Sandwell

Safeguarding Adults Board

Safeguarding Adults Review

‘Anne’

Overview Report

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1. Introduction

1.1 This Safeguarding Adult Review (SAR) considers the sad circumstances of Anne's death during 2020. Anne lived alone in a council flat with her two dogs. She had multiple health problems and received a high level of care and treatment from Primary, Community and Acute Health services.

1.2. During the last six months of Anne's life, there were increasing concerns about self-neglect necessitating hospital admissions and referrals to Adult Social Care. The Coroner found that Anne had died of natural causes. She had tested positive for the Coronavirus. However, Anne died in circumstances of self-neglect. Sandwell Safeguarding Adult Board (SSAB) identified that there was learning relating to how agencies worked together to support Anne to reduce levels of self-neglect that so adversely affected her wellbeing in her final months.

2. Context of Safeguarding Adults Reviews

2.1 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.

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

2.3 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]

2.4. The Department of Health's six principles for adult safeguarding should be applied across all safeguarding activity[2]. The principles apply to the review as follows:

Empowerment:	Understanding how the agencies involved Anne and applied Making Safeguarding Personal; involving Anne's family in the review.
Prevention:	The learning will be used to consider prevention of future harm to others.
Proportionality:	Understanding whether least restrictive practice was used; being proportionate in carrying out our review.
Protection:	The learning will be used to protect others from harm.
Partnership:	Partners will seek to understand how well they worked together and use learning to improve partnership working.
Accountability:	Accountability and transparency within the learning process

[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] Ibid

3 Terms of Reference and Methodology

3.1. Terms of Reference

3.1.1. The review has focused on circumstances surrounding the last year of Anne's life. This was the period where Anne's physical health showed greatest deterioration alongside concerns regarding self-neglect.

3.1.2. The specifics areas of enquiry are as follows:

Terms of Reference
1. To consider the effectiveness of responses to Anne's needs: I. What was the quality of agencies' assessments and interventions in responding to Anne's needs? II. What were the quality of risk assessments undertaken? Was the response by agencies appropriate and proportionate to the nature and degree of risk? III. What steps were taken to enable and empower Anne to improve her wellbeing and were agencies proactive in supporting her needs, proportionate to concerns presented? IV. How was Making Safeguarding Personal demonstrated in the treatment, care and support offered? V. Was there due consideration of her mental capacity including assessing capacity where indicated and in line with the Mental Capacity Act Code of Practice? VI. Were Anne's family and friends appropriately involved in the arrangements for her care? VII. How well did agencies consider equality and diversity and make reasonable adjustments accordingly?
2. To consider how effectively agencies worked together: I. How responsive were agencies to concerns raised including safeguarding concerns? II. Were there missed opportunities for an early multi agency response to reduce risks arising from self-neglect? III. Did a lack of multi-agency working delay a timely response (by single or multi-agency) to any concerns raised? IV. How effective was multi-agency working in communication, critical decision making and coordination of care? V. How did multi-agency responses to Anne benchmark against best practice in self-neglect?
3. To consider the systems in which services operated and how this supported or detracted from care provided: • Was relevant legislation, guidance, policies and procedures followed by staff involved in the process? Specifically, was SSAB guidance on self-neglect known and applied by front-line staff?

- Were policies and procedures adequate in supporting staff to provide effective care and support?
- Were there any organisation or wider systems factors that impacted on providing effective response to Anne (for example, organisational structural changes; staff capacity; access to adequate resources; impact of Covid 19 pandemic)
- How well has learning from previous SAR's relating to self-neglect been applied to practice?

3.2. Methodology

3.2.1 The methodology applied for this SAR combined narrative reports and chronologies from each agency with learning events. The learning events brought together frontline practitioners from the agencies to draw out learning from their perspective and tested findings with managers.

3.2.2. Understanding the experiences of those receiving support from agencies is central to learning. The involvement of Anne's son and her sister has greatly added to our understanding of Anne. The independent author and SSAB is grateful to them for their contribution to this SAR. A pseudonym, chosen by Anne's sister has been used to protect Anne's privacy and dignity. Dates have also been deliberately generalised to maintain confidentiality.

3.2.3. The role of the contributing agencies is outlined in the table below:

Participating Agencies and Context of Involvement	
Clinical Commissioning Group and Anne's General Practice	Anne was registered with the GP Practice and received support from GPs and Practice Nurse
Black Country NHS Healthcare Trust	Anne was referred to Sandwell Healthy Minds psychological therapies the month that she died.
Sandwell Metropolitan Borough Council: (SMBC) Housing	Anne lived in a SMBC property.
Sandwell Metropolitan Borough Council: Adult Social Care (SMBC -ASC)	ASC were involved with Anne through their Hospital and Community Social Work Teams and through their Adult Safeguarding team
Sandwell and West Birmingham NHS Trust (SWBT)	Providers of community and inpatient physical health services. Anne received inpatient care as well as services from Community Nursing, therapies and specialist outpatient clinics
West Midlands Ambulance Service (WMAS)	Attended Anne following emergency calls and referred Anne to Adult Social for care and support and safeguarding.

- ## Structure of the report

3.2.4. The report is structured as follows:

- Section 4 provides an insight into Anne and her background.
- Section 5 provides a summarised chronology of agency involvement in the final year of Anne's life.
- Section 6 offers analysis and learning.
- Section 7 provides a conclusion.
- Section 8 outlines changes made by agencies and their plans for improvement.
- Section 9 makes recommendations for the SSAB and its constituent agencies.

4. Anne and the Background for this Review

4.1. Anne was a woman of white British ethnicity who was in her fifties when she died. Anne lived by herself with her two dogs who were very important to her. She had three sisters but had greatest support from one of them. Anne also had a close relationship with her son who provided care to her. Anne told practitioners she hid her feelings from her son, wanting to protect him from her problems.

4.2. Anne's son and sister gave some insights into her life. Her son described Anne as being very funny and with fabulous taste in music. Anne had trained as a nurse and had worked in general and mental health care. She was very caring and kind but sadly, she would not always extend this kindness to herself. She had low self-esteem and did not feel she merited being helped. She found it difficult to ask for support and this became increasingly hard for her as she became more reliant on others. Her sister described her as always having been clean and tidy until her health limited her ability. Anne was independent and could be stubborn.

4.3. Anne had many chronic health problems including cardiac problems, osteomyelitis, and a degenerative spine condition; type 2 diabetes mellitus, obesity, poor mobility including falls, diabetes related lower limb wounds. Her health needs brought her into a lot of contact with many health professionals. She had had Occupational Therapist's (OT) involved since 2013, helping with mobility aids and adaptions but continued to have a high number of falls.

