health might all be indicators of domestic and other abuse. It is important not to jump to conclusions but rather to use professional curiosity to look at risk.

3.9.2 The presence of both substance and excessive alcohol consumption and mental health issues were seen separately and not associated to risk of abuse and/or self-neglect by all the agencies, especially those who tended to focus on practical support.

3.9.3 Agencies homed in on Sophie 's diabetes management and related diet/alcohol misuse, then her mental health and substance misuse while missing the opportunity to focus on self-neglect.

3.9.4 There was a need to explore opportunities locally for professionals to be more aware of the significance of Sophie 's adverse childhood experiences. The importance of proactive professional enquiry regarding family histories was not evident throughout all the interactions with her.

3.9.5 There is an increased awareness of the frequency with which domestic and sexual violence, substance use and mental health problems co-exist, particularly in the context of safeguarding.

## 4. Diabetes and Compliance

4.1.1. Type 1 diabetes is a lifelong, chronic condition and the most common endocrine disorder of childhood (Edge *et al.*, 2013). Diabetes complications increase the costs to the NHS more than fivefold and significantly increase the demands on hospitals. The total expenditure on diabetes complications is estimated to account for 10% of the NHS budget (Hex *et al.*, 2012). The management of this chronic, complex condition can be challenging and one that Ms. SOPHIE struggled with from an early age.

4.1.2. Effective self-management is vital to the control of diabetes. Research shows that there are better outcomes for children and young people where there is positive parenting. This in turn leads to better self-management as an adult. In Sophie 's case it was noted by Northamptonshire services that there was a poor pattern of engagement with professionals established in her childhood. Northampton Diabetic Service reported to LBH that Sophie was rarely accompanied to medical appointments by her mother and that historically the family engagement with professionals was poor.

4.1.3. Research shows that young people have poorer compliance and outcomes as measured by the number of DKA episodes where they have too much or too little family support.

4.1.4. Important variables for the prevention of diabetes mellitus and its complications are the management of risk factors. Sophie was aware of the importance of adherence to self-managing her diabetes but was unable to put it into practice. It may have been thought that her attitude towards compliance was part of her naivety and possible assumptions made about autonomy, and misinterpretation of behaviours being part of normal adolescent development.

4.1.5. Research by Garvey (2013) have shown that young people with chronic conditions are more likely to engage in risky behaviours. This includes alcohol and substance misuse. The World Health Organization (2008) found that 70% of premature adult deaths are strongly associated to adolescent behaviours.

4.1.6. Practitioners working with young people with a chronic condition like Ms. SOPHIE who engage in risky behaviour might consider the detrimental impact of poor parenting during early adulthood and identify whether it is a contributory factor that should be addressed. Whilst Ms. SOPHIE 's behaviour was well documented, there was little information about her early childhood experience shared with London organizations.

4.1.7. Research notably by Dr JS Chandon (Birmingham University 2020) suggests that exposure to domestic abuse may be associated with other lifestyle factors such as poor diet, alcohol, and smoking, as well as mental ill health.

4.1.8. Sophie would fall into this pattern but as Chandon says it is important to remember not every woman experiencing domestic abuse will go on to develop a long-term illness. His research has shown that victims of domestic abuse are nearly three times more likely to suffer from mental ill health during their lifetime, and have **above-average rates of diabetes, heart disease and death**. Although the Chandon research is based on people with Type 2 diabetes, the research on domestic abuse and disabilities evidence that disabled women are three times more likely to experience domestic abuse.

4.1.9. The Radcliffe study of adolescent and young people with diabetes were recruited from the register of the outpatient paediatric diabetes clinic aged 11 to 28 years old. They were not screened by any socioeconomic status.

4.1.10. This study was the first to examine in detail the clinical and psychological course of diabetes from adolescence to young adulthood, and the generally poor outcome for this group.

4.1.11. Bryden et.al (2003) concluded that adolescence is a difficult time for people with type 1 diabetes because glycaemic control often deteriorates and the risk of developing long-term complications seems to accelerate.

