Self-Neglect what do SAR's tell

Bath & North East Somerset Council

Improving People's Lives

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National SAR's

This second national analysis of Safeguarding Adult Reviews (SARs) in England was funded by Partners in Care and Health, supported by the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS).

This study analysed the findings of 652 SARs completed over the 4-year period, drawing out common learning themes.

The analysis showed self-neglect to be the type of abuse most commonly reviewed, featuring in 60 per cent of reviews,

https://nationalnetwork.org.uk/search.html

Observations on Direct practice?

Detailed analysis of learning was completed on 229 of the 652 SARs. There was a focus on both good practice and practice shortcomings, with the latter much more prevalent. Particular emphasis was given to key areas of policy interest: safe care at home, denied or difficult access (powers of entry), organisational abuse, homelessness, transitional safeguarding and substance misuse.

The most commonly noted **good practice** related to **risk assessment and management** (in 31 per cent of cases) and **applying the principles of Making Safeguarding Personal** (29 per cent). Also commended were recognition of abuse or neglect (including self-neglect), continuity/perseverance of involvement, and attention to health needs, each noted in around 22 per cent of cases. Observed less frequently but nonetheless present in a small number of cases were **good attention to mental capacity** (11 per cent), use of a 'think family' approach (8 per cent), use of advocacy (7 per cent), legal literacy (6 per cent), understanding of personal history (4 per cent), work with unpaid carers (4 per cent) and hospital discharge (4 per cent). Very occasional positive mention was made of recording (3 per cent), transition planning (3 per cent), use of professional curiosity (3 per cent) and attention to protected characteristics (1 per cent).

The most commonly noted **practice shortcomings** were poor **risk assessment/risk management** (noted in 82 per cent of cases), shortcomings in **mental capacity assessment** (58 per cent), and lack of recognition of abuse/neglect (56 per cent). Also frequently highlighted were shortcomings in **making safeguarding personal** (50 per cent), **absence of professional curiosity** (44 per cent) and **attention to people's care and support needs** (43 per cent), **mental health needs** (41 per cent) **and physical health** (37 per cent). An absence of professional curiosity (44 per cent) meant that circumstances were sometimes taken at face value rather than explored in detail. Other commonly found shortcomings included **absence of legal literacy** (40 per cent), **superficial acceptance of individuals' apparent reluctance to engage** (38 per cent), absence of a '**think family' approach** (37 per cent). **Poor recording, poor attention to unpaid carers, lack of understanding of personal history, absence of trauma-informed practice**, shortcomings in hospital discharge and poor attention to living conditions were each found in around a quarter of cases. Observed less frequently but nonetheless having a negative impact were a lack of perseverance (21 per cent), poor access to advocacy (21 per cent), lack of attention to substance use (20 per cent), poor transition planning (15 per cent), poor attention to protected characteristics (12 per cent) and absence of relationship-based practice (10 per cent).

Wider systemic factors that impact upon direct practice?

While good interagency practice was noted in around a fifth of cases, shortcomings were more widely noted, with **poor information-sharing** and an **absence of case coordination**

present in almost three-quarters of cases. **Shortcomings in use of the Care Act 2014 section 42 safeguarding provision and of multi-agency (risk management) meetings** were each noted in around 38 per cent of cases. Also regularly featured were concerns about the **quality of recording, how agencies understood their roles and responsibilities,** and how **services communicated across local authority and other boundaries**.

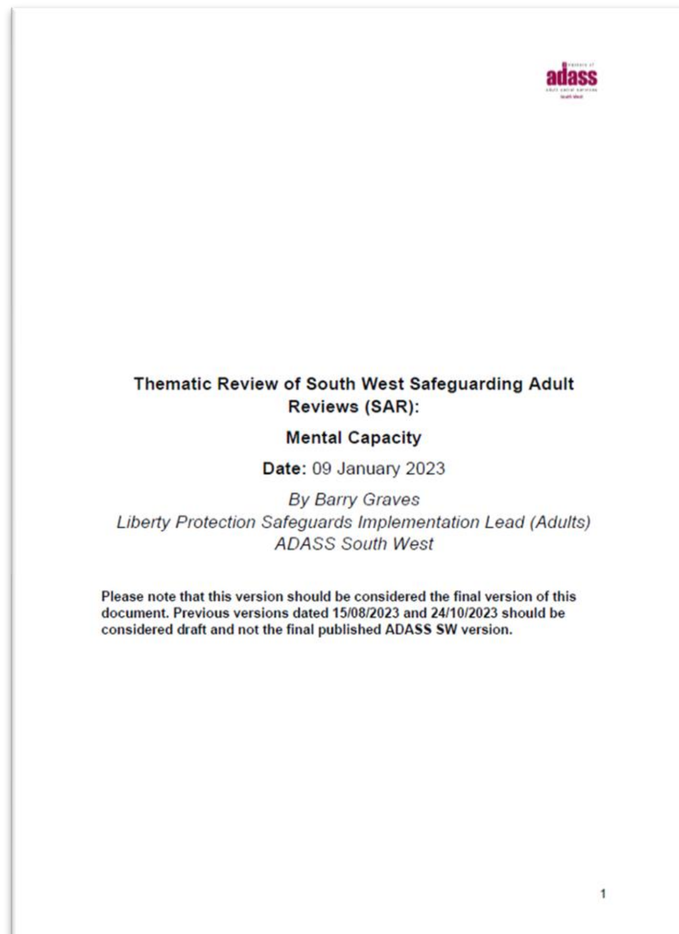
The most frequently mentioned organisational features were **lack of management oversight, poor provision or use of policies and procedures, and pressures on staffing and workloads**, each present in over a quarter of cases. Failure to provide training and concerns about commissioning practice, including **quality assurance of provider services** and communication about 'out of authority' placements, were also noted, along with an **absence of suitable, sometimes specialist, resources.**

In terms of Safeguarding Adults Board governance, a few reports noted an absence of relevant guidance; examples included lack of policies on self-neglect, escalation, risk and mental capacity

31 priorities for improvements in adult safeguarding. They include:

- Changes to law and the national policy guidance;
- Strengthening the pathway for escalating concerns to central government departments, for example about gaps in services and the impact on services of public sector austerity;
- Improved understanding of what effective safeguarding looks like;
- Improvements to the way Safeguarding Adult Reviews are carried out;
- Improvements to the use of the web-based library of Safeguarding Adult Reviews[1] so that they can be easily found and used for learning;
- Better reporting of abuse or neglect and why it may have happened.

Regional SAR



Thematic Review of South West Safeguarding Adult Reviews (SAR):

Mental Capacity

Date: 09 January 2023

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Please note that this version should be considered the final version of this document. Previous versions dated 15/08/2023 and 24/10/2023 should be considered draft and not the final published ADASS SW version.

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This thematic review of South West Safeguarding Adult Reviews (SAR) did not specifically focus on self-neglect but looked at *"practice issues identified in relation to the Mental Capacity Act 2005".*

62 published and publicly available documents informed this review covering all 12 Safeguarding Adult Boards (SAB) from the region.

Over-arching themes were identified in relation to omission of completing mental capacity assessments and sub themes discuss various examples of practice concerns identified, including one being:

> *"One of the biggest, if not the largest area of practice concern, is practitioners finding it difficult to work with and understand executive function and how to assess mental capacity with individuals with potential executive dysfunction. This includes the specific impacts that some contexts and conditions have on executive function such as self-neglect and substance misuse."*

EXECUTIVE FUNCTION AND FLUCTUATING MENTAL CAPACITY

SAR 1 -

Despite the professional acknowledgement, and in a formal forum, that the individual's expressed opinions differed to the observed behaviour, no mental capacity assessment took place. The same SAR commented that although the wishes of the service user were being respected by those around him, this resulted in it being unclear as to whether he had mental capacity to make decisions that amounted to self-neglect. The absence of a documented assessment and a legal decision-making framework prevents exploration with others and via best interests to support management of risks. Completion of a mental capacity assessment can also provide a framework to build challenges to unwise decisions around at appropriate junctures potentially reducing risk of harm.

SAR 2 - Amid self-neglect and a refusal to accept support there was an over-reliance on a misinterpretation of the Mental Capacity Act's principle three by professionals believing the individual had a right to make unwise decisions. Repeated unwise decisions should have in this instance triggered a mental capacity assessment as it is potentially indicative of problems with executive function. The SAR identified that a deeper understanding by staff of the Mental Capacity Act was required to improve practice.

SAR 3 - a cyclical pattern from the service user in compliance and non-compliance as well as the presence of compulsive behaviours. Conversations to discuss these unwise decisions that may be indicative of impaired executive functioning were not held by any professionals working with him.

Risk Formulation and Management

Mental capacity and related best interests and multi-disciplinary discussions can be very helpful and effective in sharing information and co-ordinating approaches to help formulate and manage risk within a legal framework. As one SAR reflected, best practice should be that mental capacity is considered at all risk meetings alongside mental health. The completion of mental capacity assessments around high-risk activities to evidence mental capacity (or trigger best interest decision making) can also help empower the individual to live their life as they wish whilst giving confidence and assurance to practitioners in their practice.

Multiple SARs commented on the need for practitioners to be more curious around mental capacity in their consideration of risk. There were repeated instances of individuals at risk or experiencing harm refusing offers of support and intervention or non-compliance with support and medication. These gaps in engagement or compliance were taken at face value by practitioners and potentially considered 'unwise' decisions without the completion of a mental capacity assessment or reflecting on executive function (see section 2). This over simplified model of mental capacity meant that the legal framework that stems from a

documented assessment and offers protection to the individual and practitioners was not put into place.

Issues around this were reported across some SARs in relation to medication compliance. In one SAR, critically there was no evidence of a mental capacity assessment around taking/refusing medication despite the GP reporting that not taking medication will likely result in a decline of mental capacity. In a separate SAR there was no record of mental capacity being assessed around taking medication, the care staff assumed the individual had mental capacity to decline and therefore did not raise this as a concern.

Several SARs commented on the missed opportunity of professionals from different backgrounds coming together to discuss risk and not sharing information and/or formulating risk management plans based around mental capacity. One SAR found that despite the individual's mental capacity for decisions relating to the areas of risk being tested, this was not formally recorded nor included in the risk management plan. A similar event was found in two other SARs – mental capacity was not included in the risk management plan. In one of these, it was well established that the individual lacked the mental capacity to make relevant decisions around accepting support and therefore a risk management plan should have been in place to pre-empt and provide contingencies for future refusals to help minimise harm.

Additional comments in SARs related to the theme of practitioners needing to consider the possible impact of physical health concerns stemming from risks around the person on mental capacity. There were also comments in relation to ensuring there is engagement through the best interests process to help manage risks and to consider all options with the person.

Recommendations

1. Local authorities to collaborate with care providers, NHS, and connected stakeholders through its commissioning, learning and development and other networks to support the embedding of **improved Mental Capacity practice** including the themes in this report across the Integrated Care System. Local authority practitioners including those in commissioning can support Mental Capacity Act (including deprivation of liberty) compliance across stakeholders as part of provider visits, **contract monitoring and networking** meetings.