4.4. Historically, Anne had also been diagnosed with urosepsis. She blamed a previous GP for this due to failing to treat a urinary tract infection. Anne had a lack of confidence in GPs as a result.

4.5. Anne talked of poor memory following general anaesthesia during heart surgery. Her son noted an increase in areas such as forgetting appointments and forgetting to top up her electricity and gas. However, a memory assessment carried out in 2020 indicated her memory function was normal.

4.6. Anne had a history of anxiety and depression (which may also impact on memory). She was struggling to come to terms with the death of her father in 2017 and was also coping with her mother's recent diagnosis of cancer. Anne talked to professionals about having difficulty letting her emotions out. She attributed her anxiety to her past relationship with her ex-husband who had been physically and emotionally abusive toward her. This relationship ended in 2006 and Anne moved into her own SMBC tenancy.

4.7. Although her tenancy was a ground floor flat, the small entry step and narrow hallway caused her increasing access difficulties as her mobility reduced, particularly in the last year of her life. She became more isolated and lost contact with friends.

4.8. Anne channelled her caring nature into her dogs. Unfortunately, the dogs had never been house trained and the flat was covered in puppy training pads. As Anne's mobility reduced, she went out less and the dogs mess became more and more problematic. She had increasing low mood and low self-esteem. Her son believes the dire condition of Anne's property simply became the norm for her. However, she was also very embarrassed about her home. Her son believes this was why Anne resisted his offer of paying for dog walkers and why she gradually stopped having friends around.

4.9. Anne was adamant that she would not allow the dogs to be rehomed. Her son and sister were worried that if they persisted with this issue, Anne may shut them out and matters would become worse. Anne locked the dogs in her bedroom to try and contain the mess. She slept in a chair in her living room, increasing the risk of pressure damage. Eventually, her son sought help through the RSPCA to remove the dogs, but no enforcement action had been taken by the time Anne died.

4.10. Anne's physical health had significantly deteriorated in the last year of her life. She had more than forty-five falls. Anne had a high level of involvement from Health services, including visits to her at home. Social Care and Housing were also involved.

4.11. From December 2019, there was an emerging picture of Anne disengaging from treatment. In the months that followed, Anne's living conditions deteriorated, and her increasing self-neglect necessitated admission to hospital. This was the early stages of the Coronavirus pandemic. The plan had been to support Anne in the community.

4.12. Six weeks later, Anne's son found her unconscious and unresponsive at home. The ambulance crew that attended, described Anne's property as being in an alarming condition and Anne was in an extremely poor state. Sadly, Anne died on the day she was admitted to hospital.

4.13. Anne was Covid positive when she died, and the Coroner's finding was that she died of natural causes. This SAR explores how well agencies supported Anne's well-being in the months preceding her death, particularly in relation to her wellbeing and risks associated with self-neglect.

5. Involvement of Agencies: Summary of Events

5.1. In **June 2019** Anne attended the mobility clinic due to multiple falls. She was referred for an OT assessment. The plan was also to refer Anne for counselling as she was struggling to come to terms with her father's death but Anne did not want to access this via her GP.

5.2. Anne was also seen by a physiotherapist. They talked through her history of falls and her personal circumstances. The physio encouraged Anne to talk with her GP. Anne declined but did consent to a referral for anxiety and depression. There is no further record of this referral.

5.3. Anne had been attending orthotics out- patient clinic for a wound to her toe and from **July 2019**, attended appointments with the chiropodist. In **September 2019**, the anxiety management clinic wrote to Anne as she had missed her first appointment. An OT made several attempts to contact Anne to offer help to attend. In **October 2019,** the OT successfully made contact and Anne began attending the weekly anxiety management group.

5.4. During October, Anne also attended her GP Practice for diabetic eye screening and a cardiac clinic. She had further appointments with the chiropodist and continence service in **November 2019** but then missed a further appointment for diabetic eye screening at the GP Practice.

5.5. Anne was seen at the hospital in **December 2019** due to a raised INR.[3] Doctors wanted to admit her, but Anne declined as she wanted to go home to feed her dogs. Risks were explained. Anne said she would return the next day for repeat tests. She did not follow this through. This information was not shared with Anne's GP.

5.6. Anne missed her diabetic eye screening at the GP Practice the following week and did not attend the musculoskeletal clinic. Anne did contact Housing to report a problem with her blocked toilet which was repaired the same day.

5.7. At the end of **January 2020**, the OT contacted Anne. Anne was feeling anxious and the OT referred her to Integrated Care Services (ICares), a care management service for adults with long term conditions. During this period, Anne was also contacted by the Housing Pest Control service due to potential infestation within Anne's housing block and bags of rubbish outside of her property.

5.8. In **February 2020**, the OT tried to contact Anne again by letter and left phone messages but got no response. Anne also missed her physio-therapy appointment.

5.9. Anne attended the Emergency Department (ED) in **March 2020**. She had skin loss to her heel and toe and her legs were red. She told staff that she had had chronic ulcers for the last year but did not like attending her GP. Anne was advised about care and the risk of amputation. Staff urged her to attend her GP and Community Nurse (CN).

5.10. Anne did visit the GP Practice four days later and was seen by the Practice Nurse. Anne had the same dressing from her ED attendance. The wound was leaking and Anne had taped a puppy training pad over it. She had not self-administered insulin for a week. Anne was admitted to hospital due to cellulitis and ulcers to her leg and feet. This period coincided with the early stages of the Covid pandemic when agencies were preparing for this national emergency.

5.11. Anne was in hospital for fifteen days. Anne's son raised concerns about her self-neglect and the hospital referred Anne to Adult Social Care (ASC). A social worker (SW) did not see her directly but arranged for minor adaptation works and equipment. The SW also spoke with Anne's sister and son. He was concerned about his mum's living conditions and her self-neglect. Anne had also told a ward nurse that she was worried about how she would cope.

[3] A high (or raised) INR means that the blood is taking longer to clot outside the body.

5.12. Anne was medically fit for discharge and had tested negative for Covid. The SW spoke with the Complex Discharge Coordinator. The summary being:

- Anne's house was dirty, but this was a long-standing problem
- Her toilet was blocked and it was not clear if this had been resolved
- Anne had no known mental health conditions

5.13. The Complex Discharge Coordinator felt that given the current level of strain on the NHS (due to Covid), Anne should go home, and community services could manage the situation. Anne had agreed to this and her sister was informed. Family had agreed to contact Housing about repairs to the toilet.

