Safeguarding Adult Review

Martin

Contents

1. **Introduction** ... 3
2. **SAR subject: Martin** ... 3
3. **Safeguarding Adult Reviews** ... 4
4. **SAR Referral** ... 5
5. **Terms of Reference** ... 5
6. **Agency involvement** ... 6
7. **Multi-agency Chronology** ... 7
8. **Learning event** ... 11
9. **Analysis and learning themes** ... 11
10. **Developments since the review** ... 17
11. **Responding to learning in this review** ... 18

1. Introduction

1.1 This Safeguarding Adult Review has been conducted in line with Section 44 of The Care Act 2014[1]. Information on the legislation and criteria followed is provided in Section 3.

1.2 Stockport Safeguarding Adults Partnership (SSAP) has produced this Safeguarding Adult Review (SAR) report in relation to Martin. The report includes an overview of learning from a multi-agency event held in January 2024, feedback from Martin's family, and information on how the Partnership will be taking forwards learning.

1.3 Members of the SSAP SAR Consideration Panel meeting agreed that the SAR should commence and would be focused on learning from a practitioner event to be held in January 2024. Therefore this report does not include all elements of a more traditional SAR.

1.4 The subject of this review is Martin. At the time of his death Martin was a 49-year-old White British male. He had been known to Adult Social Care, Stockport Homes, Pennine Care NHS FT, Stockport NHS FT, and Westwood Home Care. Adult Social Care received a contact in January 2023 around his increased alcohol consumption and a decline in his mobility, and following his death a SAR referral was completed.

1.5 Martin's parents contributed to this SAR through meetings with the Stockport Safeguarding Adults Partnership (SSAP) Business Manager. Information was also provided through his parents from Martin's siblings.

1.6 The purpose of any SAR is to promote learning and develop actions to prevent future deaths or serious harm from occurring. The lessons learned from this case should be shared with services who work with adults in similar circumstances to improve safeguarding practice.

1.7 Members of the Stockport Safeguarding Adults Partnership would like to express their sincere condolences to Martin's family, and extend thanks for supporting and engaging with this review.

2. SAR subject: Martin

2.1 This Safeguarding Adult Review looks at the life and experiences of Martin. Martin was born in 1973 and was White British. He was known to have a learning disability. As an adult at the time of his death Martin lived alone in a first floor rented flat in Stockport. Martin had been a Stockport Homes resident since 2007, and received support from a care provider as well as informal care from his parents. Towards the end of his life, Martin's parents had made plans to move with him out of Greater Manchester back to the area in which he grew up. Martin was in support of the move and going to live with his parents, as he had fond memories of growing up in the community.

2.2 At the age of 2 Martin was adopted by his parents in December 1975. Martin was born with global learning difficulties, neuromuscular deficiency and developmental delay. At the time of

[1] Care Act 2014 (legislation.gov.uk)

his adoption, Martin's parents were told he would not live to see his teenage years and that he would never attend school. Martin's parents worked hard to support him in his education.

2.3 At the age of 16 Martin left mainstream school with 2 GCSEs. He attended Greenbank Training Project[2] where he was supported into work. His jobs included working in a snooker hall, photocopying in an office building in Liverpool, and delivering banking for a solicitors firm. After his move to Stockport in 2007 he began working at Manchester Airport, which he enjoyed due to his interest in aeroplanes.

2.4 Martin enjoyed travelling and family holidays, music and going to concerts, collecting things, and aeroplanes. He struggled with aspects of independent living and was unable to budget for himself. He would get easily distracted and this led to some of his jobs coming to an end.

2.5 Martin's family were aware of his excessive drinking and tried to support him to reduce his consumption. They reported that Martin was unable to understand the impact of drinking alcohol on his body, and they tried to explain to him on several occasions why it was unsafe for him to continue drinking.

2.6 During the COVID-19 pandemic, Adult Social Care support to Martin ceased during which time he became isolated in his flat.

3. Safeguarding Adult Reviews

3.1 Section 44 of The Care Act 2014[3] places a statutory requirement on Stockport Safeguarding Adults Partnership (SSAP) to conduct and learn from Safeguarding Adult Reviews (SARs) in specific circumstances. The criteria for a review is set out below.

