Safeguarding Adults Review in Respect of John

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Independent Chair Wakefield and District Safeguarding Adults Board

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Contents

1. Introduction

John was a 69-year-old man who lived in Wakefield. Described by the GP as white British. He was admitted to hospital in March 2023 following a fall and a minor head injury where he died two days later. At the time of his death, John had extensive pressure area damage. On admission to the Emergency Department, he was covered in dried faeces, and was wearing hospital-provided underwear, despite not being in hospital for over a year.

A referral for a Safeguarding Adults Review (SAR) was submitted by Mid-Yorkshire Teaching Trust (MYTT) in April 2023. John had died of frailty and self-neglect and consequently it was felt that there may be learning for agencies in Wakefield around working with complex and vulnerable adults who experience self-neglect.

2. Purpose of a Safeguarding Review

The Care Act 2014 (Section 44) states that Safeguarding Adults Boards (SABs) must arrange a Safeguarding Adults Review (SAR) when an adult(s) in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult(s). SABs must also arrange a SAR if an adult(s) in its area has not died, but the SAB knows or suspects that the adult(s) has experienced serious abuse or neglect.

The purpose of the SAR is to promote effective learning and improvement actions to prevent future deaths or serious harm occurring again. The aim is that lessons can be learned from the case and for those lessons to be applied to future cases to prevent similar harm re-occurring.

3. Safeguarding Adults Review Panel (SAR)

The Safeguarding Adults Board SAR Panel met in July 2023 and defined that John's case met the legal requirements to undertake a mandatory review. The panel considered information regarding agencies known to have been involved in John's care and support:

a. Wakefield Council: Adult Social Care (ASC)
b. Health: Wakefield General Practice, Yorkshire Ambulance Service (YAS), Mid Yorkshire Teaching Trust (MYTT)
c. West Yorkshire Police (WYP)
d. Department of Work and Pensions (DWP)

There were concerns about how services worked together to keep John safe, specifically in relation to the events in a two-week period in March 2023 whereby Adult Social Care (ASC) and the GP practice were responding to significant self-neglect concerns raised about John.

4. Parallel processes

At an Inquest on in September 2023 the medical cause of death was defined by the coroner, as severe frailty, there was no mention of self-neglect on the death certificate. The conclusion of the coroner was that John died of natural causes.

5. Methodology

In October 2023, the SAR Panel agreed that this review would be undertaken based on Significant Event Analysis[1]. The rationale for this methodology choice is that it is well suited for a SAR involving a specific, short time period involving a small number of key agencies. It is a familiar methodology for primary care providers. Furthermore, it results in a short, focused report that is aimed to identify actions and recommendations.

The reviewer was provided with written fact-finding information which was supplemented with completed targeted questionnaires seeking additional detail. Relevant documents were provided as requested from agencies and the reviewer had access to the coroner's bundle.

A facilitated workshop was held on 17th April 2024 with practitioners involved with John and agency representatives to analyse information and establish: what happened, why, what is the learning, and what could be done differently. The reviewer also sought additional information from service managers when considering recommendations and has used detail from other safeguarding and learning reviews completed by Wakefield SAB.

The agencies directly involved in the review have been Wakefield Adult Social Care, the GP practice and a representative from the West Yorkshire Integrated Care Board (ICB).

6. Family

John's brother, BH, confirmed that he would like to share his experiences as part of the review process, and the Independent Chair met with him on 28th November 2023. BH was keen that the report reflected his brothers given name of John. John also has a sister whose preference was to link with the review through her brother.

John's brother was visited a second time by the reviewer on the 19th June 2024 to share an initial draft of the review, to enable the reviewer to clarify a number of issues to ensure that BH's earlier comments had been captured correctly.

[1] A significant event audit, also known as significant event analysis, is a method of formally assessing significant events, particularly in primary care in the UK, with a view to improving practice.

7. Independent Review

Diane Hampshire, WDSAB Independent Chair, was appointed as the independent reviewer for this SAR. She has an extensive NHS background and her previous roles have included work within both adult and children's safeguarding and quality of care. she has had no involvement with the case prior to review and is independent from both agencies linked with the review.

8. Review Timescales

This review was commissioned by WDSAB following a second discussion of the case in October 2023. Terms of Reference were developed and following a review of the available information a targeted questionnaire was devised and sent to the two agencies involved requesting a return by the 23rd February 2024. Subsequently a practitioners and managers workshop was convened and took place on the 17th April 2024. The delay in the workshop taking place was to enable all of the relevant people to participate in the event. Any further delay in making the review available to agencies has been due to limited capacity within the Safeguarding Adults Board impacting on the availability of the Independent Chair.

The report was shared with key people from ASC and Health on the 11th July 2024 to enable them to ensure that the facts highlighted within the review were correct. A small number of issues were raised and considered by the independent author.

9. Background and Personal information

John was a 69-year-old man who lived in Wakefield. He had a brother who lived in South Yorkshire (his sister does not live locally) and who supported John where he could. John was divorced and had two adult children.

John was described as having a 'troubled childhood'. His brother describes him as an intelligent man who at a young age left home for college to study to become a teacher. This however did not work out. He says John was a family man who enjoyed history and liked walking in the dales.

He went on to marry and held down a number of job roles resulting in him becoming a manager in a care setting. The marriage and John's subsequent ability to maintain his job was impacted by excessive alcohol consumption. In the early 2000's John was hospitalised for approximately 9 weeks due to alcohol related illness/complications. During this time, he was reported to be in a coma and was diagnosed with Korsakoff psychosis[2].

[2] Korsakoff psychosis is a late complication of persistent Wernicke encephalopathy and results in memory deficits, confusion, and behavioural changes. Korsakoff psychosis occurs in 80% of untreated patients with Wernicke encephalopathy; severe alcoholism is a common underlying condition.

John divorced and sadly his daughter died aged 23 (2010) from a rare form of cancer. He has been estranged from his son for a number of years. It appears to be around this time that John gave up alcohol although there is limited detail surrounding this. There was a period in John's life when hoarding was an issue. The family were able to assist John with this before it became a major problem.

