SAFEGUARDING ADULT REVIEW: TERRY

Professor Michael Preston-Shoot
November 2020

Acknowledgement

Members of the Swindon Safeguarding Partnership (SSP) and the independent reviewer express their sincere regret at the death of Terry. Sincere condolences are offered to his relatives and friends.

The reviewer, working with SSP members, hope and intend that this review will enable lessons to be learned about what is needed when working with people who self-neglect, and will contribute to service development and improvement.

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1. Introduction

1.1. Terry[1] died on 1st June 2019 in hospital. Cause of death was given as liver cirrhosis accompanied by Hepatitis C.

1.2. Terry was aged 71 and White British. On the Safeguarding Adult Review (SAR) referral, his next of kin was given as his brother, with whom it appears that he had some contact. Sometime after his death it emerged that Terry had been married and had a son. No contact with his son has been recorded by any of the services involved with Terry in the period of his life under review here.

1.3. Terry lived in warden assisted accommodated and had two main associates, FA and HA, who were informal carers, collecting his weekly allowance from the Swindon Borough Council (SBC) Money Management Team (MMT) and buying his shopping – food, cigarettes and alcohol. The arrangement whereby FA[2] collected his personal allowance was longstanding, having begun around October 2009 when her mother (FB) was alive and supporting Terry. Prior to this, a care agency had been collecting his personal allowance.

1.4. MMT had undertaken Appointeeship for Terry's financial affairs, having received a referral in late August 2008. This arrangement continued until September 2016 when SBC MMT's involvement was transferred to Deputyship. This, apparently, was a procedural decision unrelated to the history of this case.

1.5. 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. General Practitioner (GP) records contain references in 1997 to drunkenness and in 2003 to alcohol-related seizures. In 2011 memory problems are recorded, possibly due to a stroke and vascular disease but, possibly, not followed-up. There are references to a possible stroke in August 2013. 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.

1.6. 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 were to become running themes in the period on which this SAR mainly focuses.

1.7. 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, first, FB and subsequently FA became Terry's informal carers. Reviews of this arrangement have been recorded for 2010, 2012, 2014 and 2015, which did not result in any change.

[1] Terry is a shortened version of his given name and is used with the permission of his brother.
[2] The identity of Terry's informal carers has been withheld.

2. Safeguarding Adult Review

2.1. Swindon Safeguarding Adults Board (SSP) has a statutory duty[3] to arrange a Safeguarding Adult Review (SAR) where:

- An adult with care and support needs has died and the SAB knows or suspects that the death resulted from abuse or neglect, or an adult is still alive and the SAB knows or suspects that they have experienced serious abuse or neglect, and
- There is reasonable cause for concern about how the Board, its members or others worked together to safeguard the adult.

2.2. The Safeguarding Adults Board has discretion to commission reviews in circumstances where there is learning to be derived from how agencies worked together but where it is inconclusive as to whether an individual's death was the result of abuse or neglect. Abuse and neglect includes self-neglect.

2.3. Board members must co-operate in and contribute to the review with a view to identifying the lessons to be learnt and applying those lessons in the future[4]. The purpose is not to allocate blame or responsibility, but to identify ways of improving how agencies work, singly and together, to help and protect adults with care and support needs who are at risk of abuse and neglect, including self-neglect, and are unable to protect themselves.

2.4. The referral for consideration of the case for a SAR was sent by SBC on 19th June 2019. The referral indicated concern that there had been evidence of risk of significant harm that was either not recognised and/or not acted upon appropriately. Under characteristics of the case were indicated self-neglect, financial abuse, alcohol abuse, serious illness and neglect.

2.5. Specifically, the SAR referral commented that over the preceding 15 years, there had been numerous concerns for Terry's welfare regarding exploitation, neglect, self-neglect and possible financial abuse. Despite concerns regarding cognitive impairments, the referral stated that there were no mental capacity assessments underpinning professional decision making processes. It further suggested that Terry's misuse and dependency on alcohol was not appropriately addressed through care plans during the care management process. The referrer also stated that a robust money management care plan had not been in place and there was no evidence that professionals were monitoring appropriate use of his weekly personal allowance. Consultation between professionals and the money management team was not evident; there were periods of time when Terry was neglected and left without adequate food provision.

2.6. SSP's Practice Review Group discussed the case on 10th September 2019. It was unanimously agreed that the case met the mandatory criteria for a SAR. This recommendation was accepted by SSP's Independent Chair on 1st October 2019. Key issues were recorded as assessment and provision under the Care Act 2014, self-neglect, mental capacity assessments, financial abuse, neglect by informal carers and responses to safeguarding concerns.

[3] Sections 44(1)-(3), Care Act 2014
[4] Section 44(5), Care Act 2014

2.7. The independent overview report writer was commissioned to undertake the review on 18th November 2019.

2.8. The following agencies which had commissioned or provided services to Terry contributed to the review alongside the independent overview report writer.

- Independent overview report writers:
  - Michael Preston-Shoot
- SSP Strategic Manager: Safeguarding
- Wiltshire Police Service (WPS)
- Swindon Borough Council (SBC) – Adult Social Care and Adult Safeguarding
- Swindon Borough Council – Housing
- Swindon Borough Council - Money Management Team
- Clinical Commissioning Group (CCG)
- Great Western Hospitals NHS Trust (GWH NHSFT)
- First City Care Services (FCC)
- Turning Point (TP)
- Change Grow Live (CGL)
- Avon and Wiltshire Mental Health Partnership NHS Trust
- South West Ambulance Service NHS Trust (SWAS)
- Two GP Surgeries

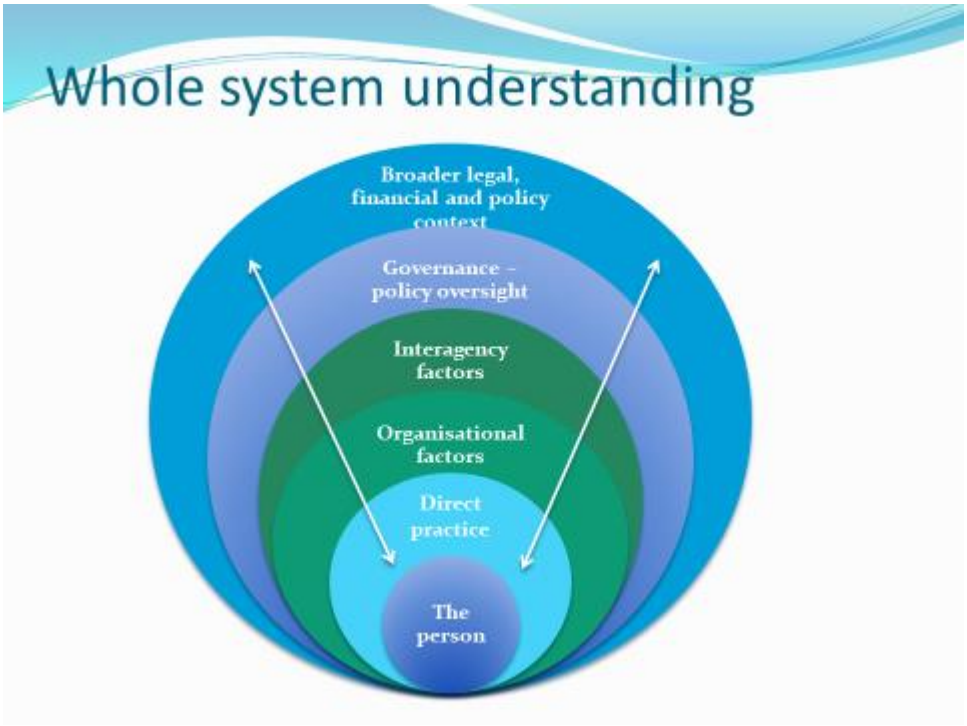
The Practice Review Group received administrative support from the SSP Business Support Officer.

3. Review Process

3.1. Focus

3.1.1. The case has been analysed through the lens of evidence-based learning from research and the findings of other published SARs on adults who self-neglect[5]. Learning from good practice has also been included. By using that evidence-base, the focus for this review has been on identifying the facilitators and barriers with respect to implementing what has been codified as good practice.

3.1.2. The review has adopted a whole system focus. What enables and what obstructs best practice may reside in one or more of several domains, as captured in the diagram. Moreover, the different domains may be aligned or misaligned, meaning that part of the focus must fall on whether what might enable best practice in one domain is undermined by the components of another domain.



3.1.3. Specific lines of enquiry, or terms of reference, were identified as follows:

3.1.3.1. Were relevant policies and procedures followed and have any significant gaps emerged?
3.1.3.2. How well was Making Safeguarding Personal applied, including when responding to Terry's non-engagement?
3.1.3.3. How well did services communicate, share information and work together with all those involved with Terry's care?
3.1.3.4. How well did agencies respond to concerns about financial abuse?
3.1.3.5. How appropriate was the multi-agency response to Terry's alcohol misuse?
3.1.3.6. How well did agencies respond to Terry's self-neglect?

[5] Preston-Shoot, M. (2019) 'Self-neglect and safeguarding adult reviews: towards a model of understanding facilitators and barriers to best practice.' *Journal of Adult Protection*, 21 (4), 219-234.

3.1.3.7. Given Terry's self-neglect and concerns about abuse and neglect by informal carers, how effective were safeguarding and money management processes used?
3.1.3.8. How well was the Mental Capacity Act 2005 applied?
3.1.3.9. Were assessments of Terry's care and support needs, and of the informal care being provided by FA and HA, thorough and followed-through?

3.2. Methodology

3.2.1. The timeframe for the review covers the period from 1st September 2016, when SBC MMT assumed Deputyship for Terry's financial affairs, to the date of his death on 1st June 2019. However, information from outside this timeframe has been included when significant for understanding learning from this case.

3.2.2. Agencies were requested to provide a chronology and reflective review of their involvement with Terry within the agreed timeframe. They were advised to also include anything that they judged significant that fell outside the agreed timeframe for the review.

3.2.3. The individual chronologies were combined and analysed by the independent reviewer and discussed with the Practice Review Group.

3.2.4. A learning event with practitioners involved in Terry's case was planned in order to explore key episodes and events within the timeframe being reviewed based on issues and concerns emerging from the combined chronology and reflective agency accounts. However, the Covid-19 pandemic interrupted this plan. In the event a virtual learning event was held, using Microsoft Teams.

3.2.5. Thus, a hybrid methodology has been used, designed to provide for a proportionate, fully inclusive and focused review.

3.3. Family involvement

3.3.1. After Terry's death it became known that he had a son. The son was informed by email of the SAR and invited to contribute. He replied, saying that he had not seen his father for a number of years and had no knowledge of how services were attempting to support him, or of any care plan, whilst Terry was in sheltered housing. He therefore felt that he could not offer any opinion or information about his care and would not have anything useful to contribute to the review.

3.3.2. Contact was also made with Terry's brother who expressed a wish to contribute. The independent reviewer spoke with Terry's brother by telephone, the Covid-19 lockdown preventing a face-to-face meeting. His contribution is woven into the analysis that follows. He asked to see the final report so that he could express a view on both the content and publication.

3.3.3. Terry's brother and son were consulted on whether or not to use a pseudonym. His son did not wish to suggest a name. Terry's brother requested that the name by which he was usually known be used.

4. Evidence Base for Best Practice

4.1. Reference was made earlier to research and findings from SARs that enable a model of good practice to be constructed. The model comprises four domains. In line with Making Safeguarding Personal, the first domain focuses on practice with the individual. The second domain then focuses on how practitioners worked together. The third domain considers best practice in terms of how practitioners were supported by their employing organisations. The final domain summarises the contribution that Safeguarding Adults Boards can make to the development of effective practice with adults who self-neglect. The domains are summarised here.

