Sandwell
Safeguarding
Adults
Board

# Sandwell

# Safeguarding Adults Board

# Safeguarding Adults Review

# ‘Anne’

# Executive Summary

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# Executive Summary

## 1. Introduction

1.1 The Care Act 2014 requires Safeguarding Adults Boards (SABs) to arrange a Safeguarding Adults Review (SAR) if an adult (for whom safeguarding duties apply) dies or experiences serious harm as a result of abuse or neglect and there is cause for concern about how agencies worked together. This review relates to self-neglect.

1.2 Sandwell Safeguarding Adults Board (SSAB) commissioned an independent author, Sylvia Manson, for the review. The author is independent of SSAB and its partner agencies.

1.3 The purpose of SAR's is: ' to *promote as to effective learning and improvement action to prevent future deaths or serious harm occurring again'*.[1]

## 2. Anne and the Background of this Review

2.1. Anne was a woman in her fifties when she died in 2020. She lived by herself in a ground floor council house with her two dogs. Anne's dogs were very important to her wellbeing, but she struggled to manage them. Anne had several medical problems which increasingly affected her mobility and ability to care for herself. In the last year of her life, Anne had had approximately forty-five falls. Anne also had a history of anxiety and depression. Her low self-esteem meant she found it difficult to ask for or accept help.

2.2. Anne had regular contact with Health services from Primary, Community and Acute Health agencies. She was also supported to a significant degree by her son and one of her sisters.

2.3. From December 2019, there was an emerging picture of Anne missing appointments for her health care. Her living conditions and self-care declined. This resulted in deteriorating physical health necessitating hospital in March 2020. Her son alerted services to concerns about his Mother's self-neglect and the hospital made a referral to Adult Social Care (ASC).

2.4. This hospital admission coincided with the early stages of the Coronavirus pandemic. Although there were concerns about Anne's living conditions, she was discharged home once medically fit and without an assessment by ASC. The plan was to support Anne in the community.

2.5. Anne's son had thought that ASC had arranged a package of support for her. However, Anne had told the Social Worker she did not need any support. The Social Worker provided her with information about a deep clean service and closed the referral. Neither the GP records nor the Community Health records specified concerns about self-neglect. There was no coordinated plan between Health and ASC. Housing remained unaware of any of the concerns about Anne's ability to cope.

[1] Department of Health, (updated 2020) *Care and Support Statutory Guidance Issued under the Care Act 2014* https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance *[Accessed December 2020]*

2.6. Anne's home environment and her physical condition continued to deteriorate during April 2020. Ambulance crew attended following a further fall and admitted her to hospital. They made a referral to ASC, recording pressure sores and her poor home conditions with clutter, dog urine and faeces. The Community Social Work team advised the family to liaise with the Hospital Social Work team.

2.7. Anne took her own discharge after four days. Hospital did not advice ASC of this. Community Nurses followed up with care and treatment at home.

2.8. Within a month, the ambulance service was called again following Anne having a further fall. The crew made a Safeguarding Adults referral to ASC. This described the dire conditions of Anne's flat: dog faeces; high levels of clutter; poor self-care, poor mobility, and high falls risk. The ASC Safeguarding Adults team passed this referral to the Community Social Work team who contacted Anne by phone. Anne said she did not need any support, and ASC closed the case.

2.9. The following day, a Community Nurse also made a Safeguarding Adults referral. Unfortunately, this went to an incorrect email address.

Over the course of the next few days, Community Health services continued to try and support Anne with care for her pressure damage. A Community Nurse spoke with a Social Worker about Anne's poor personal care; low mood; hoarding, with poor mobility and increased falls. The Social Worker contacted Anne to arrange an assessment.

2.10. Sadly, before this assessment was carried out, Anne's son found her unconscious and called an ambulance. Anne's legs were ulcerated, one down to the bone. She had open infected sores to her groin and there were maggots underneath her. Anne's home was covered in faeces with mouldy food and fleas. Anne did not recover consciousness and died on the day she was admitted to hospital.

2.11. Anne was tested as Covid positive when she died, and the Coroner determined that she died of natural causes with Coronavirus. However, this review has identified learning in how agencies worked together to support Anne in the final year of her life.