4.1.12. The study concluded there was higher psychiatric morbidity in patients with diabetes compared with the general population. Referral for psychiatric assessment was common and was most often observed in those patients who also had recurrent hospital admissions for diabetic ketoacidosis. The only predictor of the Global Severity Index of mental state at follow-up was recurrent hospital admissions for diabetic ketoacidosis, suggesting that when diabetes is significantly out of control, it raises the risk of psychological morbidity. Psychiatric disorders have been shown to be more common in both adolescents and young adults with type 1 diabetes than in nondiabetic populations.

4.1.13. It is worth quoting The Royal London psychologist in full as her conclusions about Sophie ’s need for safeguarding as a young person with type 1 diabetes summarises the learning from this Safeguarding Adult Review.

4.1.14. “Sophie presents as a slightly aloof, relatively immature teenager. She uses humour, and ‘not caring’ to defend against anxiety and fear, and to hide the fact that she is finding things difficult. She is resilient, resourceful and fiercely independent- someone who has had to take care of herself and rely on herself to get her needs met and finds showing her vulnerability difficult. She readily acknowledges that she is finding the transition to adult services difficult and she requires a thoughtful, flexible approach to her treatment in order to help her to engage and comply with what are often complex regimes. She does not

present as depressed, psychotic or display affective symptoms however she struggles with (1) having diabetes (2) being told what to do (3) having to 'comply' on other people's terms (4) not being able to rely on others. This is all within the context of a past that has been incredibly difficult, unstable, and not conducive to her basic needs being met as a child. She has no active thoughts of Deliberate Self Harm but tends to fall into a pattern of self-neglect when her life becomes stressful and in this respect, she is vulnerable, and I suspect has a limited repertoire of emotional coping skills and strategies. We forget what a challenge diabetes and complying with ward treatments are, especially for someone who has usually negotiated this from within a more child friendly environment." The Royal London Hospital, Independent Management Review & Chronology for Safeguarding Adult Review on Sophie . (September 2020).

4.1.15. The recurrent diabetic ketoacidosis was a significant risk to Sophie. She exhibited an inability and unwillingness to comply with what is a strict and time-consuming regime. The barriers to her compliance were physical, homelessness and lack of finances, also psychosocial set by the influence of her past.

4.1.16. These factors were the main areas that demotivated her to reduce the risk of harm but could not eliminate all risk

Transition

4.2.1 Transition is a complex process that cannot be addressed by a single intervention and should focus on the developmental and psychosocial needs of the young person. It is a continual process and not a single event. Ideally transition in social care should start from the age of 14 years. Sophie was 17 years old when she came to London. It is not known if any transition planning was in progress when she lived in Northamptonshire.

4.2.2 It was highlighted by NMUH that transfer between children and adult social care needed to be discussed as there was a danger that Sophie would be lost. It should however be remembered that transition is wide ranging and includes health, education, legal frameworks, consent, mental capacity and personal responsibility. It is National Diabetes care for children policy that young people with diabetes receive paediatric healthcare until they are 19years old.

4.2.3 The London Safeguarding Adults Policy and Procedures (2019) provides guidance on how young people should be safeguarded during the transition period. These are based on the Children & Families Act 2014 and the Care Act 2014. The duties in both Acts are on the Local Authority, but this does not exclude the need for all organisations to work together to ensure that the

safeguarding adult's policy and procedures work in conjunction with those for children and young people.

4.2.4 There should be robust joint working arrangements between children's and adults' services for young people who meet the criteria for safeguarding adults. It should be remembered that care and support does not have to be provided for qualifying for safeguarding but there must be a need. In Sophie 's case, it could be argued that there was a need in terms of therapeutic or psychiatric services.

4.2.5 The care needs of the young person should be at the forefront of any support planning and requires a co-ordinated multi-agency approach. Assessments of care needs should include issues of safeguarding and risk. Care planning needs to ensure that the young adult's safety safeguarding is not put at risk through delays in providing the services they need to maintain their independence, wellbeing and choice.

4.2.6 Where there are on-going safeguarding issues for a young person and it is anticipated that on reaching 18 years of age, they are likely to require adult safeguarding, arrangements should be discussed as part of transition support planning and protection. Conference Chairs and Independent Reviewing Officers, if involved, should seek assurance that there has been appropriate consultation with the young person by adult social care and invite them to any relevant conference or review.