4.2. It is recommended that direct practice with the adult is characterised by the following:

4.2.1. A person-centred approach that comprises proactive rather than reactive engagement, and a detailed exploration of the person's wishes, feelings, views, experiences, needs and desired outcomes;
4.2.2. A combination of concerned and authoritative curiosity appears helpful, characterised by gentle persistence, skilled questioning, conveyed empathy and relationship-building skills;
4.2.3. When faced with service refusal, there should be a full exploration of what may appear a lifestyle choice, with detailed discussion of what might lie behind a person's refusal to engage; loss and trauma often lie behind refusals to engage;
4.2.4. It is helpful to build up a picture of the person's history;
4.2.5. Recognition and work to address issues of loss and trauma in a person's life experience;
4.2.6. Recognition and work to address repetitive patterns;
4.2.7. Contact should be maintained rather than the case closed so that trust can be built up;
4.2.8. Comprehensive risk assessments are advised, especially in situations of service refusal;
4.2.9. Where possible involvement of family and friends in assessments and care planning;
4.2.10. Thorough mental capacity assessments, which include consideration of executive capacity;
4.2.11. Careful preparation at the point of transition, for example hospital discharge and placement commissioning;
4.2.12. Use of advocacy where this might assist a person to engage with assessments, service provision and treatment;
4.2.13. Thorough health, mental health and care and support assessments, plans and regular reviews.

4.3. It is recommended that the work of the team around the adult should comprise:

4.3.1. Inter-agency communication and collaboration, coordinated by a lead agency and key worker, which may be termed working together;
4.3.2. A comprehensive approach to information-sharing, so that all agencies involved possess the full rather than a partial picture;
4.3.3. Detailed referrals where one agency is requesting the assistance of another in order to meet a person's needs;
4.3.4. Multi-agency meetings that pool information and assessments of risk and mental capacity, agree a risk management plan, and consider legal options;
4.3.5. Use of policies and procedures for working with adults who self-neglect;
4.3.6. Use of the duty to enquire (section 42, Care Act 2014) where this would assist in coordinating the multi-agency effort, sometimes referred to as safeguarding literacy;
4.3.7. Evaluation of the relevance of diverse legal options to assist with case management, sometimes referred to as legal literacy;
4.3.8. Clear and thorough recording of assessments, reviews and decision-making.

4.4. It is recommended that the organisations around the team provide:

4.4.1. Supervision that promotes reflection and critical analysis of the approach being taken to the case;
4.4.2. Support for staff working with people who are hard to engage, resistant and sometimes hostile;
4.4.3. Specialist legal and safeguarding advice;
4.4.4. Case oversight, including comprehensive commissioning and contract monitoring of service providers;
4.4.5. Attention to workforce and workplace issues, such as staffing levels, organisational cultures and thresholds.

4.5. SABs are recommended to consider:

4.5.1. The development, dissemination and auditing of the impact of policies and procedures regarding self-neglect;
4.5.2. Workshops on practice and the management of practice with adults who self-neglect.

4.6. This model enables scrutiny of the chronology in this case and exploration of what facilitated good practice and what acted as barriers to good practice in this case through a subsequent thematic analysis.

5. Chronology

5.1. The chronology has been sub-divided into specific time episodes for ease of tracking the development of concerns regarding the risks of abuse and neglect, including self-neglect, evident in Terry's case. Again, for the purposes of tracking and analysis, italics denote links to the evidence-base.

5.2. The first time episode covers those events prior to 1st September 2016 that the agencies and services involved with Terry regarded as sufficiently significant to include in the original data collection following referral of the case for a SAR and the subsequent chronology.

5.2.1. In October 2004 records note a history of stroke and left-sided weakness, and alcohol misuse. Between May 2005 and the end of 2008 it is recorded that there were numerous concerns about financial exploitation, non-payment of bills, alcohol dependence, self-neglect and memory difficulties.

5.2.2. Adult Social Care (ASC) records indicate that a care package was commenced in January 2007 but that Terry's *engagement* was variable. In September 2007 a *multi-disciplinary team meeting* was held following concerns about Terry's lifestyle and ability to meet his care needs, but it was suggested that he was making "unwise decisions": No *mental capacity assessment* was completed to substantiate this.

5.2.3. In late May 2008 the SAR referrer has noted that a discussion took place between ASC and Terry's GP who is recorded as feeling that Terry had to "make his own decisions about alcohol misuse." No *mental capacity assessment* was completed despite concerns regarding his cognitive functioning. There were ongoing concerns regarding alcohol misuse and it appears that Terry was admitted to hospital for detox in August 2008.

5.2.4. Also in August 2008 proceedings were initiated that resulted in SBC assuming Appointeeship for the management of Terry's financial affairs. Initially a personal allowance was collected by a care agency but from October 2009 the arrangement changed whereby an informal carer collected the money weekly. From October 2011 this was FA, taking over from her mother who had died.

5.2.5. In September 2008 a social worker contacted Wiltshire Police Service (WPS) on behalf of Terry (*interagency collaboration*). Terry's bank card had been stolen from his flat while Terry was in hospital. The card was subsequently used to withdraw £190.00 from two separate cash machines. A basic investigation was conducted by the crime management unit and was subsequently closed as 'undetected'. At the time of reporting a possible suspect was named by the social worker (not a subject of this review). However, the suspect was not spoken to during the investigation.

5.2.6. In February 2011 WPS records indicate that Terry was regularly visited by two males who were under 18 for cigarettes/money and alcohol. This was being monitored by the Neighbourhood Policing Team (NPT). There is no record of this information being shared with other agencies (*interagency collaboration* and *safeguarding literacy*).

5.2.7. In mid-August 2011 WPS records indicate that a neighbour of Terry called to raise a concern that two young females were in Terry's flat and taking advantage of him. NPT officers attended the address in the late evening and found Terry very intoxicated and secretive about who had been in his flat. A strategy discussion followed for the two females a few

days later. WPS record notes that NPT officers would monitor the situation to try and prevent Terry from being exploited (*safeguarding literacy*).

5.2.8. In October 2011 Terry moved into accommodation (an upstairs flat) monitored by a Sheltered Housing Officer. The set up was that he had a 'private care arrangement' with people that he knew to deal with things like shopping. If there were any concerns the Sheltered Housing Officer (SHO) would speak to the people he had listed as contacts, namely HA and FA, and also his brother. The SHO would help out if his meals on wheels did not arrive. He was known to ASC and had been visited by occupational therapists. Terry was known to the alcohol service, they used to contact him, but he refused their assistance (*engagement*).

5.2.9. During the period under review Terry was registered with two GP surgeries. Records entered by the first GP practice note that in December 2011 a carer called reporting Terry's memory problems. A GP has recorded that Terry was a poor historian with incorrect replies for date and place when being assessed, with memory issues possibly related to previous stroke/ vascular disease. The action plan was to await a full past medical history from a previous surgery, CT results taken at the time of stroke, arrange blood test and review to decide if referral to memory clinic appropriate (*assessment*).

5.2.10. GP records indicate that bloods and an X-ray were taken in January 2012 but no further action followed. A home visit by a GP in later April found Terry inebriated, not making sense and unable to answer questions. There were empty alcohol bottles everywhere. The GP liaised with a carer and started Terry on antibiotics. In August 2013 Terry was admitted to hospital with a possible stroke/transient ischemic attack. In mid-February 2014 his carer (FA) contacted the GP about burns. An appointment was booked for the following day. Terry was also seen by walk in centre on this date and his foot dressed. Staff documented Terry's lack of memory regarding the incident leading to injury (*mental capacity*). Terry did not attend the booked appointment (*engagement*).

5.2.11. In early July 2014 FA spoke with a GP, concerned regarding deterioration in Terry's general health and his alcohol problems. On the same day Terry was seen at the surgery by the GP with their carer. Documented concerns included frequent falls, smell of alcohol, poor memory, drinking two bottles of vodka each week[6] and contact by the courts regarding non-payment of bills. The action plan was blood test, letter to social services and review by falls team and memory clinic. Terry did not attend a subsequent appointment (*engagement*). A GP review followed in mid-August 2014 following a fall. Excessive alcohol intake and poor social support were noted.

5.2.12. In mid-June 2015 Terry was seen in GWH NHSFT Accident and Emergency with a head injury, due to alcohol withdrawal. The records note that Terry was aggressive towards staff. In early July 2015 an SHO called the GP concerned that Terry was not eating and continually drinking. Terry is recorded as declining GP involvement and also support from the Alcohol Liaison Service (*engagement*), when the GP made contact (*inter-agency collaboration*). In early November 2015 Terry was seen at GWH NHSFT day service unit with his brother (*family and carer involvement*). Records note Terry's Hepatitis C status, alcohol concerns and a previous stroke and IV drug use.

[6] Terry's brother reported that Terry's alcohol consumption was around two bottles of vodka a day.

5.2.13. In early April 2016 Terry was admitted to GWH NHSFT through Accident and Emergency as a result of a seizure attributed to alcohol withdrawal syndrome. CGL report that Terry was known to Hospital Alcohol Liaison Services but had declined community-based alcohol treatment with CGL on two separate occasions. On 7th April 2016 a safeguarding concern was received by SBC from an Alcohol Liaison Nurse (*safeguarding literacy*), noting lack of formal care, Terry's unkempt and malnourished condition, informal *carers* struggling to cope, *risks* of repeated hospital admissions and of alcohol withdrawal, and questioning whether Terry had *mental capacity* to make informed decisions about his treatment. CGL comment on this referral from the Alcohol Liaison Nurse, noting that Terry was refusing medication and treatment and yet appeared very confused, unkempt and malnourished. The hospital discharge summary (*transition*) suggests the need to involve ASC for formal care arrangements, which apparently Terry's brother was expected to initiate.

5.2.14. At the end of May 2016 a student social worker and locum manager made a home visit to Terry. They identified the need for an occupational therapy assessment, consideration of Terry's mental capacity and discussion with him and FA about his finances. Neither a Care Act 2014 *assessment* nor a *mental capacity assessment* appear to have been completed. Further work was identified but not allocated (*workforce and workplace*).

5.2.15. Even before the period formally included in this SAR, it is possible to highlight what were to become repeating patterns or running themes. These include safeguarding concerns (financial abuse and self-neglect), the role of Terry's informal carers, mental capacity, and his engagement with services.

5.3. The first time episode runs from 1st September 2016 to 27th July 2017. It begins with Court of Protection authorisation for Deputyship for Terry's property and financial affairs to be held by SBC. On 22nd December 2016, according to a Housing entry on the combined chronology, FA called WPS concerned about an unwanted visitor bringing alcohol to Terry. Terry also registered concern about how FA was using his money (*safeguarding literacy*). Four days later the concern was repeated with HA again present with undiluted alcohol. WPS visited but Terry was happy for HA to stay. Terry and FA are recorded as alleging that HA was stealing from the flat (*safeguarding* and *carers*). Terry had sustained a cut on his head but it was unclear how this had been caused. The chronology records that HA had been banned from Terry's previous accommodation.

5.3.1. CGL was commissioned to provide drug and subsequently alcohol treatment services between 2014 and 2018. They had no involvement with Terry between the beginning of September 2016 and the end of March 2018.