The SAR Panel decided that on the whole agencies appeared to have worked together effectively in the February-May 2022 period, so all actions and decisions during this time did not need to be considered in full within the scope of the SAR. However, there are a number of areas identified through the review from this time which have been explored below.

During the undertaking of this review no protected characteristics as defined by the Equality Act (2010) were identified.

There were single agency concerns in relation to the GP practice which committed to monthly home visits to JH after the safeguarding input early in 2022, but these did not occur after September 2022 with no clear explanation.

A single agency review was requested from the GP practice immediately following the agreement to undertake a SAR. The outcome of the single agency review is covered further in this report.

10. The key themes of the review are set out below and have formed the key lines of enquiry:

Accessing John's voice: (a) When, and in what way, were JH's wishes and feelings ascertained and considered?

(b) How was John supported to make decisions for himself?

(c) Were there concerns about John's decision-making capacity? If so, were these appropriately recorded and shared with other agencies/practitioners involved?

(d) Were John's family appropriately involved to support him in decision making about his wishes and needs?

Self-neglect: Was there evidence of John lacking self-care or lacking care of the home environment to the extent that it endangered his safety and wellbeing? Did agencies respond appropriately to these concerns?

Joint working concerns: Was information sharing and communication between agencies and services appropriate and timely? In the final weeks of John's life, did agencies and services respond appropriately to escalating concerns about his deteriorating health? Was the response proportionate to the perceived or assessed level of risk?

Safeguarding: Were safeguarding processes considered during the March 2023 period, were there grounds to raise safeguarding concerns and might this have led to a different outcome?

Mental capacity: Was the Mental Capacity Act 2005 appropriately considered and implemented in practice? Was John's voice actively listened to in any mental capacity considerations?

Systemic issues: Did any systemic issues impact on John's care/ service delivery, including, for example, agency resource/ capacity issues, austerity, the COVID pandemic?

11. Key Learning

The SAR although having a main focus on a specific two-week period in March 2023 has also identified that there was potentially a missed opportunity in April 2022 to put a more robust Safeguarding Plan in place to protect John and provide support for family and the practitioners attempting to work with John.

February – May 2022

Following two hospital admissions in February and March 2022 (and subsequent referrals by MYTT to ASC raising concerns), John was supported by a community social worker who undertook a Care Act Assessment and a safeguarding social worker who undertook a Section 42 safeguarding enquiry relating to self-neglect. The social workers undertook several joint visits to John and organised a multi-disciplinary meeting as per the Wakefield SAB guidance 'Working with People who Self-Neglect and/or Hoard' (Wakefield Policies and Procedures) in April 2022 which included John's brother and the GP. John declined to attend.

ASC involvement ended in May 2022 with the Care Act Assessment [3] concluding that there were no eligible care and support needs, and the Section 42 [4] enquiry closed following the completion of a risk assessment and agreement that the GP practice would undertake monthly home visits to John.

John was recorded to have capacity to make decisions around his care and support and his medical needs at this time. The GP and John's brother were advised that they could refer back to ASC if required.

Professionals confirm in the targeted questionnaire that they believed that John was making informed decisions and had the capacity to do so. However, there is acknowledgement that some of John's decisions were unwise, examples being choosing **to**

[3] An assessment under the Care Act 2014 is an assessment of needs for care and support (including transition assessments), and or an assessment of a carer's needs for support. The nature of the assessment will vary depending on the person and their circumstances.

[4] The purpose of a section 42 adult safeguarding enquiry is to enable the local authority to decide whether any action is required in the adult's case, and if so by whom.

buy cigarettes over food and not eating food provided by his brother. Following the multi-disciplinary meeting the GP allocated a practice care co-ordinator to undertake monthly review visits to John. The use of the care co-ordinator role was seen as a way to manage the risk, assessing any ongoing needs or concerns and offer support. This was felt to be minimally intrusive and possibly acceptable to John.

John's brother at this meeting recalls feeling let down and not listened to. He said he felt the meeting had more focus on his right to be there even though he had John's permission to attend and John had signed a document from the GP stating that he was happy for his brother to be kept informed of his health needs.

The multi-agency meeting did not explore with John's brother whether he was happy to continue offering John a high level of support and the impact of this if it was withdrawn. His brother recalls asking the professionals at the meeting what would happen if he was not in a position to help John. At this time, he was managing his brother's finances, providing food and emotional support. John's brother was clear that John would say one thing to professionals and himself and do another. A comment written in the records highlighted that 'John could talk the talk but not walk the walk'. His brother was concerned that practitioners did not explore how frail John was following a short stay in hospital. Records have described John as being cachexic [5]. The GP did highlight that there had been concerns around a chest x-ray that John had undergone, indicating a shadow on the lung. A discussion had taken place between the GP and John about the potential that this 'shadow' could possibly be a malignancy. John asserted that he felt well and if he became unwell, he would seek further medical care.

The Care Act Assessment was not completed until the day following the multi-disciplinary meeting and so its conclusions were not discussed as part of the process.

John's brother said he felt unable to contact services for assistance throughout the following year as he felt abandoned and unheard. He describes speaking to his sister about his concerns for their brother but feeling that he would be met with the same response of John having capacity and being able to make unwise decision's even though he could see him deteriorating.

Identifying a care co-ordinator to visit John at home was an attempt to not lose sight of John and also an attempt to adopt a person-centred approach. However, reflecting on the conclusion of the multi-disciplinary meeting at the practitioners workshop it was identified that a more robust safeguarding plan should have been put in place the year prior to his death acknowledging how complex John would be to work with. This could have helped identify John's failing health and possible changes in capacity and offered support to John's brother and the care co-ordinator.

[5] Cachexia – is a syndrome of unintentional weight loss, muscle wasting, and loss of appetite in people with chronic illnesses.

What happened and Why:

A minimal multi-agency safeguarding plan was put in place following the multi-disciplinary meeting with a care co-ordinator from John's General Practice being requested to undertake monthly welfare visits. It was assumed that John's brother would continue to support his brother. Both were told to contact ASC if they had any further concerns. The case was closed by ASC a few weeks after the multi-disciplinary meeting following completion of a care act assessment and a safeguarding risk assessment.

