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

Safeguarding Adult Review Ethan

Rapid Time Methodology

Faith Margle, Swindon Safeguarding Partnership

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 harder or easier to help someone facing self-neglect, like Ethan, 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 and recommendations are posed to aid Swindon Safeguarding Partnership (SSP) and partners in deciding appropriate responses.

The Swindon Safeguarding Partnership would like to extend their condolences to the family of Ethan and thank Ethan's family for their involvement in this SAR, sharing information on Ethan and his life.

The Reason for this SAR:

The Safeguarding Partnership received a referral for a Safeguarding Adult Review (SAR) after the sad death of Ethan in January 2024 shortly before turning 62 years of age.

Ethan first came to the attention of Adult Social Care in February 2022 when a safeguarding referral was received for concerns for Ethan's environment and self-neglect. From this point in time there were two additional safeguarding referrals raised with concerns for Ethan's self-neglect and living environment. The Safeguarding Partnership identified concerns in how multi-agencies had responded to support Ethan and meet his needs. Although there was no history of Ethan known at the point of the initial referral the delay in responding and resulting in two additional safeguarding concerns being raised highlighted concerns for how the adult social care system is responding to such concerns. In addition, other agencies working with Ethan did not raise concerns when these were identified and were not always working together. There is some evidence of good practice that can be learnt from as well as points where responses were lacking and left Ethan in a vulnerable and unsafe environment.

Prior to Ethan's sad death there were multiple agencies working with him, including; Adult Social Care, Environmental Health, Live Well, GP and Big Breakfast Club.

Brief Overview of Ethan:

This overview of Ethan has kindly been shared by his ex-partner. On behalf of the Safeguarding Partnership we extend our thoughts and condolences to Ethan's family.

Ethan spent his younger years moving around a lot due to his father being in the RAF. When he was about 6/7 years old they moved to Swindon. When in his early 20s Ethan met his girlfriend, who would go on to become his long-term partner. When they met, Ethan was a photographer and she was doing nurse training. They had two children together, a son and a daughter, who he had little contact with in recent years. Ethan's long-term relationship ended about ten years ago.

Prior to Ethan's father's death, he was his carer, they lived together in his father's home. When his father died in 2018 Ethan continued to live in the home which he said was passed to him. Ethan had a housemate move in with him to help with bills. Ethan had a stroke some time

before this and it is possible this may have had an impact on his self-care, possibly leading to him self-neglecting.

Ethan's family were not contacted throughout interventions with him and it does not appear professionals knew he had children.

One professional explained that Ethan "presented as a quietly emotional and proud man".

Findings:

Finding 1:	Interagency Working: Appropriate handover between Adult Social Care teams

System findings:

Ethan was supported under the Initial Contact Team over a period of five months. At this time it was not unusual for the team to be working with people longer than the team remit of two weeks.

The purpose of this team is to review initial contacts to Adult Social Care and identify the most appropriate next steps for that individual. The team remit is to hold an individual for up to two weeks and will refer onto other teams or agencies as needed.

It was identified that Ethan would need long-term involvement to build up a professional relationship and support him in living a safer life. However, due to differing factors in ICT, such as staff annual leave, sickness and challenges in contacting Ethan this did not happen as rapidly as it should. Ethan was not being supported by a social care team more resourced to provide long-term intervention.

Questions for SSP:

1.1 How can the Safeguarding Partnership be assured that the process and handover between teams in Adult Social Care has a clear pathway, especially for cases where there are self-neglect concerns?

Recommendation 1:
Adult Social Care to review the remit of Social Care teams and handover procedures to ensure that high-risk individuals are seen as a priority and that the most appropriate support can be actioned in a timely way.

Finding 2:	Multi-agency Working

System findings:

There was evidence that professionals were working together throughout the time they were in contact with Ethan. However, this was not always consistent.

It was identified that if professionals had been more aware of local community resources then it may have been quicker to identify that Ethan was receiving support from The Big Breakfast Club. This local resource was identified by good information sharing between the

Initial Contact Team to the Live Well Team who were able to identify local resources Ethan may be accessing for breakfast. This was evidence of good multi-agency working.