2. Local authorities (including agencies with delegated functions) to assure themselves that their own Mental Capacity Act learning and development offer covers the themes of this review such as **executive function and 'dispels' some of the current misapplications of the Act's principles** such as the **over reliance on an 'assumption of capacity**'. An additional 'add on' module/session may be appropriate to deliver learning to focus on the **more complex areas of mental capacity that practitioners find difficult; executive function, fluctuating capacity, and working with unwise decision.**

3. Mental Capacity, and particularly more complex elements such as executive function and fluctuating capacity including relevant case law, to be a **regular subject for professional development** and reflected in supervision discussions about case work where appropriate. Case supervision actions set should be followed up on. This normalising of the conversation can **encourage confidence, ownership, professional curiosity and raise practice levels**. This can be further supported through **internal quality assurance processes of practitioner work** that includes executive function, engagement around mental capacity when this may be difficult, and whether best interest decisions have been taken appropriately.

4. For **professional curiosity** and the importance of making enquiries to be included in mental capacity training particularly if the individual is **repeatedly making unwise decisions**. This will support practitioners **to be confident to be curious and ask questions relating to mental capacity** and not to always accept what they are told on face value. Practitioners can be supported to develop the knowledge and skills to do this through **supervision, observations and learning and development.**

5. **Multi-disciplinary meetings** and teams to ensure mental capacity is considered and **information shared** where relevant and recorded on client data records to support sharing. Multi-disciplinary meetings should consider **evidence and concerns where appropriate around executive function** and allocate someone to complete a mental capacity assessment around relevant decision/s if concerns warrant this particularly in the context of potential harm or self-neglect.

6. All health and social care staff should be either **competent and confident to complete a mental capacity assessment** within their area of expertise and/or employment or know someone who can and is available to complete a documented mental capacity assessment within a reasonable timeframe for the decision in question e.g., care provider staff deferring to a team leader or manager.

7. Practitioners should be encouraged to **record their evidence base for decisions** around mental capacity in appropriate case records **even if capacity has been presumed**. Recording of decisions around mental capacity should include consideration of executive function where relevant. This should also be **reflected in relevant case audits of practitioner recordings**.

8. For agencies to assure themselves that their **safeguarding protocols and forms prompt for consideration of mental capacity** and that this is embedded into safeguarding and induction training. Mental capacity considerations should be a feature of any safeguarding activity including the individual's ability to make related and relevant decisions in the context of any possible coercion and duress.

9. Where there is reason to **doubt a person's ability to decide on their temporary or permanent place of residence** including tenancy arrangements, a mental capacity

assessment must be undertaken and documented. This **includes hospital discharge as well as a change in placement.**

10. Commissioners of care and support should assure themselves **through contract monitoring and quality assurance activities** that care and support providers have in place **relevant training** to support their staff in **MCA and best interest decision making practice**, and that relevant managers are competent in the application of the **Deprivation of Liberty Safeguards, including deprivation of liberty in community settings,** and know the steps that need to be taken to refer for authorisation.

BSW SAR'S

6 SAR's relating to self-neglect, since 2018

https://bcssp.bathnes.gov.uk/safeguarding-adult-reviews

10 SAR's relating to self-neglect, since 2019

https://safeguardingpartnership.swindon.gov.uk/info/18/for_professionals/64/safeguarding_adult_reviews_sars

7 SAR's relating to self-neglect, since 2018

https://www.wiltshiresvpp.org.uk/p/adults/safeguarding-adults-reviews-1

B&NES SARs

Adult C [2023]
https://bcssp.org.uk/assets/7a7eb990/executive_summary_adult_c_sar_vf.pdf

Adult C describes herself as 'happy' and having a 'normal family life' and a 'successful' career prior to becoming unwell. She is educated to degree level and was employed until 2014, when she left her position due to mental ill health and a decline in her physical health. Practitioners described her as an intelligent and articulate woman who knows and speaks her mind. Adult C is married, and both she and her husband participated in this review, along with her mother and sister-in-law.

Key Themes

- Ensuring the **voice of the person** is central throughout single and multi-agency involvement and intervention
- Consideration of **mental capacity**. When a person is unwilling to engage in an assessment it could be appropriate to review surrounding evidence to draw a conclusion as to whether they are capacitous.
- Parity of esteem should be given to **mental and physical health needs**
- The importance of **team around the person** and ensuring systems and processes allow for flexibility of response
- Understanding **legal options** and knowing when and how to **access legal** advice
- Understanding the impact on the carer and ensuring **careful assessments for both the carer and person** they are caring for
- When there are complex dynamics of the relationship between the family carer and the cared for, it is important to reflect on who is causing harm and who is being harmed
- Consideration of **independent advocacy**
- **Partnership working** between child and adult services in relation to child protection and vulnerable adults
- **Understanding of self-neglect and decision making relating to the determination of S42(2) duty and local management through the Multi-agency Risk Management process**
- The importance of applying a **trauma informed approach** to practice
- Understanding the **availability of and access to escalation pathways**

Levi Swaby [2022]
https://bcssp.org.uk/assets/7a7eb990/bcssp_7_minute_briefing_ls_vf.pdf

Levi Swaby a 36-year-old man of Black African Caribbean heritage, died unexpectedly on 19th November 2019 following a cardiac arrest. He left family including his mother, who was involved in his support, and a sister. He also had children with whom contact was variable over the years.

Key Themes

- The challenge of delivering services to individuals with long term, chronic mental health problems when there are always more pressing, "urgent" needs or crises means that there need to be mechanisms to stand back, review, and reflect on what is really going on, and to construct strategies for recovery. These procedures include how the CPA framework (or its replacement) is applied, how **information is transferred between practitioners**, the approach taken in team meetings and supervision, and how services are organised to ensure that individuals with the appropriate professional backgrounds are involved in an individual's care.
- The care and support that Levi received was dominated by his periodic relapses, probably caused by a combination of non-compliance with his prescribed medication and his drug taking. The learning is about how these **patterns or cycles** are brought into the conversations about patients and service users, how risk is assessed, how **care and support** it planned and provided.
- Assessing **mental capacity** is one of the most complex areas of work for practitioners. Whilst there is a growing literature about mental capacity and impairment through the excessive use of alcohol there is to date little written about impairment through the misuse of substances. However, this does not mean that the **Mental Capacity Act cannot and should not be used to help individuals who misuse substances**. Recommended reading: How to use legal powers to safeguard highly vulnerable dependent drinkers in England and Wales Professor Michael Preston-Shoot and Mike Ward Safeguarding-guide-finalAugust-2021.pdf

Angus' [2022]
https://bcssp.org.uk/assets/7a7eb990/bcssp_7_minute_briefing_angus_vf.pdf

Angus was a divorced man with two sons, with whom he had little contact. For a number of years, Angus was supported by his niece, but this support declined due to his niece's own commitments. He had a history of chronic alcohol abuse and presented with signs of self-

neglect. He had a diagnosed cognitive impairment and had been resident in a care home under a Deprivation of Liberty Safeguard (DoLS) in 2019. Angus returned to living in the community with a support package but a pattern of self-neglect, alcohol abuse and regular falls in his home followed. Angus developed an infected leg and pressure sores. Angus died as a hospital inpatient, aged 72 years.

Key Themes

- Where there is identification of self-neglect, particularly in cases where there is a history of this, professionals should make early use of the B&NES self-Neglect Best Practice Guidance. Where a s42(2) enquiry is opened it should not be closed prematurely on the basis that other measures are in place until it is established that they are effective, and the enquiry should **fully consider the history of the case**. The **person should be involved** in the enquiry or where there is a substantial difficulty, **a person known to them, or family member involved**. Where this is not possible consideration should be given to using an **independent advocate**.
- **Mental Capacity and Best Interest decisions** can be complex, it is difficult for front line, first attending staff to be fully equipped to deal with all eventualities and agencies need to be able assist them to allow decision making to be as straightforward as is possible. Where cases allow, it would assist to have an **agreed process and protocol** signed up to by all agencies who may perform a function in relation to the care and support which would **allow for preplanning and discussion regarding how desired outcomes can be achieved**.
- Where there are cases of mental capacity involving **best interest decisions** regarding life sustaining treatment, which involve more than one agency, there should be pre-planning to allow **all agencies to understand their role,** understand the **legislation** and what is considered appropriate and proportionate. All agencies when making best interest decisions for persons who lack mental capacity should ensure that they **consult others close to the person** who lacks capacity and where this is not possible, that consideration is given to the involvement of an independent advocate.
- There was an impasse on the issue of conveying a person to hospital who lacked mental capacity. There was a MARM meeting which discussed some of the issues, but the issues were not properly discussed and resolved although a number of the involved agencies were present. This was a missed opportunity to resolve the issue. **The partnership protocol for resolving professional differences was not considered or used**. This would have allowed professionals to work through the different stages to reach a resolution.

Martin Evans [2021]
https://bcssp.org.uk/assets/7a7eb990/bcssp_7_minute_briefing_me_vf.pdf

Martin died when he was 36 years old. He had a long history of mental health concerns and alcohol use. He was found unresponsive at his home address and could not be resuscitated. Martin was known to a number of agencies and was regarded as a 'high risk' drinker. He lived alone and concerns had been raised regarding self-neglect. Martin wished to move to a supported environment in which he could become alcohol free. His father supported him with his finances and was closely involved in number of aspects of his care. Martin has been described to this review as a 'gentle giant', with the exception of times of anger and frustration, was polite and always asked for help. He is said to have hated being a burden to his father.

Key Themes

- Risks were assessed by different services involved as high but there was **no completed care and support assessment, no risk management strategy and no crisis intervention plan**. His medical conditions were kept under review by his GP surgery and by the RUH during hospital admissions. However, while in the final months of his life his **non- attendance at surgery** appointments to discuss medication caused concern, **repeat prescriptions continued to be issued without review** in the context of his deteriorating health and self-care.

- Best practice in self-neglect advises **thorough mental capacity assessments**, which include consideration of **executive functioning;** assumptions should not be made about people's capacity to be in control of their own care and support. **Martin's mental capacity did not receive sufficient attention**. Other than some assessments by SWASFT and RUH, capacity was either not considered at all or was inconsistently addressed, with an **over-reliance on assumed capacity and an absence of formal assessment**, despite the potential impact of his alcohol use. **Executive function does not appear to have been considered** as a factor in his decision-making on drinking and self-care. Actions taken in direct work with Martin do not reflect those that would be indicated in relevant procedures. **Recourse to the MARMM was late** and even when a MARMM took place it did not produce a viable or coordinated intervention plan.

- There were **some good communications between some of the agencies involved**. Virgin Care attempted to explore sources of support for Martin, and some joint visits involving different agencies took place. One hospital discharge showed particularly robust liaison between hospital and community facilities. There were, however, **shortcomings in interagency coordination**. Some agencies experienced **difficulties in communications with other agencies** and there was some **misunderstanding of agency roles** in relation to hospital discharge planning. Referrals between agencies

did not always share key information that would enable levels of need and risk to be judged.