The safeguarding plan broke down within a few months of the multi-disciplinary meeting due in part to an administrative error, leaving John's brother alone to try to support him the best he knew how.

John did not engage well with the care co-ordinator and he would frequently be 'on his way out' when she called at an arranged time. The safeguarding plan did not have a structured contingency approach if there was a failure of engagement on John's part which given what was known about John's behaviour seemed highly likely. However, it is acknowledged that it was felt the John did have the capacity to make decisions about his health and care and that professionals concluded he did not have care and support needs.

There is limited detail available from the multi-disciplinary meeting notes so it is not clear what information was considered regarding John and the traumas in his past. At the practitioner's workshop in April this year (2024) it was suggested by ASC that they were not party to certain information about John highlighted at the meeting. Due to limited recording by both agencies, it is not clear whether this is because of failure to share information, failure to appreciate the relevance of some of the information possibly shared or lack of professional curiosity. For example, the reviewer had to seek the details of John's daughter's death from his brother and it was unclear whether ASC were aware of John's Korsakoff's Psychosis diagnosis and its relevance. It is also not clear whether John's history of Korsakoff's and its long-term damage on brain function was considered in depth by all who attempted to engage him.

What is the learning:

With the benefit of hindsight, the multi-disciplinary meeting under the Self-Neglect and/or Hoarding Guidance and the subsequent safeguarding plan was a missed opportunity to consider what had been put in place and whether it was proving effective. It was also a missed opportunity to engage fully with John's brother and, using his knowledge of John's history understand fully the traumas of his past. John was happy to have his brother involved with his medical care and so it could have been explored with John whether he was happy to have his brother involved around his wider needs. There appeared to be a lack of curiosity in regard to what John's brother could have told them in regard to his past.

We cannot forget that John was assessed as a capacitated adult with no eligible care and support needs. Practitioners at the multi-disciplinary meeting did have a focus on John's

wishes and were looking for the most acceptable way to undertake a person-centred approach. The fact that a safeguarding plan was put in place did indicate that professionals were concerned about John at some level and attempted to put a support structure in place. The relevance of past trauma and executive capacity is considered further in the report.

What could be done differently:

A suggestion from a senior manager within ASC highlighted the need to look at the approach to multi-disciplinary meetings linked to Self-Neglect/ Hoarding with a standardised agenda and a way of recording the multi-disciplinary meetings to ensure that key questions and issues are considered and recorded appropriately. Work should also be considered around ensuring that safeguarding plans consider mitigation of risk, are reviewed and cases not closed down without full consideration of such risks.

The Safeguarding Adults Board is aware that it needs to review the Self-Neglect and/or Hoarding Guidance and this is highlighted in a recent discretionary unpublished review (Clare 2023). There needs to be consideration of the level of knowledge practitioners have in Wakefield District about working with adults who self-neglect, particularly the impact of past trauma and the need to spend time building a relationship.

The work highlighted as above needs to be considered within any review of the Self-Neglect and/or Hoarding Guidance to ensure that all agencies who lead on working with these complex individuals work in a structured way, ensuring that safeguarding plans are not closed down until there is evidence that the persons situation is safe.

12. The Care Co-ordinator Role

The care co-ordinator [6] from the GP practice undertook monthly home visits to John's address up until September 2022 (although this visit was not recorded there is evidence from John's brother that the visit took place and although the care co-ordinator spoke to John, she did not gain access to the flat). The visits stopped at this time and the GP practice were requested to undertake a single agency review around this issue.

The GP has acknowledged that she could have been clearer in her expectations of the care co-ordinator when visiting John, these were to build a rapport, support John in self-care and to escalate any concerns about John directly with the GP. She also felt that she should have shared the self-neglect guidance with the care co-ordinator.

The single agency review indicated that there was an administrative error with a failure to book the follow up visit back in. The practice has initiated a number of key steps to prevent this happening in the future including 'flagging' individual records of those **people**

[6] A Care Co-ordinator is one of several relatively new roles within the Primary Care Team providing capacity and extra time. Care Co-ordinators are unqualified staff trained to undertake home visits, offering support and carrying out health checks where necessary.

identified with self-neglect to ensure that they are reviewed on a regular basis. Work has been undertaken to improve documentation of discussions and contacts and staff have been reminded to speak to the GP if they identify any new or increasing concerns including inability to make meaningful contact with the patient.

It should be noted that the care co-ordinator role was a relatively new role within primary care but they see some of the most complex individuals usually within a home setting.

13. Review of Significant Events 7th March – 16th March

The practitioner workshop on the 17th April covered the two-week period under review and 5 dates highlighting specific events. Each date was explored allowing the reviewer to understand what happened and why, using the significant event analysis approach:

- 7th March: GP Home visit/ referral to care co-ordinator for a home-visit
- 9th March: John's brother spoke to the care co-ordinator/ joint home visit arranged
- 9th March: referral to Social Care Direct (SCD) for an Assessment of Need
- 14th March:
  - care co-ordinator contacted SCD for an update regarding referral
  - Initial referral for Assessment of Need sent through to triage
  - Joint visit to John by brother and care co-ordinator
  - SCD Triage contacted care co-ordinator for update on above visit
  - Triage transferred the updated referral to the Urgent Response Team
- 15th March: Urgent Response Team contacted John who declined any help

<u>7th March 2023 - What Happened and Why:</u>

John's brother contacted the GP on Friday 4th March with concerns regarding his brother's declining health due to the impact of self-neglect. His brother recalls speaking to the GP for an hour and there being a discussion about possibly prescribing John anti-depressants but his brother was concerned that he was not capable at that time of taking medication safely.

Following this discussion a GP registrar undertook a home visit on the 7th March. John declined help and refused any examination or further action. The GP on speaking with John defined that he had capacity and therefore was unable to do anything further at that point in time. He identified that John was frail but there were no obvious signs of active ill health for example a chest infection. At the practitioners workshop the option to call an ambulance was explored. The GP was able to define why this was not a viable option for John as he was likely to refuse transfer to hospital, the GP was also clear in that as he had not been able to examine John there was no rationale for referral to hospital.