4.2.7 In Sophie 's case there was a role for the Independent Reviewing Officer by inviting Sophie to the final LAC review to clarify her ongoing needs. It does not appear that this happened.

4.2.8 Clarification should be sought on:

- What information and advice the young person has received about adult safeguarding.
- The need for advocacy and support.
- Whether a mental capacity assessment is needed and who will undertake it.
- If Best Interest decisions need to be made
- Whether any application needs to be made to the Court of Protection

4.2.9 Non-compliance to treatment was a long-standing issue, and Northamptonshire diabetes team gave a negative report on their working relationship with the family. These specific issues might helpfully have featured in transition care planning.

4.2.10 The transition planning should support a young person to plan, by providing them with information about what they can expect. All transition assessments must include an assessment of:

- current needs for care and support and how these impact on wellbeing
- whether the child or carer is likely to have needs for care and support after the child in question becomes 18
- if so, what those needs are likely to be, and which are likely to be eligible needs
- the outcomes the young person or carer wishes to achieve in day-to-day life and how care and support (and other matters) can contribute to achieving them. DH Statutory Health & Support Statutory Guidance (2016)

4.2.11 A multi-agency approach with input from all the agencies supports the young person to achieve positive outcomes. The NMUH sought to hold a professionals meeting with adult social care but in the event, this did not take place in a considered, timely manner.

4.2.12 There is a record on LBH system that states on 5th May 2017 a Pathway Plan was to be made. The Regulations for Pathway Plans state:

(1) Regulations require that the pathway plan must be prepared as soon as possible after the needs assessment and must include the care plan. The needs assessment must be completed not more than 3 months after the date on which the young person reaches the age of 16 or becomes an eligible child after that age; within 3 months of arrival if they are an unaccompanied asylum seeker; within 3 months of becoming relevant if they do not already have a pathway plan; within 3 months of the LA being informed that a former relevant young person is pursuing, or wishes to pursue, a programme of education or training.

(2) The pathway plan must set out how the young person's needs are to be met and the date by which, and by whom, any action required to implement any aspect of the plan will be carried out.

(3) The pathway plan must be reviewed within the statutory regulations and when significant change impacts upon the plan. For example, a review may be called by the young person or a PA or other professional when there is an assessed risk of crisis or a change in circumstances (e.g. planned move, homelessness, sentenced to custody, or becoming a parent). The results of the review and any changes to the pathway plan must be recorded in writing.

4.2.13 For Sophie the Pathway Plan completed by the Young Adult Service is dated 7th November 2017 approximately 8 months after Sophie`s 18th birthday, and two weeks prior to her death.

4.2.14 There was an attempt by the PA to hold a handover meeting with the previous worker, but this did not materialise.

4.2.15 There is a plethora of research and best practice guidance available about transition planning which in this case was limited. Where it is not possible for 'older' young people to engage in longer term transition planning, working on a fast-track system to improve chances of a smoother transition to adult social care focussing on essential needs might be explored further. Those young people who fall through the gaps maybe more likely to have less stable familial support to rely on.

4.2.16 The National Institute for Care & Health Excellence (NICE, 2020) pathway flowchart provides key stages for both health and social care.

- **Ordinary residence and transfer of responsibilities**

4.3.1 The question of who has the duty of care towards Sophie did to some degree place her at continued risk with inadequate support. There was confusion and misunderstanding within and between services. Professionals were unsure about legal mandates and agreed protocols.

4.3.2 s17 Children Act 1989 provides clarity that a duty is owed to safeguard and promote the welfare of children within their area who are in need. Indeed, in Sophie 's case the Southwark ruling (s20) strengthened the case that LBH was the area where Sophie was in need, despite being accommodated in another area.

4.3.3 The Local Government Association (2018) sets out for adult social care, "The question of ordinary residence should be determined after a needs assessment has identified that the person has eligible needs under the Care Act 2014. Any disputes about ordinary residence must not adversely affect the meeting of the needs identified. Therefore, one authority must accept responsibility on a provisional basis. This will be whichever authority is currently meeting the needs, or if none, where the individual is currently living, or if that is not clear where the individual is present."