- Some agencies experienced **resource pressures** during the period under review. As a result, **staff turnover** posed challenges of continuity, potentially **damaging Martin's trust in his supports, and breaks in communication between agencies**. It also compromised staff familiarity with, and understanding of, policies and procedures. There are questions about the availability of services for people with significant levels of mental ill-health but who are not acutely in need of care and treatment from secondary mental health services. Coordination of provision in complex and challenging cases clearly remains a challenge and it is possible that the **multiple commissioning and funding arrangements result in services that don't quite fit together** into a coordinated picture.
- Several agencies had frequent contact with Martin's father. He received considerable support from the community matron, who **recognised the impact of caring** for his son in the context of his own emotional needs, although he declined her suggestion of carer's support. It seems that a **'think family' approach was missing**, as was any attention to how family dynamics might be impacting on Martin's behaviour

Mark [2020]
https://bcssp.org.uk/assets/7a7eb990/sar_mark_practitioner_briefing_mark_final.pdf

Mark was 63 years old when he died. He had been diagnosed as having Obsessive Compulsive Disorder (OCD). Mark understood how his OCD manifested itself on a day to day basis and could articulate this in detail. He knew that the thoughts and actions were irrational and at times sought and responded to help, if offered, to manage the symptoms that he found distressing. At other times he endured his illness, became depressed as a result and withdrew or obscured the symptoms by drinking alcohol. His OCD also impacted on his physical wellbeing for example, his management of his diabetes; diet and medication management. Mark had lived in London for a number of years before moving to the B&NES area. He had friends, both locally and across the country. It appeared he had contact with these friends when he was well but could be isolated at other times. Mark enjoyed music. Mark lived in supported accommodation and was in receipt of support from health and social care professionals. He also had a package of care, primarily to support him to manage his housing and make sure that he was not neglecting either his physical or mental health. Mark feared throwing anything away as he was concerned that he may lose something valuable, including parts of his own body. He, therefore, had to check everything before he threw or washed it away. This led to him storing things and there had been ongoing concerns regarding his hoarding behaviour.

Key Themes

- Any review of a person's situation should include all the agencies that support them. Reviews should not be undertaken in professional silos. Both physical and mental health professionals should have training to **improve their understanding of the impact on each other of mental health and physical health needs**. Risk assessments should be completed for people where there are known risks present. If a person is **living with a number of risks, there should be an agreed escalation process in place**. This needs to include information about **what the "signs" are of escalating risk and who should be contacted with concerns**, this should include an organisational contact as well as a worker's details to ensure cover if the named worker is not available.
- A person receiving support from any health or social care agency **should have a care plan in place**. This plan should describe the support the person requires and how/by whom that will be provided. Care plans, risk assessments and escalation plans should be provided to all the agencies and people working with the person and updated regularly. Organisations should have a way **of monitoring nonattendance** for those viewed as being vulnerable/at risk. There should also be a procedure in place that outlines the action that then will then be taken.
- Commissioners of services should make sure that **providers are aware of new policies and procedures**. This should include sending out links to the new policies and having an agenda item on contract meetings or providers forums for policies and procedures. Anyone commissioning services from a provider should check that they are registered to provide the service being requested. **Providers should read through the person's care plan and assessment information before they confirm that they are able to meet their needs**. If there are needs on the plan that they are not able to provide this should be discussed with the person commissioning the service immediately. Organisations should have clear processes for identifying work that needs reallocating if the worker is off sick or on leave. This should include being aware of the **legal duties** that need to be met and how these would impact on the timescales for reallocating work. Managers should ensure that all relevant documents have been completed for a person, for example **assessments and escalation plans**. Any new worker should then read these before meeting with the person.
- When a safeguarding concern is identified consideration should immediately be given to whether any urgent action is needed to keep the person safe. This can be done by a provider agency contacting social care, by a family member or by the social care worker receiving the referral. As part of the initial information gathering, details should be sought regarding the person's **life history** and any **previous known incidents of abuse or self-neglect**. Organisations employing staff on a short-term basis must provide them with information regarding safeguarding and self-neglect

before they start working with individuals. Management discussion or supervision should be used to confirm that the staff member has understood the requirements. Any exploration of **legislative tools that could be used to support a person, should be recorded on the person's records**, even if a decision is made not to pursue any of the options. This includes consideration of legal action under the **Mental Capacity Act, the Mental Health Act**. Organisations should ensure themselves that all their staff are aware of the **referral process for people known to Mental health teams** and that this process is clearly detailed in all safeguarding procedures. Organisations, particularly provider agencies, need to make sure that their staff are aware of the safeguarding escalation process. This can be used to raise concerns about how a safeguarding matter is being responded to from the initial point that a concern is raised to the completion of a safeguarding enquiry

'ELLEY' [2018]
https://bcssp.org.uk/assets/7a7eb990/sar_elley_practitioner_briefing_final.pdf

Elley was a 93-year-old woman. The cause of her death was given as a sepsis of unknown cause together with the 'frailty of old age', dementia, and heart disease. Elley had lived in her home in the B&NES area for over 60 years and following the death of her husband, she had lived there alone for almost 20 years. She described the house as holding a lot of her memories. Elley had one son who lived abroad but returned to visit his mother on regular occasions. Elley is described as a gregarious person who enjoyed gardening, music and travelling. She drove her car until she was 90 and was often the person who organised and gave lifts to friends. Elley's family feel that her 90th year was a turning point for her as her confidence began to decline and she started to experience problems with her mobility. Elley described herself to her son as being isolated and cut off; as she no longer went out she had little contact with her friends. Elley was in receipt of support from a domiciliary care agency (which she funded), a befriender and the District Nursing Service. Elley's health and care needs were regularly reviewed and discussed at the GP surgery's multi-disciplinary meeting. There were concerns about Elley's ability to manage at home and her apparent reluctance to accept care from the carers or consider increasing the number of calls she had from the domiciliary care agency per day. Elley's son lived with her for a number of months prior to her death. He provided care to his mother outside of the support provided by agencies. Those working with Elley did talk to him about increasing the level of domiciliary care support his mother was receiving but the support was not increased. The professionals working with Elley had their views about why this was but they did not explore this further with Elley or her son, nor did they consider the legal avenues that may be available to them.

Key Themes

- It is important that all practitioners are aware of how to **access the public information** available regarding social care support and that they provide this information to those that they are working with. It is important that all health and social care staff are aware of the **Carer's Centre** and how people can contact them. District Nurses and Community Matron's should ensure that they have a basic understanding of the social care charging system. Social care staff should remind themselves of the **right every person has to a social care assessment** - regardless of their financial status or the fact that they had an assessment in the past. A lead professional should be identified to work with the person and their family when there are concerns regarding the person or their care and support.
- All **capacity assessments** should be decision and time specific. Professionals should not rely on an assessment undertaken some time ago and in relation to a different decision. Professionals should refer to the completed MCA paperwork when discussing the outcome of an assessment to ensure that the information they are recording is accurate. Before a **Power of Attorney** is acted on by a health or social care professional, a copy of the **paperwork should be viewed by the professional** and the nature and extent of the power noted in the person's records. All health and social care professionals should be aware of the role and responsibilities of the Office of the Public Guardian. This should include how to raise a concern regarding a power of attorney and how to confirm if a power of attorney has been registered.
- Any professional making or receiving a safeguarding referral involving concerns that cover an extended period of time, should ask: **Why is this referral being made now? What has changed in this situation? Have the risks increased and if so how? What steps have already been taken and what was the outcome?** Health organisations should ensure that their staff have undertaken both initial and regular "update" training on adult safeguarding. Staff should also be aware of who the safeguarding lead is in their organisation so that they can draw on their expertise. Social care assessments and carer's assessments should be considered as part of the planning process for every S42 safeguarding enquiry. All professionals should discuss their safeguarding concerns with the person and their carer, unless it is not safe to do so. This will provide the opportunity to obtain the person's views and wishes

B&NES Analysis

Engaging with, and the voice of, the person

- It is our responsibility to engage the person, not the person to engage with us
- How do we fulfil "relationship building" within an oversaturated health, social care and community safety system. How do we fulfil:
    - MSP,
    - Views, wishes and feeling - Listens to P
- By simply engaging an Independent advocate?
- What is, and how can we be, Trauma informed?

Mental capacity.

- We see there was an over-reliance on assumed capacity and an absence of formal assessment – where is the line, how do we identify it, how do we apply it to a situation and how do we evidence this within our assessment when there is reasonable cause to doubt?
- How do we complete assessment:
    - When a person is unwilling to engage in an assessment, reviewing surrounding evidence
    - Where there is complexity relating to drug and alcohol misuse and impact on decision making
- How do we fulfil and evident we have:
    - Consulted with others, without sharing too much information
    - Explored Executive functioning
    - Undertaken a Longitudinal assessment – martial time

Information sharing and Holistic Assessment of needs, vulnerability and risks.

- There were "shortcomings in interagency coordination". There is a need to include all people involved with the person, inclusion the person, carer and others [think family, think community]
- We did not always share key information that would enable levels of need and risk to be judged
- Multiagency risk assessment – one version of the truth… should there be such a thing?

- The interplay of physical and mental health needs were not fully explored, understood or planned for.
- The lack of life history, meant we lacked the ability to fully understand who the adult got to there they were.
- Professionals found the access to information, as a barrier.

Care planning and Resources to meet needs

- Multiple commissioning and funding arrangements result in services that didn't quite fit together
- A care plan "should describe the support the person requires and how/by whom that will be provided". Without close working with the adult and others, how can this be developed?
- Quality of providers were identified, with a recommendation that *"Providers should read through the person's care plan and assessment information before they confirm that they are able to meet their needs"*

Tools and resources to support practice

- Applying the law:
    - What is legal literacy?
    - Do we all have access to solicitors who can advise us?
- What are the "signs" of escalating risk, how do we identify them and who should be contacted with concerns?
    - Shared risk assessment
    - Identifying Patterns
- Shared level of Commitment and Curiosity – identifying cycles and patters of behaviours/ risks
    - I know my job, I need to focus on my part of the jigsaw, but be aware of the fulfil picture
    - Awareness of and applying policies and procedures to complex situations

Swindon SARs

Sally [2024]
https://safeguardingpartnership.swindon.gov.uk/downloads/file/1437/sar_sally_7_minute_briefing

Sally was a white British woman, aged 48, who experienced domestic abuse, exploitation (including cuckooing) and self-neglect including her health needs. She was found deceased in her home in February 2024. She had previously come to the attention of police, social care, health partners and voluntary sector

Key themes

- Sally mostly came to the attention of services at periods of crisis and through interventions led by emergency responders (police, SWAST crew, MHLT and GWH's A&E). There is evidence within these incidents that responses were person-centred, practitioners considered Sally's views and sought to empower her to accept help. **Formal capacity assessments were not recorded.** However, in line with expected safeguarding practice, emergency responders usually made follow up referrals, for example, in July 2023 Police also highlighted within their Vulnerability report that she would not be safe unless received support from police and/or partner agencies. The officer did make appropriate onward referrals, but not to SBC's adult social care.
- **opportunities to respond to direct requests for assistance by Sally did not trigger a 'team around the person' approach.** For example, when she asked for additional support for her mental health, her GP practice and the SIMS (housing) team advised her to engage with AWP's SIS or PCLT. Whilst this is within acceptable referral pathways, **better use of information held across partner agencies could have enabled a shared preventative plan** via the self-neglect protocol with a multiagency meeting.
- There was **not a lead agency** identified to coordinate her considerable needs, including when referrals were made to AWP's teams, Housing's SIMS, SBC's ICT or concerns raised through the s42 process. Given the longevity of concerns, reported within MARAC minutes between 2013-21 and **repeated unsuccessful attempts to engage Sally** with proactive support (including IDVA, social care, SIS and LiFT's psychological support) throughout the review period, a more systematic approach would be to explore patterns in contact to understand if she lacked executive capacity to coordinate her own care and if she could stay safe without additional support. Currently the strategic oversight of the application of the self-neglect protocol is unclear. There is a lack of clarity for frontline practice across the

partnership of when concerns should trigger **assertive action** either through the protocol or s42 processes. There is also no system-wide mechanism for tracking high risk cases where self-neglect is a feature or for SSP to have oversight to gain assurance that multi-agency interventions (outside the s42 process) are timely, person-centred and reduced risks for adults with care and support needs

Ethan [2024]
https://safeguardingpartnership.swindon.gov.uk/downloads/file/1418/sar_ethan_brief_findings_report

Ethan was a 62 years old white British male who moved to Swindon about 7 years old. He had two adult children with his long-term partner. This relationship ended about 10 years ago. Prior to his father's death in 2018, Ethan was his carer. Ethan had a stroke some years previously and it is possible this may have had an impact on his self-care and pattern of self-neglect. Ethan was found deceased in his home in January 2024. Several referrals for support were received by adult social care and Ethan often declined support.