The GP visited John after listening to his brother's concerns. At the home visit John was listened to as a capacitated adult. The GP was able to witness a small part of John's living environment and it was described as unkempt but not considered unsafe. At this **visit there**

was no reason to consider a safeguarding referral, John had in fact behaved as previously in that he had clearly stated his wishes.

John's brother had planned to be present at this visit but the GP spoke to him following the visit to update him.

Following this visit the GP made a request to the care co-ordinator, asking that a follow up welfare visit was made and to undertake a memory check.

What is the learning and What Could be Done Differently:

The reviewer would like to comment on the good practice of the GP Registrar in terms of undertaking a home visit following John's brother's concerns. He reviewed John's past history and gave consideration to John's capacity. He also engaged the care co-ordinator to undertake a follow up visit. The care co-ordinator was in a position to compare her previous contacts with John and report back to the GP.

The reviewer has no further comment to make regarding this specific interaction.

9th March 2023 - What Happened and Why: The care co-ordinator contacted John's brother to arrange a joint home visit. This was arranged for the 13th March but had to be re-arranged for the 14th due to unforeseen circumstances. It should be noted that the General Practice only has access to one care co-ordinator. Following discussion with John's brother and at the GPs request the care co-ordinator made a referral to Social Care Direct (SCD) for an urgent Assessment of Need.

The care co-ordinator was able to describe at the practitioner's workshop what she shared with the SCD worker and information from SCD indicated that significant concerns around self-neglect had been shared emanating from John's brother. This included concerns about John's weight loss, his being banned from a local supermarket due to his 'smell and appearance' and concerns about his home environment. It is also noted that John's landlady was wanting to undertake an upgrade to John's home, and this was proving problematic. Concerns were noted about John having faeces on his hands, his legs being discoloured, evidence of not eating and the neighbours reporting that John was shouting and talking loudly to himself.

The referral received by SCD was screened by a duty social worker or team manager and no further action recorded. Information received from ASC in the follow up targeted questionnaire states 'I can only assume that the plan from SCD was to follow up with John and get his consent to the referral and await further feedback from the care co-ordinator who was to visit on Monday the 13th March'.

What is the Learning and What Could Have Been Done Differently:

The original Fact Find information taken from John's records and shared by Adult Social Care (ASC) highlighted that significant concerns were shared by the care co-ordinator on the 9th March. The follow up targeted questionnaire highlighted that the first referral (9th March) to ASC contained significant concerns as shared about John with the GP by his brother. The targeted questionnaire also highlights that the follow up contact made on the 14th March by the care co-ordinator contained 'significant concern's' as witnessed by the care co-ordinator and John's brother.

The suggestion is that with the benefit of hindsight the information shared should have led to a safeguarding referral. If this had been the case it is likely that this referral would have been shared with the Adult Safeguarding Team within 24 hours. This is backed up by the senior social worker who completed the ASC initial fact find indicating that due to the significant concerns highlighted by the referrer the safeguarding team would have responded within 24 hours. It has also been considered that SCD could have requested a joint approach to the referral by both the Urgent Response Team and the Adult Safeguarding Team.

The referrals received at SCD are taken by operatives trained to undertake a wide range of calls into ASC, using a computer 'script' to ask questions and record answers. The information is then screened by a duty manager or someone of a similar standing. This was a potential missed opportunity to consider John's situation as a safeguarding issue as it is likely that he would have been seen within 24 hours of the referral being received.

It was explored at the April workshop what the expectations had been following the referral into ASC. The care co-ordinator was clear in that she expected an urgent response from Social Care and in that her expectation it would take a number of days before any action was taken i.e. contacting John. There was no consideration by the GP or the care co-ordinator that the referral should be considered a safeguarding referral.

At this point in time no consent for the referral had been obtained and John was still considered to have capacity based on the GP's findings on the 7th March.

Work is underway within ASC to look at flagging records [7] of self-neglect cases like John's (and all cases where a safeguarding plan has previously been in place). It is felt that this should ensure that ASC practitioners receiving information around flagged cases will be alerted to the previous level of concerns and ensure to undertake a full review of the records. This will assist in considering how to move forward with a case/situation.

<u>14th March 2023 - Care Co-ordinator contacted SCD</u>:

<u>What Happened and Why</u>:

Prior to the planned joint home visit the Care Co-ordinator contacted SCD at 9am to check on the status of the requested Assessment of Need. This was to enable her to update John's

[7] Record flags are a mechanism in which an alert can be assigned where there are high risk needs.

brother. She was informed that the referral was being triaged and checked that the referral had been marked as urgent. At the workshop the care co-ordinator did not appear unduly concerned that no action had been taken by SCD regarding the requested assessment, at that point acknowledging that 'these things do take time'. She was not made aware however that no action had been taken.

It should be noted that the referral appears to have been held within SCD from the 9th March to the 14th March, this in reality equates to around 3 working days. Senior managers within ASC believe that the information provided in the referral would not have warranted a more urgent response.

14th March 2023 - Joint visit to John by Brother and Care Co-ordinator:

What Happened and Why:

Later in the morning a joint visit to John's flat took place between John's brother and the care co-ordinator. Visiting with John's brother was a good decision in that his brother appeared to be the person who knew John the best and guaranteed access to the flat. The care co-ordinator was able to use what she witnessed, combined with his brother's knowledge of John and his circumstances to update SCD with her findings.

At this visit John was found in difficult circumstances in that he was on the ground, having been incontinent and unable to stand without help. The care co-ordinator was shocked at the physical change in John since her contact in September 2022. John acknowledged at this point that he was in need of support and agreed to a referral for respite care. The 6CIT[8] was used by the care co-ordinator with a score of 21 which indicates significant cognitive impairment. The GP on the 7th March had recorded John's memory test (6CIT) 'as alright' which pointed to a deterioration in John's memory. It is worth noting that an assessment of a person's memory is not about a person's mental capacity. It is not recorded whether John was capacitated at this visit although it is recorded that he gave consent for a referral for respite care.

The care co-ordinator recalls suggesting to John and his brother that they could call an ambulance, this she believes was declined on John's behalf by his brother knowing or believing that he was unlikely to agree to travel to hospital. John's brother does not recall this discussion, he believes that if an ambulance was thought necessary by the care co-ordinator, he would have supported this although he does acknowledge that he may have pointed out that John was likely to decline an ambulance. There is no information to suggest that John was asked about the need to transfer him to hospital or no check back with the GP on this issue.