A review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if –

(a) There is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and
(b) The adult has died and the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died) or
(c) The adult is still alive and the SAB knows or suspects that the adult has experienced serious abuse or neglect.

A SAB may also arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

Each member of the SAB must cooperate in and contribute to the carrying out of a review under this section with a view to
(a) Identifying the lessons to be learnt from the adult's case, and

[2] Home - Greenbank Disability Charity a registered charity for disabled individuals living in and around the Liverpool area to provide opportunities for education, sport and recreation.
[3] Care Act 2014 (legislation.gov.uk)

(b) *Applying those lessons to future cases.*

3.2 Stockport Safeguarding Adults Partnership members involved in this SAR agreed to work to these aims and underpinning principles.

3.3 This SAR has focused mainly on learning obtained through the practitioner learning event held in January 2024; SSAP has sought assurance through the quality of this review by consulting with the Social Care Institute for Excellence (SCIE) Quality Markers[4].

4. SAR Referral

4.1 A Safeguarding Adult Review referral was sent to the Stockport Safeguarding Adults Partnership by the local authority in April 2023, and an initial Consideration Panel meeting was held on 15th June 2023 to consider the referral. The decision from the panel to progress with a SAR and learning event was ratified by the Independent Chair and Scrutineer on 6th July 2023.

4.2 Work to progress with the SAR was delayed whilst the Partnership sought to understand the concurrent LeDeR review process[5] that was also taking place. Outside of this review the Stockport Safeguarding Adults Partnership have been working with NHS Greater Manchester[6] to strengthen joint working and learning available from SARs and LeDeR reviews.

4.3 Martin's death had been through an Inquest at HM Coroners Court Manchester South, which resulted in a Regulation 28 Prevention of Future Deaths notice[7] being issued to the system's Locality Board. As part of the response the locality made reference to the SAR and LeDeR processes, as well as the multi-agency learning event facilitated by SSAP.

4.4 The panel meeting identified key lines of enquiry that needed to be progressed through the multi-agency SAR process and a learning event.

5. Terms of Reference

5.1 The terms of reference for the SAR were agreed as follows:

a) How well did agencies work together to understand and address Martin's self-neglecting behaviours?

b) How did agencies responded to Martin's rapid decline in his physical health between December 2022 and February 2023, including escalation processes?

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[4] Safeguarding Adults Review Quality Markers - SCIE

[5] A LeDeR review looks at key episodes of health and social care that an adult aged over 16 with a learning disability or autism received that may have been relevant to their overall health outcomes, looking for areas that need improvement and areas of good practice https://leder.nhs.uk/about

[6] The Integrated Care Board for Greater Manchester NHS GM | Greater Manchester Integrated Care Partnership (gmintegratedcare.org.uk)

[7] A Regulation 28 or *prevention of future deaths* is a report written by HM Coroner after an inquest under the Coroners and Justice Act 2009 and Coroners Regulations 2013. Such reports are written where evidence suggests that further avoidable deaths could happen if preventative action is not taken. The report is sent to the person or authority who has the power to make suggested changes.

c) Understand if any concerns regarding malnutrition were identified by agencies in the months prior to Martin's death.

d) Determine if there were any missed opportunities to support Martin before and during his rapid decline in physical health, including how local self-neglect policy and procedure could be improved.

e) Explore and share good practice in this case.

f) Include Martin's voice in the review through engagement with his family and carers.

5.2 Following the Inquest, concerns relating to malnutrition originally identified by the Partnership in the SAR referral were resolved. Further information obtained from his family confirmed there were no causes for concern regarding malnutrition nor eating patterns. Therefore, point (c) above was removed from the Terms of Reference prior to the learning event.

5.3 The information provided by agencies, and discussed at the learning event, covered 1st September 2021 to 18th February 2023. Where relevant information fell outside of this timeline, it was included in the review. Information provided by Martin's family provided context for much of Martin's life going back to childhood, which ensured as much relevant information was available on his life and experiences.