## 3. Summary of the Learning Points from the Review

3.1. Working with self-neglect presents practitioners with significant challenges in meeting their duty of care. Practitioners need to respect the adult's rights to make decisions about their lives. However, this needs to be balanced with taking all reasonable steps to engage the adult in care and support, as proportionate to the risks presented.

3.2. Sandwell has adopted The West Midlands Self Neglect Guidance.[2] The review found that practitioners were either not aware of the guidance or did not apply it.

[2] West Midlands Adult Self Neglect Best Practice Guidance 2018
https://www.sandwellsab.org.uk/wp-content/uploads/2018/06/WM-Self-neglect-guidance-v2.0.pdf
[Accessed December 2020]

3.3. Research has identified factors that are most successful when working with self-neglect.[3] It highlights the importance of establishing and using relationships to try and understand the root causes of self-neglecting behaviours and negotiating change.

3.4. There was good tenacity demonstrated in helping Anne to engage in anxiety management. However, there was limited evidence of trying to understand the reasons underlying her self-neglect. There were missed opportunities to try and engage her in other psychological therapies at an earlier stage to help address her low mood and lack of self-esteem. There were occasions when Anne was more open to accepting support. However, the multiple transitions between practitioners meant that these opportunities were lost.

3.5. Anne's son and sister had a very good understanding of Anne and the extent of her difficulties. Though there was some evidence of agencies engaging with them, there was limited partnership working. The family were not truly heard, involved, or supported in trying to care for Anne. Research has identified the value of Family Group Conferences[4] in Safeguarding Adults. This could have greatly improved the coordination of Anne's care and maximised use of the assets that her family could offer.

3.6. There were many examples of individual practitioners demonstrating compassionate care in trying to provide treatment for Anne's physical health problems. Whilst this was effective in addressing her presenting health needs, there was a lack of stepping back and viewing the totality of Anne's circumstances through the lens of safeguarding. There were missed opportunities by some, to make earlier referrals through Safeguarding Adults procedures.

3.7. Safeguarding adults should be founded on Making Safeguarding Personal[5], delivered through multi-agency working, with robust risk assessment and risk management. This should be evident in all responses to self-neglect, whether managed formally as Safeguarding Adults Section 42 Enquiry or through alternate routes. There was a paucity of this in agencies' interactions with Anne. Unfortunately, these are similar findings to a 2019 SAR 'Adult A'[6] indicating more needs to be done to act on learning from SAR's.

3.8. The responses to the Safeguarding Adults referrals did not meet the fundamentals of good risk assessment. There was a need to dig deeper, to look behind Anne's assertions that she did not need any help (or, in her eyes, didn't deserve any help). There was limited gathering of information from all agencies and family and no home visits. Referrals were viewed episodically without due regard to the history that signaled a deteriorating picture and significant harm.

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[3] SCIE (2014) *Self-neglect Policy and Practice*, Available from: http://www.scie.org.uk/publications/reports/69-self-neglect-policy-practice-building-an-evidence-base-for-adult-social-care/ [Accessed: December 2020]

[4] Social Care Institute for Excellence Safeguarding Adults: Mediation and Family Group Conferences 2012 https://www.scie.org.uk/publications/mediation/ [Accessed December 2020]

[5] Local Government Association: Making Safeguarding Personal https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/making-safeguarding-personal [Accessed December 2020]

[6] Sandwell Safeguarding Adult Board SAR 'Adult A' 2019, [Unpublished]

3.9. Had the concerns been managed formally as a Safeguarding Adults Section 42 Enquiry, this should have ensured a comprehensive safeguarding plan developed with Anne and her family, coordinating care and support from across Health, ASC and Housing.

## 4. Conclusion

4.1. The review has examined the sad circumstances surrounding Anne's death and how agencies responded to self-neglect.

4.2. It is pointed that Anne's sister questioned the whole premise of describing Anne as self-neglectful. Her view was that Anne would not have neglected herself, had she had the help she needed.

4.3. The Sandwell Safeguarding Adults Board does have multi-agency guidance for working with self-neglect. The evidence from this review is that agencies were either unaware of the guidance or did not follow the guidance.

