Derbyshire Safeguarding Adults Board

Learning Brief for practitioners
Safeguarding Adults Review: William

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Learning Brief: Safeguarding Adult Review:

Derbyshire Safeguarding Adult Board carried out a Safeguarding Adults Review (SAR) following the death of a man, 'William' (a pseudonym)

A SAR is a statutory duty under the Care Act 2014. The aim of a SAR is for agencies to learn from serious incidents and deaths of adults with care and support needs, to reduce the likelihood of similar incidents from occurring.

Background

William was in his 80s when he died in circumstances of self-neglect. He lived alone in his own home where he had lived for over 30 years. In the past, William had worked in industry but then became full time carer to his mother until she died some years ago.

William had a long history of mental health needs. He had a diagnosis of schizophrenia (though had no active symptoms), and long-term depression including suicidal thoughts. In later life, William also had increasing physical health needs - arthritis that limited his mobility and macular degeneration resulting in poor eyesight. William had an increasing number of falls.

William had a limited social network. He had some telephone contact with his sister and a friend and was supported by neighbours, but he consistently struggled with loneliness. Pre-Covid, William had been relatively active, going into the local town café each day but this ended with the Covid restrictions. When restrictions were lifted, William's reduced mobility left him housebound.

William had a high level of involvement from Health agencies, Adult Social Care and Fire and Rescue services. William was well engaged with Health services and could be amenable to receiving help for his physical and mental health needs, at times, being proactive in requesting help. However, he could struggle to take medications consistently and declined some aspects of care such as aids/adaptations and some hospital admissions.

Agencies had had long term-concerns about William's lack of care for himself and for his environment. In the last 3 years of William's life, concerns had increased about risks arising from his self-neglect. William's lack of care for himself resulted in loss of weight, pressures sores, lack of personal hygiene and continence care and unkempt clothing. He was a keen smoker and often had burns to his face from lighting cigarettes from an open gas flame. The conditions of his environment were described as uninhabitable due to lack of heating, minimal lighting, levels of clutter, unhygienic conditions including slippery floors due to lack of continence. This placed him at risk of hyperthermia, increasing falls and fire risk.

William minimised the concerns. He repeatedly declined care and support, either because he did not want to pay and/or did not feel he needed it. On occasions when he had agreed to accept some support, this consent was soon retracted. William was resolute that he wished to remain in his property despite its condition.

Assessments of William's mental capacity consistently found he had mental capacity to make the relevant decisions about his self-care, care for his environment and decisions about where he wanted to live.

Findings

Direct Practice

There were multiple different professionals involved and substantial efforts made to develop care plans to address William's complex needs. However, these extensive efforts were unlikely to be successful without first building a relationship of trust with William and seeking to understand the reasons behind his self-neglecting behaviours. There was a lack of a consistent practitioner to build this relationship. There was limited evidence of practitioners seeking to understand the reasons behind his behaviours.

Practitioners demonstrated the Safeguarding Adult principle of 'Empowerment' when working with William, but this principle needed to be balanced with other principles. There was insufficient consideration of the principles of 'Protection' and 'Proportionality', specifically the need to make robust protection plans and take measures that were proportionate to the risks, to work with William's resistance to care and support.

Practitioners consistently considered William's capacity for the relevant decisions. However, capacity assessments may have benefitted from specialist opinion to fully assess his executive function related to his depression and the negative symptoms of schizophrenia.

Overall, there was an episodic and fragmented response to the concerns raised regarding William. Practitioners did not all recognise the recurring nature of the concerns, William's disguised engagement and the escalating risks. This led to repeated cycles of arranging care plans that had already proved to be unsuccessful.

There was a lack of robust shared risk assessment and risk management planning. There was not sufficient evidence of the Safeguarding Adults principle of Accountability, through ownership by a lead practitioner, oversight by senior managers, and application of procedures, including consideration of the Adult Social Care financial waver and Safeguarding Adult policies and guidance.

There was some joint working between services involved. However, there was an absence of robust multi- agency working. At no time, did all agencies involved meet to assess risks, plan responses, appoint a lead and agree contingency planning and review. The multi-agency meetings that did occur, lacked structure. The criteria for the Vulnerable Adult Risk Management (VARM) process was met and on eight occasions, a VARM was discussed or suggested. However, no agency took forward ownership to initiate the VARM process until William's final admission to hospital which sadly, was the day he died. The criteria for a Safeguarding Adult Enquiry were met and during the scope period for this SAR, there were five referrals made. However, no Safeguarding Adult Enquiry followed.

