



ROCHDALE BOROUGH  
SAFEGUARDING ADULTS BOARD

## **Rochdale Borough Safeguarding Adults Board**

### **Safeguarding Adult Review - Adult E**

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#### **Acknowledgements**

Rochdale Borough Safeguarding Adults Board (RBSAB) would wish to acknowledge the contribution to the report of the sisters of Adult E who assisted the Independent Author during the review. They provided valuable information and insight into the life of their brother which has helped shape and inform this Safeguarding Adults Review (SAR).

This SAR would not have been possible to undertake without the co-operation and information supplied those agencies that provided care and support for Adult E. This contributed significantly in the production of the final report and helped to identify recommendations for improvement.

This report reflects the combined views of the SAR Panel who have invested their time, commitment and expertise throughout this process. The input and professional support provided by the RBSAB Development Officer was also invaluable throughout this process.

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## 1 Introduction

1.1 The decision to undertake this Safeguarding Adult Review (SAR) was agreed following a SAR Screening Meeting held on the 9<sup>th</sup> January 2020. The recommendation from the SAR Screening Panel, a subgroup of the Rochdale Borough Safeguarding Adults Board (RBSAB), was agreed by the Independent Chair of the RBSAB on 2<sup>nd</sup> April 2020 in accordance with the Care Act 2014. In endorsing this SAR she noted that “There are elements in this case which mirror a previous review in respect of self neglect, and I recommend that the Terms of Reference include consideration of how well lessons from that review were disseminated and the extent to which recommendations from that review have been implemented”.

1.2 The SAR Screening Panel members considered information provided by all known agencies involved with the person who is the subject of this review and following discussion concluded that there was reasonable cause for concern about how the RBSAB members worked together to safeguard the gentleman in the context of ‘self neglect’.

1.3 The gentleman referred to in this review will be known as Adult E to protect him and his family’s identity. Adult E is a white British gentleman who was 72 years of age when he was admitted to hospital following a further and significant decline in his ability to care for himself at home.

1.4 Adult E had been married until 2008 when he separated from his wife. Following a fall later in this same year he sustained a head injury which required a brief period of care in a residential home until Adult E was well enough to return to his own home with the support of his 2 sisters. His alcohol intake gradually increased and his sisters felt he was showing signs of mental health problems including depression.

1.5 In June 2019 Adult E’s self neglect increased significantly resulting in the North West Ambulance Service (NWAS) submitting 4 safeguarding referrals to the Local Authority between June and October 2019. On 21<sup>st</sup> October 2019 Adult E was admitted to hospital after the NWAS attended his home and found him with clothing stuck to his skin and his sofa rotting away underneath him.

1.6 Adult E spent 55 days in hospital receiving treatment for pressure ulcers before being transferred to a nursing home where he remains.

## **2 Terms of Reference for the Review**

2.1 A Multi-Agency Review Panel was established by RBSAB to conduct this review and report progress through its Chair to the Board. The review panel comprised representatives from all the agencies involved in Adult E’s care with the exception of Calderdale Care who provided reports of their work with Adult E.

2.2. The review panel agreed the scope of the review should include the time period between January 2016 and December 2019 but to include key relevant events which

may have influenced Adult E's self neglect from 2008 to 2016. It was agreed that the purpose of the review would be to:

- Determine whether decisions and actions in the care of Adult E complied with RBSAB's safeguarding policy and procedures.
- Examine inter-agency working and how effective this was in the care of Adult E
- Explore the effectiveness of information sharing between partner agencies
- Examine the care co-ordination throughout the timeframe identified for the review and consider if roles and responsibilities of the key professionals were understood by others involved.
- Scrutinise the timeliness of interventions for Adult E
- Examine the quality of assessments undertaken on Adult E
- Reflect on the recommendations and action plan from an earlier learning lessons review to see if the lessons learnt were disseminated effectively and recommendations from that review have been implemented
- Identify any further actions required by RBSAB and its partners to promote learning and support improvement to systems and practice in future

### **3 Legal Context**

3.1 Under the Care Act 2014 Safeguarding Adult Boards are responsible for Safeguarding Adult Reviews (SARs) in the following circumstances:

(1) A Safeguarding Adults Board must arrange for there to be 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 a 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, condition 1 or 2 is met

(2) Condition 1 is met if

a, the adult has died, and

b, 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).

(3) Condition 2 is met if

a, the adult is still alive, and

b, the SAB knows or suspects that the adult has experienced serious abuse or neglect

(4) A SAB may 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).

