Swindon Safeguarding Partnership
Executive Summary
Safeguarding Adult Review – Terry

Introduction

Terry[1] died on 1st June 2019 in hospital. Cause of death was given as liver cirrhosis accompanied by Hepatitis C. Terry was aged 71 and White British. His next of kin was recorded as his brother, with whom it appears that he had some contact. However, during the review it became clear that there were other relatives of whom services appear to have been unaware.

Terry lived in warden assisted accommodated and had two main associates who collected his weekly allowance from the Swindon Borough Council (SBC) Money Management Team (MMT) and bought his shopping – food, cigarettes and alcohol. This arrangement was longstanding. Terry's health history involved a stroke that had left him with left-sided weakness. SBC's first contact with Terry was in 2004 at which point his alcohol misuse was identified. This was to become one of the running themes through the involvement of services with Terry. Significantly, for what emerges as a pattern in this case, GP records contain references to concern about frequent falls, poor memory and alcohol abuse in July 2014, and to concerns about Terry not eating in July 2015. Concerns about Hepatitis C are recorded from 2015 onwards, due to previous intravenous drug use it is suggested.

Between May 2005 and the end of 2008, there were numerous on-going concerns regarding financial exploitation, non- payment of bills, alcohol dependency, self- neglect and memory difficulties. These concerns become running themes in the period on which this SAR mainly focuses. From the outset Terry's engagement with care and support appears to have been variable. A care package had commenced in January 2007 but this was cancelled in 2009 when Terry's main associates became, effectively, his informal carers.

Findings – Working with Terry

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.

[1] Terry is a shortened version of his given name and is used with the permission of his brother.

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.

Findings – The Team around Terry

No lead agency was nominated and no key worker was appointed. There are recorded instances of inter-agency communication and collaboration. However, there was no risk management plan that was consistently implemented, monitored and reviewed. Plans that were put together were not followed through. Opportunities were missed to convene multi-agency meetings to discuss healthcare treatment and care and support, and indeed there does not appear to be a culture of holding as a matter of routine multi-agency risk management meetings.

There is evidence of information-exchange between services but little by way of escalation of concerns. There were two adult safeguarding concerns referred, using Section 42(1) Care Act 2014. The first was not progressed to a Section 42(2) enquiry; there was significant delay in progressing the second to the formal enquiry stage. Thus, there were missed opportunities to bring agencies together and to explore the repeating pattern of concerns. There were other occasions when an adult safeguarding concern might have been referred, again representing missed opportunities to consider how to protect Terry from abuse and neglect, including self-neglect.

Records clearly indicate how Terry expressed his wishes and feelings, for example when in hospital in December 2017. They occasionally indicate a formulated plan or a management decision. However, standards of records and record-keeping have also been criticised by the agencies involved in the case, for failing to clearly outline assessments and care planning, and the reasons behind decision-making.

Findings – Organisations around the Team

Supervision and management oversight of complex and challenging cases are central components of best practice. Although some practitioners were able to access support, overall the case reveals insufficient supervisory and management oversight of care and support planning, responses to

concerns and to risks, and safeguarding decision-making. There were examples of drift and of failure to follow through on plans. More recently improvements have been reported in the management of workflow and case reviews. It is important to acknowledge that some service development is already underway as a result of the learning from this case.

Recommendations

Recommendation One: Swindon Safeguarding Partnership (SSP) reviews the outcomes of its multi-agency audits, including responses to safeguarding adult referrals, alongside the learning from this case, to evaluate the present position on implementation of Making Safeguarding Personal, and to identify what further work is required by the Board and its partner agencies.

Recommendation Two: SSP with its partners should conduct with practitioners and managers an appraisal with respect to what might support training transfer into practice with respect to mental capacity assessments.

Recommendation Three: SSP should review the outcomes of a multi-disciplinary audit of mental capacity assessments in cases involving self-neglect and/or substance misuse, alongside the learning from this review, and consider what further work is required from the Board and its partner agencies.

Recommendation Four: SSP should review the guidance provided across partner agencies regarding risk assessment and risk management.

Recommendation Five: SSP should seek reassurance regarding how MMT assesses and reviews, working in partnership with other services within the local authority and with other agencies, the suitability of family members and unrelated informal carers when it has legal responsibility for the administration of a person's financial and property affairs.

Recommendation Six: SSP should seek reassurance about the timeliness and quality of ASC and Adult Safeguarding assessments, planning and reviews in self-neglect cases.

Recommendation Seven: SSP should seek reassurance from partner agencies that they have systems in place for ensuring that case records accurately list a person's next of kin and social history.

Recommendation Eight: SSP should seek reassurance that there is adequate professional oversight of the role of informal carers in cases where concerns have been expressed about neglect and abuse. Carer assessments must be considered and where appropriate offered, with also a focus on assessing the degree to which family members can be engaged as a "circle of support." SSP should seek reassurance from partner agencies that there is documentation that prompts staff to consider the role of informal carers and the need to assess.

Recommendation Nine: SSP should seek reassurance that all agencies and services involved in hospital discharge are complying with standards in NICE guidance.

Recommendation Ten: SSP should request an audit of case transfers between social workers and of closure summaries, to ensure that significant episodes and issues are prominent.

Recommendation Eleven: SSP reviews its policies on information-sharing and self-neglect either as stand-alone policies or included as part of the overarching safeguarding adults policy for SSP-Adults or both. In this review the SSP must ensure there is a process for risk management that requires a meeting of the professionals involved at an early part of the process. Through its Policy and Procedures subgroup SSP must ensure the revisions made are agreed and disseminated widely throughout the partnership at all the appropriate levels. Through its workforce development subgroup SSP must ensure all safeguarding adult training references the self-neglect policy and processes in place and how to activate them. Through its PQA- Adults subgroup the SSP must ensure both information sharing, the understanding of self-neglect and the use of multiagency meetings are leading to protective outcomes for individuals where there are concerns regarding self-neglect; this should be through a series of audits and tested out on the floor by SSP 'Walk about' face to face conversations with frontline practitioners.

Recommendation Twelve: SSP reviews recent audits on section 42 referrals, decision-making and enquiries, alongside the findings of this SAR and considers what further actions are required, with specific attention to timely decision-making, robust risk assessment and management, advocacy and management oversight.

Recommendation Thirteen: SSP seeks reassurance from partner agencies as to how familiarity with adult safeguarding procedures, with particular reference to self-neglect, is ensured with respect to both permanent and temporary (agency) staff.

Recommendation Fourteen: SSP, as part of its self-assessment audit of agencies, requests partner agencies to audit case recording, with particular emphasis on follow-through on referrals, and to report on proposed actions following the findings.

Recommendation Fifteen: SSP requests a report on the management and supervisory arrangements in social work and adult safeguarding teams within SBC. In addition SSP should seek assurances that other agencies have effective safeguarding adult supervision processes in place that are frequently reported on and evaluated.

Recommendation Sixteen: SSP should consider commissioning a multi-agency training programme on self-neglect.

Recommendation Seventeen: SSP should review all relevant policies and procedures in light of learning from this case and, subsequent to any necessary revisions, ensure wide dissemination and subsequent audit of their use and effectiveness.

Recommendation Eighteen: SSP engages with its partner agencies in a continuing conversation about how the learning from SARs is being used to improve policies, procedures, service development, training and practice. The SSP's own strategic business plan should also be informed by an analysis of learning from this and other SARs.