B&NES LOCAL SAFEGUARDING ADULTS BOARD (LSAB) BRIEFING

DATE: 4th September 2018

ABOUT BRIEFINGS

This is produced by the B&NES LSAB to help practitioners reflect and continuously improve their practice. Thank you for taking the time to read this information.

SAFEGUARDING ADULT REVIEW BRIEFING - 'JOHN'

WHAT IS A SAFEGUARDING ADULT REVIEW (SAR)?

Under the Care Act 2014, the Safeguarding Adults Board has a legal duty to review any case in which:

- An adult with care and support needs has died (or sustained serious injury)
- As a result of abuse or neglect (including self-neglect)
- Where there is cause for concern about how agencies worked together to safeguard the individual

The purpose is to identify lessons learnt so that these can be applied in future safeguarding work.

The full report can be found on the B&NES safeguarding website https://www.safeguarding-bathnes.org.uk/adults/local-safeguarding-adults-board/6-safeguarding-adult-reviews alongside the Board's Response and information from the LSAB Stakeholder Event on Self Neglect

THE SAFEGUARDING ADULTS REVIEW

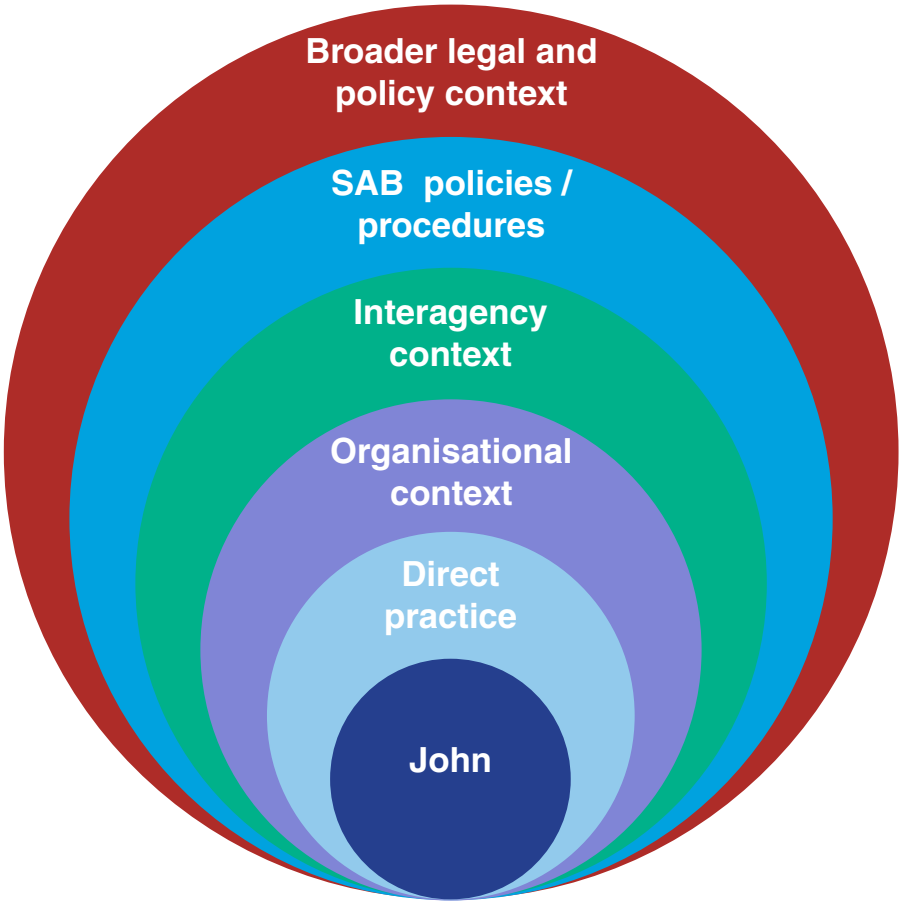
The Review Panel received written information from all agencies involved with John between 2014 and 2017. This included:

- A chronology of their contacts with John
- A reflective report on their involvement
- Responses to further questions from the panel

In addition practitioners who had known and worked with John attended a 'learning

event' to contribute their perspectives and ensure that the review was informed by those closest to practice.

The Panel's analysis sought to identify not only what happened but also why: to focus on the organisational, interagency and broader contexts that influence practice.



JOHN: A PEN PICTURE

- John lived alone. He had a number of complex health needs (type 2 diabetes, gout, arthritis, anaemia and hypertension) and his mobility was limited. He had experienced depression in the past.
- He lived for many years with his mother, relying on her to meet his domestic needs. After her death, his sister, who lived close-by, visited him every day to wash, clean and cook. After his sister's death in early 2014, his brother-in-law and nephew took on the daily support role.
- John developed a pattern of remaining in bed, not eating, drinking or taking his medication. He was at times doubly incontinent, in pain, and low in mood; his house became very dirty and cluttered.
- His GP saw him from time to time, and he had occasional involvement with community nursing. During 2016, concerns about his health and self-neglect led to periods of reablement, but he remained reluctant to engage with the support provided. A mental health assessment found no evidence of mental disorder and a mental capacity assessment found that he had capacity to make decisions on self-care and use of his finances.
- Reablement identified that he would need longer-term care and support at home, and in January 2017 John's brother-in-law arranged a domiciliary care package, which John paid for. However, he regularly refused the care provided and

declined to take his medication; he was incontinent and low in mood; his appetite was poor and he had little motivation to mobilise.