6. Agency involvement

6.1 Martin received support with daily living activities via a commissioned service by Adult Social Care for many years since 2004, and his support hours had changed throughout his life. This support was to focus on supporting him with maintaining his home environment, managing shopping, and accessing his local community. During the COVID-19 pandemic, Adult Social Care support to Martin ceased during which time he became isolated in his flat. This was due to the nature of his support being around helping Martin access the community which was not possible during the national lockdown period.

6.2 Martin had been a tenant of Stockport Homes Group since 2007. A referral to the Independent Living Team was made in 2021 to address concerns around the poor state of his flat, and a referral to the Alcohol Support Team was made in 2023.

6.3 Pennine Care NHS FT[8] work across 5 local authority areas in Greater Manchester providing mental health, learning disability and autism services to children and adults. Pennine Care NHS FT became involved in Martin's care in January 2023 following a referral the Learning Disability Clinical Health Team[9].

6.4 Westwood Home Care became involved in March 2022 where they supported Martin to access the community. By December 2022 Westwood Home Care were providing 6 hours of support over 3 days and a request was made to Adult Social Care to review the care plan and increase the number of hours.

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[8] Home :: Pennine Care NHS Foundation Trust

[9] Stockport community learning disability team :: Pennine Care NHS Foundation Trust

6.5 Martin was referred to START[10] in February 2023 with his mother named as a contact. Three attempts to make contact were made by the service with a letter sent advising of the referral and asking him to make contact. Notification was received on 20th February that Martin had passed away which closed the referral. The review was notified that where START are notified that an individual lacks capacity around substance use, the service would not proceed with an assessment unless relevant support is in place or an assessment has been agreed through a Team Around the Adult process. Individuals would require a level of understanding so they are able to agree to referrals and subsequent treatment.

7. Multi-agency Chronology

7.1 All agencies involved in the review provided reports detailing their involvement with Martin. A chronology was compiled from these records and is shown below.

Date	Agency	Event
August 2018	Stockport Homes Group	Martin's neighbour contacts Stockport Homes Group to raise concern he had not been seen for several days. Martin was abroad on holiday but on his return support was provided to bring the property up to standard.
2019	Adult Social Care	Support reduced from 9 hours per week to 4 hours per week due to limited engagement.
March 2020	Adult Social Care	Commissioned support ceased.
April 2021	Stockport Homes Group	Repairs operative unable to complete a repair due to the condition of the property. Neighbourhood Housing Officer contacted Martin's Community Support Worker at CLDT to help gain access to the property to complete repair works and assess condition.
June 2021	Adult Social Care	Social worker allocated – Care Act Assessment completed and support plan in place.
14th September 2021	Stockport Homes Group	Neighbourhood Housing Officer made a referral to the Independent Living Team for additional support following completion of a property inspection. Property was found to be in poor condition and infested with flies. NHO arranged for Hygiene Action to clean the property. Referral also stated Martin was alcohol dependent.
1st October 2021	Stockport Homes Group	A deep clean of the property is completed.

[10] START (Stockport Triage Assessment and Referral Team) - Stockport Council START is the local Stockport Triage Assessment and Referral Team who offer advice and referrals for lifestyle support including smoking cessation, alcohol and drug support, and healthy eating. The service works with individuals referred in to identify goals and appropriate support for the adult.