Key themes

- Interagency Working: Appropriate handover between Adult Social Care teams - 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.

- Multi-agency Working - 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. 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. There was **no formal MDT in place to coordinate support** and for all organisations to understand the extent of the concerns for Ethan.

- Clear recordings, rationale and decision making - 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. 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. 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.

- Professional curiosity and working with complex individuals - There was some evidence of good professional curiosity from practitioners, although this was not always clear and consistent in case recordings. 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 person's 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 Page 6 of 7 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. 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. 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 person's 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.

Richard [2024]
https://safeguardingpartnership.swindon.gov.uk/downloads/file/1417/sar_richard_7_minute_briefing

Richard was a white British man who lived alone. He was 70 years old. Richard was a qualified Physicist, in his younger years Richard worked in research, he enjoyed building amplifiers and computer programming. Richard is described by his sister as having a keen sense of humour and who loved to make 'puns'. Richard enjoyed listening to music, particularly opera's such as Wagner and Strauss. Richard also enjoyed listening to pop music such as Madonna. Richard had a diagnosis of schizophrenia and his property was known to be unkempt. Professionals were unaware of the network around him and found it challenging to engage with Richard around support with his home environment.

Key themes

- it was noted that the housing provider and care provider were **unaware of each other's involvement with Richard**. Both agencies were in contact with AWP separately, but these **communications were not coordinated** or discussed as part of a multi-agency team supporting Richard.
- AWP records also highlight concerns in regards to hoarding, cleanliness and fire risks in Richard's accommodation. Following the referral to the SBC Mental Health Team, Richard was placed on a waiting list for a Care Act assessment. During this period, the SBC Mental Health Team did not visit Richard, despite attempting to contact him via telephone without success. Although the Mental Health Team's case notes indicated that Richard's referral was a priority, this **priority status was not clearly defined,** resulting in the referral not being prioritised for allocation within the team.
- In July 2023, Richard was transferred from the Recovery Team to the Complex Intervention Team within AWP. Around this time, signs of deterioration in Richard's presentation, wellbeing, and need for further support became apparent. There were also differing perspectives between the teams regarding how to support Richard, the risks associated with his health and well-being, maintaining his property, and his nutritional needs. The Recovery Team showed **limited escalation and multidisciplinary collaboration**, but shortly after the handover, the Complex Intervention Team made referrals to the SBC Safeguarding Team and the Fire Service.
- AWP have also discussed that **increased professional curiosity might have encouraged a deeper exploration of Richard's situation**, rather than accepting his assurances that he was fine and his refusals to allow professionals into his accommodation. AWP reflected that by being **more inquisitive**, workers might have gained a better understanding of his condition, identified any triggers or signs that he was struggling, and assessed how he was managing day-to-day tasks. AWP furthermore acknowledged missed opportunities to take a more **active role in**

organising and leading multi-disciplinary meetings. This issue has been highlighted in previous safeguarding reviews and reflects a recurring theme across the partnership. Additionally, AWP noted the need for more robust risk assessments and regular reviews of these assessments as areas for improvement.

- A safeguarding concern was raised by the Complex Intervention Team (AWP) to SBC Safeguarding Team. This highlighted safeguarding concerns regarding hoarding, cleanliness of property, fire risks and the need for further support. Subsequently, a decision was made by the SBC Safeguarding Team that these concerns did not met the s42 safeguarding criteria for an enquiry. The **outcome, rational and reasoning behind this decision was not communicated** to AWP. Furthermore, a comprehensive handover, which should have included a determination and documentation of the risks associated with Richard's situation, was not conducted between the SBC Safeguarding Team and the Mental Health Team.

Wendy [2024]
https://safeguardingpartnership.swindon.gov.uk/downloads/file/1367/sar_wendy_7_minute_briefing

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 lived in a sheltered housing scheme, with support from District Nursing, carer agency, SBC Housing and AWP services. Wendy's pattern of self neglect was closely related to her mental health. Wendy's experience of being struck off from nursing greatly impacted upon her. She was described as fiercely independent by her family.

Key themes

- Professional Curiosity and Mental Capacity Act 2005: There was evidence of the Mental Capacity Act not being used to its full potential. There was evidence of **inconsistent approaches and an assumption of capacity**. Professionals needed to be more **curious** around Wendy's capacity and **consider executive functioning**. **Duty of care vs. Autonomy** was the theme.

- Working with Complex Adults: Professionals did not always maintain consistency in how Wendy was supported. When Wendy refused care and support this became challenging for professionals in knowing what to do next. This links with professionals knowing their **legal literacy**.

- Making Safeguarding Personal: The Care Act 2014 guidance stipulates that adult safeguarding practice must be person-centred and outcome-focused, with MSP as the recommended safeguarding strategy alongside the other six safeguarding principles. Wendy was **not always included in safeguarding meetings**, nor was there an agreed process or trusted person set to feedback to Wendy the outcomes. There

was evidence that Wendy was not happy about the safeguarding process and her views were not reflected.

- Multi-Disciplinary Team Working: **MDT working was inconsistent**. There is good practice shown for elements of MDT working, however **all the relevant people were not included** in meetings. When the safeguarding process ended there was **no agreed lead professional and communication and information sharing started to drop off**, impacting greatly on Wendy's wellbeing.

Robert [2024]

https://safeguardingpartnership.swindon.gov.uk/downloads/file/1344/safeguarding_adult_review_-_robert_-_7_minute_briefing

Information Technology was Robert's vocation when he passed away at 53. He initially contacted services in August 2022, where he disclosed a significant issue with alcohol. The same month, he attempted suicide by overdosing on CBD oil, and paramedics were dispatched to his home; he admitted to consuming two bottles of wine and eleven cans of lager daily. Alcohol abuse, as opposed to mental illness, was identified as the underlying cause of his condition, which led to his discharge from AWP. Between August and his death in January 2023, AWP, GWH, the police, SWAS, and Turning Point all had contact with him.

Key Themes

- There was documentation in his records, which sought to seek his views and wishes. However, the reviewer determined that **the balance of risk and autonomy was not considered**. In addition, **each occurrence was reviewed separately**, and his prior presentation of the services needed to be considered. Robert had declined assessments by Turning Point and AWP. The principle of making an 'unwise decision' is enshrined in the Mental Capacity Act 2005. However, this should also involve a discussion of the **rationales behind declining services and pursuing professional curiosity**. Supporting involvement should also be guided by the six principles of safeguarding adults, emphasised in the Local Government and Association of Adult Social Services Making Safeguarding Personal project16, in addition to the Care Act 2014: Section 11 and the manual. The **employment of legal frameworks to encourage engagement is also highlighted**

- Robert's GP to illustrate his severe weight loss and facial bruising caused by falls. She reported receiving guidance to inform Robert to attend the practice. The GP practice could not confirm why this guidance was given, and **Robert was not seen face-to-face**. Michelle forwarded these photographs to the reviewer, who subsequently forwarded them to the panel to comprehend Robert's decline better. The ambulance services attended Robert's home and observed him to be intoxicated and multiple

bruises to his face. Additionally, GWH observed multiple healed and open wounds on his face. Robert was at risk of self-neglect. The previous SARS in Swindon, 'Alison,' 'Andrew,' and 'Brian' raised concerns about the **agency's responses to dependent drinkers**, noting that neither **alcohol screening assessments nor professional curiosity** were used. The practitioner workshop brought to light the probable **unconscious bias** of those who exhibit signs of intoxication as a lifestyle choice; such an assumption prevents a more in-depth examination and comprehension of the underlying causes of the drinking. **Neglecting to exercise legal frameworks** and honouring an individual's autonomy could result in the individual dying or being vulnerable to exploitation and abuse in violation of **Article 2 (Right to life) or Article 3** (Freedom from, inhumane or degrading treatment).

- **Legal literacy, particularly the Mental Capacity Act, was a recurring issue in Swindon's four SARs**. Those who suffer from mental impairments due to the consumption of alcohol or drugs are acknowledged and governed by the Mental Capacity Act of 2005. Addictive behaviour can supersede an individual's knowledge comprehension and suggest a capacity deficiency. Including **executive capacity** in assessments and an individual's **capability to process and evaluate information** is crucial.
- Nevertheless, individuals are frequently **denied access to mental health care until their substance dependence is resolved** and may also be denied drug abuse services until their mental health is addressed. As a result, she advocated for the collaboration of services to resolve the issue. The three Swindon SARs **underscored the necessity for services to emphasise risk factors,** such as alcohol consumption, and to be professionally curious about the root causes of excessive alcohol use. Robert revealed that he ruminated on past mistakes, which led him to resort to drinking as a coping mechanism. Robert did not use the talking therapy contact information that the GP offered. The agency's documentation did not highlight what the 'mistakes' were. In October 2022, Michelle told AWP that Robert had **not engaged** with Turning Point. They reported that she would be speaking to her GP. This was an opportunity to ask Michelle how she was coping and whether she needed support. Robert disclosed to his GP in December 2022 that he was not participating in AA. No action was taken as a result of this. Robert requested a second statement to sign him off from work in late December 2022 since he had felt anxious and depressed since returning to work. Michelle went to Robert's GP Practice with photos of Robert and a request for him to be seen instead of providing the fit notes. Michelle stated she was denied her request. The practitioner workshop emphasised that a considerable number of the individuals they encounter are averse to attending Turning Point Due to several factors, including the location and the **social stigma** associated with it. It was reported that Robert underwent detoxification after his three weeks of admission to GWH; this would have been an

ideal opportunity to support his engagement with alcohol services and gain a deeper understanding of the causes of his excessive drinking to facilitate a safe discharge and community support.