5.14. Anne was discharged in **March 2020**. This was the beginning of a national Covid lockdown**.** The SW spoke with Anne by phone. She agreed to her house being deep cleaned but said she did not require any further support. The SW arranged for a quote and then ended their involvement.

5.15. There was a one-week delay after Anne's discharge before CNs received a referral asking for visits to treat her ulcerated legs. This was early **April 2020**. When CNs visited, Anne had already attended the foot clinic that day. As she was mobile, the CN advised her to attend the GP practice nurse. Anne's sister took her to the GP Practice Nurse for wound dressing. Anne also contacted SMBC to repair her toilet again.

5.16. Two days later, Anne's son found her on the floor and called an ambulance. Her son had believed that ASC had provided Anne with a package of care. Ambulance crew recorded Anne's pressure sores and her poor home conditions with clutter, dog urine and faeces. Anne was conveyed to hospital and admitted to critical care due to multiple health problems. WMAS made a referral to ASC (The WMAS recorded this as a Safeguarding Adult referral but the referral went to the ASC Community SW team).

5.17. On receipt of the referral, a SW contacted Anne's sister and learned that Anne had been admitted to hospital. Anne's sister reported that Anne had acknowledged that she needed support. The SW discussed progress with the deep clean. The cleaning company was not operating during Covid. Anne's sister had tried to sort the flat out, but the cleaning was beyond them. She asked if Anne could have temporary accommodation. Anne's sister was advised to discuss this with the Hospital Discharge team.

5.18. During the admission, Anne's son recalls that a Cardiac Consultant spoke to Anne about the risks to her from Covid. Anne's understanding of this was that she would not be treatable. This upset her greatly, interpreting this as she was not worth saving. Anne was also seen by the Tissue Viability Nurses who felt she would need a package of support on discharge. A Physiotherapist assessed her as being back at her baseline and recorded that Anne had no concerns about returning home.

5.19. Four days after her admission, Anne self-discharged against medical advice. Risks of this action were explained to her. She was assessed as having capacity, was aware of signs and symptoms and had follow up appointments. ASC were not informed of her self-discharge.

5.20. Anne contacted SMBC Housing the day after her discharge to report her toilet was blocked again. Housing maintenance established the drain run had collapsed – and attended the house on two further occasions before resolving the issue at the end of April.

5.21. Anne was followed up at home by CNs to treat her legs and feet. CNs also completed a memory assessment which indicated her memory function was normal.

• Anne's Last Three Weeks

5.22. The foot clinic visited Anne at home during April and into **May 2020**. Their records note the dogs were barking in her bedroom and her hall being cluttered. CNs also continued their visits, to treat her legs. At one visit in early May, Anne talked to the CN about having difficulty keeping on top of things. The CN recorded that her home was cluttered. Another CNs record referenced dog faeces and urine. Anne told the nurse she could not afford a cleaner and had declined help by ASC.

5.23. In mid-May, Anne's son called for an ambulance. She had fallen again and been on the floor for several hours before managing to call him. The ambulance crew noted Anne's cellulitis and infected wound. They advised admission to hospital but Anne declined and was assessed to have capacity.

5.24. The ambulance crew made a Safeguarding Adult referral to ASC with her consent. It described Anne's poor mobility due to swollen legs. Her property was unsafe with high levels of clutter. She was at high risk of falls and had no Care Line. It documented the dog faeces in rooms as Anne struggled to clean up after the dogs. Her personal care was described as poor. Ambulance crew took photos of her property. The referral highlighted that Anne lived alone and had no care package.

5.25. The referral was viewed the following day by the ASC Safeguarding team who passed it to the Community SW team. A SW phoned Anne to arrange an assessment. Anne declined support around her personal care. The assessment was not completed as it was viewed that the issues related to cleaning and that this could be addressed by Anne. The case was closed.

5.26. CNs visited Anne the next day. There were dog faeces in the hall. Anne was upset and told the nurse she had fallen and been on the floor for several hours. The CN made an incident report for a grade 3 pressure sore. The CN also made a Safeguarding Adult referral to ASC. However, it was sent through an incorrect email address and was not received. The CN also referred Anne via the GP to Sandwell Healthy Minds, a mental health wellbeing counselling service. The referral contained no information about risk. On receipt, the counselling service tried to ring Anne but got no answer so left a message, asking Anne to ring to book a telephone assessment appointment.

5.27. An OT called the next day and noted the cluttered environment. Anne was embarrassed that she was unable to cope with her property. She was not using the pressure care mattress that had been ordered for her and said she preferred to use her own bed. The OT ordered a riser recliner chair. The OT made referrals to ASC for a package of care, to a hoarding support service and to an anxiety management group.

5.28. The following day, CNs visited but Anne could not answer the door as she was stuck in her chair. She strongly declined an ambulance and did not allow the CN to ring her son on her behalf, despite the CN emphasising the risks of sitting in her chair. The CN repeatedly phoned Anne back during the day to check her well-being and confirmed her son had helped her out of the chair. The CN visited, intending to fit the pressure mattress but could not access Anne's bedroom due to her dogs (one having previously bitten her). The CN dressed Anne's wounds and discussed risks of sleeping in a chair. CNs increased their visits to alternate days.

5.29. The CN had also spoken with a SW to discuss their concerns – personal care; low mood; hoarding with poor mobility and increased falls. The SW phoned Anne the same day to discuss an assessment and to refer her to the Fire Service.

5.30. Two days later, Anne's son found her unconscious and called an ambulance. Anne's legs were ulcerated, one down to the bone. Her groin was red with open sores and she had a deep open infected wound to her heel. There were maggots underneath her. The crew noted human and animal faeces all over the floor, clutter everywhere and Anne's clothing was extremely dirty. There were fleas in the property and mouldy food everywhere. Anne was conveyed to hospital. The hospital and ambulance service completed Safeguarding Adult referrals to ASC. On receipt, ASC informed the referrer that the case was closed to the Safeguarding Adult team but that the Hospital SW team would be tracking discharge.

5.31. Sadly, Anne remained unresponsive. She died in hospital the next day.

6. Analysis and Learning

6.1. Context

6.1.1. Working with self-neglect is widely recognised as a complex and challenging area for practitioners. A recent review of SARs in England occurring between 2017 - 2019[4] highlighted that self-neglect was the most common type of abuse or neglect that had led to the SAR being held, accounting for 45% of all reviews.