5.3.2. On 9th February 2017 Terry agreed to move to a ground floor flat. A property was found in early May and Terry is recorded as being positive about the move for his wellbeing and protection. On 3rd July a mental capacity programme manager is recorded as requesting clear documentation that Terry accepted the tenancy and was happy to move (*mental capacity assessment*). On 12th July FA telephoned ASC to request assistance with furniture for the move. The Duty Worker liaised with housing officers who agreed to follow this through (*inter-agency collaboration*). By 27th July Terry had moved. The Money Management team (MMT) and Meals on Wheels service had been informed (*transition*).

5.3.3. In this time episode the themes of safeguarding concerns (self-neglect and possible financial abuse) and the role of the informal carers are evident.

5.4. The second time episode runs from 20th November 2017 to 18th January 2018. It begins with Terry being found on the floor with duvet and pillows by the Sheltered Housing Officer. It was unclear how long he had been there. The following day MMT liaised with the duty team for a report to the Office of the Public Guardian. The combined chronology refers to a *mental capacity assessment* having been completed in August 2016 when Terry was not receiving any services other than money management, and the assumption seems to have been that Terry still lacked capacity regarding his financial affairs. There is reference to "longstanding and progressive cognitive difficulties."

5.4.1. On 23rd November the SHO called SWAS and Terry was transported to GWH NHSFT Emergency Department following a fall secondary to alcohol consumption and peripheral neuropathy[7]. It appears that Terry had fallen multiple times over the preceding few days but he was difficult to assess because he was confused. He smelled very strongly of incontinent urine and his clothes were soaking wet. He was admitted to hospital with a left fractured neck of femur. A grade 4 necrotic sore was found on his right hip. A *safeguarding* referral was proposed as Terry appeared vulnerable and had carer visits. The trauma unit referred Terry to the Drug and Alcohol Referral Team (DART), noting that he lacked capacity, was cognitively impaired and showing moderate levels of confusion.

5.4.2. His broken hip was set on 24th November. On 27th November he was assessed by a Tissue Viability Nurse. The same day Terry declined referral to Alcohol Liaison (*engagement*). On 6th December he was discharged from the trauma unit to a rehabilitation ward. The following day he was assessed by an Occupational Therapist for mobility and on 12th by a Physiotherapist. There was also a swallow assessment by a Speech Therapist. On 13th December Terry fell on the ward and sustained a second fracture.

5.4.3. On 19th December FA reported that Terry's money had been stolen whilst she was at work. The following day a DART referral was sent for *assessment* of care and support prior to discharge. Terry was discharged on 18th January 2018 (*transition*).

5.4.4. Self-neglect and falls are prominent in this time episode.

5.5. The third time episode runs from 18th January 2018 when Terry was discharged from hospital to the end of March 2018. The Sheltered Housing Officer monitored Terry's situation and by 30th January was reporting that his flat was smelling of urine and his mobility was very poor. On 19th February there was no food in the flat and Terry was hungry. A social worker visited on 22nd February to complete a detailed *assessment*. Terry declined a formal care package (*engagement*). The record notes that a long-term social worker was required.

5.5.1. On 14th March a discussion with Terry, M and N result in an agreement for reablement to be introduced. By 23rd March the reablement supervisor was reporting concerns (*safeguarding*) about food and medication management. A referral to the continence service was sent. On 26th March an unpaid electricity bill was found and agreement reached that in future FA would pay bills from Terry's weekly allowance. The same day reablement closed Terry's case (*case closure*) as he was capable but not engaging (*engagement*) as he was drinking heavily. He was intoxicated during reablement visits. His GP conducted a home visit and reported the outcome to a social worker (*inter-agency collaboration*). Terry was not taking his prescribed medications.

[7] This was Terry's first attendance at GWH NHSFT since 1st September 2016. Peripheral neuropathy is a type of nerve damage that can cause pain, numbness and/or weakness.

5.5.2. Self-neglect remains a prominent theme, with concerns beginning to re-emerge about how well Terry was being looked after by his informal carers.

5.6. The fourth time episode runs from the beginning of April 2018 to the end of May 2018. Much of the focus in this time episode was on Terry's physical health. There was an ENT follow-up on 8th April and correspondence between a Consultant Gastroenterologist and Hepatologist and Terry's GP that resulted in a referral for Hepatitis C review (inter-agency collaboration). Positive screening results had been obtained in December 2017.

5.6.1. On 2nd May a continence nurse made a home visit and reported the outcome to a social worker (*inter-agency collaboration*). Terry was still refusing formal care support so the nurse concluded that there was little she could do. Terry's confusion (*mental capacity*) and mobility (*risk*) issues were reported. It emerged that Terry's Hepatitis C diagnosis was not known to ASC (*information-sharing*). Concerns remained about Terry's poor nutritional condition. Following liaison with the continence nurse the social worker made a home visit. Terry agreed to accept a formal care package and also a stool from occupational therapy. The social worker observed that there was more food in the flat than previously. He reported that he was drinking vodka mixed with cider.

5.6.2. A pre-assessment domiciliary service was introduced from 10th May 2018 and the social worker requested allocation of the case in a long-term team (*continuity and relationship-based practice*). However, by 18th May the SHO was noting that Terry was refusing personal care (*engagement*). By 21st May First City Care (FCC) staff were reporting to the social worker Terry's high levels of alcohol consumption.

5.6.3. On 23rd May a long-term team social worker made a home visit. Terry is recorded as being very open about his alcohol intake, indicating that he had no intention of changing his use. He is also recorded as stating that he would let carers change his clothes when they were dirty. The FCC care package was to continue as a preventive measure and the social worker emailed FCC with advice about the best approach to take with Terry (*inter-agency collaboration*). Two days later the social worker sent a referral to podiatry at the request of FCC staff.

5.6.4. Concerns remain about Terry's physical health and self-neglect. His engagement with care services remains variable.

5.7. The fifth time episode runs from the beginning of June to the end of August 2018. On 8th June FCC listed its concerns: Terry was not eating the community meals provided and was evidently losing weight, he was unsteady on his feet and was not using a frame (*risk* – falls), the SHO warden was supplementing Terry's food from his own pocket (*informal carers*), and providing personal care was proving difficult because the visit was timed when meals on wheels were delivered (*commissioning*). Social worker input was requested.

5.7.1. On 27th June Terry's case was allocated to a different long-term social worker (*continuity*) who visited. HA was present when Terry said that he was not comfortable accepting care, preferring FA's support. He declined help (*engagement*). He was unshaved and his appearance is recorded as unkempt. FA requested an increase in Terry's personal allowance to cover her support. The social work plan was recorded as being to meet FA and Terry and then to request MMT to increase the allowance.

5.7.2. On 3rd, 13th and 17th July FCC staff reported that there was no food in the flat (*informal carers*). The combined chronology records that on each occasion the next of kin was contacted but actually this appears to have been the informal carers, who promised to bring food, rather than Terry's brother (*family involvement, legal literacy and recording*). On 6th July FCC was informed of Terry's Hepatitis C diagnosis (*information-sharing* and *commissioning*).

5.7.3. On 30th July Terry attended an ENT appointment with his brother. This was repeated on 13th August as on the previous visit healthcare staff had been unable to remove wax embedded in Terry's ears. Some wax was removed on the second outpatient appointment. On both occasions advice was given about how Terry could ameliorate the condition. Nothing abnormal was detected in Terry's throat (this followed a possible lesion having been detected when Terry had been in hospital in November/December 2017).

5.7.4. On 8th and 14th August FCC reported ongoing concerns to ASC. There was no toilet paper or other toiletries and informal carers did not appear to be purchasing essential shopping. When FA had been approached about this (*informal carer*), she "bit back" and became "defensive." Terry was refusing personal care. A meeting between FCC, FA, Terry and the social worker occurred on 22nd August. There were unopened community meals. FA said that she was delivering food daily in the afternoon, which is why no-one saw it. FA repeated that she had insufficient funds to buy what was needed. The social worker agreed to follow this up with FA and MMT. However, the next social worker entry on the combined chronology does not occur until 18th October.

5.7.5. Concerns are repeating about Terry's self-neglect, management of his financial affairs and the role of the informal carers.

5.8. The sixth time episode runs from the beginning of September 2018 to the end of the year. It appears that Terry did not attend an outpatient follow-up appointment with ENT on 6th September. On 19th September he fell (*risk*). This was not witnessed. Terry sustained a damaged toe nail and head graze. The GP advised that he attend hospital. Three days later NHS 111 received a call about the damaged toe. As Terry sounded confused, with slurred speech, the call was transferred to 999 and SWAS attended. Terry had pulled off his nail. Observations were normal, there was no sign of infection. FCC provided NHS 111 with contact details.

5.8.1. Terry cancelled an ENT follow-up appointment for 27th September. On 7th October, with Terry complaining of chest pains, a carer called SWAS. The carer observed chest bruising that was not there the day before and Terry could not account for this. There was speculation that he may have fallen (*risk*). Terry did not want to attend hospital (*mental capacity*). Referrals were sent to the GP, falls team and (possibly) to safeguarding for self-neglect and alcohol abuse.

5.8.2. On 18th October mainstream funding was agreed for Terry's care package, visits to be twice daily (*commissioning*). On 22nd October the social worker closed the case (*continuity, relationship-based practice*), approved by managers on 8th November as "no other concerns [had been] raised or identified at the time of review."

5.8.3. On 30th October Terry is recorded as now being on medication for Hepatitis C. On 6th November he failed again (*engagement*) to attend his ENT appointment. The clinician wrote to his GP seeking support to ensure Terry's future attendance (*inter-agency collaboration*). On 9th November MMT refused to hand over Terry's personal allowance as FA did not have

identification. Four days later MMT raised the possibility with the social worker of FA taking over Appointeeship "to free up capacity in the team". On the basis of having met FA once, the social worker thought that she seemed "genuine and concerned" about Terry.

5.8.4. On 24th November and 29th December FCC recorded that Terry was not taking his medications. FCC policy is to notify the GP in such circumstances when the person does not have mental capacity but Terry had capacity (*mental capacity assessment* and *procedures*).

5.8.5. Concerns are ongoing about Terry's self-neglect, engagement with care and support, and falls. Issues of money management and the purchase of provisions to meet Terry's needs occur again periodically.

5.9. The seventh and final time episode runs from January 2019 until Terry's death on 1st June. On 14th January a review in the Hepatology clinic concluded Terry's treatment for Hepatitis C; the virus was now undetected. Terry would be reassessed in three months. On 28th January Terry was registered with a new GP surgery. Apparently Terry did not *engage* with the registration process.

5.9.1. On 30th January FCC telephoned ASC Initial Contact Team. Concerns were the same, namely no food in the flat, which meant that formal carers could not prepare snacks (*informal carer*), alcohol misuse and Terry refusing personal care and his medications (*engagement*). A social worker spoke to Terry on the telephone. He sounded intoxicated. He dismissed concerns about not eating but stated that FA's boyfriend was taking his pension and that she was not visiting. The combined chronology records the social worker speaking to one of Terry's previous social workers who reported no previous concerns about FA (*case history*). The social worker made a *safeguarding* referral.

5.9.2. The following day, 31st January, the safeguarding referral was followed up with a telephone call to Terry. He was unsure about his care and support needs and who was supporting him. He was concerned about his pension. He did not want WPS to be informed but was told that police involvement could not be discounted if financial abuse was likely. On the same day FCC held a review with Terry and his next of kin.[8] Terry was waiting for a wet room to be installed[9] to assist with his personal care. No concerns were apparently raised although it appears that he was only rarely eating his community meals and was mostly declining medication and personal care.