14th March 2023 - Triage contacted Care Co-ordinator for update on joint visit

[8] Six Item Cognitive Impairment Test (6CIT) (6CIT - Kingshill Version 2000, Dementia screening tool). 6CIT test The National Institute for Health and Care Excellence (NICE) recommends it as one of the validated tests for use in a non-specialist setting.

What Happened and Why:

At this point on the morning of the 14th March the initial referral had been reviewed by Triage and they actively sought an update from the care co-ordinator. She reported concerns about John being on the floor unable to rise, being incontinent, significant weight loss, his lack of mobility and the condition of his feet and socks (which his brother felt he had been wearing for over a year). It is not clear whether the results of the 6CIT test were shared with Triage or whether they were aware of John's agreement to respite care.

14th March 2023: - Triage transferred the updated referral to the Urgent Response Team (URT):

Following the update from the care co-ordinator SCD Triage sent the referral over to the URT at 15.42 that day. No consideration appeared to have been given regarding a safeguarding referral and given the significant concerns recorded there was no telephone call alerting the team to the serious nature of the referral.

What is the Learning and What Could Have Been Done Differently:

There are a number of issues to consider from the 14th March contacts. The first being possible inaction regarding the initial referral from the 9th. The care co-ordinator believed she had made an urgent request for an assessment of need and was anticipating that ASC would be working on this, this is evidenced by the care co-ordinator contacting SCD to check on the progress of the referral. SCD were made aware that the care co-ordinator would be undertaking a home visit at the initial referral stage. SCD appear not to act on this referral until the care co-ordinator contacted them to check on progress with regards to the assessment of need.

On review of the information provided by ASC in the targeted questionnaire there is an assumption by the person completing the questionnaire that because the care co-ordinator did not provide any additional concerns from the GPs home visit that the referral made on the 9th March was held within SCD (Front Door) team from the 9th until the 14th march 2023, rather than being passed to the locality social work team or the safeguarding team for a duty response or for allocation to a named social worker. The information provided by ASC 'assumes' that the plan from SCD was to follow up with John and get his consent for the referral, and to await further feedback from the care co-ordinators visit. Nothing appears to have been recorded within the records that this was the plan.

It would appear that the initial referral was not triaged until the day of the follow up contact by the care co-ordinator (9am on the 14th March). Late into the progress of this review it has been suggested by ASC that the triage worker contacting the care co-ordinator on the morning of the 14th March was co-incidental and not linked to the care co-ordinator following up the initial referral. None of the opportunities offered to ASC such as the initial fact find, the targeted questionnaire and the work shop identified this **as a possible co-**

incidence. The follow up by ASC did coincide with worsening findings of John's situation and work was undertaken to refer John to the Urgent Response Team.

It needs to be acknowledged that the length of time the referral was not triaged was over 3 working days, not 6 days as the dates would suggest. It was also acknowledged by the practitioners at the April workshop that 'significant concerns' had been shared with SCD. It should be acknowledged that the care co-ordinator believed that she had shared significant concerns about John in her referral made on the 9th March based on John's brother information. She was not aware that SCD did not agree and were not treating the concerns as significant.

It is worthy of note that there appears to be no recognition that the significant concerns were considered as safeguarding issues at the time of referral and following on from the home visit by any of the practitioners involved.

On reflection if the initial referral had been considered as safeguarding more prompt action would have been taken based on the information shared. Also, a prompter triage response is likely to have resulted in an earlier referral to the Urgent Response Team.

There appears to be a discrepancy between what the care co-ordinator believed would be happening following the referral and what was happening. Feedback following referrals into SCD has been highlighted to the Safeguarding Adults Board as an issue and is identified within their strategic development work – the need to identify feedback standards following referrals into ASC.

A further key issue is whether or not the care co-ordinator spoke/ made contact with the GP Registrar who had visited John on the 7th March and updated him on her findings and action. It maybe that a comparison of visits and what appeared to have been a major difference in findings might have resulted in a different course of action, with possibly a safeguarding referral or the suggestion to reconsider the need for hospital admission.

Record keeping for both the GP and SCD appears to have been an issue with records not fully capturing what was happening or expected to be happening. Both the GP and ASC acknowledged this issue and will look at this at an individual practitioner level. The SAB will also issue updated information regarding the importance of record keeping using examples from John's case.

<u>14th March 2023: Triage transferred the updated referral to the Urgent Response Team (URT)</u>

<u>What Happened and Why:</u>

It appears that once the information regarding John was reviewed and collated that action is taken by transferring to the URT. This was done as indicated above at 15.42.

<u>What was the Learning and What could have been done differently:</u>

This referral was received towards the end of the day and it should be noted that the URT are not an emergency service and that referrals received are prioritised alongside other work. We have no way of knowing what else the team were responding to at the point in time.

15th March: What Happened and Why - Urgent Response Team contacted John

The Urgent Response Team contacted John via telephone the day after receiving the referral and at that point John stated that he 'was fine' and that he did not need any support. Little is recorded regarding this conversation and so it is unclear if the worker was in a position to explore with John fully the concerns of those around him. It may have been that John refused to engage in discussion thus limiting the workers ability to help John. The practitioner undertaking the contact is no longer employed in Wakefield so there is not an opportunity to seek further information.

The URT records describe attempting to contact John's brother twice on the 15th and 16th March to provide him with an update via telephone. Although John's brother is clear that his phone does not have an answerphone message facility. He was keen to point this out as he did not want it to be thought that he was not concerned about his brother's needs. Further exploration of this issue has identified that the URT had an incorrect telephone number for John's brother.

There is no evidence of the URT contacting the care co-ordinator who had made the referral or any consideration of a follow up joint visit. It maybe that following contact with John's brother the worker would have considered this further.