6.1.2. Making Safeguarding Personal[5] (MSP) recognises individuals' rights to self-determine how they live their lives. Safeguarding interventions need to be person centred and guided by the adult toward the outcomes they want. MSP can be challenging to achieve where a capacitous adult's resistance to care leaves them at high risk from self-neglect. Duty of care means taking all reasonable and proportionate steps to manage presenting risks. This is reiterated in policy:

> *'Making Safeguarding Personal does not mean 'walking away' if a person declines safeguarding support and/or a S42 enquiry. That is not the end of the matter. Empowerment must be balanced for example, with Duty of Care and the principles of the Human Rights Act*

[4] Local Government Association: Analysis of Safeguarding Adult Review April 2017- March 2019; October 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]

(1998) and of the Mental Capacity Act (2005). People must not simply be abandoned in situations where, for example, there is significant risk and support is declined and/or coercion is a factor.'

ADASS Advice Note 2019[6]

6.1.3. The Care Act 2014 sets out duties on the Local Authority for needs assessment (section 9) and to make Safeguarding Adult enquiries (section 42). The statutory guidance does reference self-neglect as a type of abuse but guides that duties to make Safeguarding enquiries need to be made on a case-by-case basis.

6.1.4. SSAB adopts the Pan West Midlands Self-Neglect best practice guidance.[7] The guidance highlights the need to understand the person's unique circumstances and take a person-centred approach to engage the person. It specifies that merely accepting self-neglect as a lifestyle choice is not an acceptable solution. The guidance highlights:

'Where the risks to the person are high/serious, the case should not be closed simply because the person refuses an assessment or to accept a plan to minimise the risks associated with the specific behaviour(s) causing concern'

6.1.5. Research has highlighted factors that are most successful in working with self-neglect.[8] These are summarised in the table below:

Practice Factors Most Successful in Self Neglect
1. Time to build rapport and a relationship of trust, through persistence, patience and continuity of involvement
2. Trying to 'find' the whole person and to understand the meaning of their self-neglect in the context of their life history
3. Working at the individual's pace, but spotting moments of motivation that could facilitate change, even if the steps towards it were small
4. Creative and flexible interventions, including family members and community resources where appropriate
5. Understanding the nature of the individual's mental capacity in respect of self-care decisions
6. Having an in-depth understanding of legal mandates providing options for intervention
7. Being honest, open and transparent about risks and options

[6] ADASS Advice Note: A Framework for Decisions on the Duty to Carry Out Safeguarding Adult Enquiries July 2019 https://www.adass.org.uk/media/7326/adass-advice-note.pdf [Accessed November 2020]

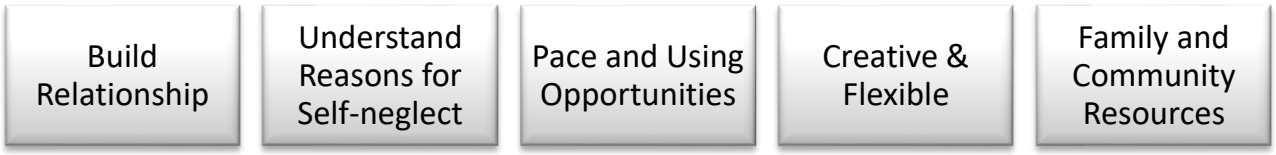
[7] West Midlands Adult Self-Neglect Best Practice Guidance 2018 https://www.sandwellsab.org.uk/wp-content/uploads/2018/06/WM-Self-neglect-guidance-v2.0.pdf [Accessed December 2020]

[8] Ibid.

8. Effective multi-agency working to ensure inter-disciplinary and specialist perspectives, and coordination of work towards shared goals

6.1.6. This review considers how well these best practice factors were applied in agencies' responses to Anne.

6.2. Building and Using Relationships



6.2.1. Anne had multiple interactions with many different services. There were some good examples of using relationships to help Anne access care and treatment. However, there was limited evidence of using relationships purposefully to understand and address self-neglect.

6.2.2. Unfortunately, Anne had fixed views about GP's due to a historic negative experience. This presented a barrier to developing a relationship with her GP. The Practice Nurse had a good rapport with Anne and used this to help reduce her anxiety about accessing treatment. Anne's sister described the nurse's efforts as '*fabulous*.' This relationship was important to utilise. As discussed in the following section, there was a lack of a coordinated plan where this relationship could have been mobilised to address Anne's self-neglect.

6.2.3. There were many different CNs involved with Anne. Although these relationships were not consistent, there were good examples of engaging Anne with care and compassion to encourage her to accept healthcare. The responses by CNs in the last month of Anne's life were good examples of this. Attendees at the practitioner's learning event identified that a key worker system for patients with greater vulnerabilities would improve engagement and holistic care.

6.2.4. There were some other examples of holistic practice. This could be seen in 2019 with the mobility clinic and physiotherapist taking time to talk with Anne about her background and the impact of domestic abuse, discussing counselling and anxiety management with her. However, there is no record that a referral for counselling or cognitive behavioural therapy was followed through at that time. The efficacy of these psychological treatments for depressive disorders is well evidenced.[9] Anne had been on anti-depressants long-term and referral for psychological therapies was indicated.[10] This may well have helped Anne address her chronic sense of low self-worth, in turn, improving her motivation regarding her living conditions. Exploring underlying mental health needs and using the resources of Primary Care based psychological therapies needs to be at the forefront of practitioners thinking when working with self-neglect.

[Recommendation 1]

[9] NHS The Improving Access to Psychological Therapies Manual 2018 https://www.rcpsych.ac.uk/docs/default-source/improving-care/nccmh/iapt/the-iapt-manual--final--republished-7-3-18.pdf?sfvrsn=a192d1af_0 [Accessed January 2021]
[10] National Institute for Health and Care Excellence: 2009 Depression in adults: Recognition and Management https://www.nice.org.uk/guidance/cg90 [Accessed February 2021]

6.2.5. Services appeared to be working on the basis that Anne was declining to attend appointments. However, information given by the family suggests other possible reasons. Like many people with multiple vulnerabilities, Anne was in a lot of debt. She had an aversion to answering the phone due to the debt collectors and nuisance callers and screened out unfamiliar numbers. As noted, Anne also described herself as having poor memory, albeit that a subsequent memory assessment indicated her memory function was normal. Clearly it is important to identify any additional communication needs in order to make reasonable adjustments in line with the Equality Act 2010. The records do indicate extensive efforts by the OT to engage Anne in anxiety management in 2019 and followed up in 2020. This tenacious approach was good practice.