## **4 Methodology**

4.1 This SAR has been conducted using a modification of the multiagency Child Practice Review (CPR) model which is an evidence based model implemented in Wales for conducting Child Serious Case Reviews (Protecting Children in Wales 2013). The methodology is consistent with the principles set out in the Care Act (14.167) and essentially endeavours to reflect and learn from what has happened and to improve local multi agency practice to improve outcomes for adults at risk of abuse or neglect. The focus of this review is twofold; highlighting current good practice, and learning to improve future practice to improve the quality of outcomes. It is not about apportioning blame on either individuals or agencies.

4.2 The process involved a Review Panel of representatives which included Safeguarding Leads and Senior Managers from the agencies who had been involved in the care of Adult E. The review panel was chaired by a SAB member who had no previous knowledge or involvement in the case. The role of the Review Panel's members was to provide the independent author and other panel members with all relevant information held by their agency in order to identify practice challenges and themes and to agree learning.

4.3 Using this methodology allows for a collaborative and analytical approach to the SAR process. Chronologies were provided by all agencies evidencing their involvement with Adult E, this information was then used to support discussions at the panel meetings and assisted in the planning of a practitioners learning event. It enabled the bringing together of front-line practitioners from the key agencies to a facilitated Learning Event. The aim of the Learning Event was to explore why those involved acted in the way they did at the time, and included analysis from their perspective of significant events and the practitioner's experiences of working with Adult E during the period agreed by the terms of reference.

4.4 Following the Learning Event the themes drawn out were discussed at a further panel meeting to explore whether the front-line practitioners views on the challenges and learning themes were concordant with the initial views of the panel members.

## **5 Significant Events January 2016 – January 2020**

### 2016

25.01.2016 Adult E's sister called the GP surgery because of her concerns over his alcohol intake and because she felt he was unwell. He was sent to the North Manchester General Hospital (NMGH) and admitted as an inpatient.

28.03.2016 Adult E attended the Emergency Department (ED) Presenting condition was noted as 'doubly incontinent, smelling strongly of urine. Not coping at home, increased confusion and has not moved from sofa for 2 days. Excoriation marks to buttocks'. A history of self-neglect was documented. Adult E was admitted and treated for a urinary tract infection.

30.03.2016 Adult E was found to be medically fit for discharge. Staff spoke to his sister who stated "He isn't managing and his house is very unkempt. He uses alcohol to excess and usually goes out to get his own alcohol". On mobility assessment that day staff documented Adult E was very unsteady, able to walk but needing support at all times. Not safe to try stair assessment and would need an Occupational Therapy (OT) assessment prior to discharge and referral to podiatry. Adult Care received a referral from hospital ward staff requesting assessment for hospital discharge.

31.03.2016 The OT assessment recommended equipment for the home which included amongst other aids: a commode for downstairs and a toilet frame for upstairs. It was documented that Adult E would benefit from re-ablement from the Short Term Assessment and Re-ablement Service (STARS) Team<sup>1</sup>. Adult E was then discharged from OT service, seen and treated by podiatry with no further follow up being required.

01.04.2016 Physiotherapy staff assessed Adult E documenting that Adult E had been mobile on the ward with no concerns; unsteadiness on his feet was likely to be due to withdrawal from alcohol. The physiotherapist recorded that Adult E did not require a stairs assessment prior to discharge and no further follow up was required.

03.04.2016 ward staff recorded that the social work assessment had been completed describing Adult E as having 'Acopia' meaning not formally unwell, but unable to cope with living independently. A package of care discussed and agreed. STARS visits to Adult E's home were arranged for twice a day to provide daily living support and medication prompts.

10.04.2016 Personal Assistant from STARS called Adult Care concerned that Adult E was not eating properly and not drinking adequate fluids. Adult E had told staff that he had already eaten and had had a wash before they arrived. By the 14.04.2016 STARS informed Adult Care that they were cancelling his lunchtime visit as he was now managing independently.

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<sup>1</sup> STARS This service provides short-term support of up to six weeks to help people recover or cope after a decline in their health. <https://staywell.rochdale.gov.uk>

28.04.2016 STARS staff requested a GP review as Adult E's feet reporting they were swollen with possible signs of cellulitis. A GP referral was made to the Out of Hours GP Service (BARDOC)<sup>2</sup>

04.05.2016 STARS support ended as Adult E was considered enabled.

## 2017

28.05.2017 Greater Manchester Police (GMP) were contacted by Sister of Adult E in relation to fraudulent transactions on his bank account by someone who had befriended him. This safeguarding episode was managed in accordance with the RBSAB policy and procedures by Adult Care and the Police it was closed on 22.08.2017 after a safeguarding protection plan was agreed with actions for Sister Y to apply to be Adult E's appointee and Adult Care referring to a home improvement agency for assistive technology aids to improve home safety, and referral for a fire safety check.