What was the Learning and What could have been done differently:

As been highlighted in previous interactions the recording of the workers contact with John is limited and it is unclear if this is due to John limiting his responses to the workers questions or if the worker did not spend time attempting to explore John's circumstances with him. If it appeared that John was not wanting to engage in discussion this should have been reflected in the records. Senior ASC managers have stated that given the significant issues highlighted about John's circumstances they would have expected a home visit on the day the referral was received by the URT (if resources and priorities allowed) or the following day.

14. The key themes of the review are set out below and have formed the key lines of enquiry:

Accessing John's voice: (a) When, and in what way, were JH's wishes and feelings ascertained and considered?

There is evidence in the Care Act Assessment of Needs and the Safeguarding Risk Assessment that John's wishes and feelings were taken into account. Overall, he wanted minimal contact with services and that if he needed anything he stated he was able to seek support himself.

John made his wishes and feelings known about input from the General Practice by being unavailable for planned home visits. A note provided by John's brother following the care co-ordinators attempted visit on the 1st September 2022, shows that John has written in capital letters – the name of the worker and the fact the she is going to visit AGAIN! Indicating a level of frustration around the home visits.

(b) How was John supported to make decisions for himself?

In early 2022 John was given the opportunity to discuss his wishes and feelings and was seen by both a safeguarding and a community social worker. He was clear that he did not want outside input into his life. The GP (outside the scope of the review) has also said that John did not want follow up for a concerning chest X Ray, stating that the potential serious consequences were discussed with John.

(c) Were there concerns about John's decision-making capacity? If so, were these appropriately recorded and shared with other agencies/practitioners involved?

Where practitioners from ASC and GP were involved with John, they had no concerns with John's decision-making capacity, they were aware that he was making unwise decisions that could impact on his health and so put the safeguarding plan in place. There does appear to be information that suggests practitioners did look at both John's decisional and executive capacity. On reflection and appreciating what John's brother witnessed, prior to and including during 2022 more time should have been spent assessing John's capacity. Assessments of mental capacity are considered by Cameron, E. and Codling, J. (2020) 'When mental capacity assessments must delve beneath what people say to what they do'.

(d) Were John's family appropriately involved to support him in decision making about his wishes and needs?

John's brother was involved in the multi-disciplinary meeting in March 2022 but struggled to appreciate that John was able to make such unwise decisions and the limitations of workers surrounding the law around capacity. John's brother felt that John was able to say one thing to professionals and would do another. An example of this was that prescribed medication went straight into the bin. John's brother was the main person who had continued contact with him over the following year where it appears John's unwise decisions resulted in him becoming so frail that he lost his life. With the benefit of hindsight more should have been done to involve John's brother in understanding self-neglect and empowering him to contact agencies for support earlier. A comprehensive safeguarding plan could have provided John's brother with links to professionals working on John's behalf.

John's brother also felt that there should have been more exploration of the past trauma and health issues in John's life.

Self-neglect: Was there evidence of John lacking self-care or lacking care of the home environment to the extent that it endangered his safety and wellbeing? Did agencies respond appropriately to these concerns?

John's brother highlights a past history of hoarding which could have resulted in him losing his tenancy. His family intervened and work was undertaken to ensure his surroundings were safe for him and others. It is unclear if ASC or the GP were aware of this in 2022.

When John was reviewed in 2022 there was no major concerns highlighted regarding the lack of care of his home environment, the focus was around lack of self-care (low nutritional intake and levels of personal hygiene). John was assessed and considered by the GP, safeguarding social worker and community social worker as having the capacity to make unwise decisions. He was also identified at this time as not having care and support needs. There were sufficient concerns for the practitioners involved working with the Wakefield SAB Self-Neglect and/or Hoarding Guidance to put a basic safeguarding plan in place.

The safeguarding plan was put in place in acknowledgement that there remained a potential self-neglect risk to his physical health and/ or potential environmental risks to either himself or others. A member of GP staff reviewing John on a monthly basis was felt to be a way of respecting John's wishes, allowing self-determination and also being able to identify any significant changes in John's circumstances.

Having the capacity to make unwise decisions does not mean that practitioners walk away from offering support to the individual concerned. Braye, S. et al (2011) states 'if the person has capacity, this is not the end of the story, do not walk away, be clear when to reassess'. Research into self-neglect highlights the complex nature of individuals who self-neglect and the difficulties of practitioners/family members attempting to engage and support them. It is a balance where practitioners are attempting to adopt a person-centred approach to offer support.

By March 2023 John's lack of self-care was having a major impact on his health and his ability to access food. He was banned from his local supermarket due to his appearance and smell (this had apparently happened back in October 2022). Agencies were in contact with John from the 7th March to 15th March 2023 and it would appear from the referral that John's self-neglect situation had worsened and that there was a life-threatening impact to John. With the benefit of hindsight, it appears there was a missed opportunity to call an ambulance on the 14th March given that there were major concerns about John's physical appearance and cognition. It was also a missed opportunity for the care co-ordinator to have contacted the GP Registrar to compare 'visit's'.

There was also a missed opportunity to request/ consider a safeguarding referral together with a referral for an assessment of need. Work needs to be undertaken so that practitioners understand more fully how people with self-neglect can be supported.

Joint working concerns: Was information sharing and communication between agencies and services appropriate and timely? In the final weeks of John's life, did agencies and services respond appropriately to escalating concerns about his deteriorating health? Was the response proportionate to the perceived or assessed level of risk?

There is evidence of ASC and the GP collectively discussing the concerns highlighted by the acute trust and John's brother back in 2022. It is not clear from the multi-disciplinary (MD) meeting whether the meeting considered John's past history in full. Of note the meeting should have considered John's history of alcohol dependence syndrome, leading to hospitalisation and a diagnosis of Korsakoff's Psychosis (and the potential for its impact on John's ability to make executive decisions), past history of hoarding, the breakup of his marriage and the impact on John following the death of his daughter from a rare form of cancer aged 23 which left John depressed. John's brother was also in a position to highlight some of the trauma John suffered in his childhood. It would appear that the focus of the MD meeting was on the 'here and now' and not considering John's needs in the context of what is known about self-neglect.

The assessment of need and the safeguarding enquiry may not have had a comprehensive history regarding John when they were completed as it appears they only focused on what John wished to share. At this point the lack of professional curiosity limited what practitioners knew about John resulting in an inability to ensure a robust safeguarding plan was put in place. There was much to learn about John from those around him.