Date	Agency	Event
6th October 2021	Stockport Homes Group	Independent Living Officer completes introductory home visit to Martin. Initial Risk Assessment and Support Plan completed.
22nd November 2021	Stockport Homes Group	2nd visit from Independent Living Officer – noted property conditions were good.
26th November 2021	Stockport Homes Group	3rd visit from Independent Living Officer noting property condition remained good.
March 2022	Adult Social Care	Westwood Home Care started supporting Martin, providing 7 hours support per week over three days.
3rd March 2022	Stockport Homes Group	4th visit from Independent Living Officer with Martin's father present. Property condition noted as being good. Martin's alcohol dependency was noted as being an issue, and referrals to alcohol support services had been declined on a number of occasions. Independent Living Officer referred Martin to the Community Hub service for support to explore social activities to attend in the area.
29th March 2022	Stockport Homes Group	Independent Living Officer visited Martin to discuss his ongoing support needs. A level access shower had been installed in the property to support with bathing needs, and property condition was noted as good. A referral to alcohol support service was discussed and declined. Martin advised he had a care package in place and therefore felt his needs were being met and agreed for support to come to an end.
28th October 2022	GP records	GP review takes place – Martin is seen with his father. Referral made to Gastro in relation to liver disease.
14th November 2022	GP records	GP has a telephone call with Martin's father regarding a cough.
2nd December 2022	GP records	GP has telephone call following A&E referral relating to swelling / significant ascites. A face-to-face appointment is arranged for a physical review at the practice with a GP. Martin's father is present. Leg swelling symptoms are noted. Furosemide issued and blood tests are requested.
January 2023	Westwood Home Care	Concern raised regarding Martin's mobility, increased alcohol consumption, low mood, pain in his legs and that he wasn't getting out of the home.

Date	Agency	Event
6th January 2023	Stockport Homes Group	Martin re-referred to Independent Living Team by Neighbourhood Housing Officer following concerns raised by his mother as property conditions had declined and Martin remained alcohol dependent.
12th January 2023	Pennine Care NHS FT	Referral received from Adult Social Care Learning Disability Team. This was flagged as a routine referral with a triage response deadline of 2 weeks.
24th January 2023	GP records	A home visit takes place to complete the LD annual assessment with Martin's Care Coordinator, Practice ANP. Noted parents were moving out of area to another borough outside of Greater Manchester. Martin had a clinical assessment and noted able to make considered choices. Under Gastro Alcoholic fibrosis / sclerosis of Liver / blood investigations arranged
24th January 2023	Adult Social Care	EAAT visit and assessment completed; a plan to request equipment including a profiling bed, mattress and trolley.
27th January 2023	The Prevention Alliance	Phone call to Martin's father following a referral by Viaduct Care to support parents in their application for Lasting Power of Attorney.
30th January 2023	Adult Social Care	Community Learning Disability Nurse visited to complete a triage; Martin was recommended as high priority for allocation. CLD Nurse contacted Martin's GP to report concerns regarding his distended stomach.
31st January 2023	The Prevention Alliance	Follow up phone call to parents following Lasting Power of Attorney referral.
31st January 2023	Stockport Homes Group	Home visit conducted by Independent Living Officer. Martin's parents were present. Martin was in poor physical health due to alcohol consumption, with parents advising he was consuming 2 bottles of wine each day. ILO advised they would refer Martin to the alcohol support service and request a Care Act Assessment; Martin agreed to both actions.
2nd February 2023	GP records	Telephone call with Martin's mother and a home visit arranged.
2nd February 2023	Pennine Care NHS FT	Nurse spoke with Martin following the referral on 12th January.

Date	Agency	Event
2nd February 2023	The Prevention Alliance	Martin's mother calls to advise his physical health needed to improve before support could be offered around social activities. Martin's mother asked if The Prevention Alliance could support with applying for Lasting Power of Attorney and was advised to contact his Social Worker, following which the referral was closed.
3rd February 2023	GP records	Home visit takes place regarding pressure areas. GP noted Martin's carers were trying to help with his personal care but this help was refused by Martin.
3rd February 2023	Adult Social Care	Social worker allocated.
6th February 2023	GP records	Ascitic drain put in and urgent outpatient investigations arranged. Follow up was made for Martin in 6 weeks following gastro review. Noted in that letter that Martin was continuing to ask friends and family to purchase alcohol for him.
7th February 2023	Stockport Homes Group	Martin's mother contacted Independent Living Officer to confirm he had attended hospital and been referred to a nutritionist. Martin's mother also confirmed a Care Act Assessment was being scheduled by Adult Social Care.
8th February 2023	GP records	Failed home visit. Messages left.
9th February 2023	Adult Social Care	Home visit arranged and follow-up visit arranged for 16th February 2023. An additional 14 hours per week from Westwood was agreed as an interim measure whilst the reassessment was completed.
14th February 2023	Stockport NHS FT	Martin admitted to MDCU[11] for routine procedure, concern raised by nursing staff to the safeguarding team, which was escalated to the local authority.
15th February 2023	GP records	Martin's mother advised he had been admitted to hospital.
15th February 2023	Stockport NHS FT	Martin admitted to Ward D1 from the Acute Medical Unit.
16th February 2023	Stockport Homes Group	Adult Social Care notify Stockport Homes that Martin was in hospital.
18th February 2023	Stockport NHS FT	Martin passed away on Ward D1.