## 2018

There is no direct contact with Adult E by any agency during these 12 months for the purposes of this safeguarding adult review.

## 2019

16.01.2019 GP surgery received an ED discharge notification stating that Adult E was seen in the local ED with a chest infection. No documentation about self neglect was recorded.

19.06.2019 111 Call for Adult E by Sister Z to the ambulance service, she was concerned that her brother was self neglecting and not managing his toileting and hygiene needs. She felt he was becoming increasingly frail and losing weight. The call handler spoke to Adult E himself and he consented to the GP being contacted with a view to a home visit being made and a safeguarding referral being raised as he admitted he needed some help. 1<sup>st</sup> Safeguarding referral submitted to Adult Care by the North West Ambulance Service (NWAS).

19.06.2019 Adult E's sister contacted the GP practice to request a home visit because of her concerns about her brothers deteriorating physical and mental health. She was concerned that he had been losing weight, was increasingly frail and had mental health issues that had never been addressed. His GP referred to BARDOC for a home visit and a Practice Nurse visit for bloods and recording of

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<sup>2</sup> BARDOC is a seven day access service for Heywood, Middleton and Rochdale which allows patients to have more flexibility on where, when and how they use local health services. The service helps patients who have difficulty getting to the doctors in person. <https://BARDOC.CO.UK.7-day-access-service>

weight. GP record for Adult E evidenced that Adult Care were liaising with the surgery and the family had been updated.

20.06.2019 Safeguarding referral reviewed by Adult Care who were also aware that the GP had been contacted and advised to call Sister Z in the hope of arranging a home visit. An assessment of Adult E's care needs was now necessary; from the information on the safeguarding referral he was found not to be at immediate risk but did require an urgent review.

20.06.2019 Adult Care spoke to Sister Z after being unable to contact Adult E by telephone she explained that her brother had deteriorated in a short time period and was not washing and neglecting himself. He was reported to have pressure ulcers and Sister Z suggested this was due to him not moving from his chair and urinating where he sat. She reported him to be struggling with mobility and getting upstairs to the toilet. Sister Z said his GP was supporting with medical needs and she was collecting a prescription for him that afternoon. Sister Z felt that he was becoming depressed and was unable to complete tasks due to his health. She explained that she and her Sister visited him regularly but were struggling to provide all necessary support due to their other commitments. Sister Z expressed that she felt it was urgent that Adult Care see him. Adult Care then contacted the GP surgery for further information and were told that a BARDOC Doctor had visited the previous night and referred to a Focused Care Worker<sup>3</sup>. After this discussion the case was sent for urgent allocation.

24.06.2019 Adult E seen by a GP in his own home as no access previously, his sister was present at the visit. It was noted that the house and patient were unkempt. Adult E's beard was orange, there was a smell of urine and faeces, he was refusing to change clothing, possible scratch mark and pressure ulcers, socks stuck to feet. Mood in high spirits, dosette box unopened. Adult E appeared short of breath, sepsis considered. Drinking 29 units of alcohol a week. Clinical impression was exacerbation of chronic obstructive pulmonary disease (COPD).

26.06.2019 Telephone call from the GP surgery to offer support for Adult Care visit. District Nurse involved, surgery seeing if Focused Care can add anything.

27.06.2019 Adult Care completed their assessment visit at Adult E's home address, also present was his Sister Y. Adult E was described and being unkempt and there was a strong unpleasant smell in the house. His clothes appeared threadbare and heavily soiled. His left foot was swollen with an open wound underneath. Adult E was questioned and was unaware of the wound. Sister Y reported that a nurse had visited on 24.06.2019 to take bloods and observations. There were approximately 24 packs of medication next to the television. Adult E explained that he currently had a chest infection and was taking medication for this. Sister Y explained that she

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<sup>3</sup> Focused Care CIC is a partnership agency working to reduce health inequalities and empowering people to take responsibility for their own health <https://focusedcare.org.uk/what-is-focused-care>

used to buy him several 4 packs of lager when doing his shopping but these would be gone in a day and she now bought him less. She expressed concern that he didn't hydrate himself with anything else. Adult E disagreed with his Sister's comments on him not using the toilet and not taking his medication. Adult E could not remember the last time he had shaved or had a wash. He said that he chose to sleep downstairs and didn't eat regular meals. Adult E was asked about his mobility and he said he didn't go out anymore and his mobility wasn't what it used to be.