5.9.3. On 1st March an Enquiry Officer from SBC Adult Safeguarding advised Terry on a home visit of the allegation of financial abuse from FA's boyfriend. Terry stated his belief that money had been stolen. The intention was to explore the alleged financial abuse and to request a care management review of his care and support needs. On 13th March SBC Adult Safeguarding advised Terry's SHO about discrepancies in Terry's finances (*inter-agency collaboration*) and that MMT was involved. On 21st March a senior practitioner from the SBC Mental Capacity Act Team made a home visit to review the money management support being provided and a referral was sent to WPS (*safeguarding literacy*) and *information shared* with the SHO.

[8] As earlier in the chronology, this appears not to have been Terry's brother, his then known next of kin, but FA who was his informal carer.
[9] This began on 5th February.

5.9.4. On 1st April an SBC Adult Safeguarding staff member made a home visit and undertook to arrange for bedding to be delivered and the flat to be prepared for installation of a washing machine. The FCC care package was increased to two visits daily (morning and lunchtime). Two days later FCC called the social worker to report that Terry had no suitable clothes or bedding, all soiled (*inter-agency collaboration* and *safeguarding*). On 10th April a safeguarding meeting was held, the SHO only being informed on the day of the meeting. The combined chronology gives no details as to the outcome of this meeting. However, the information collected at the time of the SAR referral indicates that actions were agreed, including establishing Terry's views and desired outcomes. WPS advised that FA was not a suitable person to manage the finances of a vulnerable adult.

5.9.5. On 16th April a senior practitioner from the MCA/DoLs Team called FCC for feedback on the latest concerns (*inter-agency collaboration*). Terry was declining his medications, he needed a shower chair, his clothes did not fit him, and there was little food in the flat and no regular laundry. Terry disliked his meals on wheels and would not eat them. His friends were providing alcohol. Two days later Terry refused personal care from FCC and sat in his faeces, half dressed. His sofa was soiled (*risk assessment*).

5.9.6. On 23rd April the social worker[10] asked the GP to see Terry. It emerged that informal carers were watering down the alcohol that Terry was drinking to help reduce his intake. There was concern that, should ASC stop the informal carers visiting, Terry would experience cold turkey and seizures. The plan was to prescribe vitamin B to help with memory and protect brain function. Thiamine was issued and a referral to drug and alcohol services suggested.

5.9.7. On 2nd May the social worker referred Terry to Turning Point following an earlier telephone call (date unknown). It was the view of the referrer that Terry did not want to stop drinking. Concern was expressed about the dangers of immediate withdrawal (*risk assessment*). Turning Point requested by email information and support from the social worker about how to proceed with Terry owing to his cognitive and poor mobility issues. No response appears to have been received (*inter-agency collaboration*). SBC Adult Safeguarding remained concern about financial exploitation (*safeguarding literacy*).

5.9.8. On 8th May FCC raised further concerns that Terry was aggressive and incontinent. There was disagreement between the SHO and FCC care staff about exactly how much alcohol Terry was consuming daily (*risk assessment*). On 8th and 9th May the GP attempted to contact the social worker, without success. Also on 9th May FCC carers made a 999 call as Terry was not himself. The clinician on triage called the GP who agreed to visit the following day, Terry's care staff having advised that hospital admission did not seem appropriate. Terry's ankles were very swollen, with reduced sensation. There was concern about the state of the flat also. FCC also notified duty social work that Terry's drinking had reached a high level, even when staff were present, and that he was refusing personal care, was covered in faeces, refusing help and verbally abusive (*risk assessment, information-sharing* and *safeguarding literacy*).

5.9.9. On 10th May the GP visited and observed signs of decompensated liver disease. SWAS transported Terry to GWH NHSFT with a letter from the GP. He was admitted to a medical assessment unit where bilateral leg swelling was observed. It was recorded that Terry had

[10] Entries on the combined chronology from other agencies involved refer simply to a social worker from this point onwards. The detailed chronology from SBC ASC clarifies that this was the senior practitioner from the MCA/DoLs Team.

reduced appetite and had not eaten for seven days, and that he had a longstanding bad memory. It is also recorded that Terry and his brother (*family involvement*) had agreed to a "not for resuscitation" approach (*mental capacity assessment*). The GP spoke to the social worker (*inter-agency collaboration*), noting that Terry was incontinent of faeces, had been resisting care, had swollen feet and was confused and lethargic. His alcohol consumption may have reduced recently.

5.9.10. On 12th May GWH NHSFT referred Terry for post discharge support. Terry was alert and orientated. Over the following days Terry was *assessed* by occupational therapy, dieticians and physiotherapy. Terry was not medically fit for discharge. His dietary intake was poor and there was a very high risk of re-feeding syndrome. His *engagement* was variable but he appeared increasingly mobile, such that he was assessed as having only minimal rehabilitation needs. Return home with support when medically fit for discharge was the plan.

5.9.11. On 15th May arrangements were made for Terry's flat to be cleaned. On 16th May a discussion was held with Terry about *safeguarding* and financial abuse. A *mental capacity assessment* was completed regarding the safeguarding enquiry. On balance it was concluded that Terry lacked capacity and a change to his financial arrangements was made in his best interests. MMT removed Terry's name from the list of collections of personal allowance.

5.9.12. On 18th May a gastroscopy report noted that previous statements about alcoholic hepatitis were incorrect. Terry was not jaundiced. Rather he was very frail with decompensated cirrhosis; in other words advanced liver disease. End of life discussion with his next of kin was recommended.

5.9.13. Terry's brother observed that he was in a lot of pain, especially when moved, but in his view was given insufficient pain relief because he did not request it. At the end his brother could not speak. Terry's brother felt that there was insufficient palliative care until the end and said that he was unhappy with how his brother was treated.

5.9.14. For the remainder of May physiotherapy, dietician and occupational therapy reviews took place. Terry was sometimes muddled and confused (*mental capacity*); his *engagement* was poor. He was considered for hospice care but had minimal acute palliative care needs. Palliative care at home was therefore suggested with Community Health Care (CHC) funding. The necessary equipment was ordered. His brother was included in some of the end of life discussions (*family involvement*). However, before arrangements for palliative care at home could be commenced, Terry died in hospital on 1st June 2019.

6. Thematic Analysis – Direct Work with Terry

6.1. A core component of the evidence base for direct work is Making Safeguarding Personal[11]. This should be a proactive rather than reactive approach. It should focus on the person's wishes, feelings and desired outcomes. However, it should also demonstrate concerned and authoritative curiosity, especially about the choices that the individual is taking, with detailed exploration of what might lie behind refusals of care and support, such as loss and trauma. It is helpful, therefore, to build up a picture of the person's history.

6.2. What is often striking when reviewing cases is how little appears known to the agencies involved of the life history of the person with whom they are working. This is the case here, at least judging by the content of the combined chronology. It was only after Terry's death that it became known that he had a son. His brother was able to provide the independent reviewer with some background. Terry had been employed as a highly skilled professional, sometimes working abroad. He could not identify a trigger for his heavy drinking but it had begun whilst he was employed and had been a feature of Terry's life for a very long time. He had increasingly become very withdrawn and did not like going out. After a stroke he was difficult to talk to because "his brain was not functioning properly" and his brother found it difficult to see him. On average he visited monthly except at times of crisis. In his brother's view, not all staff were kind towards Terry, especially when he was in hospital. However, he did acknowledge that Terry was "not easy to deal with". He disliked hospital and could be aggressive towards staff. Terry's brother said that he could not change him and that deterioration had been gradual and difficult to notice until towards the end. Indeed, one feature of self-neglect is that deterioration can be hard to spot when it is gradual and when practitioners normalise what they continue to see.

6.3. Some elements of a Making Safeguarding Personal approach are discernible from the combined chronology to which the agencies involved contributed reflections on practice. The 2016 adult safeguarding referral was closed as Terry appeared open to support to manage his alcohol consumption and withdrawal. On his admission to hospital in November 2017 his wishes and feelings from his previous admission have been recorded, including that he had mental capacity to decide to decline formal detox. His request for more help was actioned via care management by GWH NHSFT and SWAS staff. Whilst he was in hospital staff engaged with Terry to seek his participation and involvement in his care. He consented to a referral to ASC and to contact with his next of kin for a detailed social history. His wishes and feelings are clearly recorded, with Terry noted to be happy to be guided by his medical team.

6.4. Contact was made with Terry by telephone the day following receipt of an adult safeguarding referral in January 2019. The detail of the concern was discussed but Terry does not appear to have been told formally that a safeguarding concern had been received, what that meant and what might happen as part of an enquiry process. Commentary on the combined chronology notes that there was some understanding of Terry's views but the overall approach taken did not comply with all the tenets of Making Safeguarding Personal. One aspect of Making Safeguarding Person and the evidence base for working with people who self-neglect is an understanding of the person's history and how life experiences are influencing and impacting on their present situation and behaviour. Very little such detail is recorded on the combined chronology or the SAR referral. It is questionable whether there was sufficient professional curiosity regarding the background to his alcohol abuse, rejection of formal care, and self-neglect. For example it is observed that Terry had a dislike of formal carers but it is unclear

[11] Sections 4.2.1 to 4.2.5.

whether anyone tried to understand the origin of this dislike; in any event the outcome of any such a conversation was not recorded.

6.5. As the combined chronology identifies, there were many occasions when Terry refused assessments and/or personal care, and declined referrals, sometimes aggressively. There were occasions, both when in hospital and at home, when he initially engaged with services only then to withdraw. The combined chronology does not record any exploration of these decisions or choices. Indeed, when he declined an alcohol liaison referral when in hospital in November 2017, a reflection on the combined chronology observes that a conversation with Terry would have been beneficial about the benefits of a substance misuse referral. There was a missed opportunity to discuss with the substance misuse service how to approach Terry to enlist his engagement. The same might be said when the reablement service withdrew because Terry would not engage.

6.6. Terry appears to have been consistent in wanting the involvement of FA as an informal carer although he did express several times concerns about whether his money was being stolen. His wishes regarding the involvement of his informal carers were respected. After his hospital discharge in January 2018 he declined care and support, with the result that the social worker closed his case. There does not appear to have been any exploration of the reasons why Terry preferred informal care to a formal care package. There does not appear to have been any exploration as to whether Terry's decision-making was influenced by duress or coercive and controlling behaviour. Put another way, the combined chronology does not offer any evidence of professional curiosity. Indeed, when in January 2018 FA advised that Terry's "bizarre and eccentric behaviour" was "normal", this appears to have been accepted at face value.

6.7. At the learning event those attending felt that those working with Terry took their lead from him, in line with Making Safeguarding Personal but felt that, alongside this, it would have been important to also pay due regard to risks of significant harm. At the learning event also questions were asked about how much services should seek to offer support, for example in relation to alcohol misuse, when an individual is declining to engage. This raises the familiar dilemma of how to balance a person's autonomy and self-determination with a duty of care that sometimes will encompass intervention to prevent or protect an individual from abuse/neglect. Using multi-agency meetings to discuss this dilemma is best practice but those attending the learning event felt that such meetings had been the exception rather than the rule.

6.8. When analysing how the 2019 adult safeguarding referral was managed, the combined chronology reflects that Making Safeguarding Personal as an approach continues to be developed through supervision, quality assurance and audits. By contrast, it appears that in this case little was known about Terry, his history, his life journey, and his wishes and feelings. **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.

6.9. The evidence base advises thorough mental capacity assessments, including consideration of executive capacity[12]. It also highlights the potential significance of repetitive patterns[13]. It was correctly identified that, as part of the response to the April 2016 adult safeguarding referral, a view was needed on whether Terry had mental capacity regarding consent to treatment and, in

[12] Section 4.2.10.