Ethan had consistent support from Environmental Health who had responded within twenty-four hours from receiving the referral regarding concerns of the condition of his home. Environmental Health were the most appropriate team to support him in terms of the condition of his property. However, the team would have benefited from a clear multi-agency plan to support the intervention needed to help improve Ethan's circumstances. The Initial Contact Team were not the most appropriate team to be supporting Ethan as they do not have the resources to spend the same time getting to know Ethan and building up a relationship. The nature of the team is to initially identify what support is needed, not to case hold. There was no formal MDT in place to coordinate support and for all organisations to understand the extent of the concerns for Ethan.

Practitioners within organisations recognised there was a need within their own agencies to know more of what local resources were available which may have reduced the likelihood of quicker identification of where Ethan was going to receive his breakfast, which would have given a quicker identification of another service working with him that professionals could have linked in with at an earlier opportunity.

Questions for SSP:

2.1 How can the Safeguarding Partnership embed a positive culture of multi-disciplinary and multi-agency working? Including planning at the earliest opportunity, when working with adults with complex needs and identified risks?

Recommendation 2:

Safeguarding Partnership to have clear guidance on multi-agency meetings, when to hold these meetings and how to escalate when organisations are not engaging in this process.

Recommendation 3:

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.* This is also in line with SAR Wendy.

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

2.3 How can the Safeguarding Partnership be assured that the Multi-agency Policy and Guidance on responding to Self-Neglect and the Quick Guide to Self-Neglect

Procedures has been implemented across organisations and is being used to inform practice and impact outcomes?

Recommendation 4:
Single agency assurance requests to be sent out to partner agencies asking for evidence on how they are implementing the policy and guidance, how this is being used across their organisation and gain assurance on how agencies will evidence meassurable improvements in multi-disciplinary working. Any identified non-compliance should be escalated to Partnership Executives via the executive risk register.

Finding 3:	Clear recordings, rationale and decision making

System findings:

It was not evident through case recording and evidence reviewed whether there were any risk assessments being undertaken. For example, the evidence showed that Ethan was at one point 'locked in his house having lost his key since coming home', the two professionals visiting agreed with him to come back another day to see him. Case recordings did not indicate whether any dynamic risk assessing was undertaken in the moment to understand the risks this left Ethan at. From discussing this with the professionals who were with Ethan on this day it became apparent that this was explored, it was understood that he had access into and out of the property via the back door which he was able to access. It was 'usual' that Ethan lost his keys but that he did always find these and was able to leave the property in the event of an emergency. The next step in risk assessing was not evident, for example, in the event of an emergency Ethan could leave his property into his back garden, what would he do from here? Ethan's garden was enclosed and he was unable to exit his garden. How, therefore was Ethan to get away from the property in the event of a fire, or if he was unable to find his keys how would he leave his property to access food, water and additional support?

Although significant risk was identified by ICT and Environmental Health around his home environment, access to electricity, heating and usable facilities. These risks were not always recorded in any formal way to ensure the risks and concerns were clearly documented by professionals. The impact of this was that the risk wasn't always known and shared by everyone which impacted decision making.

When concerns for Ethan increased this was communicated and shared with managers. Those managers liaised with each other to determine next steps. This conversation took place via email, which may have inadvertently diluted the seriousness of concerns and should managers have had a call or face to face discussion the level of concern may have been better reflected and responded to in a more timely way.

Questions for SSP:

3.1 How are the Safeguarding Partnership assured that risk to individuals is clearly recorded and shared with the relevant professionals.

Recommendation 5:
Agencies to provide evidence of how risk and concerns are recorded in case records and how this is managed within the organisation, especially where there is an adult with complex

needs. Any identified non-compliance should be escalated to Partnership Executives via the executive risk register.

Finding 4:	Professional curiosity and working with complex individuals

System findings:

There was some evidence of good professional curiosity from practitioners, although this was not always clear and consistent in case recordings. An example of this was a joint visit undertaken with Ethan at the Big Breakfast Club with the Initial Contact Team and Live Well. Professionals worked well together and there was evidence in case recordings that gave a sense of who Ethan was and what was important to him. The approach and environment meant that the worker from Live Well was able to get a lot more detail from Ethan on what support he needed and actions were then able to be taken to work on this.

A full picture of who Ethan was as a person and his lived experiences were not clear during the time professionals were working with him outside of the example given above.

