This is a Rapid Time methodology review of the sad death of Wendy. The focus of this review is to highlight the key systems findings that have been identified through the review of Wendy's death.

Safeguarding Adult Review Wendy

SAR in Rapid Time Methodology

Faith Margle, Swindon Safeguarding Partnership, April 2024

Introduction:

This document is the final output of the SAR In-Rapid-Time developed by SCIE. This report focuses on the systems findings that have been identified through the process of the SAR In-Rapid-Time. They focus on social and organisational factors that will make it harder or easier to help someone who is self-neglecting, like Wendy, in a timely and effective manner. As such, they are potentially relevant to professional networks more widely.

In order to facilitate the sharing of this wider learning the case specific analysis is not included in this systems findings report. Similarly, an overview of the methodology and process is available separately. Each systems finding is first described, then a short number of questions are posed to aid the Safeguarding Partnership in deciding appropriate responses.

The Safeguarding Partnership would like to extend their condolences to the family of Wendy and thank her sister for her involvement in this SAR and sharing information on Wendy and her life.

The Reason for this SAR:

Safeguarding Partnership received a Safeguarding Adult Review (SAR) referral on the 18/01/2024 from Adult Social Care following the sad death of Wendy, aged 60 years.

Wendy was first highlighted to Safeguarding Adults Team in August 2017 due to concerns about self-neglect including, poor personal care, nutrition and home conditions. A package of care was provided to Wendy in November 2017 which appeared to have a positive impact. In April 2021, Wendy was referred to Safeguarding Adults Team due to concerns about self-neglect. Wendy was reported to have capacity around her care and support needs. She was under care of Mental Health team (since 2015).

There was a history of self-neglect and mental health decline which impacted on her ability to look after herself. Wendy had the support of multiple agencies, including, Swindon Borough Council Housing, Care Agency, Mental Health, GP, District Nursing and Adult Safeguarding Team. Sadly, Wendy died in August, the cause of death was '1a: Severe Gram-Negative Sepsis, 1b: Lobar Pneumonia 2: Asthma COPD Chronic Pulmonary Emboli'. This SAR was commissioned as there was evidence of concerns for multi-agency response.

Brief Overview of Wendy:

Wendy was 60 years old and was previously a Nurse at GWH. Wendy was White British and her first language was English.

Wendy had a visual impairment, and mental health needs including depression and anxiety. Wendy's sister has kindly shared with the Safeguarding Partnership a picture of Wendy and her life, we would like to thank her for sharing this information and helping us to better understand Wendy and what was important for her. Wendy's mother died when she was in her teenage years under tragic circumstances and she was then living in the sole care of her father. Wendy felt that her emotional needs were not met by her father and spent a period of a few months in care and had access to support before returning to live with her father. Wendy didn't do well in school but wished to become a nurse and put a lot of work into achieving this goal. She loved her job and it was important to her, sadly she was dismissed from her nursing job. In 2011 Wendy was detained under the Mental Health Act and discharged in 2014.

Between February and August 2015, she was hospitalised due to an episode of Psychosis, on discharge Wendy moved into sheltered housing. Wendy moved to the Swindon area with her fiancé who was a soldier, at some point this relationship broke down but Wendy did not share this with her sister for some time after.

Wendy was described by her sister as someone who was fiercely independent, could be stubborn/headstrong, determined and private. Wendy would not always tell the whole picture of her reality and her sister felt this is in part because her independence was so important to her. Wendy would be in contact with her sister when she wanted to and would often be cheerful, upbeat and make jokes. Wendy's sister was not aware of much of Wendy's life and this seems to have been how Wendy wanted it, she never wanted to be a burden or put people out of their way.

Wendy is described by a housing officer as someone who wanted to care about herself, she would purchase creams and lotions for her skin but did not use these.

Findings:

Finding 1:	Professional Curiosity and Mental Capacity Act 2005

System findings:

Professionals working with Wendy did not use the Mental Capacity Act to its potential. Practitioners were clear that the use of the Mental Capacity Act felt like a barrier in how to get support for individuals. For example, Wendy declined admittance to hospital however, it was raised with paramedics that it was likely that Wendy had an infection in a wound, this did not trigger curiosity in practitioners to reconsider her mental capacity and the impact an infection may have had on the 'functioning of her mind or brain'. It is not clear how this was understood in the context of Wendy being deemed to have capacity. It is unclear who completed the mental capacity assessment, when this was completed and if this looked at whether Wendy was able to 'use' the information in order to manager her health needs and maintain her safety and health (executive functioning) and also whether Wendy's capacity was reviewed or consideration as to whether her capacity may be fluctuating. It was known that when Wendy experienced a decline in her mental health this impacted on her self-care. This information was not considered in relation to the possibility that Wendy's capacity could be fluctuating and therefore impact her decision making.