- These findings echo the past SARs and those from Swindon on **insufficient professional curiosity and legal literacy**. The University of Bristol discovered that clinicians occasionally utilised capability to justify not intervening in cases of suspected self-neglect, thereby placing individuals at grave risk. **"Social care practitioners burdened with an overwhelming workload may inadvertently or deliberately "dispose" of cases utilising capacity as a means to do so**. Supporting **protection and promoting autonomy should not be mutually exclusive; rather, they should be harmonised** to assist those neglecting themselves effectively.
- Although information was communicated to the GP, there was **no coordinated response** in the agency records. Multi-agency working allows practitioners to **evaluate an individual's issues from multiple perspectives rather than focusing on one area**. Michelle had informed Robert's GP, AWP, GWH, the police, and the ambulance of her concerns for Robert and her difficulty managing them. Research findings consistently demonstrate that **female family carers endure a greater degree of substantial psychological suffering, shame, and carer load**. Any adult over 18 who provides care for a disabled, older adult or ill adult is entitled to a carer's assessment under Section 10 of the Care Act 2014. The carers' mental and physical health, capacity, willingness to provide care, and interpersonal relationships should be discussed during these assessments. Robert informed AWP of his supporting partner that his mental health deteriorated when Michelle left the home; this was shared with the GP.

Andrew [2022]
https://safeguardingpartnership.swindon.gov.uk/downloads/file/1103/sar_andrew_practice_brief

Andrew was a 77-year-old male who on the 14/09/20 was found unresponsive inside a property besides his adult son Christopher who was found deceased at the scene. Andrew subsequently passed away in hospital on 22/9/20. Since that time both deaths have been ruled as suicide by the coroner. It was reported that they were holding hands and had Andrew's late wife's wedding ring in their hands. Andrew was transferred to hospital for treatment. Toxicology report indicates that Andrew had ingested Benzodiazepines which were not prescribed, Andrew never recovered and no further information was obtained before his death on the 22/09/20. Andrew was open to Safeguarding Adults team within Swindon Borough Council with a Section 42 enquiry on-going at the time of his death. A referral had been made by the Ambulance Service on the 12/03/20 as a result of an incident whereby Andrew's son Christopher had given Andrew Pregabalin which he had bought from a friend which then resulted in Andrew being hospitalised and it was this enquiry that was

still open. Andrew lived alone and had a number of health conditions, including Atrial Fibrillation, history of depression and anxiety, hearing loss, prostate cancer and he had been shielding due to high risk of COVID-19. Andrew's wife died in 2017 and in the years that followed, he was treated for depression and low mood. There is evidence from practitioners' reports that Andrew began to show signs of self- neglecting behaviours including a deterioration in his living environment, the cancellation of a care package from domiciliary care agency and poor self-care. Andrew's son was his unpaid family carer and was heavily involved in services being able to access his father to provide support.

Key Themes

- Coercion and Control: There was recognition of a risk around coercion and control by agencies working with Andrew but no clear work to address it
- Mental Capacity and coercive control: there are a continued need to emphasise the need for a **formal capacity assessment** where there are any concerns raised about a person's capacity to make a decision, including documentation of all parts of that capacity assessment within the records. Should there be any concerns about coercive control, discussions with the patient including any capacity assessment should take place without the possible perpetrator of the coercive control present. -If necessary to involve the police to enable (b) this should be organised (i.e. if the alleged perpetrator will not leave).
- The inclusion of GPs in adult safeguarding planning meetings: In this case there was a lot of multi-agency communication, and the agencies were working together and liaising at the beginning of September. It was suggested that the organisation of additional adult safeguarding planning meetings and the development of a specific associated **adult safeguarding plan** for Andrew may have benefited him and impacted the outcome of events. The **GP** would have then been involved in the additional safeguarding planning meetings and could have **helped to formulate the plan**. The circulation of the plan (to agencies including the GP surgery) would have meant that the GP and other agencies would have been **kept up to date** with the safeguarding plan without needing to rely on the adult safeguarding team for regular updates.
- Bereavement Support: exploration of bereavement support for vulnerable people could be looked at in more detail. Often vulnerable people are significantly **more socially isolated** than the rest of the population and **managing grief without friends/family support** can make the process more difficult to manage, and in turn **can precipitate a decline in mental health**. Turning Point's understanding is that a referral to CRUSE cannot take place until 6 months post mortem. It also raises the question of whether or not services recognise that **drug/alcohol users are**

vulnerable and need support in coping with caring responsibilities. What would it be like in to seek bereavement or carer support as an Opiate user?

- Trauma Informed Practice: The understanding of trauma is now recognised as being a key development area for a number of services areas and agencies working with children and families and adults who may have care and support needs. Agencies should ensure that trauma informed approaches are being used and developed within their agencies when working with all their service users at the earliest opportunity. Trauma may not be known at the point at which agencies are working with people, a trauma informed approach enables professionals to open up conversations about possible **trauma histories and if identified can respond better to the impact of this trauma**.

Alison [2022]
https://safeguardingpartnership.swindon.gov.uk/downloads/file/1031/sar_alison_learning_brief

Alison was a 49-year-old woman who was found collapsed in a stream in woodland near her home in July 2020. It was determined that she had taken her own life. Alison reported a history of trauma as well as chronic mental health problems and a pattern of alcohol misuse. She had been engaged with the local Mental Health Services for at least 25 years. Her mental health history included: anxiety and depression, a diagnosis of emotionally unstable personality disorder, self-harm episodes including cutting, burning and overdoses, alcohol abuse and drug use. She also had poor physical health with chronic liver disease (she was hepatitis C positive) and asthma. Evidence provided to the review suggests that Alison may have been subject to exploitation by her neighbours. In November 2021 a SAR was undertaken following Alison's death and key areas for learning were identified.

Key Themes

- Multi Agency Approach: This comes out in the chronology and is supported by the Trust's patient safety report which acknowledges that it was problematic that the **decision in May to convene a multiagency professionals meeting was not followed up**. The Safeguarding Plan from the October 2019 safeguarding enquiry included two multi-agency meetings, although the first of these was not held within the timescales of a Planning Meeting in line with Swindon's Policy and Procedure for Safeguarding Adults, there was good participation from Primary Care, Mental Health Services and Police within the meetings held. This process faltered, however, because of the problems identified above. In May 2020, the PCLS Multi-disciplinary Team meeting agreed that a professionals meeting should be arranged due to the **volume of contacts Alison was having with services** and the number of referrals that were continually made to PCLS by her GP. Given that this decision was at the height of the

pandemic, it may be understandable that no action was taken on this. However, it is surprising that such a step had not been taken much earlier. Alison was a woman who had **long had a multi-agency impact and been difficult to manage**. A multi-agency perspective could have **improved risk assessment and identified opportunities and approaches that could have improved interventions**. This would have been facilitated if Mental Health Services had, as suggested above, pursued the principles of the **Care Programme Approach** with Alison. However, this approach could have been initiated by other agencies including Primary Care. In the discussion of the report it was highlighted that the local Risk Enablement Panel could have been a framework for these multi-agency discussions

- Risk Assessing and Risk Management A model of good practice based on research and finding from previous SARs shows that **comprehensive risk assessments** of individuals are advised, especially in situations of service refusal. Mental capacity assessments should form part of a risk assessment, especially of **executive functioning** in cases where there is shown to be **medical evidence of changes in the brain** which would affect this functioning. **Professional curiosity** and assessment are fundamental when concerns occur repeatedly and **when a person's decision-making maintains or increases risks of significant harm**. It is important to ensure that **risk assessment procedures are regularly reviewed** and training updated. When working with service users, often for extended periods of time, then can be a danger that familiarity with a service user can lead to an **unjustified minimisation of the risks** they pose.
- Mental Capacity Act: **Decisions about mental capacity were not central to the care** of Alison. However, the case raises general questions about the application of the Act to these complex clients. The Safeguarding Team report that in both the two main enquiries, the enquiry managers question Alison's ability to make informed decisions about the concerns being raised. The October 2019 enquiry sets actions for Alison's capacity to be assessed by Mental Health staff in relation to concerns and risk areas. The outcome of this is that Alison has **capacity for the decisions tested, however, there is no record of the assessment**. This is clearly a practice failing. The more general question is about the assessment of capacity with these complex clients. At three points, Alison seeks to self-discharge from hospital, leading to questions about her mental capacity to take that decision. In addition, it should be remembered that the Code of Practice comments that: ***2.11 There may be cause for concern if somebody: • repeatedly makes unwise decisions that put them at significant risk of harm or exploitation...These things do not necessarily mean that somebody lacks capacity. But there might be need for further investigation…***1 Even if Alison did have the capacity to care for herself, the Code suggests that professionals seeing this **repetitive behaviour by Alison should certainly have explored** what lay behind this pattern.

Kieran [2022]

https://safeguardingpartnership.swindon.gov.uk/downloads/file/580/sar_learning_brief_-_kieran

Kieran died at his home in January 2019 following a period of illness. Kieran was diagnosed with mild learning disabilities around the age of 18 and first had contact with mental health services following his father's death 3 years later. Kieran lived with his Mother until she passed away in 2002. Kieran experienced self – neglect, hoarding, mental illness and exploitation in the years leading up to his death. Following Kieran's death, a SAR was undertaken and key areas for learning were identified.

Key Themes

- However, a **balance has to be struck between his autonomy or self-determination and the duty to safeguard** him from known or likely significant risks. It is questionable whether that balance was appropriately considered in Kieran's case. **Too much reliance may have been placed on the presumption of capacity, with an emphasis on building rapport and a relationship with Kieran,** at the expense of a more holistic assessment of his needs and the risks inherent in his situation. As a result, there was **no care plan** to address adult safeguarding concerns, including vulnerability to exploitation and significant self-neglect. Risk assessments, and risk management and contingency plans, were not up-to-date and were not revised after key episodes. **The roles of different services and practitioners, in addition to a neighbour and the private carer, were not clarified, including for emergency response.** Kieran's relatives do not believe that he had decisional capacity with respect to his health and welfare. There were missed opportunities to develop a greater understanding of his **executive functioning** and whether he could use or weigh what practitioners were saying to him about the risks inherent in his self-neglect.
- The second of the five statutory principles in the Mental Capacity Act 2005 appears to have been highly influential in how this case was managed. That principle states that "a person is not deemed unable to make a decision unless all practicable steps to help them to do so have been unsuccessful." Also influential appear to have been **uncertainty and ambiguity in his presentation**. However, earlier and robust assessment would not have compromised this principle and would also have identified, in line with the first statutory principle and the **starting point of capacity**, whether it was necessary to **balance his decision-making with his right to safety and protection.**
- There was also delay in assessing Kieran's care and support needs and in commencing a care package, initially because of Kieran's **reluctance to engage with the plan** and subsequently because of **difficulties in commissioning a Care Agency**.