4.3.4 For Sophie she was ordinarily resident in LBH, so when she was discharged from hospital although living in LBE, it would be LBH who would remain responsible for her care and support. (s74 Care Act 2014)

4.3.5 For safeguarding it is the host authority. In Sophie 's case LBE held overall responsibility for any s42 enquiries under the Care Act 2014. In undertaking their responsibility, it would be good practice to involve the placing authority in this case LBH to contribute to any safeguarding plan as they retained responsibility for needs assessments and care and support planning.

4.3.6 For Sophie there was potential for disputes about duty and responsibility to take precedence over care planning, safety, and wellbeing. Where this existed it created uncertainty, frustration, and poor communication. Strong partnership working was adversely affected.

4.3.7 Work carried out by ADASS (2016) note that, “there is increased safeguarding risk and complexity associated with adults whose care and support arrangements cross local authority boundaries.” Unfortunately, it is likely the increased risk and complexity was a challenge not entirely overcome for Sophie .

4.3.8 Sophie had received services from Northamptonshire Children and Families services and from Kettering Hospital Paediatric Diabetes Team. These services appeared to cease their engagement once they were aware that Sophie had left the local area. What would have been best practice was to provide a Transfer Summary within the parameters of information governance to the receiving services to promote Sophie ’s welfare.

4.3.9 It would have been useful to learn about any tried and tested ways of engaging with Sophie ; the support previously offered; risks from within the family and her personal network, especially in the light of Sophie being encouraged to return to the area for at least the holiday period.

4.3.10 Previous planning on transition if shared with the London teams would have provided some building blocks for discussion with Sophie .

4.3.11 Chapter 19 of the Care and Support Statutory Guidance (updated 2020) sets out roles and responsibilities under the Care Act 2014. The LBH ASC services acquired the legal responsibility to provide care and support when Sophie became an adult. The transfer to ASC could have been better managed if there was a clear pathway for all organizations to understand and follow. More timely decision making would have reduced confusion for professionals and Sophie .

## Section Five

### Conclusions

5.1.1 Organisations and individuals working with Sophie were responsive to her needs but failed to plan strategically to improve her situation. They were not individually neglectful but there was an overriding need to improve how they worked together.

5.1.2 Risk assessments were not routinely and systematically undertaken and did not inform shared decision making with Sophie or between partners.

5.1.3 There was no evidence that Sophie ’s history, beliefs, values, and goals were explored with her to support her own thought planning. Evidence of work to ‘find’ the whole person and to understand her life history rather than just the need that might fit into an organisation’s specific role seemed to be the pattern of working with Sophie .

5.1.4 Engagement in effective multi-agency working to ensure inter-disciplinary and specialist perspectives, and coordination of work towards shared goals was limited. There was little planning and joined-up systems to ensure coordination between organisations or within them.

5.1.5 For young adults who or it is suspected self-neglect referral pathways, safeguarding and self-neglect forums, flexibility in work allocation practices, training and support all have a key role to play in working towards better outcomes. as does an ethos of shared ownership between the agencies whose interventions can make a difference.

5.1.6 There was a failure to escalate the case for senior management discussion to make a risk appraisal. There was no strategic mechanism to support complex high-risk cases of Self-Neglect.

5.1.7 Understanding of and application of Executive Capacity, Vulnerability and Self-Neglect was not on the radar. Identification of psychological and behavioural problems in young adults who self-neglect and the significant morbidity associated with poor adherence to medication management requires targeted more effective interventions. This might include understanding links between Deliberate Self Harm and Self-Neglect.

5.1.8 There were some areas of good practice shown by some individuals and organisations. Most notably the effort to go the extra mile by the PDSA to try and engage with Sophie . Working across paediatrics and adult health provision focussing on Sophie 's circumstances and taking a flexible approach rather than strict adherence to remit.

5.1.9 The clear psychological assessment of who Sophie was and what factors influenced her life, and her current behaviour was exemplary.

5.1.10 There was timely response to safeguarding concerns. Where there might have been domestic violence best practice on meeting people in their own homes and face to face took place.