6.2.6. SMBC Housing referenced that Anne may have benefitted from floating support. This service is designed to support people in vulnerable situations, including people with physical and mental health needs. Floating support had the potential to build a relationship with Anne and help within her home as well as accessing health care. This would also have been an opportunity to review the suitability of her flat given her increasing mobility needs and the fact that she had had approximately forty-five falls in the last year. However, Housing had no information that would have triggered this referral.

6.2.7. Housing's sole involvement was attending to fix her toilet on multiple occasions. The was caused by a collapsed drain, but Anne was anxious that the maintenance engineers would think she had caused it by flushing pads down. Anne had avoided reporting the blockage and stopped using the toilet, resorting to using puppy training pads instead. This was humiliating for her and she hid it from her family. It was many months before she disclosed this and the blockage was reported to Housing.

6.2.8. ASC rightly focuses on enablement and supporting people toward independence. However, when working with self-neglect, the pace of change can be slow and is reliant on building trusting relationships over time. Attendees at the learning event recognised that the structure of ASC services worked against SWs achieving this. The chronology demonstrates a lack of consistent SWs with repeated transitions between different parts of ASC – Safeguarding Adult services, Community Social Work teams and Hospital Social Work teams. The author of the ASC report referenced the adverse impact this had on continuity and personalised care. No SW had face-to-face contact with Anne.

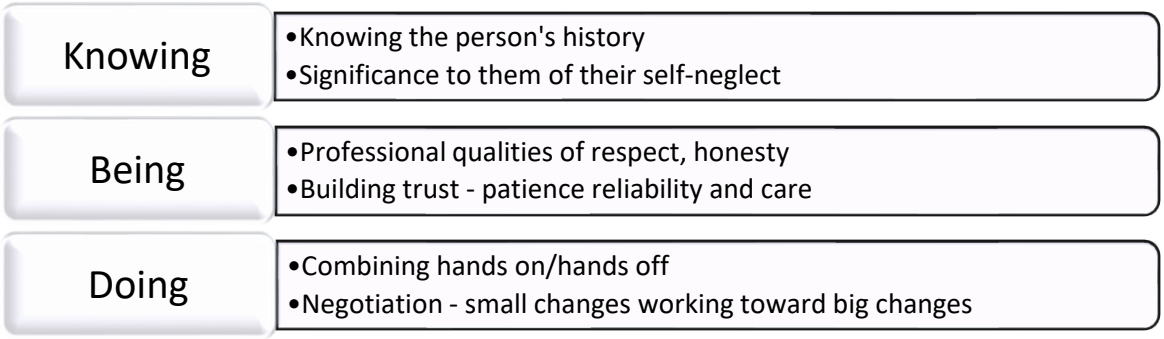
6.2.9. The absence of a sustained relationship meant there was no real understanding of Anne; the reasons for her self-neglect and what would motivate change. Assessment needed to explore if there was a psychological basis for her behaviour and whether it was an inability or unwillingness to care for herself. Self-neglect is multi-factorial. Offering a deep clean may have been of some help (although it transpired it was not available at the time). However, of itself, it was unlikely to lead to lasting improvement.

6.2.10. Anne's son described how important it was for workers to build a relationship with his mum, but she had no consistency. Whenever anyone got in touch with her, she would have to start again. Her son believed she needed workers to engage with her, have conversations rather than what seemed to him to be a tick box exercise.

6.2.11. The lack of continuity also meant professionals were not positioned to capitalise on opportunities when Anne may have been more amenable to accepting support. Nor did they take time to look behind the superficial presentation and her assertions of coping.

6.2.12. There were occasions when Anne had acknowledged she was not coping. Her son described that it would have taken a lot for Anne to admit she needed help. Family recalled Anne's admission in March 2020 and her dread at the prospect of returning to her flat. However, she did not believe she deserved anything better. When asked, the hospital record was that she was willing to go home and did not need support.

6.2.13. The West Midlands procedures refer to the skills of 'knowing, being and doing.'



6.2.14. Parts of these skills and values were evidenced by individual practitioners but this was not sustained or purposeful in relation to addressing all aspects of her self-neglect.

6.2.15. Anne's family understood her and the conditions she was living in. Their knowledge and potential to contribute to a care plan were not sufficiently tapped into. The author of the SWBT report highlighted that neither hospital or community staff discussed with Anne or gained her consent to involve family for support.

6.2.16. There was some evidence of SWs talking with Anne's family and negotiating areas they could support her with. However, the ASC author felt that this did not amount to expected practice of consultation and inclusion. Their view was supported by Anne's family. From the one contact her son had, he was left with the impression that all was in hand but then nothing happened. He felt his concerns were not taken seriously. Anne's sister had more contact with ASC, but once Anne was discharged from hospital, she never spoke to the same person and was not aware of any care plan.

6.2.17. Research has highlighted the value that Family Group Conferences can bring in Safeguarding Adult work.[11] Anne's family had insights into her behaviours and vulnerabilities and were trying their best to support her in difficult circumstances. However, they were not aware of what help she was being offered or accepting from agencies. They may have been able to influence her and would have funded support such as the deep clean. A Family Group Conference would have helped draw

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

out these different perspectives and developed a meaningful shared plan, combining the strengths and assets of Anne, her family, and professionals.
[Recommendation 2 and 4]