The care and support package did not adequately address his needs, in particular his self-neglect and hoarding, even allowing for the importance of building up a relationship of trust. **Reviews did not result in any fundamental shift of approach.**

- It is also possible that the conditions in which Kieran was living became in some way "**normalised**", to which **practitioners became accustomed or desensitised** with the result that they did not **see the risks clearly** enough. Kieran would only permit limited cleaning and entry to some parts of his home. Not all the rooms were inspected and there was **no escalation of concern and no multi-agency meeting** when Kieran was reluctant to engage. This links back to questions about understanding of Making Safeguarding Personal and application of the Mental Capacity Act.
- There was an **over-reliance on the support supposedly being provided by the private carer**. Services did not work together in their **efforts to make contact with** him to express concerns about how Kieran's weekly allowance was being used and about what support Kieran would accept from him. Whilst it appears to have been Kieran's preference to be supported by his private carer, reportedly having a profound **attachment to him**, practitioners **did not convene a meeting** when efforts to engage the carer in the care plan failed. As a result, there was **no oversight of this arrangement** and this part of Kieran's potential **support network was not clarified**. None of the services and practitioners involved **made contact with Kieran's relatives** until after he had died. Not all agencies appear to have had details of Kieran's next of kin and other family members. It appears that Kieran may not have wanted contact to have been made with his relatives. However, without Kieran's consent, **making contact with his relatives would have been appropriate to collect information and justified because of concerns about how to safeguard him** as an adult at risk. As a result, his support network was not well understood; neither was his history and his lived experience of his family.
- There were other occasions when communication and collaboration between different services could have been enhanced. Complex and challenging cases require a **uniform and agreed response**, where services **work closely together and where all views are valued and listened to**. Holding planning meetings should be standard practice, together with **the circulation of case summaries to highlight the key concerns that need to be addressed**. There were examples of good practice regarding the sharing of information. There were also **delays in information-sharing**. A marked feature of this case is that **at no time did all the services and practitioners come together to discuss how best to meet Kieran's needs and mitigate the risks in his case**. One had been planned but Kieran died before it could take place. Multi-agency meetings should be the norm in such cases. Some uncertainty was found with respect to when the **Section 42 Care Act 2014 adult safeguarding concern pathway**

might be used and when a multi-disciplinary team meeting pathway might be considered. Referred adult safeguarding concerns did not result in an adult safeguarding enquiry, despite the criteria being met. There were **shortfalls in recording**, for example details of Kieran's next of kin, responses to fire hazards and repair work undertaken in his home.

- Supervision and management oversight of complex and challenging cases are central components of best practice. Although practitioners were able to access support, there was **insufficient supervisory and management oversight** of care and support planning, responses to concerns and to risks, and safeguarding decision-making. None of the documentation submitted for this review indicates use of available self-neglect procedures. A review is underway of a policy on escalation of concerns.

Brian [2021]
https://safeguardingpartnership.swindon.gov.uk/downloads/file/1212/sar_brian_practice_brief

Brian was a 43-year-old white British man who had mental health needs and a history of drug use. He lived alone in a flat, where he died in a fire in February 2021. From July 2020 until his death, Brian was in contact with several agencies including the police, the ambulance service, mental and physical health services, and specialist drug services in response to self-neglect and drug dependency. Agencies struggled to engage with Brian who spent periods of time away from his flat, staying in hotels. In November 2021 a SAR was undertaken following Brian's death and key areas for learning were identified.

Key Themes

- There was **no co-ordinated multi-agency** response to Brian's needs. Despite the number of agencies involved with Brian, **no multi-agency meetings** were held. These could have enabled all the agencies to **pool their knowledge of Brian**. This may have resulted in the generation of new **and co-ordinated approaches to engage** with Brian and to meet his complex needs. (See Finding 6) The Police contacted the SIS shortly before Brian's death to suggest a multi-agency approach be taken to working with Brian. Other events which might have triggered a multi-agency approach, such as safeguarding concerns and GWH's **high intensity user letter**, did not prompt such a response. The self-neglect pathway, which may also have brought agencies together, was not considered. There were reports of individual agencies communicating with each other, but **knowledge sharing was fragmented** in places, so no one had a full picture of Brian. **No one took on case leadership for instigating joined-up multi-agency inventions**. The lack of a multi-agency approach is significant because it appears that **no single agency had sufficient knowledge** and understanding of Brian to meet his complex needs

- Understanding of **circumstances which may be predictive of poor outcomes and using these to inform practice** Brian, and the response of services to him, shared most of the characteristics with the cases identified in the Alcohol Change UK July 2019 report, and the Stoke and Staffordshire “Andrew” SAR. This pattern of circumstances might be predictive of poor outcomes. In consequence, services should consider how **the presence of this pattern of characteristics might be identified in the future and** how this might lead to interventions that result in better outcomes. (See Finding 1) While the Great Western Hospital had identified that Brian was potentially at high risk due to his **frequent Emergency Department attendances and was a high intensity user**, this does not appear to have led to different responses by agencies or to a coordinated multi-agency response.
- There was **little exploration of the effects of traumatic events** on Brian Whilst practitioners believed that Brian has been adversely affected by the death of his mother in 2019, there seems to have **been little exploration of events in Brian’s life** prior to 2019. Brian started taking drugs and misusing alcohol well before then, he first became involved with mental health services around 2010/11 presenting with anxiety and depression from the age of 18 he was described as having obsessive compulsive disorder traits and at some point, he was diagnosed with PTSD. There appears to be **no exploration of what the trauma was and the extent to which it affected** Brian. There was no exploration of Brian’s **life history and what had led to his excessive use of alcohol and drugs**. Brian’s sister contacted Brian’s Care Coordinator in January 2021 concerned that Brian needed more support, and this may have been an opportunity to have gathered some history. (See Finding 2)
- There was **little or no operational realisation of Brian’s diagnosis of ASD** The ASD team were commissioned only to diagnose ASD. There were **no specialist ongoing treatment services for people with ASD currently commissioned** in Swindon. There was no consideration of how Brian’s **autism and mental health concerns could be managed in tandem**, nor indeed consideration of how best to support someone with a triple diagnosis of ASD, mental health needs and substance dependency. Although GWH were aware of Brian’s ASD diagnosis, apart from AWP**, no other services appear to have been made** aware of it. This would have been a **barrier to considering how they might have responded** to Brian in a way which took account of his needs. It also meant that other agencies would not have taken account of ASD in considering Brian’s **capacity to make decisions**. (See Finding 3)
- Risk assessments: AWP completed risk assessments, but they did not consider how **risk fluctuated depending on circumstances** (such as substance intoxication) and how occasions of heightened risk could be mitigated. During the risk assessment conducted by AWP in January 2021 specific examples of risk which were rated in the

risk assessment as "high" risk, yet these did not appear to have been translated into any action plan.

- Staff understanding of hoarding could be improved the reports of the level of hoarding in Brian's flat before and after the fire are inconsistent and suggest that **the understanding and recognition of hoarding and of the need for intervention may need to be improved.**
- The effect of **long-term substance dependency on mental capacity** was not understood or was not applied. It appears that practitioners were unaware that people with **frontal lobe damage** caused by alcohol use and traumatic experiences might have the mental capacity to predict what might happen but are less likely to be able to take action to prevent it from happening. This understanding was not applied in assessing Brian's mental capacity. (See Finding 5)

Brenda [2021]
https://safeguardingpartnership.swindon.gov.uk/downloads/file/1209/sar_brenda_practice_brief

Brenda was a 75-year-old female who passed away at GWH in February 2021.Prior to her death, a safeguarding adult's referral was raised by the community nursing team on January 2021 regarding concerns that Brenda was not eating with a history of depression and at risk of self-neglect. Brenda lived alone at home and had become estranged from her son. There was little known about her life. Brenda had multiple health needs (heart disease, kidney disease, Sjogren's syndrome, anaemia), Depression and experienced Self-neglect. Brenda had contact with services leading up to her death including Community nurses visited weekly to give an Eprex injection, Advanced Clinical Practitioner from GP surgery, GP, Adult Safeguarding Team and Initial Contact Team at Swindon Borough Council.

Key Theme

- 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.

- 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.

- 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. **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 and Mental capacity act 2005: **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, preassessment 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.

Terry [2019]

https://safeguardingpartnership.swindon.gov.uk/downloads/file/780/safeguarding_adult_review_-_terry_-_learning_brief

Terry died in hospital in June 2019 aged 71 from liver cirrhosis accompanied by Hepatitis C. Terry experienced self-neglect, financial exploitation and alcohol dependency in the years leading up to his death. In November 2019 a SAR was undertaken following Terry's death and key areas for learning were identified.

Key Themes

- **Little was known** about Terry's life and background when building up a history can be helpful in understanding what a person is now presenting. Some elements of a Making Safeguarding Personal approach are discernible. However, there was **insufficient professional curiosity** regarding the background to his alcohol abuse, rejection of formal care, and self-neglect. There were many occasions when Terry refused assessments and/or personal care, and declined referrals. There were occasions, both when in hospital and at home, when he **initially engaged with services only then to withdraw**. These decisions or choices do not seem to have been explored with him.

- There were **missed opportunities to complete a thorough mental capacity** assessment. There were occasions when his mental **capacity appeared to fluctuate**. Throughout 2018 and into 2019 **repeating patterns** stand out, most notably self-neglect (lack of self-care and increasingly squalid living conditions), alcohol misuse

and cognitive issues. By March 2019 he was assessed as lacking capacity to understand the adult safeguarding enquiry process and the management of his financial affairs. The patterns in this case highlight the importance of **multi-agency consideration of fluctuating capacity**, assessment of **executive capacity, and impulse control relating to substance misuse.**

- Risk assessment is of central importance. Some risk assessments were completed at different points, concerning falls and self-neglect. The risk of financial abuse or exploitation was never fully resolved. The management of his personal allowance by his informal carers was not reviewed robustly. Other risks became more prominent as the case progressed, for example the **lack of food and other necessities for daily living** in his flat, an increasingly soiled environment and Terry's faecal incontinence, lack of nutritional intake and **failure to consistently take prescribed medication**. There is **no evidence** that there was a **comprehensive risk assessment, periodically updated through services working together**, when concerns were raised.
- It is possible that Terry's decision-making, especially regarding his alcohol misuse and rejection of care and support, was seen as **lifestyle choice**. If so, that reflects a **misunderstanding of the Mental Capacity Act 2005 and a failure to balance self-determination/autonomy with a duty of care**. This can be a difficult balance to strike. **Professional curiosity and assessment are fundamental** when concerns occur repeatedly and when a person's decision-making maintains or increases risks of significant harm
- There was misunderstanding by some agencies involved of who was Terry's next of kin, his informal carers wrongly being identified as such. **Little contact was made** with terry's brother, **either to gather information or to explore what further support he could offer**. A formal care and support package was eventually provided but **concerns then raised by the care provider were not satisfactorily addressed** before Terry died. A late referral to a substance misuse agency again did not result in an assessment before Terry died.

Swindon Analysis

Engaging with, and the voice of, the person

- *"Social care practitioners burdened with an overwhelming workload may inadvertently or deliberately "dispose" of cases utilising capacity as a means to do so".* Again, this leads to the question; How do we fulfil "relationship building" within an oversaturated health, social care and community safety system.
- What is, and how can we be, Trauma informed? Would this better support:
  - rationales behind declining services and pursuing professional curiosity
- And avoid
  - unconscious bias
  - And risks associated with "long had a multi-agency impact and been difficult to manage"
- If the adult is involved with other services make contact with them to explore the best way to engage the adult.

Mental capacity.

Again, we see

Duty of care vs. Autonomy - Article 2 (Right to life) or Article 3 - protection and promoting autonomy should not be mutually exclusive; rather, they should be harmonised. And starting point of capacity, whether it was necessary to balance his decision-making with his right to safety and protection.

inconsistent approaches and an assumption of capacity

2.11 There may be cause for concern if somebody: • repeatedly makes unwise decisions that put them at significant risk of harm or exploitation...These things do not necessarily mean that somebody lacks capacity. But there might be need for further investigation…

- How do we complete assessment:
  - When a person is unwilling to engage in an assessment, reviewing surrounding evidence
  - Where there is complexity relating to drug and alcohol misuse and impact on decision making
- How do we fulfil and evident we have:
  - Consulted with others, without sharing too much information
  - Explored Executive functioning

- Undertaken a Longitudinal assessment – martial time

Information sharing and Holistic Assessment of needs, vulnerability and risks.