Systems Factors

Services are increasingly configured around a model of short term, task focused care delivery. This model is often not appropriate for adults who are self-neglecting, particularly when the adult is declining to engage in care and treatment. Agencies need to be able to offer longer-term, proactive outreach, and enable practitioners to have the time to build a relationship, and the remit to work creatively to meet individual needs.

The absence of a shared electronic record meant that practitioners were not able to view all episodes of care. Work is underway to develop a shared record. The lack of a shared record reinforced the need for robust multi-agency meetings with effective information sharing, coordination and communication of a care plan.

Practitioners were unclear about the pathway for responses to self-neglect. The interface between VARM and Safeguarding Adult procedures is not clear. A previous Safeguarding Adult Review had identified the need to support practitioners toward a more consistent response to self-neglect. This message is reiterated in this review.

The learning from this review indicates more needs to be done to establish a clear pathway for self-neglect. A pathway should provide proportionate response relevant to the complexity and risk. Each stage of the pathway must still be characterised by effective multi-agency working, risk assessment and management, and maximising Making Safeguarding Personal.

Learning for all professionals

Working with self-neglect can be challenging for practitioners, particularly where the adult is declining care and support. Taking time to build a relationship and understand the reasons for the adult's behaviours, may be necessary before the adult is able or willing to engage in care planning.

Work to balance the Safeguarding Adult Principles. Empowerment is of key importance, involving the person throughout in decisions and respecting their views. However, this needs to be balanced with the other Safeguarding Adult Principles, with proactive outreach to reduce harm, proportionate to the nature and degree of risk. A key message is that Making Safeguarding Personal does not mean walking away when an adult declines support.

Multi-agency working should be the default position when working with adults who are self-neglecting, whether this be under Safeguarding Adult procedures or where there are lower levels of risk that do not require a Safeguarding Adult Enquiry.

Accountability requires using guidance, following procedures and knowing when to escalate concerns to managers where risks cannot be mitigated.

Learning for managers and commissioners of services

Working with self-neglect where adults are resistant to change is complex. Staff need support from managers to explore barriers to engagement and endorse risk management plans.

Service models that are short term and task orientated may have very limited success. Investing time and building a relationship is likely to result in improved outcomes for the adult, and ultimately be a more effective use of resources.

Not all self-neglect needs to be managed as a Safeguarding Adult Enquiry. However, all responses should be characterised by effective multi-agency working, robust risk assessment, coordinated care plans and review; maximising Making Safeguarding Personal throughout. There is a need to develop the culture and structures to make this happen.

Good Practice

There was a high level of involvement from agencies, with professionals demonstrating care and compassion. There were repeated efforts to provide care and treatment. Concerns were raised and overall, practitioners made timely responses to the concerns.

William's views were consistently sought and respected. His capacity for the relevant decisions, was consistently considered and assessed. William was visited at home, improving the quality of assessment through face-to-face contact, and viewing his environments.

Signs of self-neglect were recognised, and agencies were attuned to fire safety.

Recommendations

Recommendation 1
The DSAB should seek assurance from Health and Social Care Services that they have additional, proportionate measures in place for practitioners who are working with adults who are at severe risk from self-neglect and who are resistant to engagement – specifically, systems that allow additional time and, wherever possible, a consistent practitioner to enable them to build and sustain a relationship with the adult.

Recommendation 2
Derbyshire Adult Social Care and Health should revise their practice guidance for charging and ensure that is it being referred to and implemented by practitioners and their line managers.

Recommendation 3
Learning from this review should feed into this review process, to create:

i) A clearer pathway for responses to self-neglect, enabling step-up and step down from a section.
ii) 42 Enquiry, according to complexity and risk.
ii) A pathway underpinned by balanced application of Safeguarding Adult Principles
iii) That multi-agency working is the default way of working across all levels of the pathway

Next steps

The primary purpose of SAR's is for agencies and practitioners to learn and improve the services provided to people.

Please reflect on the findings from this review and consider what you can do to make a difference to the service that you provide.

The review made a number of recommendations that the DSAB has developed into an action plan.

The DSAB will be working across agencies to seek assurance that the learning is making a difference to the lives of adults such as William.