6.3. Multi-Agency Responses and Managing Risk within Legal Frameworks

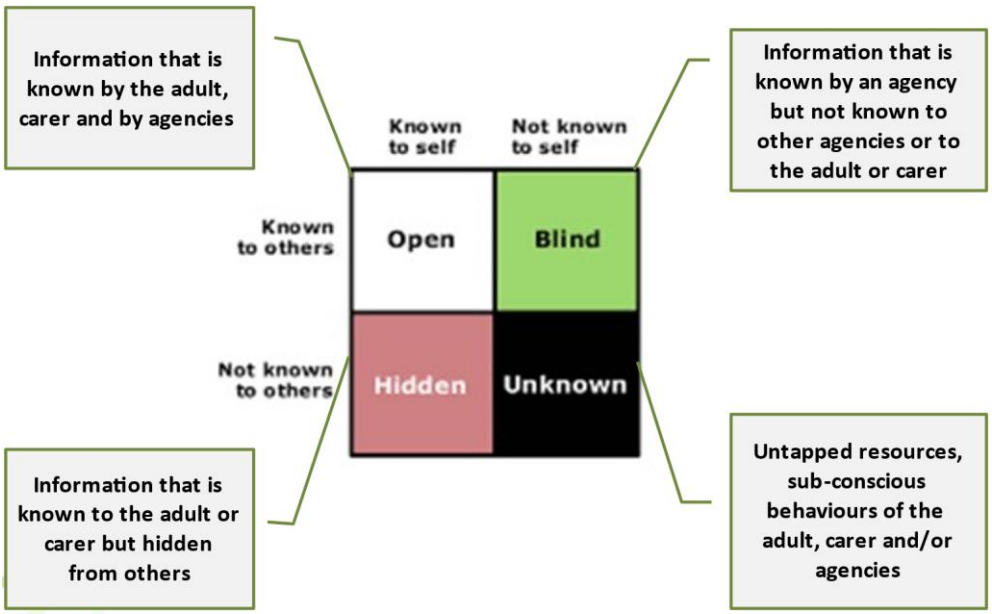
- ### Multi-agency Working and Managing Risk

6.3.1. Safeguarding, (whether under Care Act section 42 or earlier preventative intervention) should be founded on Making Safeguarding Personal, characterised by robust multi-agency risk assessment and coordinated care planning to manage those risks. Lack of effective multi-agency working is a recurring theme nationally in SARs.[12] This was also a finding in a 2019 Sandwell SAR of self-neglect, 'Adult A'.[13] The 'Adult A' SAR also highlighed concerns about the quality of assessments and application of the Safeguarding Adult pathway.

6.3.2. Unfortunately, these concerns were also evident in agencies' responses to Anne. At no time was there a multi-agency meeting.
[Recommendation 1]

6.3.3. Information held by different parts of the system was not brought together to give a fuller picture of Anne's situation. The 'Johari Window' effect was discussed at the practitioner's learning event i.e.; individual agencies and family members being blinded to the whole picture. [14]

[12] 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), pp.219-234. https://uobrep.openrepository.com/handle/10547/623309 [Accessed January 2021]
[13] Sandwell Safeguarding Adult Board: Safeguarding Adult Review 'Adult A' 2019 [unpublished]
[14] A psychological model first created by Joseph Luft and Harry Ingham in 1955, adapted by the author to apply in Safeguarding Adults



6.3.4. As one attendee commented when reviewing events in Anne's final year, '*If only I'd known all of this*.'

6.3.5. There were missed opportunities for early multi-agency intervention from December 2019 when Anne began to miss health appointments and her self-care and living conditions deteriorated. The review tried to understand the reasons for these missed opportunities, particularly for agencies that were going into Anne's home.

6.3.6. SMBC Housing, clarified that Covid restrictions meant that their maintenance staff would not have seen Anne's main living area. Housing confirmed that maintenance staff had been trained in Safeguarding Adults and would have escalated any concerns had they viewed anything of concern. As was the case in SAR 'Adult A', no agency sought information from Housing nor shared information about concerns of self-neglect.

6.3.7. As outlined in section 6.2, health professionals worked hard to try and meet Anne's health needs and there was evidence of good practice within this. However, for many interactions, the focus appeared to be on the presenting problem rather than stepping back to view the totality of Anne's circumstances through the lens of safeguarding. Had this occurred, Anne's self-neglecting behaviours may have been recognised at an earlier stage. The author of the GP report for this review highlighted that GP practice staff were not aware of the process to refer to ASC or of the West Midlands Self-Neglect Guidance.
[Recommendation 1]

6.3.8. Throughout the review scope period, there was an absence of risk assessment to identify emerging concerns as well as to identify when a Safeguarding Adult referral was warranted. A well formulated risk assessment should establish:

1. Nature and Severity:
    I. Defining/quantifying the conditions of self-neglect (including the adult's perspective)
    II. Describing potential harm arising (and the adult's view of their risks)
2. Likelihood:
    I. Historic and current failure/inability to meet care needs or declining services
    II. Capabilities and assets – of the adult; their family/carer; community and agencies

6.3.9. The absence of a risk assessment meant there was no shared understanding of concerns between the agencies or clarity about the actions that should be taken. The West Midlands guidance does provide tools to help practitioners quantify risks from hoarding but there is limited guidance on risk assessment in other aspects of self-neglect.

[Recommendation 4]

6.3.10. During Anne's admission to hospital in March 2020, her self-neglect was recognised. It may have been a reasonable and proportionate response at that time to address the concerns through other routes than a formal Safeguarding Adult section 42 enquiry:

> *'Raising a safeguarding concern – this should happen when all reasonable attempts have been made to assess and engage the person in meeting their health and social care needs and there is a risk to their independence, health and welfare and/or that of others.'*
> West Midlands Self Neglect Guidance 9.2.

6.3.11. However, this still required multi-agency working with robust assessment (including well formulated risk assessment), leading into a care and support plan to manage the risks. This was not in place.

6.3.12. Anne was discharged without any formal assessment by ASC and the SW had no face-to-face contact with her. The discharge plan relied on one visit to Anne in hospital by the Complex Discharge team. There was no coordination between the key parties: Anne; her family; ASC; Primary Care; Community Nurses and Housing. There was no contingency plan. It must be acknowledged that agencies were coping with significant pressures at the time due to the Covid pandemic. Nonetheless, this was a missed opportunity.

6.3.13. Attendees at the learning event reflected on the lack of culture and systems to support multi-agency working outside of Safeguarding Adult procedures.

6.3.14. Multi-agency working should be the default position at the earliest point of emerging concerns about self-neglect. This is set out within the West Midlands Guidance. Any agency should be able to convene a multi-agency meeting and partnership working should be part of every practitioner's skill set. However, there are limited structures and mechanisms outside of Safeguarding Adult enquiries to support this in Sandwell.

6.3.15. At the time of the review, the SSAB was developing a Vulnerable Adult Risk Management (VARM) process. This is a framework to facilitate effective working with vulnerable adults who are at risk of significant harm but where criteria for a Safeguarding Adults section 42 enquiry may not be met.

6.3.16. The VARM could provide a framework (under the West Midlands Guidance) to convene a multi-agency meeting with model agendas; risk pro-formas; intervention plans etc. Family Group Conferences (outlined in 6.2.17. above), could also operate within this. Attendees at the learning event also voiced the value of a panel to consult with in challenging and higher risk cases. Such panels have proved positive in other areas.[15] These are solution focused panels of senior practitioners/managers, providing consultation and guidance, with the ability to access resources and endorse decisions making in more complex situations.
[Recommendation 2 and 3]

6.3.17. The development of the VARM offers a timely opportunity to use learning from this review to strengthen multi-agency processes outside of Safeguarding Adult criteria. This is also an opportunity to maximise new ways of working that have developed during the Covid pandemic. The on-line platforms that have been utilised, make meetings and panels easier to convene, with more effective use of time. This needs to be harnessed to shift the culture toward improved multi-agency working.