5.1.11 Referrals to psychological and psychiatry were considered and appropriate. Sophie was an emergency admission to hospitals and efforts were made to understand her story and make social care referrals.

5.1.12 There was good consensus on identifying risk but limited agreement on how it might be managed. The absence of a lead co-ordinator and managerial separation of agencies created a gap in recognising that a different approach to time limited stages of intervention was needed.

## Section Six

- **Learning**

6.1.1 It is three years since Sophie died. There has been development in practice and policies throughout this time. Assessing areas of practice that worked well and areas that requires improvement was assisted by some of the commentary and reflection made by the IMR authors.

6.1.2 The NMUH has undertaken a 'Rapid Review' in 2018 and produced its own action plan, which will be disseminated internally once the SAR is complete.

6.1.3 The LBH is working on development of its High-Risk Panel under the Make Every Adult Matter agenda which is designed to support work with complex cases like Sophie .

6.1.4 Training and guidance on Self-Neglect is being disseminated and the work of Braye et al is making an impact on practice.

6.1.5 The work of Michael Preston-Shoot on Mental Capacity and understanding Executive Capacity is gathering momentum.

6.1.6 ADASS produced a Guidance Note on Commissioning an Out of Area Care and Support Services which the LBE with colleagues in the North Central London borough coalition are working on to tackle information sharing and partnership working.

6.1.7 Some of the agencies involved in this SAR, provided written commentary on the work that they were developing, either as a direct consequence of this SAR or had identified work whose aim is to improve outcomes for young adults like Sophie .

**Barts Health**

6.1.8 At the time when Sophie was in hospital, any young person admitted to the wards was seen by the Mental Health Liaison Team who specialise in adults attending or admitted to the Royal London Hospital. Since Sophie death there has been changes in who sees 16- and 17-year olds admitted onto adult wards, they are now seen by CAMHS and make decisions with the Paediatric Liaison Team. Since 2018 Barts Health has employed jointly with East London Foundation Trust a psychiatrist who specialises in people with Type 1 diabetes with a focus on people who are non-compliant with their medication.

6.1.9 Bart's Health are adopting the 'Ready, steady, go, hello to adults' transition framework, which is supported by the Children's Clinical Health Board and the Medical Board. Clinical teams who do not have an identified framework are encouraged to use this framework. This aligns with Bart's Health being part of cohort 1 of the NHSE/I transition transformation collaborative in 2019. The Trust wide diabetes team are involved with the implementation plan. There have been awareness sessions during 2019 which was attended by multi-disciplinary members from acute and community services, within adult

and children's services. Due to current restrictions on face-to-face training sessions, there are discussions about virtual awareness sessions.

6.1.10 Cerner records show CP-IS as 'not performed'. The safeguarding team identified issues with some CP-IS checks showing as 'not performed' in Nov 2019. The issue has been resolved and ongoing audits are taking place to monitor this. In July 2020, some additional 'not performed' cases have been identified and are being investigated. The lack of a CP-IS check for Sophie would have delayed CSC being notified that she had attended an unscheduled care setting, however the Social Worker was updated on 03.03.2017

**GP Service**

6.1.11 Although NMH children's diabetes care is supposed to be entirely holistic (see 1.5 Service provision 2004, amended 2016), the GP could have a greater role in flagging Type 1 diabetes and mental health children DNA's on our system, so we can contact them and – if patient doesn't want to engage in secondary care, GPs can help to manage the patient under specialist guidance and using their own skills.

6.1.12 This is already happening to an extent, but an improved service will be launched next week making it official practice policy to contact young person when they Do Not Attend (DNA) re mental health and type 1 DM and other serious/life-threatening conditions.

6.1.13 Numbers are small and not possible to ever prove that you've saved a life, but a lesser criterion such as numbers of DNAs that the GP has successfully manged to contact the patient who DNA'd would be a reasonable outcome measure.

6.1.14 As soon as patient has registered with new GP the GP held patient record is sent over electronically to the new GP. If we see evidence that patient lives out of our catchment area, we are pro-active in contacting the patient to let them know this and encourage them to find a new GP. GP can also inform hospital if patient DNAs and is living at a new address.