[13] Section 4.2.6.

a clear reference back to Making Safeguarding Personal, what he wanted and/or required help with. In recognition that he might have decisional capacity, an adult safeguarding manager advised an assessment of his ability to make informed decisions and to seek his views. However, the records do not provide any evidence of a subsequent assessment and, therefore, of an understanding and application of the Mental Capacity Act 2005.

6.10. When Terry was admitted to GWH NHSFT on 23rd November 2017 he was recorded as confused, cognitively impaired and lacking capacity, although in respect of what decisions is not noted. SWAS records for this admission do not document a mental capacity assessment. For some days the hospital acted in his best interests because he was confabulating. An application to deprive Terry of his liberty whilst in hospital was submitted.

6.11. There was no mental capacity assessment in respect of his refusal to engage with a referral to alcohol services and whether he understood the consequences of not being referred. By early December 2017 he appears to have regained mental capacity since this is explicitly stated when a referral for care and support assessment was sent on 6th December by the rehabilitation ward. Subsequently no concerns about his cognition and orientation are recorded until "mild confusion" on 20th December and a decline in cognitive functioning, such that he was very confused and behaving inappropriately on 27th December. He remained "very muddled and incoherent" on 2nd January, and aggressive, such that a physiotherapy assessment had to be aborted. Nonetheless, by the time he was referred to mental health services his agitation had improved with a change of medication and he was deemed to have capacity to consent to mental health assessment. On 10th January he was assessed by a hospital consultant as having capacity with respect to the decision to return home and to decline formal care and support. Terry's reiteration of this decision was accepted at face value by a social worker two days later, with the combined chronology giving no indication of professional curiosity.

6.12. Throughout 2018 and into 2019 repeating patterns stand out in this case, 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. Three lines of enquiry arise in response to the patterns in this case, namely how to respond to fluctuating capacity, assessment of executive capacity, and impulse control relating to substance misuse.

6.13. In cases of fluctuating capacity, for example with respect to alcohol misuse, the courts have advised the adoption of a longer-term perspective on someone's capacity rather than simply assessing a person's mental capacity at one point of time[14].

6.14. Throughout the combined chronology reference is made to Terry's cognitive impairment, sometimes linked to the outcome of a previous stroke. It is less explicitly linked to the impact of his long-term substance misuse. The importance of focusing on executive functioning arises because of the impact on the frontal lobe of the brain as a result of alcohol-related damage and/or stroke. This concept has been very clearly addressed in one SAR which concerned the murder of a woman with a chronic alcohol problem. It says that: *the concept of "executive capacity" is relevant where the individual has addictive or compulsive behaviours. This highlights the importance of considering the individual's ability to put a decision into effect (executive capacity) in addition to their ability to make a decision (decisional capacity). Therefore, for an*

[14] Greenwich RLBC v CDM [2019] EWCOP 32 and Cheshire West and Chester Council v PWK [2019] EWCOP 57.

individual such as Carol the assessment of mental capacity is unlikely to be as straightforward as a simple yes or no[15].

6.15. NICE guidance also advises the assessment of executive capacity. It recommends that assessment should include real world observation of a person's functioning and decision-making ability[16], with a subsequent discussion to assess whether someone can use and weigh information, and understand concern about risks to their wellbeing.

6.16. Two SARs, in particular, link the assessment of mental capacity to impulse control disorder. In one SAR[17] it is observed that alcohol use was seen as a behaviour of choice. Howard was not assessed with respect to Impulse Control Disorder even though this is associated with significant alcohol misuse. In a second[18] the partner of a woman who had died having experienced multiple exclusion homelessness, commented that she had been unable to maintain abstinence from substance misuse because past traumas and adverse life experiences "kept bubbling up." This captures quite graphically how individuals can be governed by impulses to distance themselves from emotional distress. She was caught in a life-threatening double-bind, driven to avoid suffering through ways that only deepened her suffering.

6.17. For very dependent drinkers thorough mental capacity assessments are advised, which incorporate consideration of fluctuating capacity, executive dysfunction and impulse control. The Court of Protection is available where assessment is unclear and/or where there is uncertainty about what is in person's best interests[19]. Agencies have provided training for staff but it does not always appear to have the desired outcome in terms of its follow-through impact on practice. The complexity of practice at the interface between mental capacity and substance misuse should be acknowledged. There may be useful learning in terms of the barriers or difficulties in transferring training into practice.

6.18. Those attending the learning event felt that mental capacity assessments continued to prove challenging for practitioners, especially in cases where it was difficult to conclude definitively either that a person did or did not have capacity in respect of particular decisions. Once again, it was observed that it would be useful to have a forum in which such complexities could be shared and discussed.

6.19. **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.

6.20. Another core component of the evidence base is risk assessment[20]. The risk of falls features throughout the period under review and, indeed, when in hospital in December 2017 there were both witnessed and unwitnessed falls. Although on these occasions GWH NHSFT's falls protocol

[15] Teeswide SAB (2017) Safeguarding Adult Review – Carol.

[16] NICE (2018) *Decision Making and Mental Capacity*. London: National Institute for Health and Clinical Excellence.

[17] Isle of Wight (2019) Safeguarding Adult Review – Howard.

[18] Tower Hamlets SAB (2020) Thematic Safeguarding Adult Review – Ms H and Ms I.

[19] London Borough of Croydon -v- CD [2019] EWHC 2943 (Fam)

[20] Section 4.2.8.

was followed, with medical and physiotherapy review, and CT head scan, a reflection entered on the combined chronology questions whether there is evidence of clear documentation of risks. During that hospital admission it is recorded that Terry did not appear to be aware of the risks, which highlights the importance of mental capacity assessment as part of risk assessment, especially of executive functioning when the CT head scan showed age-related change, extensive small vessel disease and mature left cerebral infarct[21].

6.21. A Dementia and Later Life Nurse completed a risk assessment when Terry was in hospital on 4th January 2018. This concluded that the risk to self was low and that the risk to others was also low. His agitation had been resolved with changes to his medication. A risk of self-neglect was recorded, with Terry awaiting reablement to support personal care at home. In a context of falls and of alcohol abuse, it is questionable whether the risk to self was indeed low. The risk assessment does not appear to have been updated subsequently, for example when Terry rejected reablement and that service withdrew.

6.22. Another risk that permeates the entire period under review is that of financial abuse. Reading the combined chronology it appears never to have been resolved whether Terry's informal carers were misappropriating his weekly personal allowance. Terry's brother, when interviewed by the independent reviewer, could only recall one occasion when he was asked about the management of Terry's money after he had signed over control to SBC. He said that he had felt a few qualms about how FA was managing his weekly allowance but on reflection thought that she and HA were genuine and that Terry was not exploited.

6.23. 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. The combined chronology provides no evidence that there was a comprehensive risk assessment, periodically updated through services working together. As indicated in the combined chronology, FCC raised concerns on several occasions during 2018 and 2019, for example on 8th June 2018 highlighting evident weight loss and mobility issues, but no fundamental reappraisal of the case occurred.

6.24. In relation to the availability of food, Terry's brother observed that he was not eating adequately and that, after a throat operation, hardly at all. Food had piled up. From his perspective, his brother's dietary intake might account for why little food was observed in his accommodation. Whilst Terry might have refused to engage with dieticians and with encouragement to eat, it does not appear that his nutritional intake was the focus of assessment or intervention other than when seen by dieticians in GWH NHSFT.

6.25. All the concerns regarding risks come together in the 2019 adult safeguarding referral. A home visit on 1st March records the lack of food in the flat, Terry's refusal of personal care and medication, drinking alcohol to excess, concern about use of his weekly allowance, loneliness and Terry's inability to say what outcome he wanted from the safeguarding concern. The conclusion of this visit was a medium risk of financial abuse and a decision to conduct a formal adult safeguarding enquiry[22].

[21] Terry's brother informed the review that he wasn't aware of the information from the CT Scan or the damage that it had identified.

[22] Section 42 (2), Care Act 2014.

6.26. A similar account emerges from a home visit on 21st March. Terry did not have suitable clothing or bedding, it remained unclear what the weekly personal allowance was being spent on, and Terry had neither a microwave nor luxuries. The combined chronology contains a comment on this visit that could equally apply to much of the professional contact with Terry, namely what was the outcome and actions following this appraisal? Greater depth of exploration, assessment and coordinated planning in an attempt to mitigate risks would have been good practice.

6.27. 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, as a previous SSP SAR highlighted[23]. Professional curiosity and assessment are fundamental when concerns occur repeatedly and when a person's decision-making maintains or increases risks of significant harm.
Recommendation Four: SSP should review the guidance provided across partner agencies regarding risk assessment and risk management.

6.28. The evidence base indicates the importance of maintaining contact with the person, rather than closing down involvement, to maintain continuity and build up trust[24]. It also advises thoroughness of health, mental health and social care assessments, planning and reviews[25].

6.29. On case closure, as indicated in the combined chronology, when Terry did not attend outpatient ENT appointments in November 2018, the responsible clinician wrote to the GP requesting support to facilitate ongoing contact. This is good practice. By contrast, in January and again in October 2018 social work involvement was concluded despite evidence of ongoing risks and concerns. A reflection entered on the combined chronology seriously questions the second closure decision, stating that the decision to terminate involvement should not have been authorised, not least because concerns had not been resolved about how Terry's personal allowance was being used and a financial assessment with respect to charging for FCC's support package had not been completed.

6.30. There are example of good practice with respect to triage of NHS 111 calls, for example in September 2018 when, because of his slurred speech and confusion, Terry's call was transferred to 999 and SWAS sent a crew. Similarly, the clinician on triage for 999 calls on 9th May 2019 contacted the GP to assist with the evaluation of risk.

6.31. When Terry was in hospital a full range of assessments and reviews were completed, including occupational therapy, dietician and physiotherapy, with clear treatment objectives and plans put in place, for example when a lesion in his throat was noticed and when pressure ulcers were found on admission. His past medical history was well-known and informed decision-making, for example when his fractures required setting. Following his hospital admission in November 2017, his social care needs were recognised and an appropriate referral for care and support sent. His self-neglect was recognised, which should have provided an opening for a multi-agency risk management approach[26]. However, services responded to Terry's needs individually and an overall coordinated approach was missing.

[23] SSP (2018) Honor.
[24] Section 4.2.7.
[25] Section 4.2.13.
[26] There was no apparent consideration of referral to the Risk Enablement Panel.

6.32. One such example is the completion of the one mental health assessment in the period under review. This occurred on 4th January 2018 and concluded that there was no need for input from the mental health liaison team. Terry wanted to go home and his discharge appeared to be a social rather than mental health issue. No further mental health involvement was requested.

6.33. The Adult Social Care plan for care and support on Terry's discharge from GWH NHSFT in January 2018 was not reviewed immediately when Terry declined formal support, with the result that Terry was discharged without services in place. The SHO was left to monitor the situation until his supervisor contacted ASC. As Terry was vague on the telephone when a social worker called, a home visit was made the same day (22nd February). This was good practice. The visit is described in the combined chronology as a "fairly detailed assessment." Self-neglect was apparent. There was no food in the flat. Terry admitted that he was struggling with his personal care and agreed to have an occupational therapy assessment, for which a referral was made four days later. Terry declined a formal care package, which could have begun immediately. Allocation to a long-term social worker was requested.

6.34. A subsequent home visit on 14th March when Terry was seen in the company of FA and HA secured agreement for a reablement service, which began immediately. However, social care planning was not revised when the service withdrew because of Terry's non-engagement. Neither a risk assessment nor a mitigation plan appears to have been in place throughout 2018 and 2019, involving the GP, ASC and FCC staff with respect to Terry's periodic non-compliance with medication and refusal of personal care.