The lack of, leading to:

- The lack of "*evaluating an individual's issues from multiple perspectives rather than focusing on one area*"
- The fact that we *"did not always share key information that would enable levels of need and risk to be judged"*
- Not making contact with relatives, led to lack of knowledge, where it *"would have been appropriate to collect information and justified because of concerns about how to safeguard him"*
- Lack of life history, where *"pool their knowledge"* would have supported better understanding
- And possibly leading to "*unjustified minimisation of the risks*" **and** Lack of curiosity and scrutiny into "*Impulse control* "

We also saw, again

- Interplay of physical and mental health needs, but also neurodiverse needs

All of which leads to some observations, in that: Even with a Multiagency risk assessment, without monitoring risk fluctuation, there will be no continued one version of the truth. And even though a Section 11 assessment may not achieve the adult's outcome or provides a framework to apply care to a situation. It does support a holistic assessment of risk and vulnerabilities and provides an opportunity to meaningfully engage the adult in conversation about needs, risks and outcomes.

Care planning and Resources to meet needs

- Again, resource issues and quality of provision were identified, but also there was an absence of an agreed lead professional, leading to communication and information sharing to "dropping off"

Tools and resources to support practice

- Again, we saw reference to "trauma histories" and if these are identified and support offer that adult could be supported to respond better to the impact of this trauma. There was also reference to attachment, leading to whether Attachment theory is applied to adult interventions, especially when hoarding and self-Neglect is present
- It was noted that "repetitive behaviour" was not explored and "the presence of this pattern of characteristics" could support identifying risks in the future.

- Shared level of Commitment and Curiosity was a theme once more. Whereby it was identified that if there is not a culture of "*work closely together and where all views are valued and listened",* there is a risk of to "*practitioners becoming accustomed or desensitised*."
- Further supportive infrastructure was identified as being:
    - There is need for professional support and supervision, where it was noted that there was occasion of "insufficient supervisory and management oversight"
    - The need to developed a "Team around the person" to support better "culture of collaboration and giving weight to other professional's concerns "

"with no shared language and hence was less powerful in driving the need for action" - Good recording supports good practice intervention, not just good evidence. -

Wiltshire SARs

Wiltshire Safeguarding Vulnerable People Partnership

Adult A

https://www.wiltshiresvpp.org.uk/p/adults/safeguarding-adults-reviews-1

Adult A (aged 84), was admitted to hospital in December 2015 after having been found on the floor of her flat by paramedics. They raised a safeguarding alert about the condition Adult A's flat, which indicated possible self-neglect and neglect. Adult A also told the paramedics that there was money missing. Adult A was admitted to an intermediate care bed and then discharged home. In mid-January, Adult A activated a care line.

The paramedics reported that Adult A was found in a situation of serious self-neglect, sitting in a cold, dark flat and was severely hypothermic. There was no fresh food in the flat and Adult A had not been taking her medication.

Adult A died in hospital the following day. At the time of death, Adult A was suffering from hypothermia, bronchopneumonia, left ventricular hypertrophy, hypertension, diabetes, kidney disease and dementia. The coroner concluded that Adult A would not have died at that time had she not been discharged home.

Key Themes

- The Mental Capacity Act is designed to empower people to make decisions about their own care, even if others think those decisions may be unwise. However, the MCA principles clearly state that, if a person repeatedly makes decisions that put them at significant risk, despite advice to the contrary, then this should be re-viewed. "…historically Adult A had been **assumed to have Mental Capacity. It does not appear that,** as time progressed, this was revisited in order to explain issues of concern or decisions she made." p11 In Adult A's case, professionals reported at a learning event held as part of the SAR, that Adult A seemed to understand the decisions she was making and was very sure of these. The review found that **no agencies challenged these decisions**, suggesting a **systemic lack of understanding of appropriate application** of the Mental Capacity Act 2005.
- The issues surrounding the Mental Capacity Act are directly related to those of self-neglect. "Assumption of capacity therefore had an impact on practice regarding self-neglect" p14 Since the Care Act (April 2015), self-neglect has been a recognised category of abuse that requires safeguarding interventions. A Care and Support Assessment was made whilst Adult A was in hospital, instead of a safeguarding referral, as her self- neglect issues were not judged to be evident. **None of the professionals working with Adult A raised any concerns about self-neglect, despite**

there being several factors indicating that this may be an issue. There was a lack of **professional curiosity** about some of the decisions Adult A made which contributed to her self-neglect. "It appears that staff did not have a good under- standing of self-neglect and **how to approach dealing with Adult A's self-neglecting** behaviours." p15

- Adult A was assessed as being a **self-funder** in 2012, due to the amount of care provided being under the threshold for social care funding. Following subsequent referrals for increased care, her **financial status was not reviewed**, and some types of support were refused as a result. A care and support assessment by **Adult Social Care was not undertaken for this reason,** a missed opportunity to identify increased support needs. "There appeared to be an acceptance by those making referrals for increased support, that the given reason for not offering further review of care and support being self-funding was valid and was not challenged. This compounded the decisions that were being made." p16
- The issue of mental capacity also applies to safeguarding concerns, in considering whether an individual can make decisions that allow them to keep themselves safe. The initial safeguarding referral was made due to concerns around this, but it was made second-hand, not by the attending paramedic, and so there were **gaps in the information passed on**. There were also discrepancies over the extent of the **financial abuse** that Adult A had reported to various agencies. The Acute Hospital Trust safeguarding referral was made by an agency nurse who did not understand the safeguarding procedures, so it **did not go to the correct place in order to join up with other safeguarding information**. "…there was a **lack of robust application of safeguarding procedures and sharing of information** evident in more than one agency" p17. A number of measures have already been put in place to address these, and other, concerns relating to safeguarding.
- Effective discharge planning should involve good **planning to anticipate potential problems** and **resolve these barriers using a multi-disciplinary approach**. Therefore, it is important to consider why Adult A died less than 48 hours after she was discharged from hospital. "It is important to note that Adult A was being **discharged to a situation that had caused previous concern with no apparent changes being made**. Adult A was discharged on a winter's afternoon to the flat where she lived alone and could not leave". P22 It was noted by a number of professionals that Adult A had significant mobility difficulties and was unable to independently use the stairs leading to and from the flat, rendering Adult A **house- bound**. It could be argued that the property was not suitable, but considerations about an assumption of Mental Capacity apply here, as Adult A's **decisions were not challenged**. There was a **lack of communication** between the Intermediate Care Team and the Care Agency upon discharge, as the latter had no knowledge of Adult A's release. Although A's elderly

sister and neighbour were informed of her discharge, an **assumption was made that they would be supporting** Adult A, despite having **health issues of their own**, which made this difficult. Adult A's nephew was also not informed of her discharge. "It is now apparent that there were no definite arrangements in place to ensure that Adult A had what she required on discharge and arrangements were based on assumptions." p24

Adult B

https://www.wiltshiresvpp.org.uk/p/adults/safeguarding-adults-reviews-1

Adult B (aged 72) died after being struck by a car whilst out walking alone, something he did often. Following two referrals to Adult Mental Health Care by his GP between 2013-

2015, Adult B was diagnosed with Alzheimer's Disease. He was given medication which stabilised his condition. In October 2013, Adult B moved into independent living accommodation, after separating from his wife. In May 2015, it became apparent that Adult B was struggling, and his ex-wife offered to support him. Between March and September 2016, Adult B's memory and cognitive functioning further decreased. He was not managing his medication well, and support from his ex-wife had broken down. He was often out walking when staff arrived for his care package visits.

In early November 2016, Adult B was found by a friend walking in the middle of the road, carrying his washing, and he was taken home. A safeguarding referral was made but not accepted. Four days later, paramedics were called after he fell asleep in a pub, and he was taken to hospital. A second safeguarding referral was made and accepted. On 21 November 2016, Adult B was found on private military land, 10 miles from his home, inappropriately dressed for the cold weather. He was taken home and then, after getting very dis- tressed, to the police station. His care pack- age was increased, with more visits but he was not in for some of them. On 27th November 2016, Adult B was struck by a vehicle whilst walking alone on an unlit road, and later died from his injuries.

Key Theme

- There was **little standardisation of risk assessments,** so any being done informally were not obvious to other agencies, an issue now being addressed by the Community Health Trust. "…there was no robust plan of care in place that could have been shared and understood by all of those involved. This then did not prompt risk assessments which were vital to keep Adult B safe." p11. A **lack of risk assessment around Adult B's drinking** was also evident. Whilst not viewed as a problem on its own, memory loss may have caused Adult B to drink more than he intended. It also may have interfered with his medication. The biggest risk was Adult B's love of walking, with to his Dementia diagnosis making it more likely that he would become lost or confused. As Adult B lived independently, no-one knew if he had gone out,

and the report advises that a risk assessment could have been undertaken sooner. The Learning Event, held following Adult B's death, also identified points where **multi-agency meetings** may have been useful, but highlighted the **lack of a clear process for initiating them**. A High-Risk Behaviour Policy is in development, which will address this issue. **Absence at staff team meetings and ineffective supervisions** were also cited as an area for improvement, as the issue of Adult B being out for many appointments was not identified by managers sooner and therefore could not be risk- assessed. **Professionals also did not communicate Adult B's ex-wife's wishes to withdraw from supporting** him. She continued to be contacted by professionals, and the **erroneous belief that she was still supporting him** meant that an **advocate was not sought**, nor the risk of reduced support adequately assessed.

- The report cites a number of missed opportunities for **communication between agencies**. For example, officers could not respond to a local pub's concerns about Adult B's behaviour in early November 2016, due to a lack of resources. Pub staff deemed he was safe to take himself home but neither Adult B's GP nor the manager of his living accommodation were notified that these concerns had been raised. **Communication over medication was also an issue**. Adult B's medication was halted due to the **risk of accidental overdose** until a care package could be implemented, but this **took a long time**, potentially affecting Adult B's level of memory function. Also, **many assumptions were made** relating to beliefs that Adult B was being safeguarded by other agencies. Referrals were made assuming that they would lead to more support, specifically respite care, but this was not the case. Furthermore, there were no arrangements to ensure Adult B was home for appointments, as it was not always shared that he liked walking and therefore may be out. This led to many **missed appointments, delaying support**. "When more than one agency is involved with supporting an adult, [communication and coordination are] key to effective multi-agency working". P7. At a Learning Event, it was suggested that having a lead worker as one point of contact would have improved communication and co-ordination. Additionally, the National Institute for Clinical Excellence (NICE) guidelines around assessment and care plans were not adequately followed, which if they were, may also have helped. Other issues for consideration here are; **lack of access to an advocate** in the absence of close family, **delays in assessments, lack of risk assessment, and the limitations of some roles** leading to a reliance on other services.