Outcomes were recorded as: discussed having STARS homecare for 2 week assessment which Adult E agreed to consider. Financial charges after the assessment period were discussed, both Adult E and his Sister Y agreed to this. Adult E also consented to referrals to District Nurses for his feet and to Community Physiotherapy for mobility and walking aids. Adult Care spoke to the GP surgery for further information on the visit mentioned on 24.06.2019. They were informed that the nurse who visited did not look at Adult E's feet as he had refused. The Nurse had escalated this to the Doctor when she returned to the surgery.

28.06.2019 999 call for Adult E by GP, BARDOC had visited the day before and Adult E had refused to attend hospital but today he had been persuaded to attend by his family. The GP was treating Adult E with antibiotics for a chest infection. The crew completed clinical observations, it was noted blood pressure was low and heart rate was slightly elevated. Adult E was transported to hospital. The crew completed a 2<sup>nd</sup> Adult Safeguarding referral which was sent to Adult Care. The referral reported that Adult E was self neglecting and not eating properly. His mobility was poor and he soiled regularly.

28.06.2019 Adult E was brought into hospital by ambulance, GP had been treating Adult E for a chest infection and called ambulance due to concerns around self neglect. Records documented that Adult E was alcohol dependent, drinking 4 cans of 9% lager per day, no spirits. Social history was documented as living alone with a sister who lived next-door. Adult E stated that his two Sisters helped him. He had a wound to his left toe which was discharging pus. Diagnosis was documented as self neglect secondary to alcoholism. An appropriate plan of care was commenced. Documented in ED was a discussion about involving Adult Care but Adult E stated he could manage well himself and his sister was next door.

29.06.2019 Adult E was transferred from ED to the Admission Medical Unit (AMU) for observation and clinical follow up. Pressure relieving mattress was in place on the bed due to pressure ulcers to buttocks. Community acquired pressure ulcers reported as a clinical incident on Datix® the hospital incident reporting system. Nursing records documented that Adult E was referred to Adult Care, podiatry and tissue viability, that Adult E was very unkempt but for discharge home later that day. Adult E was seen by the hospital discharge coordinator at 13:10 who documented that Adult E was self-caring and independent. He had 2 sisters one lived next-door and the other not far away. They supported him with meals and shopping, he didn't

have carers and stated that he didn't need them as he felt he was ok. He declined referral to alcohol liaison saying he drank 4 cans of lager a day but didn't feel this was excessive. On assessment he was a little unsteady, therefore a walking frame was provided. Documentation stated that he was able to toilet independently and go up and down stairs safely. He agreed to a referral to Community Physiotherapy and said he would contact his sister when he was at home. Medications were arranged for discharge along with transport to take him home.

01.07.2019 Adult Care received a notice to assess from NMGH.

02.07.2019 Home visit made by GP following handover of care correspondence from the hospital it was documented by the GP that Adult E had recently been discharged from hospital on 29.06.19 with infected toe, he declined any social input, but has been reported to have mental capacity there were no concerns about Adult E's mental capacity.

02.07.2019 Adult Care contacted the hospital ward for an update and was told that Adult E had been discharged home on 29.06.2019. The NWS adult safeguarding referral was received by Adult Care documenting concerns about the condition of Adult E's home and lack of up to date medication. Referral stated furniture was heavily soiled and there were many unopened letters. Adult E's personal hygiene was extremely poor and he was unable to recall when he last changed his socks. A referral letter dated 02.07.2019 from the GP stated that Adult E's Sister had recently contacted them with concerns about her brothers ability to self-care. The letter gave information about a Practice Nurse visit completed on 24.06.2019 and an out of hours GP visit following concerns raised by Adult Care from a visit completed on 27.06.2019. The letter gave an update that he was advised to attend hospital regarding foot wound, did so and was now discharged back home. The GP explained that they attempted a home visit on 02.07.2019 but were unable to gain access.

04.07.2019 Sister Y contacted Adult Care following telephone message being left; they discussed referring to District Nurses for support with foot wound and a period of homecare assessment from the STARS team. The potential difficulties with services gaining access to the property were discussed and Sister Y agreed to arrange to have a keysafe fitted to Adult E's property. This was fitted the same day and Sister Y agreed that the code to the keysafe could be shared with the District Nurses and STARS team.

Adult Care contacted the District Nurse coordinator to explain the reason for the referral in relation to wound management of left foot. They also requested a continence assessment and assessment of skin condition, key safe details were shared. District Nurse coordinator agreed to put a scheduled visit in the following day. A referral was also completed to the STARS team requesting 2 visits per day.

08.07.2019 STARS team recommence visits which can only be provided with Adult E's consent. Adult E discussed at GP surgery MDT regarding concerns for his health and welfare. The outcome was that the District Nurse and Focused Care Worker were to visit Adult E's home.

