CITY OF YORK
Safeguarding Adults Board

7 Minute Briefing

Safeguarding Adults Review

Julie

THE ADULT

Julie had a long history of complex needs including anorexia, mental health issues, substance misuse, and self-neglect. She lived in private rented accommodation in York, which became unsuitable due to her declining mobility and health. The accommodation did not meet her needs towards the end of life, and she was unable to leave the property due to her reduced mobility and health. She was known to several services throughout her life for her physical, mental health and social care needs. Julie had periods of time in hospital and rehabilitation establishments due to ongoing self-neglect,

THE BACKGROUND TO THE REVIEW

Despite being known to multiple services, she often declined support, becoming increasingly isolated, especially during the COVID-19 pandemic. Julie was admitted to hospital Intensive Care Unit and diagnosed with being underweight and suffering with malnutrition. She sadly died in hospital in 2022 from complications related to malnutrition.

The City of York Safeguarding Adults Board (CYSAB) initiated the SAR after a referral in 2023. The review met the criteria under Section 44 of the Care Act 2014. It aimed to understand how agencies worked together, the impact of the pandemic, and whether Julie's needs were appropriately assessed and met.

RECOMMENDATIONS

- Promote professional curiosity: Encourage practitioners to explore beyond surface-level information.
- Improve understanding of the Mental Capacity Act and Depravation of Liberty Safeguards (DoLS): Ensure timely reviews and proper communication.
- Use advocacy: Especially for individuals with complex needs or facing legal proceedings.
- Adopt holistic, multi-agency approaches: Avoid siloed working.
- Enhance information sharing: Use proportionate and timely communication.
- Support for DNAs: Develop multi-agency guidance for managing non-engagement.
- Clarify funding pathways: Increase awareness of entitlements like NHS Continuing Healthcare and Section 117.

KEY LEARNING POINTS

ONE

Professional Curiosity:

A recurring theme was the lack of professional curiosity. Agencies often accepted Julie's statements at face value without verifying them, despite her history of mental health issues and capacity concerns. There were missed opportunities to explore inconsistencies and to assess her needs more thoroughly. There were periods of time that Julie was not seen in person to ensure information was substantiated.

TWO

Mental Capacity and Advcoacy

Julie's fluctuating mental and physical health raised questions about her capacity to make complex decisions. While she was subject to Deprivation of Liberty Safeguards (DoLS) during hospital stays, there was poor communication about these arrangements. Julie would have benefited from an independent advocate, especially when facing legal issues and during discharge planning.

THREE

Complexity of Needs

Julie's case highlighted the challenges of supporting individuals with multiple, overlapping needs. Agencies worked in silos, failing to adopt a holistic approach. There was a lack of coordinated care planning that considered her physical health, mental health, trauma history, housing, and safeguarding risks.

FOUR

Information Sharing and Did Not Attend (DNAs)

Information was not shared effectively between agencies, leading to fragmented care. Julie frequently missed appointments (Did Not Attend - DNA), but there was little evidence of follow-up or consideration of her barriers to access. This contributed to her disengagement and unmet needs.

Click on the link below for the Jule SAR executive summary on the CYSAB website

https://www.safeguardingadultsyork.org.uk/downloads/file/35/julie-safeguarding-adults-review-executive-summary