There were also reflections in the curiosity shown between Wendy's assessed mental capacity versus duty of care. The balance between when someone is assessed as having capacity versus duty of care are reflected in the findings of a local SAR, Alison.

The lack of clarity on how mental capacity assessments are being completed needs further exploration. This theme has been identified in previous SAR recommendations including, Brian, Robert, Summer and Alison in addition to a wider findings in the not yet published 2nd SAR National Analysis.

There was evidence of a lack of professional curiosity across the time reviewed, not only in terms of completing and reviewing mental capacity. Risk assessments in relation to Wendy were embedded in care plans by the care agency and this was not shared. Other agencies did not consider completing a risk assessment when the potential level of concern increased due to Wendy's reluctance to engage in the required treatment.

There is evidence that professionals spent time speaking to Wendy about her life history and experiences. This curiosity however, was not evident across all professionals and information known was not shared with the multi-agency team working with Wendy. This led to the work with Wendy not being Trauma Informed.

Questions for the Safeguarding Partnership:

1.1 How can Swindon Safeguarding Partnership be assured that agencies understand the Mental Capacity Act and its application to practice, including executive functioning, fluctuating capacity, reviewing of capacity and being professionally curious.

Recommendation 1:
Safeguarding Partnership to request single agency assurance reports around the application of the Mental Capacity Act in practice and consider the development of Mental Capacity Act training and / or a guidance tool. This links to several local SAR recommendations and in particular to SAR Robert recommendation *3.a Swindon Safeguarding Partnership members to ensure that practitioners receive Mental Capacity Act training that emphasises the principle of "unwise decisions" and requires a reasonable and proportionate response. Regular reviews of such instances by senior management ensure that frontline practitioners can access necessary support.*

Recommendation 2:
Safeguarding Partnership to understand the barriers in practice to being professionally curious and ensure that this understanding informs the ongoing development work within the Safeguarding Partnership.

Finding 2:	**Working with complex adults.**

System findings:

There was evidence of good practice from many interactions with Wendy where professionals spent a considerable amount of time speaking to her and explaining the risks/consequences of different behaviours. This was not always consistent though and Wendy was known to tell different people different things, which added to the complexity of how to support her. There was no evidence that concerns were escalated when it was difficult to engage Wendy.

A practice issue was identified in relation to capacity, specifically where a person is assessed to have capacity and is making 'unwise decisions'. There is a challenge in how this is balanced against duty of care. There were several occasions where the presumption of capacity led to this overriding professional's duty of care to Wendy.

There was also evidence that risk assessments in relation to Wendy were embedded in care plans by the care agency and this was not shared. Other agencies did not consider completing a risk assessment when the potential level of concern increased due to Wendy's reluctance to engage in the required treatment.

Questions for the Safeguarding Partnership:

2.1 How can the Safeguarding Partnership be assured that practitioners and agencies are provided with the appropriate time needed when working with an adult who is self-neglecting in order to develop positive relationships, support person centred working and protected learning spaces in order to develop practice knowledge and skills?

Recommendation 3:
Safeguarding Partnership to develop a self-neglect peer support forum for practitioners across all agencies to access in order to seek advice, share learning and good practice and learn from others.

2.2 How can the Safeguarding Partnership be assured that the *Multi-Agency Process for the Resolution of Professional Disagreements Relating to Safeguarding & Protection of Adults Policy* is known about and utilised by practitioners?

Recommendation 4:
Swindon Safeguarding Partnership to relaunch and promote widely the use of the new *Multi-Agency Process for the Resolution of Professional Disagreements Relating to Safeguarding & Protection of Adults Policy* to support practitioners and managers where there may be professional disagreement on how to support the person.

2.3 How can the Safeguarding Partnership be assured that professionals across Swindon have the appropriate support in place to help them to understand the balance of duty of care and Mental Capacity?

Recommendation 5:
Safeguarding Partnership to review training and learning resources to ensure that learning is available on the balance between capacity and duty of care.

Recommendation 6:
Safeguarding Partnership to be assured that risk assessments are being completed with individuals where there are concerns for self-neglect. Once published, the Welfare and Safety Plan which has been co-produced with experts by experience, should be widely promoted alongside the guidance for this tool.

Finding 3:	**Multi-Agency Self-Neglect Policy and Guidance was not utilised.**

System findings:

There was no evidence that professionals were aware of or had used the Self-Neglect Policy and Guidance to inform their approach and decision making whilst working with Wendy.