09.07.2019 Adult Care recorded a case note from a STARS Personal Assistant advising that Adult E had declined all support with personal care or continence care. He was described as a 'lovely man' who enjoyed a chat but would not accept further support. The STARS Personal Assistant raised concerns regarding the little toe on left foot; Adult E had also declined any food or drink. Details were given of condition of soiled furniture in the property. A chair was described as having 'no bottom' with a rotten wooden frame.

Telephone call from Adult Care to GP surgery passing on concerns raised by STARS that he had refused support and was sat in faeces. Telephone call received from Dr K, they had discussed and were sending a Focused Care Worker and District Nurse to visit at home that day. Adult Care discussed their concerns regarding his left foot and Dr K agreed to speak to Adult E's family about the need for hospital treatment if the foot was in as bad a condition as described by STARS.

Following the home visit to Adult E the District Nurse redressed the foot and was ordering additional dressings for when she returned on 12.07.19. She felt Adult E did not need to be in hospital for treatment of his foot. She raised concerns about the condition of the furniture and advised him to move his bedroom downstairs. District Nurse confirmed he had a commode stored in his porch which he should have been using.

A telephone call from Adult Care to Sister Y provided an update of feedback from the District Nurse regarding moving the bed downstairs and using the commode. Sister Y confirmed that family could organise these changes at Adult E's home.

Discussion recorded between Adult Care and Mental Wellbeing Practitioner from MIND Wellbeing Service. She agreed to visit as he may be suffering from depression. Adult Care completed referral forms and handed these to the District Nurse to complete with Adult E to gain his consent when she was to visit him as planned on 12.07.19.

A further telephone call from Adult Care to Sister Y was made to summarise plans made to keep District Nurses involved, obtain Adult E's consent for a Mental Wellbeing Practitioner to begin to work with her brother and progress his home care through transition from the STARS service to a home care agency.

09.07.2019 GP staff spoke to Sister Y who raised the same concerns about safety. The toe on one of Adult E's feet required treatment. Adult E needed to go to hospital because of the risk of sepsis. He was refusing to engage with services or receive any medical input. A further referral was made to BARDOC. Practice Nurse and

District Nurse arranged and attended a home visit together with the knowledge of his sister. On attending, the District Nurse dressed his toe and the record noted that he was very polite and did not refuse treatment. The GP surgery also received an update from Adult Care regarding the conditions in Adult E's home.

10.07.2019 Adult Care informed by STARS Coordinator that the STARS Personal Assistant found Adult E was difficult to assist the previous night and refused to engage with any of the support offered. He was reported to have been incontinent of faeces and urine and said he would get a shower later. The Personal Assistant stated she pointed out to him he had faeces on his clothes and feet and reported he did not appear to be concerned about this. The case note also reported feedback from the morning visit of the same issues. The Personal Assistant had tried to persuade Adult E to engage in support with personal care, continence care, dressing, and preparing food and drinks and prompting with medication but he repeatedly declined to engage. Staff explained she had reported the concerns to the District Nurse and GP practice and requested a medication review.

STARS Coordinator informed Adult Care that due to the poor condition of the property and health hazard due to faeces, urine, extremely strong odour and air quality as well as Adult E not engaging in support, that STARS would not be able to continue to work with him. Family made aware.

Social Worker required to complete Mental Capacity Assessment of Adult E regarding understanding of care needs. Case allocated, telephone call from Social Worker to Sister Y to arrange assessment visit. Sister stated she would also be present.

15.07.2019 Adult E was discussed in the District Nurse huddle meeting, who gave feedback from her visit on 12.07.19. She had attended to Adult E's left foot which was responding well to treatment. Adult Care updated the nursing team about the planned mental capacity assessment visit for 17.07.19. District Nurse stated Adult E had agreed to move his bed downstairs and agreed he needed a new sofa. Adult Care had spoken to his family about this and they had agreed to support with changes to downstairs living. An update was also given about STARS starting on 08.07.19 but ending the following day due to the lack of engagement from Adult E. District Nurse also reported she had taken the referral forms for input from Mental Wellbeing Practitioner but Adult E had declined to sign them.

The Social Worker had also attended the meeting and agreed to complete a joint visit with the District Nurse on 16.07.19. A telephone call from the Social Worker to Sister Y was made informing her of the planned joint health and social care visit.