[11] The MDCU ward provides services for gastroenterology, urology and respiratory patients

Date	Agency	Event
18th February 2023	Stockport Homes Group	Martin's mother informed Independent Living Officer that he had died in hospital.

8. Learning event

8.1 Stockport Safeguarding Adults Partnership facilitated a multi-agency learning event on 31st January 2024, which included input from the below services.

- Stockport Council – Adult Social Care
- NHS Greater Manchester
- Stockport NHS Foundation Trust – Safeguarding Team
- Westwood Home Care
- Viaduct Care
- Stockport Homes
- Pennine Care NHS Foundation Trust

8.2 The learning event was structured around themes in Martin's care, focussing on good practice, any missed opportunities and identified learning as a result. The event also included a discussion on multi-agency working and information sharing, with services in attendance providing a summary of their agency and referral pathway.

8.3 The lead reviewer for Martin's LeDeR review was also present on the day, to support in identifying and sharing learning, and in an effort to avoid duplication between the 2 review processes.

9. Analysis and learning themes

9.1 The links with mental capacity and self-neglect are well documented in Safeguarding Adult Reviews, and national research[12]. The Local Government Association (LGA) commissioned national SAR analysis in 2019[13] found themes in self-neglect and learning disability SARs around poor engagement with parents, absence of clarity around which organisation was leading care, a failure to integrate understanding of an individual's mental health, learning disability and physical health needs, and missed opportunities to fully complete assessments and health reviews. These themes were evident in the learning event held for Martin.

9.2 Panel members discussed how self-neglect falls within 'abuse and neglect' as defined in The Care Act 2014 at the point of the SAR referral. During the timeframe in this review, custom and practice in Adult Social Care was that concerns for self-neglect would be put under case management rather than progressed as a Section 42 enquiry.

[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), 219-234

[13] Analysis of Safeguarding Adult Reviews, April 2017 – March 2019 (local.gov.uk)

9.3 The nature of this SAR has led to learning and recommendations being made and themes for agencies to respond to. A multi-agency action plan sets out how the Stockport Safeguarding Adults Partnership will respond to the learning from this review, and seek assurance that learning has been embedded across all appropriate agencies.

9.4 How well did agencies work together to understand and address Martin's self-neglecting behaviours?

9.4.1 Throughout Martin's life, and in particular towards the end of his life, there were different agencies and services involved in his care and support, addressing specific needs that he had. When viewed in isolation some of his care and support needs would not have been recognised as self-neglect concerns, although his family were aware that he was unable to live independently and care for himself. Care and support for Martin was not fully coordinated and at times it was unclear who was coordinating or leading on the support plan and making relevant referrals.

9.4.2 The review has found opportunities in Martin's life where it may have been helpful for a co-ordinated multi-agency response to some of the concerns identified, and to agree a plan to meet his needs. For example, this may have been useful in January 2023 where concerns were escalating regarding his physical health.

9.4.3 Agencies were aware of self-neglecting behaviours, as identified from the above chronology, however this information was not always shared with other professionals.

- Martin's GP was aware of particular instances of self-neglecting behaviours and his alcohol consumption (03/02/23 – Martin refusing personal care, 06/02/23 – Martin was asking friends and family to buy him alcohol)
- Stockport Homes Group was aware of poor home conditions in April 2021 and initiated support through the Independent Living Service.
- Westwood Home Care were aware of his alcohol dependency.

There is evidence within the individual case records that when made aware of concerns, actions were taken, for example discussions with Martin regarding onward referrals to services who may be able to support him. However, it is not as clear how well this information was shared with others working with Martin.