6.3.18. Following the self-neglect concerns being raised in March, it would be reasonable to expect Primary and Community Health services to be vigilant to further signs of neglect. However, there is no evidence that risks of self-neglect were flagged in Anne's clinical records and had not been highlighted in her Hospital Discharge Summary.

6.3.19. Photographs of Anne's property provided by her son, demonstrate the dire circumstances she was living in at that time. In relation to the clutter, this was equivalent to Level 6 on the West Midlands guidance 'clutter image rating scales.'[16] However, the conditions were made much worse by the nature of the clutter i.e. dog urine and faeces strewn across the floor and on the walls. It was striking that WMAS was the only agency to make onward referral to ASC during April 2020, despite the continuing evidence of Anne's unkempt living conditions and poor health associated with neglect. WMAS informed the hospital they had made a Safeguarding Adult referral, but it was an omission that other Community Health services had not also escalated concerns through Safeguarding Adult procedures. This reinforces the need to use risk assessment guidance to reduce the subjective nature of assessing a person's self-neglect.
[Recommendation 4]

6.3.20. Anne taking her own discharge from the hospital admission in April 2020 was a further missed opportunity to notify ASC and trigger multi-agency risk assessment and care planning. Had this notification been made, this *should,* according to the guidance, have led to a Safeguarding Adult enquiry under Care Act section 42.

6.3.21. During May 2020, a CN did make a Safeguarding Adult referral. It is unfortunate that this was sent to an incorrect email address. The CN's concerns were not recorded within the Primary Care records as self-neglect. The subsequent referral from the GP to Sandwell Healthy Minds for

[15] Established in some areas as 'Community MARAC' https://empowering-communities.org/2018/07/12/community-maracs-sharing-and-solving-complex-risk/
[16] Appendix 5, 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]

counselling did not describe any self-neglect and stated 'no' to risk. This meant she was not offered a face-to-face assessment which would be more able to identify mental health needs.

6.3.22. The Safeguarding Adult referral made by WMAS in May 2020 had Anne's consent and was good practice. It defined the severity of Anne's situation and described the harm arising. The photos of her property quantified the concerns. It is concerning (and contrary to guidance), that despite this escalating picture, this Safeguarding Adult referral was not progressed by ASC through the Safeguarding Adult pathway.

6.3.23. The response by ASC at that time did not meet the fundamentals of a good risk assessment. Despite learning from SAR 'Adult A' ('*Telephone contacts with Adult A relied on self-report of the support he required,'*[17]*),* telephone contacts were again relied upon. The West Midlands guidance also emphasises the importance of home visits and not relying on proxy reports wherever possible. The ASC author acknowledged the constraints of Covid at that time but confirmed the restrictions still allowed for home visits and that a SW should have visited Anne at home with a CN. Anne's son recalled thinking that if he could just get someone to see the flat then it would be ok.

6.2.24. There was also limited gathering of information from key agencies such as Housing; GP and Community Health, and as noted, limited involvement of family. There was no evaluation of potential harm to Anne's health or of fire hazard, despite the vulnerability factors arising from clutter and high risk of falls. Nor did the assessment weigh the likelihood of Anne's situation improving without intervention. The ASC author referenced an episodic approach that did not take due account of Anne's recent history of self-neglect. This would have indicated she was not likely to cope or resolve matters without significant support.

6.3.25. This concerning picture is compounded in Anne's final admission to hospital, the day before she died. Hospital and WMAS both made Safeguarding Adult referrals. The description of Anne's condition resulting from self-neglect was vivid, but ASC continued to divert the referrals away from being managed as a section 42 enquiry. The ASC author commented:
'*The referrals highlighted significant and persistent concerns being raised which should have been progressed through the safeguarding pathway. This would have enabled a more robust multi agency approach to be applied.'*
[Recommendation 1]

6.3.26. Had the self-neglect concerns been managed as a Safeguarding Adult enquiry at an earlier stage, this should have brought the system together to assess and coordinate support for Anne, working with her and her family. In the absence of this, there was a piecemeal approach to her needs.

6.3.27. Agencies were under significant pressures due to the Covid pandemic and trying to adapt to new ways of working in unprecedented emergency conditions. Attendees at the learning event recalled the uncertainty and anxiety this provoked. The review acknowledges that agencies were grappling with new systems and without the guidance that became available during the later stages of the pandemic.[18] This undoubtably would impact on the services that agencies were able to provide.

[17] Sandwell Safeguarding Adult Board: Safeguarding Adult Review 'Adult A' 2019 [unpublished]
[18] Social Care Institute for Excellence: Risk identification and virtual interventions for social workers November 2020 Risk identification and virtual interventions for social workers | SCIE [Accessed December 2020]

However, as noted, the lessons about multi-agency working are not new.[19]Restrictions did not prevent multi-agency meetings occurring (albeit virtually) nor did it change the fundamentals of good risk assessment. Coordinated care becomes even more important in challenging times.

6.3.28. The ASC author called for improved supervision and managerial oversight of cases involving self-neglect. Proposed improvements are outlined in section 8.

- ## Mental Capacity and other Legal Mandates

6.3.29. Anne's son found it difficult to understand how in those last weeks, professionals could witness the state that his mum was in but not do more to improve this.

6.3.30. Working with the person through consensus is most likely to deliver sustained change and improve the person's wellbeing. However, practitioners must understand the legal parameters they work within, including legal measures that can lever change.

6.3.31. The Health and Social Care records demonstrate that Anne's mental capacity was considered. Principle one of the Mental Capacity Act and Code of Practice [20] makes clear that the starting point is a presumption of capacity. As noted, Anne described some memory impairment although it does not appear that this was to the extent of impacting on her ability to retain information long enough to make a decision. Health agencies explicitly recorded Anne as having capacity and understanding the consequences where she declined care and treatment. There was evidence of helping Anne understand the risks in declining care and seeking alternatives routes to reduce risks e.g. home physiotherapy, alternative pressure relieving equipment. On some occasions a formal mental capacity assessment was carried out, confirming capacity.