16.07.2019 The home visit was completed by Social Worker with Sister Y also present. Adult E was given an explanation of the purpose of the visit and nature of concerns raised by professionals. He was described as being in a good mood and was willing to talk and was making appropriate jokes. His personal appearance was

described as 'unkempt' with matted hair. Clothing was described as 'fairly clean' and he was wearing clean socks. He explained that he sat on his sofa all day and slept on it at night. Adult E was aware of the poor condition of the sofa and agreed to replace it. Risks around health and infection were discussed and he was described as 'appearing to understand'. He said his reluctance to engage was due to it making him feel 'useless and desperate'.

When questioned about using the commode he appeared to be 'embarrassed and evasive'. He did agree to consider moving his commode into the living room. His medication pack was checked which showed he had taken some medication correctly but not taken the antibiotics he had been given. Following discussion about ongoing need for support and risk of him neglecting his own needs he agreed to a morning visit from a home care agency.

On the same day a telephone call from the District Nurse was taken by the Social Worker advising her that she saw Adult E shortly after Adult Care had finished their visit. She advised he had scored highly on a sepsis screening tool and she had asked the GP to visit that afternoon. The District Nurse had also discussed a rehab placement to improve mobility and Adult E had agreed to this.

16.07.2019 GP visit resulted in an ambulance being called by Practice; Adult E was taken to the ED. NWS crew reported he lived alone and self-neglected, poor hygiene and the house is untidy. 3<sup>rd</sup> Safeguarding Adult referral made to Adult Care from NWS crew.

16.07.2019 18:10 Brought in to ED by ambulance, sent by GP as concerns around Sepsis. District Nurse had been in attendance completing regular dressings to the wound and was concerned that patient had possible signs of sepsis. Currently on antibiotics for wound to left foot. Reviewed in ED following a full clinical review there were no signs of sepsis recorded. Adult E was discharged home and instructed to come back if persistent fever developed and follow up with GP would be requested.

17.07.2019 Adult Care received the 3<sup>rd</sup> safeguarding referral from NWS. Ambulance crew expressed concerns about condition of property and raised concerns about him having no care package in place. Assessment from Adult Care requested. Joint visit by Social Worker and District Nurse arranged for a joint visit on 22.07.19 to confirm if Sister Y can make necessary changes to living situation and whether Adult E would agree to a short term placement.

22.07.2019 The home visit was completed by Social Worker without the District Nurse. Adult E's brother in law was dropping off clean clothing for him. Adult E was on his sofa when the Social Worker arrived and was able to recall who she was. She asked if he had found any new furniture yet and Adult E said his sister had found someone to take up the old carpet and get rid of the armchair and sofa. The Social Worker continued her Mental Capacity Assessment regarding Adult E's

understanding of his care needs and risks from self-neglect. He was still consenting to have carers support him at home.

23.07.2019 A further home visit was completed by Social Worker with District Nurse. Adult E agreed to nurses supporting him to change his clothing and wash. During the visit the Social Worker phoned Sister Y who was arranging removal of soiled furniture. The Social Worker agreed with Adult E to find a mobile barber to come to cut his hair and beard. She told Adult E that the Mental Wellbeing Practitioner would be visiting on 25.07.19.

23.07.2019 Mental Capacity Assessment completed by Social Worker with the outcome that Adult E had capacity to make decisions about his care and support.

24.07.2019 The Social Worker contacted a Care Agency to arrange a start date for home care visits, agreed to start on 26.07.19.

25.07.2019 Adult E was seen at home by Mental Health Liaison Nurse, psychological primary care services for first of 3 assessment visits. Adult E was observed to be much neglected in both his self-care and care of his environment. He lived in 1 room of his house, and was supported by his sisters. Close liaison with District Nurse's and Adult Care via the huddle was noted with reference to this case.

29.07.2019 Adult Care case noted that the District Nurse raised concerns that Adult E was again declining support from the Care Agency, allocated Social Worker aware.

31.07.2019 A further home visit was completed by the Social Worker. Furniture and old carpet had now been removed. Bed had now been moved downstairs and a small sofa delivered that morning. Rugs on the floor at present with plan to put cushion flooring in the following week. Adult E had had his hair and beard cut by his brother in law. Home was described as having a more pleasant smell with old furniture removed. Adult E appeared to be in a better mood. Agreed actions were for Sister Y to continue supporting him with his finances and with financial assessment and to review care in a few weeks.

05.08.2019 GP spoke with Social Worker, Practice Nurse was closing episode of proactive care as Adult E now has care support.

30.08.2019 Request for visit by GP from one of Adult E's carers, concern was expressed that he had deteriorated and needed a home visit. This was undertaken by BARDOC, redness to right foot noted receiving care from DN's every three days, antibiotic prescribed.

03.09.2019 GP staff spoke to sister who stated her brother looked depressed, GP agreed to complete a home visit the following day.