6.1.15 The GP is monitoring the success and aim for improvements when GP proactively chases up every young-person serious-condition DNA. Success will be measured upon receipt of evidence of successful registration with new GP.

6.1.16 The GP viewed transition between children and adult services as the responsibility of secondary care. GP proposed that their admin team chase secondary care and encourage the young person + family to chase them if we see evidence that transition has not been successful.

6.1.17 The GP recognised that there were constraints to how persistent NHS staff could be, where a young adult refuses psychiatric/psychological support and the steps that primary care can make to persuade them.

6.1.18 The GP commented that they would welcome further discussions on decision making when a young adult either refuses support or is seen as ineligible for support.

**NMUH**

6.1.19 The Diabetes Paediatric Service were keen to learn from the SAR to tie in with learning from the Rapid Review. They proposed that where children and young adults attended clinics unaccompanied by a responsible adult this should flag up the young person's possible vulnerability.

6.1.20 At a meeting with the Reviewer the emotional impact on staff following Sophie 's death was discussed. A concern shared by staff was whether anyone attended Sophie 's funeral and suggested that ending involvement with patient's needed to be considered.

**LBH**

6.1.21 Adult Social Care in addition to their 'Multi-Agency Solutions Panel' under the Make Every Adult Matter agenda has also produced a Vulnerable People Protocol, to support people who did not meet eligibility criteria for care and support services under the Care Act 2014.

6.1.22 LBH also reported that there were changes in transition arrangements from children to adult services.

6.1.23 Barnet, Enfield & Haringey Mental Health Trust were not initially part of the SAR Panel. It was agreed that this was an oversight and that this oversight can be partly rectified by ensuring that the Trust contribute to Learning Events around this SAR.

6.1.24 In summary, the main learning thread for all the agencies was how to balance respect for autonomy and self-determination with duty of care and promotion of dignity.

## Section Seven

### Recommendations

1. A multi-agency (health, housing, environmental health, social care, mental health) Task & Finish Group to draw up and implement lasting improvements to practice and services aimed at safeguarding and promoting the welfare specifically of people at risk of self-neglect. (Consider MEAM)

2. Ensure that the SAR is discussed with the family prior to publication.

3. Partner agencies should ensure their records capture the detail and rationale for actions and decisions and have processes for timely information sharing.

4. When children and young people move to live permanently in the UK and are known to social care, support should be given to ensure their Rights under UK legislation to be included in CYPS plans, Pathway Plans, Transition Planning etc. Likewise support to be offered in ASC via Information & Advice as per the Care Act 2014.

5. The SAB might consider sharing learning opportunities with Northamptonshire.

6. Independent Reviewing Officers to ensure that transition plans are in place for all Looked After Children and ASC invited to final LAC Review

7. Understanding Mental Capacity/Executive Capacity and Self-Neglect/Deliberate Self Harm to be included in future training programme

8. Review how agencies work together on risk, by the development of a shared risk management plan.

9. Review with Advocacy Networks how advocacy is commissioned and supports people to prevent duplication of scarce resources

10. Where there is uncertainty whether an adult has care and support needs liaise with health professionals (GP request for recommendation)

## References

Michael Preston-Shoot (2019) Self Neglect & Safeguarding Adult Reviews: towards a model of understanding facilitators and barriers to best practice

Making Safeguarding Personal – Local Government Association

DHSC (2016) Care and Support Statutory Guidance

SCIE Self-Neglect (2015) Self-Neglect Policy and Practice

Radcliffe Hospital- Oxfordshire Diabetes Service

Braye and Preston-Shoot – Best practice evidence from research and reviews

Edge et al (2013) Diabetes in children and young people

Hex et al (2012) Estimating the current and future costs of diabetes type 1 and 2

Garvey (2013) Health Care Transition in Young People with Type 1 diabetes

JS Chandon (2020) Institute of Applied Health Research

Bryden et al (2003) Self Neglect and Adult Safeguarding

NICE (2020) Pathway Plan Transition from Children to Adults Overview

LGA (2018) Ordinary Residence Guide