6.3.32. Executive functioning refers to the ability to carry out decisions and intentions. There was some evidence that Anne was unable to carry out decisions about her welfare, for example, stating she did not need support with care needs but then being unable to meet her care needs. A lack of executive functioning does not give others the legal authority to make decisions in the adult's best interests or to compel a person to accept care without their consent. However, this inability to follow through on a decision should inform risk management. ASC and SWBT identified that executive functioning was not given sufficient consideration and as outlined above; risk assessment was lacking.

6.3.33. There were no grounds to consider intervention under the Mental Health Act 1983, nor of Environmental Health legislation. SMBC Housing raised that had they been made aware of concerns this would have triggered further information gathering and a visit to the property. Housing could have provided supportive measures as well as considering any enforcement action through the tenancy agreement and the Housing Act 2004.

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[19] Local Government Association: Analysis of Safeguarding Adult Review April 2017- March 2019; Executive Summary October 2020 https://www.local.gov.uk/analysis-safeguarding-adult-reviews-april-2017-march-2019 [Accessed Jan 2021]

[20] Office of the Public Guardian Mental Capacity Act Code of Practice 2007, Updated 2020 https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice [Accessed November 2020]

6.3.34. The Animal Welfare Act 2006 relates to meeting the welfare needs of animals as well as prohibiting cruelty. Anne's son had had to resort to contacting the RSPCA to try and get the dogs removed. This was not done lightly, knowing how important the dogs were to her. It is difficult to determine the impact this would have had on Anne – the emotional trauma of being separated from her dogs weighed with the improved hygiene and reduced risk of falls within her property. What does seem clear is agencies may have been able to offer alternative solutions. Anne's son should not have been left unsupported in this. It reinforces the need for agencies to come together with Anne and her family to develop a safeguarding plan.

> *'……where the risks to independence and wellbeing are severe (e.g. risk to life or others) and cannot adequately be managed or monitored through other processes, it will be necessary to have a safeguarding plan to monitor the risk in conjunction with other agencies. In self-neglect cases this would usually involve health service colleagues, but other agencies may well need to retain ongoing oversight and involvement (e.g. environmental health, housing). If the plan is still rejected and the risks remain high, the meeting should reconvene to discuss a review plan.* ***The case should not be closed just because the adult is refusing to accept the plan****. Legal advice should be sought in these circumstances.'*
>
> West Midlands Self Neglect Guidance 13.4**.**

6.3.35. We now know that Anne's death was due to Bilateral Bronchopneumonia with Covid-19 and Ischaemic Heart Disease as secondary factors. Anne's death was not preventable. Nonetheless, had agencies coordinated a safeguarding plan, this could have made a vital difference in improving the quality of her final months of life.

7. Conclusions

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

7.2. The Sandwell Safeguarding Adult 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.

7.3. 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 Adult 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.

7.4. 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.

8. Acting on Learning

8.1. The agencies that contributed to this review have highlighted changes that are relevant to the circumstances of this review, some as a direct consequence of the learning.

• Adult Social Care

8.2. ASC has strengthened arrangements for transfer between teams of cases involving self-neglect.

8.3. ASC had already carried out an internal learning review relating to Anne and had also gained learning from other SAR's relating to self-neglect. They are holding regular staff briefings to look at lessons learnt and develops thinking around good practice and professional curiosity. The author of the ASC report also identified the following services improvements following the learning from their review of Anne's care:

- Multi-agency Risk Assessment/Multi-agency meetings chaired by managers.
- Risk Management panel for Social Care staff to discuss and reflect on cases with their managers and to inform senior management of cases that are high risk.
- Reinforcing a long-term approach to establish person centered relationships.
- Face-face visits for *all* cases where there are environmental concerns.
- Recording of direction and evidencing of managerial oversight on all cases.

8.4. It will be helpful for the SSAB to receive an update from ASC on whether these measures have been taken forward and how this has improved outcomes for people who self-neglect.

[Recommendation 1]

• Sandwell and West Birmingham Clinical Commissioning Groups

8.5. The GP Practice involved, has developed a vulnerable patients' list within the surgery to reduce risks during the Covid period. Patients with needs such as Anne's would now be contacted weekly to enquire about their health and wellbeing.

8.6. All the GP Practice clinical staff had booked to attend the updated Safeguarding Adult training which includes self-neglect as a main theme. The GP practice will hold an internal training session on self-neglect in addition to attending SWBCCG Level 3 Safeguarding training.

8.7. SWBCCG Safeguarding Team is supporting all GP Practices through providing a training session on self-neglect to all GP Practice Safeguarding Leads. The team will develop a 7-minute briefing to be circulated to all primary care staff highlighting the potential signs and symptoms of self-neglect and professionals' responsibility in addressing this issue.

• Black Country Healthcare NHS Foundation Trust

8.8. Sandwell Healthy Minds service has revised their referral form to encourage the referrer to provide more detailed information risk profile and about other agencies' involvement.

- Sandwell and West Birmingham Trust

8.9. Community services had carried out an internal review and highlighted learning relating to making Safeguarding Adult referrals and carrying out mental capacity assessments. Self-neglect and assessment of mental capacity is the focus in both bespoke and mandatory training being rolled out across the Trust. The finding of this SAR will also be shared with the SWBT clinical ethics group to disseminate learning.

8.10. The SWBT Safeguarding team check monthly that contacts numbers and emails available on the Trust internet monthly are up to date.

9. 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
Recommendation 1: **Monitoring and Review: Assure Use of the West Midlands Self-Neglect Guidance** The evidence from this SAR is that the West Midlands self-neglect guidance was not known or not complied with. The Sandwell Safeguarding Adult Board should design and deliver assurance activity to **i)** Evaluate front-line practitioners' knowledge of the guidance and any barriers to application **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: • Quality of multi-agency risk assessment and risk management/safeguarding plan. • 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.

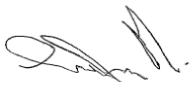
This panel should be available under the West Midlands Guidance for cases managed through VARM as well as cases managed as Safeguarding Adult enquiries.

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)



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Date: May 2021

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Glossary

ASC Adult Social Care

CN Community Nurse

ED Emergency Department

IDT Integrated Discharge Team

MDT Multi-Disciplinary Team

MSP Making Safeguarding Personal

OT Occupational Therapist

SMBC Sandwell Metropolitan Borough Council

SSAB Sandwell Safeguarding Adult Board

SAR Safeguarding Adult Review

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 (Mental Capacity Act; Mental Health Act) 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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