4.4. Anne's final months were during the first wave of the Coronavirus pandemic. Undoubtably, this put agencies under significant pressure and may well have impacted on the care that practitioners were able to provide. However, the lessons are not new. This Safeguarding Adults Review, like many others, has reinforced the need for multi-agency working, comprehensive risk assessment and safeguarding plans developed with the person and their family. This is even more important in times of significant pressures.

4.5. Anne's son commented that it was no-one's fault that Anne died but her wellbeing and dignity in her final months could have been and should have been vastly different. The author of this review agrees.

## 5. Recommendations

The author has taken the changes and planned actions by agencies into account and made the following recommendations to strengthen multi-agency working with self-neglect.

| **Recommendations** |
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| **Recommendation 1:**<br>**Monitoring and Review: Assure use of the West Midlands Self Neglect Guidance**<br>The evidence from this SAR is that the West Midlands Self Neglect Guidance was not known or not complied with. The Sandwell Safeguarding Adults Board should design and deliver assurance activity to :<br>**i)** Evaluate front-line practitioners' knowledge of the guidance and any barriers to application.<br>**ii)** Undertake qualitative audit/appreciative inquiry of self-neglect cases that have been managed both as Safeguarding Adult S42 Enquiries and through alternative routes where S42 has not been assessed, as necessary. The audit should focus on key points of learning from this review to include:<br>• Quality of multi-agency risk assessment and risk management/safeguarding plans |

- Involvement of the adult and their families
- Consideration of mental health determinants and referral for psychological therapies where indicated
- Evaluation of improved outcomes from the ASC improvement measures (as cited in section 9 of this report)

**iii)** Use the findings to direct a programme of training and quality improvements.

**Recommendation 2:**
**Procedural Development: Development of Vulnerable Adults Risk Management Guidance (VARM)**

The SSAB should use learning from this review in the development of VARM. This provides a mechanism, under the West Midlands Self Neglect Guidance, to structure multi-agency working in circumstances where Safeguarding Adult criteria are not met. VARM should include:

i) Guidance and tools for any agency to convene and hold a multi-agency meeting
ii) Guidance and tools to offer a Family Group Conference
iii) Escalation routes where risks cannot be effectively managed

**Recommendation 3:**
**Staff Support: Consultation Panel**

The SSAB partners should establish a multi-agency panel for more complex and challenging self-neglect cases. The panel comprising senior practitioners/managers, should be solution-focused, offering practitioners consultation and guidance; levering resources as well as scrutinising/endorsing decision making in higher risk situations.
This panel should be available under the West Midlands Guidance for cases managed through VARM as well as cases managed as Safeguarding Adult enquiries.

**Recommendation 4:**
**Procedural Development: Use learning from SAR's to review and revise West Midlands Guidance**

The West Midlands Self Neglect Guidance would benefit from review and revision, building on learning from this and other SAR's related to self-neglect within the West Midlands region.
Findings from this review highlight areas that could be included in a revision:

i) Additional risk assessment tools and guidance to complement the existing guidance on hoarding
ii) Guidance on the benefits and application of Family Group Conference
iii) Setting out the inter-face between VARM (recommendation 2) and a Safeguarding Adult enquiry
iv) Incorporating reference to Consultation Panel (recommendation 3)

Sylvia Manson

Date:

Date: May 2021

## References

Care Act 2014 section 42 http://www.legislation.gov.uk/ukpga/2014/23/section/42/enacted [Accessed December 2020]

Department of Health and Social Care; Care and Support Statutory Guidance (updated June 2020) Ch14, Available from: https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance [Accessed: December 2020]

Local Government Association: Making Safeguarding Personal https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/making-safeguarding-personal [Accessed December 2020]

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## About the Reviewer

The review report was written by Sylvia Manson, of Sylman Consulting. Sylvia is a mental health social worker by background and has many years' experience in Health and Social Care senior management and commissioning. Sylvia has held regional and national roles in implementing legislation and developing safeguarding policy, including as Department of Health, lead for NHS, developing the Safeguarding Adult Principles, now incorporated into the Care Act statutory guidance.

Sylvia now works for the Mental Health Tribunal along with independent consultancy focused on partnership development, service improvement and statutory learning reviews.

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