9.4.4 The learning event dedicated part of the session to exploring multi-agency working and understanding the range of commissioned services across health and social care, that can work with adults who have a learning disability. This discussion identified opportunities to strengthen multi-agency understanding of the local system, including referral pathways and ways of sharing information.

9.4.5 A 2017 study published by MENCAP[14] found that 75% of adults with a learning disability said that hospital staff explaining things to them in a way that is easy to understand would improve their experience of going to hospital. The same report found that 66% of healthcare professionals included in the study would appreciate more learning disability training. There is an opportunity in Stockport to review what information and training is available for multi-agency professionals who work with adults with learning disabilities, as well as how information is shared with them.

[14] 2017.005.01 Campaign report digital.pdf (mencap.org.uk)

Learning point 1: Not all agencies working within the Stockport Safeguarding Adults Partnership are aware of the different services available to support adults with learning disabilities. There is an opportunity for leaders and practitioners to raise awareness of system pathways across Stockport.

9.4.6 Martin did not have a hospital passport in place; Stockport NHS FT records indicated that at the time of his hospital passport being completed, staff were unable to get information from Martin and they were waiting for his mother to provide the information. Martin was known to the trust's safeguarding team and records show that he had a blue butterfly[15] placed above his bed.

Learning point 2: Agencies working with adults with a learning disability should review processes for maintaining hospital passports to ensure all partners are included in ratifying documents and all pertinent information for the individual is recorded and available.

9.4.7 At the time of his admission to Stepping Hill Hospital in January 2023, Martin's capacity was presumed. At different times throughout Martin's engagement with services, he was presumed to have capacity which resulted in him being provided with full and detailed information regarding his physical health treatment. The documenting of Martin's capacity was not always as clear as it could have been.

9.4.8 Martin's family were not fully aware of his physical health conditions and in particular his liver failure. At the end of his life, Martin's family found correspondence from health providers regarding his diagnoses and treatment. His family noted that due to his learning difficulties, Martin "did not like brown envelopes" and wouldn't open them, and that he struggled to comprehend complex information. During the review process his family raised concern that they were not as included in Martin's physical health as much as they could have been and that it would have been helpful for them to have been included in correspondence from professionals to ensure Martin understood what was being said to him.

9.4.9 It appears that Martin was spoken with on a number of occasions regarding his alcohol consumption and whether he would benefit from a referral to services that could help with this. However, it was not always clear that this was a consistent offer and that it was followed up or fully explained how this would benefit Martin. His mother spoke of various ways she, and the rest of the family, tried to help with his understanding of the impact of his drinking.

9.4.10 The learning event raised a query regarding Martin's literacy skills and whether or not services were aware of any additional learning needs that he had that would have meant he was unable to understand written correspondence. There was no reference to any assessments nor reasonable adjustments made regarding communicating with Martin to account for any additional needs. Martin's family did not make comment on his literacy, however they did note that he would have struggled to understand more complex medical terminology regarding his physical health diagnoses.

[15] A blue butterfly sticker is placed above the bed of inpatients at Stockport NHS FT to identify patients who have a learning disability or memory impairment.

Learning point 3: Professionals to consider how to engage wider family networks in care planning when working with adults with learning disabilities.

9.4.11 The learning event heard that there were opportunities through supporting Martin where additional mental capacity assessments may have been useful to complete or revisit regarding his lifestyle choices, in order to understand the broader context of his self-neglect and circumstances. A study by the University of Bristol[16] found that individuals "who experience self-neglect are more at risk if professionals fail to assess mental capacity". There are numerous SARs completed where this same link has been found, with reference made in the 2019 National SAR Analysis. Engagement with Martin through additional mental capacity assessments may have supported opportunities to understand his current circumstances and re-visit any risks posed to him through his alcohol addiction. This point is re-visited later in the report, and it is important to reflect on possible missed opportunities under this theme.

9.5 How did agencies respond to Martin's rapid decline in physical health and escalate concerns?

9.5.1 The learning event identified that there were opportunities in Martin's life to coordinate a multi-agency safeguarding response.