Professionals found it difficult to get in contact with Ethan as he did not always wish to speak with them. This was evident on visits to his home where he was seen entering the home, but a few moments later declined to answer the door. Efforts were made by professionals waiting some time and calling out to him but Ethan did not respond. This made progress slow.

When the initial referral was received by Adult Social Care the social worker who spoke to Ethan about the concerns, recorded that Ethan had declined support and said he felt that he did not need this.

Attempts should have been made to enquire further and be more curious around Ethan's response to the offer of support, specifically due to the concerns regarding self-neglect. It is highly likely when an individual is experiencing self-neglect that they will decline support for many reasons. Relying on a phone conversation in this situation is not the most appropriate way to assess need and get a true picture of a persons circumstances.

When a further referral and concern was reported to Adult Social Care, it appears that the history of previous referrals was taken into account by the allocated initial contact worker, this was expected practice. Considering the history of contacts and case recording would have been important to start to build a picture of Ethan and his needs.

It was known that Ethan had previously had a stroke. However, no attempts were made to liaise with his GP surgery to better understand any treatment plans or to share concerns about his home environment and share information.

It was known that Ethan had not been taking his medication at this time. Liaising with the GP may have led to a home visit to Ethan by the GP, a social prescriber or surgery social worker to better understand his support needs, rather than relying on Ethan coming to the surgery for appointments and health checks.

The GP who met and spoke to Ethan in December 2022 had noted concerns regarding Ethan's presentation, with his clothes being torn, stained and shirt buttoned incorrectly. Ethan's presentation was described as 'spaced and sleepy'. The GP spoke to Ethan about

his concerns that Ethan was not taking medication as prescribed and ascertained that Ethan was not able to afford his medication. Ethan was given advice by the GP to apply for benefits and how to do this. However, more practical support to achieve this was not provided. Ethan was not referred to the internal Social Prescriber to assist in the practicality of achieving this. It does not appear that the GP considered whether Ethan was able to achieve this without assistance or identified these as possible signs of self-neglect.

If Ethan had been referred to a Social Prescriber, it may have been an early opportunity to build up a relationship with Ethan, support him to access finances, for professionals to access to his property to understand his living situation and support him to receive and proactively take the medication he was prescribed.

Once professionals were meeting with Ethan (on the occasions he was home and allowing entry), and attending his home they noted the smell of the property was significant and impacted on their ability to work effectively due to the smell. This should have highlighted additional levels of concerns for Ethan living in this property and for Ethan's safety, physical and emotional wellbeing by living in this home and prompted more urgent responses and options to support him. During situation where the nature of a persons home environment is adding challenges to hold necessary conversations it can be beneficial for professionals to think creatively about how they can have the conversations needed. For example, it may have been beneficial to suggest to go for a walk or to a local café to talk, although it was reported that Ethan's mobility did not allow for this.

The Environmental Health Team were conducting very regular visits to Ethan and having multiple good conversations with him. The lack of a clear MDT working and knowing whether there was a lead professional made it hard for them to know what alternative steps to take outside of their remit to support Ethan. Working with individuals living in a home that requires the support of environmental health adds increased need for long term working. Often this intervention leads to significant changes in someone's living environment, which can add repeated trauma to a persons experience. Long term support and relationships needs to be considered carefully and the necessary time needs to be provided by agencies and continued MDT working.

There were multiple points where early involvement opportunities were missed. Once the work with Ethan started in October 2023, there were signs of improvements and changes starting to take place with regard to multi-agency working, the work with environmental health was at a point where a deep clean would have been able to take place, Live Well were working with Ethan and building a relationship, supporting with benefit applications and an MDT was starting to be built. However, Ethan's health appeared to deteriorate around October 2023 and seeking advice from his GP surgery was not considered.

The Multi-Disciplinary Self-Neglect and Hoarding Policy and Guidance was considered and Adult Social Care professionals reported being aware of this policy and guidance which was considered in work with Ethan. Although this was not directly referred to during the course of the work with Ethan.

Questions for SSP:

4.1 How can the Safeguarding Partnership be assured that adult practitioners know how to apply professional curiosity in practice?

Recommendation 6:

Safeguarding Partnership to review and update the Professional Curiosity Resource pack. To re-circulate this across the Partnership and to gain assurance that this is being delivered in teams and is forming part of staff inductions.

4.2 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 7:
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.

Recommendation 8:
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.