In the final 2 weeks of John's life the GP and care co-ordinator undertook home visits based on concerns voiced by John's brother. John was found to be frail but refused a medical examination and was judged to have capacity. The GP requested follow up by the care co-ordinator who had previously had contact with John. This contact was 5 working days later when it would appear that John's health and situation had deteriorated further.

Prior to the home visit the care co-ordinator on the GP's behalf referred to SCD for an assessment of need. This referral stayed within SCD until 3 working days later. There is evidence of differing expectations from the care co-ordinator who was not made aware that the referral concerns were not being considered as significant. Information received from ASC received on the initial fact find from ASC did see the concerns as significant. There is also evidence of limited recording by both SCD, General Practice and the Urgent Response Team resulting in it being unclear what actions were being undertaken. Assumptions can be made but in record keeping practice if it is not recorded then it did not happen.

Safeguarding: Were safeguarding processes considered during the March 2023 period, were there grounds to raise a safeguarding concern and might this have led to a different outcome?

It is clear from the practitioner's workshop that there were significant concerns shared by the care co-ordinator (these came from John's brother and what the care co-ordinator witnessed) that should have led to consideration of a referral into adult safeguarding. This does not appear to have been explored as an option by any of the involved practitioners. There also does not appear to be any evidence of any senior oversight of the referral by either agency that would identify this gap.

The ASC Fact Find suggested that consideration needed to be given as to whether the 'script' used by customer service advisors allowed them to explore questions around self-neglect and if they are able to highlight the need to request both a safeguarding and an assessment of need process. Feedback from ASC states that the above would not be the role of a customer services advisor and that consideration as to whether the referral although requesting a Care Needs Assessment should also have been considered as a potential safeguarding referral would only be made at the later triage stage. This highlights an issue where there is potential delay in the allocation of work. It also flags up an issue as to how we can ensure where we have inexperienced 'referrers' into SCD the correct level of information is provided and the customer services advisors are able to capture the most relevant information.

There were grounds to raise a safeguarding concern on the 14th March and it is recommended that work around self-neglect highlights how a referral for a needs assessment could be explored to ensure that is the correct route for the level of concern raised.

Mental capacity: Was the Mental Capacity Act 2005 appropriately considered and implemented in practice? Was John's voice actively listened to in any mental capacity considerations?

From the information shared practitioners worked hard to listen to John and ensure that his wishes were respected. Information from ASC indicates that despite the significant risks of potential self-neglect John was deemed to have capacity regarding his life style choices and his home environment (March – May 2022). The records reflect that he was able to show the ability to retain information given and weigh up consequences through his communication with both the community social worker, safeguarding social worker and the GP. At this point John was accessing his local supermarket for provisions. The information provided implies that the workers were considering at the point in time John's executive capacity[9]. It should be acknowledged that assessments appear to have been undertaken with what we now know limited knowledge of John as a person.

There are a number of nationally published SAR's which suggest executive capacity is not always considered and that practitioners are often 'held back' by working with individuals

[9] Executive capacity is the person's ability to execute (carry out) a decision not just to make it in the context of the Mental Capacity Act (2005).

who self-neglect by their interpretation of the law. A recommendation will be made around this issue to ensure that we are learning from other SARs on self-neglect.

Given what we know of John's last few days it is highly likely that his capacity was compromised. The 6CIT test carried out by the care co-ordinator showed a significant change in John's cognition over 8 days. John was able to state that he would accept a period of respite care. However, John's physical situation worsened following a fall and he was admitted to hospital and died 2 days later.

John's medical records indicate a diagnosis of alcohol dependence and of Korsakoff's Psychosis in the early 2000's. There is no suggestion in any of the information provided for the review that the potential impact of Korsakoff's Psychosis on John's capacity to make decisions was considered. At the time of multi-agency involvement John had discontinued drinking a number of years previously so it is likely that this issue was not explored.

Systemic issues: Did any systemic issues impact on John's care/ service delivery, including, for example, agency resource/ capacity issues, austerity, the COVID pandemic?

Both the GP and ASC were given the opportunity to highlight any systems issues which may have impacted on John's care. No areas were raised.

There does need to be some acknowledgement that staff in all or most public sector environments do work at pace with increasingly complex cases being brought to their attention. But in the latter 2 weeks of John's life there does not appear to be any major systems issues impacting on practice.

Consideration going forward needs to be made around how the wider system is able to support individuals who self-neglect. It is important that practitioners feel able to spend time working with complex individuals and that systems do not only accommodate short term working. It is recognised that people who self-neglect need workers who are able to creatively build relationships (suzy Braye, 2020)

15. GP Single Agency Review:

The General Practice were requested to review why the monthly review meetings with John discontinued. The outcome was that it was an administrative error in that a follow up visit was not programmed into systmOne (a clinical record system).

Outcomes for action from the single agency review are:

- Practitioners to improve documentation of and discussions and outcomes of encounters
- Consideration of a review multi-disciplinary meeting with ASC to assess progress of the safeguarding plan
- Care co-ordinator to review outcomes of home visits of patients with self-neglect concerns within the relevant team meeting (using the self-neglect guidance). To also

raise any ongoing concerns/new concerns with the GP to seek support for themselves and the patient

- All of the primary care team who undertake home visits to familiarise themselves with the self-neglect and/or Hoarding Guidance (including the flow chart escalation processes)
- The home visiting team to access available training on self-neglect and escalation processes
- Records of patients with identified self-neglect and those with safeguarding plans in place to be flagged

16. Good Practice

- A multi-disciplinary meeting was called in March 2022 by ASC attended by a community social worker, a safeguarding social worker, the GP and John's brother. At that meeting it was felt that John was a capacitated adult but that there were significant concerns around John's 'unwise' decisions that a safeguarding plan was put in place. Practitioners were looking for a way to support John whilst allowing him some self-determination.
- The GP undertook a home visit to see John after listening to his brother's concerns.
- Following the GP's visit on the 7th March it was good practice that a home visit for a welfare and memory check was requested. The GP had been unable to examine John and he wanted to ensure that John was followed up.
- The care co-ordinator arranged to carry-out a home visit with John's brother who had been maintaining close contact and was the one who appeared best able to support John. Visiting with John's brother would ensure that the co-ordinator was able to access John's flat.