9.5.2 The review and learning event heard that at the time of working with Martin, practice in the local authority was that concerns for self-neglect would be put under case management rather than progressed as a Section 42 enquiry. For Martin, this introduced a risk that coordination of multi-agency information was not captured at an early opportunity as part of initial enquiries.

Learning point 4: Where concerns regarding self-neglect are referred to the local authority, these should be managed initially under a Section 42 process to facilitate multi-agency working and information sharing to the point of an initial multi-agency protection plan being implemented.

9.5.3 Information provided at the learning event, and in the chronology in section 7, show that there were numerous home visits undertaken to Martin's flat by various agencies. On some occasions, visits by carers and nursing staff were unsuccessful or not fully completed. Where visits had to be re-attempted or followed up due to incomplete assessments or equipment not being available, Martin experienced an amount of frustration as explained by his parents. Additionally, the learning event identified that escalation processes were not always followed where unsuccessful visits took place, nor was this information consistently shared with other professionals working with Martin and his family.

9.5.4 There were also known instances where Martin was missing health appointments and there did not appear to have been an escalation process followed in light of this. Identifying these instances as opportunities of increasing risk for Martin may have helped a system-wide approach to supporting Martin or reviewing his care plan. This was identified as a learning point following a previous Multi-Agency Learning Review and a piece of scrutiny work was completed as part of the review's action plan[17].

[16] Mental Capacity, Self-Neglect, and Adult Safeguarding Practices: Evidence Synthesis and Agenda for Change | PolicyBristol | University of Bristol

[17] Did Not Attend Appointments multi-agency audit completed in 2021 the Multi-Agency Learning Review into "Tom" https://www.stockport.gov.uk/safeguarding-adult-reviews/toms-review-in-brief

9.5.5 There were some occasions where agency records referred to Martin as “not engaging”. Discussions with family as well as during the learning event highlighted the importance of language and communication when working with individuals with learning disabilities similar to Martin. Learning around adults who “do not engage” with services has previously been explored in Stockport[18].

Learning point 5: How can systems work together to identify adults with additional vulnerabilities who do not consistently allow professionals into their homes, including escalating concerns where appropriate.

9.6 What missed opportunities were there?

9.6.1 Martin’s support from the local authority was based around issues that were important to him. Support provided included help to access social opportunities in the community and to address financial issues he was having. There is evidence within this support that elements of his support plan was responsive and personalised to his needs. However, this did not fully take account of other needs that Martin had.

9.6.2 During the COVID-19 pandemic, this support ceased as opportunities to access the community were limited during lockdown periods. Information provided by Martin’s siblings explained how he had difficulty in understanding why there were changes to his support, and the impact that social isolation during COVID-19 lockdown had on Martin.

9.6.3 The learning event heard there were occasions in his care and support where it would have been helpful to have conducted a mental capacity assessment. Upon admission to Stepping Hill Hospital in February 2023, records indicate that Martin’s capacity was presumed, and that he had capacity regarding his physical health. Learning from the 2019 national SAR analysis[19] identified that there can be a ‘tendency to deem someone to have capacity’.

9.6.4 Martin’s family dispute that he had capacity regarding his alcohol consumption and that he couldn’t understand why others in his family could drink but that he should not. Examples were given by his parents of Martin losing consciousness and “turning blue” following incidents of him drinking to excess. As part of concerns regarding the condition of his property, numerous empty bottles of wine and cans were found stacked up in the living room.

9.6.5 Attendees at the learning event acknowledged that end of life services could have been utilised to support Martin and his family. However this was not possible due to the rapid decline in his physical health at the end of his life.

9.6.6 There is no evidence of a capacity assessment, nor a risk assessment, being completed in March 2020 when his support was reduced by the local authority.

[18] Multi-agency learning review “Tom” https://www.stockport.gov.uk/safeguarding-adult-reviews/toms-review-in-brief

[19] Analysis of Safeguarding Adult Reviews: April 2017 - March 2019 | Local Government Association

9.7 What good practice was evident in this case?

9.7.1 As part of the review and learning event, one of the lines of enquiry was regarding good practice identified in work done to support Martin.