04.09.2019 Dr K completed a home visit with Adult E's sister present. His toe was improving but feet were swollen. Adult E had been taking prescribed medications, he expressed no suicidal thoughts, house conditions were noted to have improved and a medication review was undertaken.

09.09.2019 Concerns were raised at the District Nurse huddle meeting attended by the Adult Care. There were continued issues with self-neglect and incontinence with concerns that personal hygiene was not being managed and was getting worse. MDT to determine what further support could be provided. The Social Worker arranged a review meeting with Home Care Agency for 11.09.19. Case note by Social Worker stated District Nurse's to be invited to the review meeting.

11.09.2019 A joint visit was completed by Social Worker and staff from the Home Care Agency. Adult E was described as being able to engage with the discussion although was dismissive of concerns about skin and his refusal to use the commode. He stated at the review that he had been going upstairs to use the toilet and did not use the commode. The Social Worker gave her opinion that 'it was evident that he was not using the toilet and was instead choosing to urinate and defecate on his sofa'.

At this visit the Home Care Team reported concerns that he appeared to be bleeding from his bottom as they had found a bloodstained incontinence pad in the kitchen bin and blood on the kitchen floor. Adult E had refused to allow carers to examine his skin and stated he had used the pad when he had cut his hand. Adult E's Sister stated she had called the GP but they had refused to attend a home visit. A further health and social care meeting was to be convened following discussion with Adult E's GP.

12.09.2019 Phone call received by GP staff from Adult E's sister saying that patient was bleeding anally and had not eaten for 6 days. 5 attempts to contact patient and sister were recorded.

12.09.2019 Mental Wellbeing Practitioner visited Adult E at his home. His living room was in a much better condition, having had his flooring and furniture replaced. He suggested he was using the bed provided to sleep in, although this did not look like it had been used at all. He also reported he was visiting the lavatory rather than using his commode, but again this was questionable as there was still a smell of urine. The practitioner was concerned that he was spending all day laid on his sofa. There was alcohol (can of lager) and cigarettes at his side. Adult E maintained his sister was providing him with food.

Adult E stated he had no interest in receiving visits any further, and reported he was perfectly ok. The Practitioner noted that they may need to respect this decision but will in the short term continue to try and build a therapeutic relationship. Adult E had agreed to consider the woodworking classes at the Lighthouse Project and the Practitioner stated they would obtain the details of this for him. The agreed plan was

to return in 2 weeks and try to explain to him the benefits of continuing to see someone from their service.

23.09.2019 Adult E was seen at home by Mental Health Wellbeing Practitioner again to continue to attempt assessment. Adult E was noted to be clearly quite passive in his engagement, and on questioning, he was ambivalent to the service input. However the Practitioner would continue to try and build up a clear assessment over the coming weeks.

23.09.2019 Patient seen in own home by Practice Nurse for an asthma review. He refused consent for her to take a blood test only allowing his blood pressure to be checked. The Adult E was noted to present as smelly and unkempt.

24.09.2019 Social Worker left a message for the District Nurse to contact her to arrange an MDT with the Home Care Agency also present.

25.09.2019 Adult Care received feedback from Community Physiotherapist that Adult E had refused a falls assessment.

07.10.2019 MDT meeting held, members present were from Adult Care, District Nursing service Mental Health Wellbeing Practitioner and the Home Care Team, Sister Z was also in the meeting via telephone. Ongoing concerns were raised that Adult E continued to refuse care and support with toileting or personal care. He continued to accept home visits and was engaging in conversation. He was refusing to use his commode and instead urinated and defecated on his sofa which he also sat on all day and slept on.

Carers raised concerns regarding a bloodstained continence pad found in the kitchen bin. Sister Z stated that she called the GP surgery but they declined to complete a visit. Adult E was reported to be physically able to mobilise to the commode but was not doing so. He was stating to family, carers and professionals that he was going upstairs to use the toilet but was not doing so. His sister believed he had mental health problems and required an assessment of this. Professionals agreed, and the Social Worker agreed she would contact the GP to request a home visit to examine his skin and to make an urgent referral to mental health services.

It was agreed that carers would continue to visit to provide updates and persist with offering and persuading Adult E to accept support with personal hygiene and continence needs.

09.10.2019 the Home Care Agency contacted Adult Care to provide information that Adult E was not allowing the carers to wash him and he was sat in his own faeces undressed from the waist down. She reported that he had been like this 'for a couple of days'. The Social Worker telephoned the GP surgery and was advised to send a letter making the requests for home visit and mental health referrals. Letter emailed securely.