6.35. The social worker was able to persuade Terry to accept a formal care package in May 2018 and again requested case allocation to a long-term social worker. Almost from the very beginning FCC reported concerns about Terry's alcohol consumption, self-neglect and neglect by his informal carers. Social work input was requested but the repetitive nature of the concerns did not seem to prompt responsiveness and reappraisal of the approach to case management. There was a change of social worker in June 2018, which may have disrupted continuity and follow-up of concerns about self-neglect. His preference for FA's informal care as opposed to receiving support from formal carers was accepted at face value. It is certainly clear from the combined chronology that social work plans with respect to engaging with Terry and FA about management of his personal allowance (late June 2018 and also later August 2018) were not followed-up. In July and August there were delays in ASC responding to concerns raised by FCC. The funding of the care package provided by FCC was only authorised in October 2018, at which time FA's request for an increase in the funds she had to dispense had still not been resolved.

6.36. There was a delayed response from ASC once a referral had been sent to Turning Point. The additional information that Turning Point had requested, for example about his capacity to attend an appointment, had not been sent by the time that Terry died. Consequently, although an assessment had been offered by Turning Point, no assessment had therefore been undertaken before Terry died. SBC Adult Safeguarding has also acknowledged that the January 2019 referral was not assessed in a timely manner.

6.37. One final aspect of assessment and review concerns MMT and the administration of Terry's financial affairs. A running theme through the case is concern about financial abuse and whether FA was spending Terry's personal allowance in the way intended to meet his care and support needs. It is not clear from the documentation how MMT assessed FA's suitability and kept it under review. In the context of the history of concerns it is certainly puzzling how one social worker could inform another social worker that FA seemed genuine and concerned, and therefore potentially suitable to assume greater control of Terry's financial affairs to "free up

capacity" in MMT. It was only in March 2019 that action was taken to change the arrangements for the collection of Terry's weekly personal allowance in his best interests. [27]

6.38. The combined chronology does not offer any indication of annual visits and reviews by MMT, or of reports to and responses from the Office of the Public Guardian. The independent reviewer understands that this is an obligation that follows from the assumption of Deputyship. Terry's brother told the independent reviewer that, in his opinion, the large amount of money that Terry had was not used for his benefit and that no-one contacted him about Terry's financial affairs once SBC assumed this responsibility.

6.39. At the learning event and in panel discussion, it has become clear that MMT has tightened its procedures regarding third party agreements for people collecting cash. Professional curiosity should now be evident, rather than just accepting situations at face value, in order to ensure that the individual's needs are being met when their financial affairs are being managed by MMT and when private carers are spending money on their behalf. It has also become clear that MMT and other services involved with individuals need to work more closely together, with expressed views responded to, so that there is one joint system response to address concerns that arise. **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.

6.40. The evidence base advises that family members and, where appropriate, informal carers should be involved in assessment and care planning[28]. As the chronology identifies, at various points Terry's brother was present when Terry attended outpatient appointments or was in hospital. He was involved in discussions about resuscitation and end of life care. In December 2017, during Terry's hospital admission, it was suggested that his next of kin should be contacted to provide a social history. It is recorded that Terry's brother advised that contact be made with Terry's friends for an accurate social history and assessment of the home environment and Terry's functional baseline[29]. It is not recorded what, if anything, his brother knew of his history. It may be that the suggestion that he might disclose what he knew about Terry's social history was not pursued. No discussion is recorded in the combined chronology of the support that Terry's brother could offer and neither he, nor FA and HA, appear to have been offered a carer's assessment.

6.41. Terry's brother told the independent reviewer that he was only ever contacted when Terry needed to attend hospital appointments. He said that he was only rarely contacted by social workers and sometimes both he and FA had been unable to secure visits from the Social Worker to Terry. Neither does the combined chronology report any conversation with Terry about the story of family relationships.

6.42. As informal carers FA and HA are ever-present in the chronology. Indeed, FA is mistakenly referred to as Terry's next of kin, for example by the Dementia and Later Life Nurse in January 2018 when Terry had his only mental health assessment. FA was sometimes consulted about Terry's care and support. To the Dementia and Later Life Nurse FA described Terry's eccentric

[27] Terry's brother commented that he was not fully informed in Terry's financial affairs.
[28] Section 4.2.9.
[29] Following Terry's brother reviewing the report he does not recall this.

behaviour as normal due to his wanting to leave hospital and to drink and smoke. FA was concerned about his personal care. To a social worker in March 2018 FA and HA described Terry as having trust issues with formal carers, although precisely what these might be and from where they might have originated is not recorded. It is unclear from the chronology whether Terry had consented to their involvement. It is also unclear the degree to which their comments were explored rather than simply accepted at face value.

6.43. Throughout the period under review concerns revolve around the care actually being provided by FA and HA, and whether Terry's personal allowance was being used for its intended purpose, namely to ensure that there was sufficient food and other daily living necessities in his flat. Explanations provided by FA and HA were often taken at face value, judging by the chronology, rather than critically challenged. Requests that they ensure that sufficient food and other necessities were left in the flat were not always responded to or adequate deliveries subsequently maintained. When FA was challenged by FCC staff she became "defensive" and "bit back." At a subsequent meeting her reassurances and explanations, for example about the presence of food in the flat, appear to have been accepted rather than subjected to detailed scrutiny given the history of the case.

6.44. On a few occasions FA requested an increase in the personal allowance that she collected weekly. On one occasion (December 2017) she reported theft from her place of work of Terry's personal allowance. That report was taken at face value. Judging from the chronology, it is possible to conclude that insufficient curiosity was shown about how the personal allowance was being used and whether the amount was sufficient to meet Terry's needs. It is not apparent whether any consideration was given to the nature of the relationship between Terry and his informal carers; specifically whether he was subject to undue influence and/or whether he was a victim of coercion and control[30]. When someone is dependent on others, power can be exercised through the withholding of essentials for daily living and warnings of retribution if they complain and in the case of someone like Terry, availability of alcohol. It is noteworthy here that the chronology for 26th December 2016 records that HA had been banned from Terry's previous accommodation.[31] This does not appear to have been followed up by WPS or any other agency. **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.

6.45. The evidence base advises careful preparation at points of transition, such as hospital discharge[32]. NICE guidance for people in inpatient general hospital settings[33] recommends on admission that a person's housing status is established and that, prior to discharge, if a person is likely to be homeless, liaison occurs with the local authority's Housing Options service to ensure that advice and help is offered. Homelessness, housing and safeguarding issues should be

[30] This observation was also made in the Swindon SAB (2017) SAR on HS (Honor).

[31] Terry's brother did not feel there was any coercion to the best of his knowledge.

[32] Section 4.2.11.

[33] NICE (2015) *Transition between Inpatient Hospital Settings and Community or Care Home Settings for Adults with Social Care Needs*. London: National Institute for Health and Clinical Excellence.

addressed by agencies working together to ensure a safe and timely discharge. Those at risk of readmission should be referred to community practitioners prior to discharge for health and social care support. The guidance emphasises the importance of person-centred care, the involvement of family members with consent or in a person's best interests, the development of a care plan, with carers and next of kin named and their willingness to provide care and support ascertained, shared assessments and a coordinated discharge that addresses any safeguarding risks.

6.46. During Terry's hospital stay from late 2017 into January 2018, a discharge plan was discussed between medical and healthcare staff in GWH NHSFT, and with FA. A reablement package was considered and a social worker was involved. Hospital records indicate that Terry would have social care needs on his return home. However, Terry was declining personal care on the ward and was deemed to have mental capacity to decline support to address his care and support needs. He was discharged without a care plan in place. Meals on wheels had not been arranged. Terry was unable to get to his bathroom, highlighting that an occupational therapy assessment of Terry in his home environment prior to discharge had not occurred. It appears that it had been left to FA to arrange further care and support. It is unclear what the plan was to address concerns about his mouth and throat due to Terry's self-neglect regarding dental care.

6.47. By 22nd January 2018 Terry was reportedly using a vodka bottle into which to urinate. Meals on wheels were being left out of reach. It appeared that FA had not been sorting out arrangements for Terry's care and support. Concerns continued into February 2018 without referral for further social work intervention.

6.48. Another important transition relates to transfer of cases between social workers and their teams. In May 2018 there was a change of social worker, with the combined chronology containing a reflection that there had been a lack of clarity on reallocation. The care package in place at that time had only been an interim and non-chargeable measure. The care package should have been converted to a mainstream chargeable service (this was not done in fact until October 2018). The newly allocated social worker used their first home visit to review the care package rather than conduct a full assessment.

6.49. Information regarding concerns about financial abuse and the involvement of FA and HA with Terry may have been in case files but newly allocated social workers do not seem to have fully registered these concerns, evidenced in a lack of follow-through with MMT about the use of the personal allowance and the statement from one social worker to another that FA seemed genuine and suitable to manage Terry's financial affairs when MMT was raising the possibility of relinquishing their Deputyship. **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.

6.50. Finally, the evidence base reminds practitioners and managers that advocates should be involved where the person requires assistance to engage in assessments, reviews and safeguarding procedures[34]. It is noted that on 1st March 2019 Terry was assessed as lacking mental capacity to participate in the adult safeguarding process. However, no advocate was enlisted to support his engagement.

[34] Section 4.2.12.

7. Team around the Person

7.1. The evidence base strongly advises communication and collaboration between agencies, overseen by a lead agency and key worker[35]. No lead agency was nominated during the period under review and no key worker was appointed. The combined chronology does record instances of inter-agency communication and collaboration. For example, GWH NHSFT staff liaised with the Dementia and Later Life Nurse to facilitate their mental health assessment at the beginning of January 2018. The Sheltered Housing Officer supervisor contacted ASC on 22nd February 2018, concerned by Terry's self-neglect and the absence of care and support, and spoke to a social worker on 5th March about ongoing concerns regarding lack of food in the flat and Terry's refusal of personal care.

7.2. Similarly, as noted in the combined chronology, from the beginning of Terry's hospital admission in November 2017, GWH NHSFT made efforts for wider consultation regarding Terry's treatment and support. There were exchanges of information and conversations between GPs and ASC staff. FCC staff quite frequently contacted ASC with their ongoing concerns and there were occasional joint visits and email exchanges. On 22nd May 2018 a continence nurse fed back to a social worker the outcome of their home visit, including concerns about Terry's poor nutritional condition and rejection of formal care support.

7.3. However, there were missed opportunities. Plans made during joint visits were not followed-through, at least not in a timely way. SWAS might have raised an alert to ASC of Terry's increased care and support needs when he was transported to hospital in November 2017. There is no evidence that MMT and SBC ASC worked closely together to investigate concerns about financial abuse and how Terry's weekly personal allowance was being spent. When GWH NHSFT determined that a social history and functional baseline assessment was necessary (December 2017), an approach was made to Terry's next of kin. It is not clear whether SBC ASC and MMT were asked to share what information they held about Terry's history. When FCC staff informed the social worker of concerns, for example on 21st May 2018, no response was received and there was no follow-up.

7.4. On 1st March SBC Adult Safeguarding discussed the safeguarding referral with the SHO but liaison between the Enquiry Officer and MMT was delayed. On 21st March 2019 a referral regarding financial abuse was raised, to which WPS responded the following day. A senior Practitioner also liaised with FCC, learning again of concerns about Terry's self-neglect and lack of support.