17. Contributions to the Review

The reviewer would like to thank everyone involved in the review of this case for their willingness to reflect and contribute to a number of challenging discussions. She would specifically like to thank John's brother for sharing his experiences of supporting his brother over a prolonged period of time and his contact with professionals linked to John.

18. Recommendations

The recommendations have been developed based on the findings above. Consideration has also been given to recommendations and actions which are currently been progressed across Wakefield and District linked to other reviews.

Recommendation 1 The Wakefield SAB to identify a Task and Finish group that looks at all elements of self-neglect to ensure that practitioners within the area are provided with the knowledge and support to work alongside individuals experiencing self-neglect. This work

will encompass recommendations from highlighted SARs and consider national messages around self-neglect.

Recommendation 2a: The SAB to review the Wakefield Multi-Agency Guidance: Working with People who Self-Neglect and/or Hoard to ensure that it fully covers robust safety planning and person-centred safeguarding:

- Where possible people with lived experience of Self-neglect and /or hoarding (including family members/ carers) should be included in the development of policy/ guidance.
- Practitioners should also be invited to provide their views on the development of the guidance.

Recommendation 2b: The SAB will ensure that practitioners are made aware of the newly revised guidance through identified communication methods including for example Lite Bite sessions, updated training packages and agency emails.

Recommendation 3: The SAB Task and Finish group (Recommendation 1) will work alongside the Learning and Development Subgroup to consider the need to develop/ strengthen training on self-neglect, professional curiosity and legal literacy.

Recommendation 4a: The SAB to link with Adult Social Care who are currently reviewing key areas of their team structure including their 'front door' processes. Recommendations within this report will take account of the work underway, influence and inform any relevant multi-agency actions. This work should include the ability to question whether a request for a needs assessment should be considered a safeguarding referral.

Recommendation 4b: The SAB will link with ASC/SCD and the work being undertaken around 'front door' processes to ensure that there is a quality assurance process in place around triage decisions (for example dip sampling of cases/ audit processes).

Recommendation 5: The SAB as part of the review of the Self-neglect/ Hoarding Guidance will include work on developing structured recordings of multi-disciplinary meetings and a standardised agenda to ensure key questions and issues are explored and recorded. The work will also ensure that safeguarding plans that are put in place are reviewed and where closed down how risks have been minimised will be recorded.

Recommendation 6: The SAB will ensure that the outcomes of any single agency actions related to this review are reported into the SAR action planning process.

Recommendation 7: The SAB will issue updated information regarding the importance of good record keeping using examples from John's case in a rapid read format.

Recommendation 8: The SAB should ensure that there is continued messaging (briefings/ training) to practitioners regarding self-neglect and working with individuals in such situations.

All recommendations from this review will be streamlined with the same or similar recommendations identified in recent Wakefield and District SAR's.

Claire (learning lessons review)

- 'What do we need to change'- guidance around self-neglect, particularly in relation to the importance of a multi-agency response should be adhered to.

- Wakefield SAB to promote awareness and understanding of the self-neglect guidance across agencies, Wakefield SAB to consider a review of the self-neglect guidance (particularly if multi-agency risk meeting MARM) framework is developed).

-WDSAB to consider an audit of self-neglect cases to establish a baseline of practice.

Derry & Joyce (mandatory SAR) – The SAB to include the development of a shared risk management approach in its strategy (2023-2026)- including consideration of the establishment of a Multi-Agency Risk Management (MARM) panel.

19. Conclusion:

Self-neglect has been highlighted in the Wakefield and District Safeguarding Adults Board Annual Report (March 2023 to April 2024) as a priority area, due to it being an issue that is coming to the fore within local and national SAR's.

With the benefit of hindsight there were missed opportunities when working with John alongside some positive work. Those practitioners known to John attempted to support his expressed wishes but also had reservations about his ability to continue to care for himself. A Safeguarding Plan was put in place in April 2022 which on reflection should have had more rigor with mitigations identified if the plan did not work. There should have been a multi-agency action to review the situation overtime.

The case open to ASC in April 2022 was closed quickly following the MDT meeting without practitioners fully considering what is known regarding supporting and working with individuals who are experiencing self-neglect.

John appeared willing to allow practitioners to speak to his brother about him and this could have been utilised in a more robust way. Had John's brother been part of the safeguarding plan in a structured way he may have felt more able to engage with services as John's situation deteriorated.

In John's final two weeks it appeared that his health due to the impact of self-neglect went downhill rapidly possibly with missed opportunities to consider the significant concerns voiced by his brother and make a safeguarding referral on the 9th March. None of the practitioners at this time considered that John was in need of a safeguarding referral and an urgent review of his capacity, or call an ambulance on the 14th March.

Cases of self-neglect are becoming more prominent in Safeguarding Adult Reviews (Analysis of Safeguarding Adult Reviews April 2019 – March 2023). They are in the main regarded as complex cases and highlight the difficulties that practitioners face when working with individuals in such circumstances. In John's case there are a number of areas which can be improved in order to reduce the likelihood of similar circumstances occurring in Wakefield again. John's wishes were listened to as a capacitated adult but more could have been done to hear those around him. There was a great deal of trauma in John's life impacting on his behaviour to neglect himself this was not fully explored with John or his family. Practitioners could have been more professionally curious about John's life in order to understand his unwise decisions.

Practitioners working with Individuals experiencing self-neglect need time to develop trust and as other SARs and research highlights it can be incredibly difficult to move forward in such circumstances. The systems that practitioners work in do not always allow the time needed to develop relationships, most systems are configured for short term focused work.

Going forward the Wakefield and District SAB needs to ensure that practitioners are alert to self-neglect and how to work together to identify and support these individuals and their families. Practitioners would benefit from having access to more robust self-neglect guidance, information and training regarding professional curiosity and understanding the legal implications of self-neglect.

It is important to state that looking back on specific cases where there is a high level of complexity is a far easier task than being faced with a complex situation in the here and now.

20. References:

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