9.7.2 Involvement at late stages of Martin's life was identified as good practice including input from Adult Social Care and Stockport NHS FT. Martin had developed a good relationship with Westwood Home Care and they shared concerns regarding his physical health with Adult Social Care.

9.7.3 Martin was also noted to have a good relationship with his Social Worker in 2023, which was commended by both his family and HM Coroner.

9.7.4 In January and February 2023 there was a rapid multi-agency response to Martin's escalating needs with support increased whilst formal assessment work was ongoing so that the updated care plan was not delayed. Unfortunately Martin passed away before he could be discharged from hospital and the increased support plans could be delivered.

9.7.5 Martin was accepted to have lived a relatively independent life, although he required additional care and support. Until his physical health deteriorated he was able to access the community himself. Some aspects of his life could be seen as 'aspirational' for other adults known to services.

9.7.6 Learning identified in this review focuses on the system, and not individual practice; this point was emphasized at the learning event to ensure that the context of available learning is understood.

9.8 How Martin's voice is included in this review?

9.8.1 At the point of triaging the SAR referral, it was clear to SAR Consideration Panel members that Martin's family played a strong role in supporting his care and support throughout his life. It was therefore important that any review, or learning event, included Martin's family's voice. This was achieved through Martin's parents, and eldest sibling, providing their views ahead of the learning event.

9.8.2 The views of Martin's family are that not all agencies fully understood Martin as part of their work with him.

9.8.3 The main comments from Martin's family are summarised below; these were shared with attendees at the learning event.

a) Martin found dealing with his emotions difficult and this was not always fully understood by professionals. Furthermore, professionals did not always share information with each other.

b) In preparing him for adulthood, Martin was not supported in his employment. Professionals and services did not keep re-visiting information and instructions with him.

c) Martin was not kept informed when his support workers or care packages changed and he struggled why he was working with someone new who needed to repeat an assessment process he had been through before.

d) Martin's parents were not told about the extent of his physical health issues and diagnoses. As Martin was deemed to have capacity, his family faced barriers in getting information about him.

e) The main issues Martin faced were a cut in his support hours, a lack of stimulation and activities, changes in support worker, and not receiving support with personal hygiene or cleaning[20].

9.9 <u>Summary of learning points</u>

9.9.1 The learning points identified above throughout Section 9 are repeated below for reference. A multi-agency action plan to address learning points has been developed.

9.9.2 Not all agencies working within the Stockport Safeguarding Adults Partnership are aware of the different services available to support adults with learning disabilities. There is an opportunity for leaders and practitioners to raise awareness of system pathways across Stockport.

9.9.3 Agencies working with adults with a learning disability should review processes for maintaining hospital passports to ensure all partners are included in ratifying documents and all pertinent information for the individual is recorded and available.

9.9.4 Professionals to consider how to engage wider family networks in care planning when working with adults with learning disabilities.

9.9.5 Where concerns regarding self-neglect are referred to the local authority, these should be managed initially under a Section 42 process to facilitate multi-agency working and information sharing to the point of an initial multi-agency protection plan being implemented.

9.9.6 How can systems work together to identify adults with additional vulnerabilities who do not consistently allow professionals into their homes, including escalating concerns where appropriate.

10. Developments since the review

10.1 Martin died in February 2023, and the practitioner learning event was held in January 2024. The reasons for this delay have been addressed earlier in this report. Since that time there have been service developments across agencies that are relevant to acknowledge so the review provides a full account of learning implemented as either a direct or indirect result of Martin's death. These developments are outlined below.

[20] This is a direct quote from a text message from Martin's sibling. Points (a) to (d) are summaries of discussion with his parents.

10.2 A multi-agency group has been established to run alongside the Autism Partnership Board to capture ongoing lived experience and raise any current issues to feed into the all-age Autism Strategy.

11.Responding to learning in this review

11.1 The 5 main learning points identified in section 9 will need to be responded to through delivery of a multi-agency action plan. The plan monitored through the Safeguarding Partnership's sub-groups for assurance alongside the review that the required learning and improvements will be delivered across the Stockport Safeguarding Adults Partnership.