7.5. On balance it appears that collaboration and communication was intermittent. No agency, professional or service appears to have escalated their concerns when patterns repeated or when there was a perceived lack of responsiveness. The evidence base emphasises the importance of a comprehensive approach to information-sharing[36] so that each service has a holistic rather than a partial picture. There is evidence of information exchange, for example during the adult safeguarding investigation in March 2019 but, for instance, it is unclear whether WPS knew that MMT held Deputyship for Terry's financial affairs and that SBC had known, or retained information historically from WPS, that FA was known to police for dishonesty and involvement with drugs. Similarly, it appears likely that MMT only became fully aware of the financial abuse concerns towards the end of Terry's life.

[35] Section 4.3.1.
[36] Section 4.3.2.

7.6. It appears to be the case that ASC only learned of Terry's Hepatitis C diagnosis on 2nd May 2018. It also appears that sometimes FCC staff did not communicate their concerns with SBC ASC, contacting Terry's informal carers instead, for example during July 2018. On receipt of a referral Turning Point asked for further information from SBC ASC regarding how to proceed but there was no response to this request before Terry died.

7.7. The evidence base also strongly recommends that multi-agency meetings are used[37] to pool information, and risk and mental capacity assessments, to agree a risk management plan and to consider legal options. Despite the repetitive nature of the concerns and risks in this case throughout the period under review, there was only one such meeting, in April 2019 as part of the investigation of the adult safeguarding referral. The combined chronology does not record that any agency or service requested a multi-agency risk management meeting. The combined chronology gives only sketchy detail of the outcome of the one meeting held, it is unclear whether legal options to address the possibility of financial abuse and Terry's ongoing self-neglect were considered. Legal advice does not appear to have been sought. Other than changes to the arrangements with respect to Terry's weekly personal allowance, it is unclear how Terry's inability to protect himself from neglect and self-neglect as a result of his care and support needs was to be addressed, although a section 42 (2) enquiry was proceeding.

7.8. It is possible to conclude that multi-agency risk management meetings would have been appropriate on several occasions, for instance in early January when Terry's mental capacity was fluctuating and when he was rejecting personal care and formal care and support, or when the reablement service withdrew in late March 2018, or at any point when there were concerns about the informal care being provided by FA and HA, and Terry's increasing self-neglect (May, July and August 2018 would be examples), including response to faecal incontinence.

7.8.1. An additional reason for convening multi-agency meetings is to ensure that all services involved understand each other roles and responsibilities in the case. An example to illustrate this observation is the expectation, as recorded in the combined chronology, that the SHO would monitor the situation (sections 5.2.8, 5.5 and 6.30). What is not clear is whether it was understood by all agencies involved that SHO contact needed Terry's consent, or if the SHO was being expected to do something that would have required consent. An SHO is only allowed in with the permission of the tenant and cannot make contact without a request.

7.8.2. Multi-agency meetings are also one mechanism for ensuring that all contributions are given adequate consideration; in other words for ensuring parity of voices. In this case it has been observed that SHOs and care provider staff do not always feel listened to by other professionals but may have useful information to contribute.

7.9. Those attending the learning event strongly endorsed the use of multi-agency risk management meetings and felt that these should become the norm, especially for challenging and complex cases, such as self-neglect. Views were expressed that neither the infrastructure nor organisational culture yet existed to ensure consistent use of multi-agency meetings, which would include decision-making about lead agency and key worker, and review of the outcomes of agreed plans. At the learning event there were positive references to a risk enablement panel but views were expressed that the operation of this panel was too reliant on one individual and there were concerns regarding whether thresholds for use of this panel might prevent a multi-

[37] Section 4.3.4.

agency consideration of some complex and challenging cases. It was felt that it would be timely to reinforce the practice that any service could convene a multi-agency meeting, using a standard template on how to proceed if one was made available. In essence, those attending the learning event felt that multi-agency planning meetings should be standard practice in cases of self-neglect.

7.10. The independent reviewer understands that SSP has a policy on information-sharing and on self-neglect, and that audits have demonstrated that policies are not used effectively and consistently across partner agencies. Partner agencies have also expressed doubts about the degree to which self-neglect is understood across the workforce. **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.

7.11. The evidence base recommends use of the duty to enquire (section 42, Care Act 2014) where this would assist in coordinating the multi-agency effort[38]. Sometimes known as safeguarding literacy, there were two adult safeguarding referrals. The first, in April 2016, was screened and allocated to a Response Officer on the day of receipt, with immediate communication with a care manager. The need to understand the role of Terry's informal carer was recognised in order to ensure that this was not a "neglectful arrangement." However, decision-makers were unsure if the referral met the safeguarding criteria or whether Terry's needs would be more appropriately followed-up with the care and support he would like. At this point the criteria in section 42 (1) should be recalled, namely whether Terry had care and support needs, was experiencing abuse and neglect, including self-neglect, and was unable to protect himself because of his care and support needs. Arguably, what was known at this stage would suggest that the criteria were met.

7.12. The combined chronology and the information and agency reflections collected following the SAR referral contain criticisms of how this adult safeguarding referral was handled. The referrer was not contacted for further information. There does not appear to have been any consideration of involving or sharing information with other agencies in order to ensure a multi-agency screening of the referred concerns. Conduct of the screening and information-gathering phase was not compliant with the policies and procedures for safeguarding adults then operational in Swindon, and the prescribed timescales for progression from concerns to enquiry were not adhered to. Risk assessment was delayed, therefore. Within documentation submitted for the review, it is concluded that the outcome (June 2016), namely that the safeguarding referral be closed, with support to be offered by way of care management, did not demonstrate practice that aligned with legal and procedural duties and safeguarding principles.

[38] Section 4.3.6.

7.13. The second adult safeguarding referral was received at the end of January 2019. Initial screening was completed within twenty-four hours, concluding that further information was required. Once again, reflections offered in the combined chronology and initial information provided for decision-making surrounding the SAR referral, express concerns. It is suggested that initial instructions given to the Enquiry Officer were reasonable but could have been more clearly defined. Contact was made with Terry immediately, but only be telephone when the statutory guidance[39] cautions about reliance on telephone assessments, and he was only informed that a formal referral of concern had been received some weeks later. Information-gathering was not timely, with insufficient assessment of risk and no apparent consideration of any interim plan to safeguarding Terry. It was not until mid-March (seven weeks after the referral) that a decision was made to proceed to a formal enquiry (section 42 (2)) but in recommending this course of action the Enquiry Officer did not align that recommendation to how the criteria in section 42 (1) were met. At that point a plan to safeguard Terry had not been formulated, for example relating to financial abuse, and risk assessment was incomplete. The recommendation to proceed to a formal enquiry noted, however, possible indications of duress, coercion and control, repetitive concerns, an informal carer in a position of trust, possible crime, and Terry lacking capacity. The need for an advocate for Terry was suggested. Risk was recorded as moderate but it is unclear how that assessment was reached. It was only thereafter (and not until May) that some steps were taken to protect Terry, mainly by way of changes in his best interests to the dispersal of his weekly personal allowance. **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.

7.14. There were also missed opportunities to refer adult safeguarding concerns. Terry alleged concern about how FA was managing his money in December 2016. When SWAS transported Terry to hospital in November 2017, a safeguarding referral was not submitted and there is no reference to self-neglect on their records. Once at GWH NHSFT his self-neglect was apparent alongside skin integrity concerns. The combined chronology observes that an Emergency Department nurse completed a safeguarding referral form but thereafter GWH NHSFT procedures were not followed and neither the Hospital safeguarding team nor SBC adult safeguarding staff were aware of concerns. This is recognised in the combined chronology as a missed opportunity, attributed to a lack of staff familiarity with procedures. It is suggested that GWH NHSFT adult safeguarding procedures are now more robust.

7.15. Following Terry's hospital discharge in January 2018, as the combined chronology identifies, concerns continued to be expressed, for example by the SHO, a continence nurse and FCC staff of self-neglect, deteriorating home conditions as a result of Terry's incontinence, risk of falls, alcohol abuse, confusion and incoherence, neglect by his informal carers and possible abuse of his weekly personal allowance. There were many missed opportunities to refer these concerns formally for an adult safeguarding enquiry. **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.

[39] Department of Health and Social Care (2018) *Care and Support Statutory Guidance: Issued under the Care Act 2014*. London: The Stationery Office.

7.16. The evidence base emphasises the importance of clear and thorough recording of assessments, reviews and decision-making[40]. Information submitted for the purposes of this review contains many criticisms of the standard of recording, some of which are suggestive of poor information-sharing practice. Thus, the GP surgery knew in September 2016 that SBC ASC intended to apply to the Court of Protection with respect to Terry's financial affairs but did not know the outcome. Housing records note that FA called WPS in December 2016 about an unwanted visitor bringing alcohol to Terry's flat but details are patchy. GWH NHSFT records note that a referral for care and support was made when Terry was in hospital between November 2017 and January 2018 but the social work team did not enter onto the same record the outcome on hospital records and it is not recorded either on the discharge letter to the GP. It appears possible that some agency records had wrongly identified Terry's next of kin. As indicated in the chronology, a hospital consultant also found it necessary to correct the medical record regarding Terry's diagnosis of hepatitis. There is no record of discussion between SBC ASC and MMT following a home visit in August 2018; nor is there a record of a financial assessment when, in October 2018, the formal care package was at last transferred to mainstream authorisation.

7.17. In reflecting on the 2016 adult safeguarding referral, the combined chronology comments that recording does not evidence an understanding and application of the Mental Capacity Act 2005. In reflecting on the process of the adult safeguarding referral from January 2019, the combined chronology notes that the transfer of data between systems has meant that it is not always straightforward to locate past case history. This has been noted in other SARs[41]; care must be taken when records are transferred from one system to another. The reflection arises because it is noted on the record that there had been no previous safeguarding concerns, which is clearly an error indicative of lost case history. Similarly, Turning Point became the new provider for substance misuse services in April 2018. Only the records of open cases were transferred from the decommissioned provider. As Terry's case had been closed, his records were not transferred and therefore were not available when he was referred in the final weeks before he died.

7.18. Commentary on standards regarding the 2019 adult safeguarding referral also note the lack of recording to evidence that areas outlined by the screener had been fully shared and considered with the case manager, for example about the role of Terry's informal carer. The recording by the Enquiry Officer is described as a descriptive list rather than an assessment of risk. The combined chronology does not contain details of the outcome of the one multi-agency risk management meeting that was convened, in April 2019 as part of the section 42 (2) enquiry. It appears that information about the outcome may not have been shared with the SHO. There is no record of any outcome of the adult safeguarding referral other than the change to financial arrangements regarding the personal weekly allowance.

7.19. More positively, records clearly indicate how Terry expressed his wishes and feelings, for example when in hospital in December 2017. The records of the 2019 adult safeguarding referral clearly contain the manager's briefing for the Enquiry Officer, namely to liaise with the care manager to request a case review and to explore the alleged financial abuse.

[40] Section 4.3.8.

[41] Preston-Shoot, M. (2017) *What Difference Does Legislation Make? Adult Safeguarding Through the Lens of Serious Case Reviews and Safeguarding Adult Reviews*. Bristol: South West ADASS. http://www.swcouncils.gov.uk/media/ADASS/Safeguarding_Review_2017.pdf

7.20. In its contribution to the combined chronology, FCC observes that the absence of follow-up and escalation of concerns when no response had been received from ASC was explained by the way records had been kept at the time. A new electronic system has been introduced that sends alerts when a follow-up is required. In its contribution to the combined chronology, Turning Point observed that it had no audit trail of Terry's case at the time, and no follow-up when ASC did not provide requested additional information, because records were not set up on receipt of a referral but only once a service had been offered. That has now changed. **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.