- Growing concerns by the care agency led to them raising a safeguarding concern on 7th March 2017, but his condition deteriorated further before this referral was considered.
- On 8th March an ambulance was called because he had slipped out of bed; he declined hospital admission, but the following day an ambulance was called again when his care worker found him with lowered consciousness. The ambulance crew noted pressure sores, poor oral hygiene, possible ascites, blister burns and significant oedema, and observed a quantity of unused medication. His family reported he had not left his bed for 6 weeks. The ambulance service admitted him to hospital and raised a safeguarding concern.
- John remained very unwell and was unable to participate in a safeguarding enquiry. His condition continued to deteriorate and the hospital provided end of life care until his death 6 weeks later.

WHAT WE LEARNED / WHAT WE NEED TO DO DIFFERENTLY.

MENTAL CAPACITY

- John's executive capacity was not consider by the people working with him during the last year of his life. The fact that he was not engaging with the support being provided to him was viewed as a life style choice rather than an indication of a possible lack of executive capacity.
- Professionals appeared to believe that because John had not agreed to safeguarding intervention safeguarding action could not be taken.
- The views of those that knew John best were not sought when considering his capacity to make decisions regarding his care and support.

INVOLVEMENT OF PROFESSIONALS

- No-one really got to know John. No one had a long term relationship with him. A long term relationship is needed with people who self-neglect to understand their particular situation. For John this could have included some insight into the reasons for his care refusal, or the impact of his life history and bereavements on his decision making.
- Agencies and individuals assumed that someone else was taking action to support John and did not check to make sure that this was the case.
- John was understood to be self-funding his care. His financial situation was not checked during the period under review. John and his family should have been asked if they needed support to arrange or manage his care. This was never done.
- The ability to provide care without charge was not known to those working with John. This is something that should have been considered.

POLICIES AND PROCEDURES

- Self-neglect and safeguarding policies were not sufficiently embedded across all agencies.
- Effective multi-agency risk assessment and complex case management was missing.
- The supportive arrangements that are contained within safeguarding and self-neglect procedures, particularly multi agency meetings, were not used, with the result that agencies were working in parallel rather than together.
- The sharing of information about John was not supported by the way different agencies recorded information about him. This included feedback on safeguarding decisions which were not shared with those who had raised the concerns.
- The need for and importance of Care Act Assessments was not recognised. Although John was supported by the reablement service at times during the period reviewed he was not referred for a Care and Support assessment. His brother in law and nephew were never offered a carers assessment despite John's reliance on their support and care.

John's case is not unique. The review panel made recommendations to strengthen how agencies work together in similar cases in future. These have been incorporated into the SAR Action Plan and Board Response.

WHAT YOU CAN DO:

- Read the full report for John on the B&NES safeguarding website.
  Full Report- SAR John
  Board Response
- Read the local Revised Adult Safeguarding Self Neglect policy, Quick Guide and LSAB & LSAB Escalation Protocol on the safeguarding website
- Ensure that your organisation's policies and staff knowledge are up to date in order to embed the above Policies
- Read and share in your team the information from the LSAB Stakeholder Event on Self Neglect from the Safeguarding website

  https://www.safeguarding-bathnes.org.uk/adults/local-safeguarding-adults-board/6-safeguarding-adult-reviews
- Update your learning and knowledge and confidence about Mental Capacity, risk assessment and Self Neglect
- Deliver or participate in staff briefing sessions to discuss the case and the issue of Self Neglect.

WAYS TO REDUCE RISK IN THE FUTURE:

- Everyone should be aware of what they need to do regarding self-neglect and Mental Capacity.
  - Quick Guide to the Self Neglect Policy and Guidance (July 2018)
  - Self-Neglect Policy and Guidance (July 2018)
  - Appendix 1 - Assessment of Need and Risk
  - Appendix 2 - Self Neglect Agenda Template
  - Appendix 3 - Self Neglect Crisis Intervention Plan
- Training on Self Neglect will be available from the LSAB from late 2018 but agencies can do their own training
- The B&NES LSAB & LSCB Escalation Protocol (June 2018) and Escalation Report Proforma should be used to manage professional disagreements about safeguarding decisions.
- The B&NES LSAB will be holding a 'One year on' event in summer 2019 to hear what difference we have all made.

FEEDBACK, SUGGESTIONS AND IDEAS:

Tell the B&NES LSAB how you have used this briefing in your team by Email : dami_howard@bathnes.gov.uk

Please also let us know if you identify work that could be completed by the B&NES LSAB which would support multi-agency professionals to implement the report's findings.

If you have any questions about the review, or the Safeguarding Adults Board's actions since, please contact the Board Business Support Manager dami_howard@bathnes.gov.uk

www.safeguarding-bathnes.org.uk