- Adult B lived in independent living accommodation, with no 24-hour monitoring and only basic care checks. The accommodation **manager didn't feel able to challenge other agencies** about his care package. When the care agency met Adult B, five weeks after he was referred, they thought his needs exceeded what they had been asked to provide but did not feel able to escalate these concerns. In both cases, there were **no clear processes for escalation.** Lack of escalation was often due to

limitations of roles, and perceived difficulties in how to **challenge other agencies' decisions without being seen as 'difficult**', potentially highlighting a **cultural issue** in this area. "Practitioners who perceive their role to be limited must still have the ability and process to escalate their concerns legitimately and feel as though their views will be taken seriously and valued." p16 Adult B was referred for an assessment of care and support needs on 9th September 2016. It **took almost two months before he received further care,** and weeks more until he was allocated a Social Worker. This delay could have been escalated much sooner, an issue that may be addressed with the implementation of Wiltshire's Adult Multi-Agency Safeguarding Hub (MASH) in May 2018. Safeguarding decisions here are made by a multi-agency group, making information sharing easier, as well as providing a clearer route for challenge and escalation. The MASH may also more quickly address outstanding actions such as, for Adult B, the lack of a **Mental Health Social Worker** referral, and a **delayed Community Mental Health Team assessment.**

- The report suggests that some of the areas above would have been helped by robust application of the Mental Capacity Act (2005). The Act requires an assessment of capacity before any treatment or care is carried out, if there is a reasonable belief that someone lacks the capacity to make decisions about treatment themselves. If Adult B was deemed not to have capacity to understand his own needs, a best interest decision could have been made and could also have led, if necessary, to the application of a Deprivation of Liberty Safe- guards authorisation, to keep him safe. For Adult B, there was a belief that a **Social Worker should do the Mental Capacity assessment, with other agencies citing a lack of confidence or resources to do so themselves.** However, the report states: "They should all have been assessing Adult B's capacity to make those decisions at the time any specific decision was being made regarding an issue. P19 It was decided that Adult B should not have possession of his medication, as he didn't know what it was for or when to take it. A Mental Capacity assessment could have been done here by the Care Co-ordinator and the GP, with the outcome formally recorded as evidence. Discussions about providing **tracking his whereabouts were dismissed as an infringement of his human rights**. The MCA could have been applied here to support Adult B to continue doing an activity he loved, more safely.

Adult C

https://www.wiltshiresvpp.org.uk/assets/02523611/adult-c-learning-briefing.pdf

Adult C, aged 74, had been diagnosed with Paranoid Schizophrenia in 1989. Although he was supported to live independently, he was very reluctant to engage with professionals and Community Treatment Order ensured that he received anti-psychotic medication. The Court of Protection Team were given a Deputyship Order in 2012 to manage his finances. However, after concerns were raised about Adult C's behaviour and physical health, he was recalled to

a mental health hospital for assessment. Adult C waited a week for a bed and, on admission, a physical examination revealed he was emaciated and starved. Adult C was then admitted to hospital where he died eight days later as a result of community acquired pneumonia and paranoid schizophrenia. After his death, Adult C's family found that payments to his personal account had been stopped and there were only a few pounds in the account. Adult C had not received regular physical health assessments and assessment of his capacity to make decisions in his own best interest were not sufficiently evidenced. The complexity of Adult C's case, his reluctance to engage and a failure to work effectively across agencies increased the risks to Adult C's health.

Key Themes

- Although a Community Treatment Order was successfully used, other areas of the **Mental Health Act could have been applied more effectively**. Under the Act, a more formal 'nearest relative' is appointed rather than a general 'next of kin' and, where there is no spouse or children, the oldest sibling is automatically given this role. Adult C's older brother and then sister took on the role, however his younger brother was the main family contact. This caused **confusion about who to contact** when Adult C was admitted to hospital. It is crucial that roles are clear to all, especially in large families. "The family … had no idea about the care plans, or some of the issues that had arisen, until after the death of Adult C". p11 Adult C's daily care was managed through the Care Programme Approach (CPA), but this could have been applied more robustly. Whilst **Care Plans** were reviewed and shared with the GP, they were **not shared with Adult C's family**. Multi-agency reviews can involve family members, particularly in complex cases. As there were increasing difficulties with Adult C's behaviour, **CPA reviews could also have happened more often**. This opportunity to share information may have resulted in a **multi-agency plan, involving family members**. **Large caseloads and the case's long-term nature** may explain why this was not considered, and why the case did not receive a **fresh and objective view**.
- **Parity of esteem means giving mental health equal value to physical health**. However, in Adult C's case, it appears that assumptions were made because of his mental ill-health, about his physical health treatment. For example, although it was thought Adult C may have a hearing problem, the assumption that he would not agree to be tested meant an appointment was not pursued. When professionals made referrals to the GP about Adult C's weight loss, it was not clear what they were asking for. Letters to GPs should be as clear as possible - with requests set out clearly at the start of a document rather than the end, a **technique known as 'BLUF' (bottom line up front).** "… in a practice that receives hundreds of letters regarding many patients… it is crucial that any action required of the GP is clearly highlighted." p12 Adult C did not present as a typical case of self neglect. His appearance and living conditions gave no cause for concern. Despite that, the **Mental Capacity Act** could

have been applied when Adult C **refused physical health interventions.** This would have meant his capacity to make decisions about his health was assessed and a multi-agency plan, perhaps with a Court of Protection application, could have been put in place if not. When Adult C received his medication by injection five weeks before death, he had enough muscle mass for a normal needle to be used. At that time, the mental health professional who saw him had **no concerns about significant or sudden weight loss**. However, as there was no post mortem or report to the coroner, it is not known if Adult C had underlying medical conditions or how quickly his weight loss progressed.

- When **new professionals tried to engage with Adult C, they did not always request support from the professionals who knew him well**. In addition, Adult C's family were not made aware that he was avoiding professionals. By working with those professionals who knew him best and with Adult C's family, the chance that Adult C agreeing to visits, assessment and treatment may have increased. Adult C was well-known in the community. He was **familiar to the police, with increasing frequency**. Police knew Adult C was vulnerable and when they were contacted about his behaviour, instead of criminalising him they sought to help him. However, this approach meant multi-agency meetings that would have been organised if the police had taken a more traditional approach, did not happen. "A person who is **treated more liberally and sensitively because of their mental health condition receives a less robust intervention**". p17 Supervision is crucial in supporting professionals working with people like Adult C, who have enduring mental ill-health and are resistant to services. When someone has been known to services for a long time, sometimes it takes a **fresh pair of eyes** to see what could be done differently.
- Adult C was known to spend only around £100 a month. This low amount was **not questioned** although, alone, the amount seems unlikely to have been **sufficient to cover his basic living costs**. Eventually Adult C's regular payments were suspended when the amount in his account had built up significantly. This seems to have been the right decision at the time and his finances were managed by a Deputyship Order made to the Local Authority from that point. However, that **decision should have been reviewed regularly**. For a number of reasons, that did not happen and this meant that no-one realised Adult C had limited funds until after his death.

Adult M
https://www.wiltshiresvpp.org.uk/assets/02523611/item_1b_learning_briefing_adult_m.docx

Adult M had a learning disability and complex physical and mental health needs. She died because of 'Inanition' – death by exhaustion caused by lack of nourishment. The case had been subject to a LEDER review that identified learning related to delays in referrals to dietetic services and quality of annual health checks. Although this case did not meet the

threshold for a Safeguarding Adult Review the SVPP wanted to learn from this case to explore our ability as a system to be alert to risks associated with supporting adults with complex needs in care home settings

Key themes

- Mental Capacity Act (**MCA**) remains an area that is **not well understood or applied by all agencies**. In this case mental capacity **should have been revisited, reassessed and recorded**. An assessment of capacity must be done on a specific decision, not an over-riding assessment for every decision in an individual's life.
- There is a **lack of any coordination or 'lead professional**' role when it comes to adult safeguarding. In this particular case there was need for an individual practitioner to have **oversight of actions and escalate concerns about the quality of care**. Such a coordination role does not exist in either health or social care.
- There was evidence of **'Diagnostic Overshadowing'** in this case where professionals assumed **changes in Adult M's behaviour and deterioration** in health was due to their learning disability or coexisting mental health condition. This meant the **cause of the symptoms were never fully explored.**
- **Service structures allow for 'wrong doors' and referrals can be rejected without any recourse for follow up**. This creates gaps between services and raises risks for vulnerable adults.
- Commissioned services are difficult for service users and practitioners to navigate and **can lead to delays in accessing the right support** at the right time.
- Learning Disability Mortality Reviews (LEDER) findings are that older adults with learning disabilities are regularly presenting to services with very complex needs. These individuals are often not known previously to services, require a high level of specialist support and, for that reason, can experience a delay in provision.
- **Routes for challenging concerns over the quality of care are not well known** particularly for cases without obvious trigger points for escalation.

Wiltshire analysis

Engaging with, and the voice of, the person

- We saw “Large caseloads and the case’s long-term nature “impacting on engagement and approaches to adults.
- But we also saw “Service structures allow for ‘wrong doors’ and referrals can be rejected without any recourse for follow up
- Lack of multiagency approaches also impacted on opportunities to capitalise on other people’s relationships to support engagement. An example of this being “new professionals tried to engage with Adult C, they did not always request support from the professionals who knew him well”.

Mental capacity.

Again, we see

Duty of care vs. Autonomy - Article 2 (Right to life) or Article 3, but also article 5 and 8 rights were present, for example “tracking his whereabouts were dismissed as an infringement of his human rights”

We saw an overreliance on assumption but also misunderstanding on roles and lack of capability and/or confidence in making assessments. Leading to responsibilities being pushed between agencies and professionals an example being “Social Worker should do the Mental Capacity assessment, with other agencies citing a lack of confidence or resources to do so themselves

Information sharing and Holistic Assessment of needs, vulnerability and risks.

- We saw “delays in assessments, lack of risk assessment, and the limitations of some roles” impacting on appropriate assessments and judgments
- Overreliance and assumptions on informal carers meeting needs and risks. For example, "Professionals also did not communicate Adult B’s ex-wife’s wishes to withdraw from supporting”

Again, seeing the lack of information sharing and multiagency working, leading to:

- The lack of evaluating risks and needs “*evaluating an individual’s issues from multiple perspectives rather than focusing on one area*”
- Lack of life history, being taken form people with long legacy involvement

We also saw, again

- Interplay of physical and mental health needs,

Again, leading to similar observations, in that: Even with a Multiagency risk assessment, without monitoring risk fluctuation, there will be no continued one version of the truth. And even though a Section 11 assessment may not achieve the adult's outcome or provides a framework to apply care to a situation. It does support a holistic assessment of risk and vulnerabilities and provides an opportunity to meaningfully engage the adult in conversation about needs, risks and outcomes.

Care planning and Resources to meet needs

We saw a number of factors adversely impacting on both resource allocation and care planning. Some examples being:

- It "took almost two months before he received further care,"
- CPA reviews could also have happened more often
- "multi-agency plan, involving family members" were not present
- Again, resource issues, quality of provision and an absence of an agreed lead professional, were key features. For example, "lack of any coordination or 'lead professional'

Tools and resources to support practice

- Again, we saw reference to "trauma histories" and if these are identified and support offer that adult could be supported to respond better to the impact of this trauma.
- Again, it was noted patterns were not identified or picked up on, for example *"professionals working with Adult A raised any concerns about self-neglect, despite there being several factors indicating"*
- Further supportive infrastructure was identified as again being an issue. In that there is need for professional support and supervision, it was noted "Absence at staff team meetings and ineffective supervisions, being present.