7.21. Those attending the learning event emphasised the importance of ensuring that the views of all practitioners involved were listened to and taken into account. They endorsed the importance of escalating concerns when necessary, the process for which is currently being reviewed by SSP. They questioned whether an organisational culture was as yet fully established to normalise communicating with other services with respect to complex and challenging cases.

8. Organisations around the Team

8.1. There are fewer references in the combined chronology and in the information collected as the SAR referral was being collected to this domain of the evidence base. That evidence base recommends supervision[42] that promotes reflection and critical analysis of case management, and management oversight[43], for example of commissioning and contract management.

8.2. The chronology records that the SHO's supervisor became involved in early 2018 when Terry's situation was deteriorating. The chronology also records the involvement of senior practitioners as a response to the lack of timely resolution of the 2019 adult safeguarding referral.

8.3. However, management and supervisory oversight is criticised in the reflections submitted as part of the combined chronology. For example, commenting on the 2016 adult safeguarding referral, management oversight of the closure of the referred concern is said not to provide any quality assurance of feedback to the Enquiry Officer. Commenting on the process of the 2019 adult safeguarding referral, it is observed that the Screening Enquiry manager did not submit the concern form for authorisation and review in March 2019, possibly because of staffing capacity issues in the adult safeguarding team and since the Assessment and Review team had agreed to manage the section 42 (2) enquiry. It is stated that there is now a strong emphasis on active and supportive management to improve practice and support decision-making, including monthly team supervision, independent supervision and weekly meetings with enquiry officers.

8.4. The combined chronology raises questions about the social work response in this case. For example, FCC raised significant concerns on 8th June 2018 but a social worker did not visit until 27th June. Thereafter the next social work entry on the chronology is 8th August, raising questions about the social work responses to the concerns about self-neglect fall risk and informal care that had been raised. In October 2018 a social worker closed Terry's case, leading to a reflection in the combined chronology that this decision should not have been authorised because concerns had not been resolved. NICE guidance in relation to care and support recommends that assumptions should not be made about people's mental capacity to be in control of their own care and support, and account should be taken of their history and life story. Account should also be taken of the negative effect of social isolation on wellbeing, with care and support plans including contingency planning. Assessment should begin with finding out and exploring what people want. Judged against the standards identified in this guidance[44], the social work response fell short.

8.5. Those attending the learning emphasised the importance of supervision but cautioned that, because this was mainly one practitioner talking with one supervisor, multi-agency meetings were also important to share perspectives. They also observed that supervision had to be a safe space in which both supervisor and supervisee could question the approach being advocated. For example, recommendations to close down cases should be carefully scrutinised.
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.

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[42] Section 4.4.1.
[43] Section 4.4.4.
[44] NICE (2018) *People's Experience in Adult Social Care Services: Improving the Experience of Care and Support for People Using Adult Social Care Services*. London: National Institute for Health and Clinical Excellence.

8.6. The evidence base also recommends attention to workforce and workplace issues, such as staffing levels and organisational cultures[45]. Commentary in the combined chronology regarding the 2016 adult safeguarding referral notes that the unqualified position of Response Officer no longer exists. The screening of concerns and information-gathering was not completed by an experienced social worker. Commentary on the 2019 adult safeguarding referral refers to capacity issues that led to delays in moving to the formal enquiry phase. It refers to the high proportion of locum staff in Enquiry Manager positions with varied experience and different interpretations of how to manage section 42 duties.

8.7. Entries on the combined chronology state that there has been improvement in screening workflow and assurance since the 2019 referral, and that learning sessions have been completed with adult safeguarding staff on the implementation of local policy and of LGA/ADASS guidance on adult safeguarding enquiries[46]. A basic induction package is now in place. Overall, it is stated that this should ensure greater compliance with legal duties, although it is also observed that practice and capacity issues mean that implementation is slow and subject to regular modification, with some impact on the quality of case work. Recommendation Twelve has already referred to an audit of management and decision-making of safeguarding referrals, and this should include a focus on workforce and workplace development[47].

8.8. During the process of this SAR it has been suggested that providers need greater support when neglect and self-neglect is identified, and that staff do not necessarily have sufficient understanding of how to approach such cases. In relation to all practitioners, a suggestion was made at the learning event that access to a toolkit would be useful – briefing on what to know about self-neglect and how to approach such cases. E-learning is available to all partners on self-neglect and a task and finish group is currently working on reviewing the guidance and on developing a toolkit. **Recommendation Sixteen:** SSP should consider commissioning a multi-agency training programme on self-neglect.

[45] Section 4.4.5.

[46] Hodson, B. and Lawson, J. (2019) *Making Decisions on the Duty to Carry Out Safeguarding Adults Enquiries: Suggested Framework to Support Practice, Reporting and Recording*. LGA and ADASS.

[47] An ASC improvement plan is in place and SSP is seeking assurance regarding its implementation.

9. Governance

9.1. SSP has an extensive range of guidance, policies and procedures, and protocols relating to self-neglect. This range includes tools to use for high risk professionals meetings and a policy on escalation of concerns. The latter policy on escalation has recently been developed by a task and finish group and will be disseminated once formally ratified.

9.2. The combined chronology gives little indication to suggest that these policies and procedures were utilised by those involved in this case, for example when statutory services did not respond in a timely way to concerns that had been raised.

9.3. Those attending the learning event understood that SSP is currently reviewing its self-neglect policy. **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.

10. Revisiting the Terms of Reference

10.1. The review group and the independent reviewer have observed that some of the findings in this SAR parallel what other reviews have reported. An earlier SAR published by SSP[48] found that there was no coherent assessment of mental capacity and the factors influencing an individual's decision-making in that case. Safeguarding referrals were closed because the lens through which the case was seen was one of lifestyle choice and carer stress. That SAR also found that there had been pressure on adult safeguarding systems.

10.1.1. Beyond Swindon reviews have expressed concerns about issues that have also appeared in this case. SAR Adult C (Wiltshire SAB) found learning about the management of Deputyship (as does an unpublished SAR by Brent SAB, Adult A). The Adult C SAR also found lessons regarding family involvement and care planning in self-neglect cases where there was also refusal to engage, physical needs and concerns about use of the MCA 2005.

10.1.2. Other SARs have also expressed concern about how little is known about people's history, for example Cambridgeshire and Peterborough SAB, SAR Arthur, Salford SAB, SAR Andy, and Wiltshire SAB, SAR Adult A. One cannot begin to understand the causes and triggers of behaviour without understanding the person's social history. In a case involving alcohol abuse and self-neglect, a SAR[49] reminds practitioners and managers of the importance of attempting to gain insight into the "why?" of someone's behaviour.

10.1.3. As in other cases, for example involving people who experience multiple exclusion homelessness (Tower Hamlets SAB, Ms H and Ms I) people who are known to self-neglect are nevertheless left with the responsibility to attend appointments and to administer self-care, such as taking medication. A "vicious circle" is thereby created, namely one of referral, non-engagement, case closure, and re-referral.

10.1.4. The review group and the independent reviewer are agreed that there is valuable learning for SSP and its partner agencies from SARs that have been conducted locally, regionally and nationally. These SARs can be used to shine a light on policies, systems and practices locally. They can be used to inform an analysis of the degree to which findings in this particular SAR are unique to the case or emblematic of more deep-rooted systemic issues, which present obstacles to achieving best practice. **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.

10.2. The Care Act 2014 requires a focus on wellbeing. This includes having regard to the person's wishes and views about outcomes. As section 6 of this report makes clear, application of the principles and practices of Making Safeguarding Personal (MSP) was patchy[50]. However, it also includes a focus on preventing and delaying the development of needs for care and support and reducing needs that already exist. People must also be protected from abuse and neglect, with

[48] Swindon SAB (2017) Report of Learning Together Safeguarding Adults Review: HS (Honor).
[49] South Tyneside SAB (2017) Adult D: The Response of Agencies to Severe Self-Neglect.
[50] MSP as a line of enquiry (Section 3.1.3.2).

known risks and experiences of abuse and neglect prevented/minimised. Autonomy has to be balanced with a duty of care. To reach an informed decision about how to strike the balance in each unique case required professional curiosity, concerned questioning and not accepting anything at face value. How this balance is worked through in Swindon in current cases requires constant scrutiny, for example through supervision and multi-agency risk management meetings. Whilst there was information-sharing and communication[51] within and between services, greater coordination would have been achieved by the use of multi-agency meetings and the formal designation of a lead agency and keyworker.

10.3. In cases of self-neglect where the person is assessed as having decisional capacity but where there is a risk of significant harm, legal options must be considered, such as application to the High Court for use of inherent jurisdiction. The question of whether Terry was being financially abused was never really satisfactorily resolved.[52] There is a balance to be struck between supporting a person's informal care network and counteracting risk. To achieve this balance also required professional curiosity, concerned questioning and multi-agency information-sharing, and assessment of the degree to which a person's decision-making is free from undue influence[53], to a degree that was not achieved in this case.

10.4. In answer to the "why?" question, it would appear that there was insufficient familiarity with self-neglect and escalation procedures[54]. As this report identifies, there is an evidence-base for best practice in self-neglect cases[55]. Perhaps because of staffing and workloads, including the numbers of temporary and agency practitioners, perhaps because of how services were constituted, there were shortfalls in this case when compared with the evidence-base.

10.5. Regarding the effectiveness of adult safeguarding[56], section 42 (Care Act 2014) in self-neglect cases depends on whether the person can control their own behaviour. There is clear evidence that Terry could not do this. Responses to Terry's alcohol abuse[57] were limited, perhaps because there was insufficient understanding of addiction and its impact across the workforces involved. Once again, there is an evidence-base for positive practice[58] in this field against which to benchmark local policies and practice. It is important to acknowledge also that abuse and neglect can be masked by addiction, and that substance misuse can render more complex and complicated assessment of mental capacity. Important here is the availability and accessibility of specialist advice and support, from mental capacity, mental health, substance misuse and legal expert practitioners.

10.6. It is important to acknowledge that some service development is already underway as a result of the learning from this case. For example, MMT is currently working with providers, developing guides and procedures, and a support plan for use with service users to capture their

[51] Line of enquiry (section 3.1.3.3).
[52] Lines of enquiry (section 3.1.3.4 and section 3.1.3.7).
[53] Line of enquiry (section 3.1.3.8).
[54] Line of enquiry (section 3.1.3.1).
[55] Line of enquiry (section 3.1.3.6).
[56] Line of enquiry (section 3.1.3.7).
[57] Line of enquiry (section 3.1.3.5).
[58] Alcohol Concern UK (2019) Learning from Tragedies. London: ACUK. https://alcoholchange.org.uk/help-and-support/get-help-now/for-practitioners/blue-light-training/the-blue-light-project

wishes and desired outcomes regarding their financial affairs. ASC intends to work more closely with Housing practitioners, for example when reviewing care and support packages.

11. 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.

Glossary

ASC	Adult Social Care
CCG	Clinical Commissioning Group
CGL	Change, Grow, Live
DART	Drug and Alcohol Referral Team
ENT	Ear, Nose and Throat
FCC	First City Care Services
GP	General Practitioner
GWH NHSFT	Great Western Hospitals NHS Trust
MCA	Mental Capacity Act
MMT	Money Management Team
MSP	Making Safeguarding Personal
NPT	Neighbourhood Policing Team
SAB	Safeguarding Adults Board
SAR	Safeguarding Adult Review
SBC	Swindon Borough Council
SHO	Sheltered Housing Officer
SSP	Swindon Safeguarding Partnership
SWAS	South West Ambulance Service
TP	Turning Point
WPS	Wiltshire Police Service