**Swindon Safeguarding Partnership**
**Executive summary**
**Safeguarding Adult Review – Brenda**

## Introduction

Brenda was aged 75 years when she died on 03/02/21 in hospital, after several weeks of accelerating deterioration at home. From Christmas Eve 2020, Brenda withdrew from essential activities of daily living. The first signs of this were neglect of the home environment with rotting food and milk and a build-up of unwashed dishes. By 14/1/21, the visiting community nurses were concerned about poor food and possibly poor fluid intake. Conditions were exacerbated by the results of unmanaged incontinence of faeces, visible about the home and on clothes, on the bed and on Brenda.

Brenda lived alone, did not go out, and wanted to avoid Covid 19 exposure. Brenda was estranged from her son, for reasons that were not explored at the time. In the past he had arranged food deliveries for her but there was otherwise not a known history of family involvement with Brenda. On 2/2/21 when Brenda was extremely ill and being taken to hospital, her son could not be notified since there was no current telephone number on record.

## Summary of Themes

A number of factors emerge which are associated with poor outcomes identified in research, guidance and previous SARs featuring self-neglect.

**Brenda's Mental and physical health.** Brenda received minimal support with her mental health needs, which may have needed more monitoring. Brenda's presentation was believed to be due to depression, hence she may have benefitted from a review of her treatment. As she was virtually housebound and alone Brenda's psycho-social needs resulting from isolation could have been considered at an earlier stage. Brenda's physical health needs, including undiagnosed cirrhosis of the liver, could also have impacted on her mood by causing fatigue.

**Self-Neglect procedures not referred to.** Brenda was identified as self-neglecting, with no reference to the self-neglect policy and procedure hence there was no interagency or best practice framework to inform work with Brenda and between

services. Prior to this review, the need to embed training in practice was recognised as a priority and a staff survey was undertaken on the obstacles to working with people who self-neglect. The outcome of this will be used to inform future policy and procedural revisions.

**Lack of Person-Centred Work.** This did not appear to have been central to the community nurses' role and there was not the rapport with Brenda to enable the nurses to gain trust and negotiate when Brenda's situation worsened. The nurses, however, did raise concerns about Brenda and tried to obtain services for her. They did not explore Brenda's reasons for self-neglecting and this hampered their ability to help and to speak up for her.

**Multi-agency "team around the person" work was not effective.** The agencies worked in silos and did not communicate effectively. Information from health was not systematic enough to alert ASC to the need to prioritise Brenda and ASC did not seek to clarify Brenda's needs with the nurses, or between its own teams. The benefits of shared expertise dealing with the dilemmas and complexities and joint problem-solving were not available for Brenda. The services had no escalation routes to highlight risk when it appeared that Brenda was stalled in the system and at risk. The culture of collaboration and giving weight to other professional's concerns was not well developed on this occasion.

**At an organisational level there was a lack of flexibility**. ASC did not seem able to respond quickly to a person with multiple unmet needs and who was at risk of deteriorating further. This is not an uncommon presentation among older adults with sudden deterioration in self-care. There was not the flexibility in role for community nurses to respond either to Brenda's mental health needs or to meet her basic needs of nutrition and incontinence. Instead weekly medication visits were maintained. Managers did not have enough oversight of the issues highlighted. The community nurses did not seem to have an escalation route to a senior ASC decision maker after their efforts to raise a concern about Brenda had not met with a timely response**.**

**Strong risk assessments were not completed.** There did not appear to be a practice of completing formal risk assessments. This left recording and communication incomplete and subjective, with no shared language and hence was less powerful in driving the need for action. This contributed to starting afresh with each contact about Brenda.

**An overarching theme is the need for more professional curiosity.** There were assumptions made without sufficient investigation. The community nurses did not explore reasons why Brenda did not accept outside or family involvement and assumed that Brenda's decisions were capacitous. ASC did not look into what was happening in Brenda's home and to Brenda. The safeguarding team did not make an enquiry after Brenda's telephone presentation seemed to contradict the nurse's concerns. Brenda's word was taken at face value on several occasions despite indications to the contrary. Although the safeguarding team had assessed Brenda as

being willing to accept care, when this was handed over to the Initial Contact Team the urgency of the situation appears to have been lost.

**Application of the Care Act 2014** several relevant powers and duties under the Care Act were not used for Brenda's safety and well-being. She had no offer of advocacy to help her engage and have a voice, she did not receive Section 19, pre-assessment services, nor an assessment of need. Section 42 Safeguarding was not used to make enquiries, bring agencies together and make Brenda safer. Health professionals may not know of these elements of the Act.

**The Mental Capacity Act 2005 and Autonomy versus Duty of Care.** The processes in the Code of Practice for the Mental Capacity Act were not used to undertake an assessment of Brenda's capacity to make decisions about remaining in an unsafe situation without essential services. There were comments about capacity in community nurse records but Brenda's inability to understand the risks of her decisions were not pursued. This was not challenged by ASC until an Initial Contact Team social worker visited Brenda on 2/02/21. There was more emphasis on Brenda's autonomy than on her need for protection from harm and unwise decisions were not seen as part of a pattern.

## Recommendations

Building on these changes, the following recommendations are made, divided into single and multi-agency action

### Single Agency Actions:

**RECOMMENDATION 1:** GP Surgeries should review patients coded with "severe frailty" annually and create a care plan which includes actions if there is rapid deterioration. These adults can be identified using the "electronic frailty index", which uses data available in the GP electronic health records to identify and severity grade frailty. This enables the identification of older people who are fit, and those with mild, moderate and severe frailty. GP surgeries should ensure that they follow these processes.

**RECOMMENDATION 2:** Community Nurse health risk assessments should be made for people coded as of high frailty who are living in their own homes and where there are risks such as skin integrity, incontinence, very low food or fluid intake. The presence of these factors can indicate the need for a multi-agency approach

### Multi-agency actions

**RECOMMENDATION 3:** The SSP through the PDG should ensure there is multi-agency training available to all staff that promotes strength-based approaches to working with individuals who are considered to be self-neglecting.

**RECOMMENDATION 4:** The SSP should seek assurance that the organisations involved on this review are raising awareness of key elements of the Care Act 2014 (especially as highlighted by this report: assessment, representation, the wellbeing principle, Section 19) amongst their staff using mechanisms such as supervision and professional development.

**RECOMMENDATION 5:** The SSP should seek assurance that all organisations involved in this review are auditing the knowledge and skills of their staff on the Mental Capacity Act, including executive capacity using mechanisms such as supervision and professional development.

**RECOMMENDATION 6:** The SSP should seek assurance that all organisations involved in this review have effective safeguarding supervision arrangements in place including safeguarding supervision where escalation and acting on a basis other than consent can be considered and actions agreed.

**RECOMMENDATION 7:** The SSP should review how the process in the self-neglect policy for multi-agency meetings, where there are concerns that a client may decline care despite their high level of need, is applied. A further practitioner survey could be used to determine if there has been a change since the last practitioner survey completed as part of this review.