Questions for the Safeguarding Partnership:

3.1 What are the barriers to professionals being aware of and using the Self-Neglect Policy and Guidance?

Recommendation 7:
Swindon Safeguarding Partnership to understand these barriers and act to mitigate these. Using this knowledge the Safeguarding Partnership to relaunch and carry out promotional work on the Self-Neglect Policy and Guidance, with a monitored implementation plan and review of the effectiveness of implementation.

Finding 4:	Making Safeguarding Personal

System findings:

There was little evidence that the safeguarding enquiry had followed the principles of Making Safeguarding Personal. There was evidence that Wendy had been invited to a meeting prior to the review timeframe, however she was not included in any follow up meetings and it was not clear who, if anyone, was there to represent her views and wishes or to feedback the discussions and any agreed actions from these meetings.

There was evidence that Wendy expressed her frustration at there being a safeguarding enquiry and that she was not pleased with this.

Practitioners reflected on Wendy not being involved in the safeguarding enquiry process. Practitioners recognised how Wendy may have been impacted by not being involved in conversations and decisions about her.

In addition, the Section 11 and Care Act Audit for 2023 highlighted that not all agencies include safeguarding in supervision nor is there a set space to have these discussions.

Questions for the Safeguarding Partnership:

4.1 How can the Safeguarding Partnership be assured that any adults we are working with are being meaningfully included in discussions and plans about them and are leading in interventions about themselves and that Making Safeguarding Personal is embedded in organisations?

Recommendation 8:
Ensuring Making Safeguarding Personal is embedded in practice across the partnership. All agencies to put the person they have concerns about at the start and centre of their work:

- Involve the Individual
- Positive Risk Taking (being mindful of over optimism and duty of care)
- Supported Decision Making
- Freedom from Undue Influence

Swindon Safeguarding Partnership should receive assurances in evidence of policies, guidance, anonymised supervision notes and team meeting agendas.

4.2 Safeguarding is everyone's business, therefore safeguarding should be a factor in supervision for all organisations. How can Swindon Safeguarding Partnership be assured that safeguarding concerns are discussed as a priority in supervision?

Recommendation 9:
All agencies to include safeguarding in supervision agendas for those professionals who should be receiving safeguarding supervision. Considering how safeguarding processes may impact on the individual, how engaged they are and the level of understanding the individual has in relation to concerns regarding them. There is a cultural shift that is needed across agencies to bring Making Safeguarding Personal to the forefront of safeguarding.

Finding 5:	Multi-Disciplinary Team Working

System findings:

It was clear that the relevant people were not consistently invited to safeguarding or multi-agency meetings, including Wendy. This led to information not being widely shared and teams working in silos. Professionals reported that they were not sure where to go for learning and support when working with someone who was self-neglecting.

Professionals were unclear on different team roles and the routes of support that they could have considered when a person is self-neglecting in order to escalate concerns.

Practitioners expressed that they do not feel that there is a space where they can come together to discuss cases and seek advice from a multi-agency perspective, gain knowledge and have learning discussions on self-neglect.

Questions for the Safeguarding Partnership:

5.1 Is there a clear directory of team roles and remits available for agencies to access?

Recommendation 10:
Safeguarding Partnership to consider the development of a directory of teams, their roles, responsibilities and remit that can be shared widely and be accessible to all partnership.

5.2 How can the Safeguarding Partnership be assured that there is a clear pathway for where there are concerns regarding self-neglect?

Recommendation 11:
The Safeguarding Partnership to consider the development of a Multi-Agency Risk Meeting (MARM) for self-neglect cases, or the consideration of the development of an Early Self-Neglect Pathway.

The purpose being that all multi-agency meetings should take place at the earliest opportunity. An Early Self-Neglect Pathway would mean that all referral routes for self-neglect are clear and expectations in regards to Multi-Disciplinary Team working are set in this pathway.

Consideration should be given to the value of a regular multi-disciplinary team meeting to discuss those cases highlighted as high risk and multi-agency agreements on how to support the individual with concerns. It may be that a MARM process would be best placed to support this.

This is in line with recommendations from SAR Robert, 6.a *Swindon Safeguarding Partnership to consider reinstating the Risk Enablement and Positive Risk Taking Panel. Structures of meetings to be meaningful with relevant participant attendance set up in advance to agree on key stakeholders' attendance.*

The chairing of any such panel should be multi-agency.

5.3 How can the Safeguarding Partnership be assured that professionals are working in an effective multi-agency way that is evidencing positive outcomes for the individual?

Recommendation 12:
The Safeguarding Partnership to seek assurances how agencies will evidence meassurable improvements in multi-disciplinary working?

Recommendation 13:
Swindon Safeguarding Partnership Executives should request an update in 6 months' time on whether actions from recommendations have had a positive impact on practice. If Executives are not assured of any positive impact, escalation to relevant organisations should be considered and whether there is a need for a risk management plan.