10.10.2019 The Social Worker telephoned the GP surgery for an update and response to her letter. The surgery receptionist advised her to re-send the letter which was done. Several follow up calls are made later in the day and the Receptionist stated that she would speak with the Practice Manager. No telephone call was received from GP or Practice Manager with an update.

10.10.2019 Adult E was seen at his home by the Mental Health Wellbeing Practitioner. They noted that he continued to display very poor personal hygiene but he would disagree with this and suggested he was showering/bathing regularly. There continued to be a powerful smell of urine and faeces in the property. The Practitioner discussed with him various professional concerns, including the possibility of a pressure sore to his sacral area due to him not moving around, and possibly having urine and faeces in that area. Adult E denied all of this and stated he was ok. With regards to making this decision the Practitioner concluded that Adult E had mental capacity. He denied feeling low in mood or anxious and suggested he had no worries. The Practitioner confirmed they would visit again in 2 weeks.

14.10.2019 Telephone call received by Social Worker from the home care agency sharing information that Adult E had refused all support with toileting and personal hygiene and had been sitting in faeces and urine since 11.10.19. He was not allowing any carers to change his clothes or wash him and was becoming verbally aggressive when they tried. The Social Worker telephoned the GP surgery and was told a GP was visiting later that day. A telephone call was taken by the Social Worker from Sister Z informing her of the time of the GP visit and requesting she be present too.

14.10.2019 Adult E was seen by GP as he was refusing care and aggressive the Social Worker was concerned about his mental health. GP noted recent discussion in MDT (District Nurse assessed him to have capacity despite refusing input from community services). The GP made an urgent referral to the mental health crisis team. On assessment the GP concluded that Adult E lacks capacity - living in such detrimental conditions.

14.10.2019 Rochdale Approved Mental Health Practitioner (AMHP)'s were told physical checks had been completed by the GP on 14.10.2019 Adult E's sister who was present at the time disagreed that the GP had done any physical health check. The AMHP Informed Sister Z that the Intensive Home Treatment Service (IHTS) would be visiting her brother tomorrow morning. She requested that they contact her with the time of the visit.

17.10.2019 The Consultant Psychiatrist was willing to complete a joint visit for a Mental Health Act assessment. A member of the team spoke with Consultant Psychiatrist as they believed it was inappropriate for Adult E to be on a Mental Health ward due to his physical health which would be more appropriately managed in an acute hospital, the AMHP felt that Adult E had capacity. The GP insisted that

Adult E needed assessing by Mental Health Services, following this conversation a referral to IHTS was completed.

The GP requested a Mental Health Assessment due to Adult E's health deterioration. He believed he did not have capacity and advised 'His cognition has significantly declined and based on his assessment from last visit, he lack mental capacity or understanding of living in such poor unhygienic condition. This is leading to pressure sore, infected wounds; risk of sepsis etc. which could be fatal and detrimental for his life.

18.10.2019 Two Mental Health Nurse's assessed Adult E at his home address where he was with his Sister Z. Adult E was documented as being slouched on his sofa presenting in an unkempt manner and only partially dressed. Adult E was told that staff had been requested to do a home visit following concern from his family and professionals about his ability to self-care. Adult E did not appear to have any insight into his current circumstances and staff did not believe he currently had capacity to make decisions regarding his wellbeing and health care. Adult E was asked if he would consider going to hospital to have an assessment. Adult E declined this saying he would be ok. On receipt of this information a Consultant Psychiatrist agreed to make the recommendation for a Section 2 Mental Health Act (MHA) assessment<sup>4</sup>.

21.10.2019 A 999 call to NWS was received from Adult E's home by a mental health care professional. Adult E was being admitted to hospital under Section 2 of the Mental Health Act. The crew completed a 4<sup>th</sup> Adult Safeguarding referral which documented severe self-neglect: with conditions in the home extremely poor, it was noted that the sofa had rotted away with Adult E sat on it.

21.10.2019 Adult Care were aware of the MHA assessment recommendation being made. AMHP informed Adult Care that on arrival Adult E was slouched on the sofa and there was an overpowering aroma of urine. He was only partially dressed sitting in faeces and urine, he was unable to move from this position. Adult E denied defecating and urinating on the sofa and denied being uncomfortable. He stated he was independent with cooking and could look after himself and use the commode. Adult E did not feel there were any concerns with his mental health or physical health and said he was fine. He showed no insight into why others would have concerns for him.

AMHP stated that his physical state and self-neglect was their primary concern although the GP felt he was showing signs of 'senile squalor syndrome'<sup>5</sup> and he completed a section 2 recommendation, as did the AMHP.

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<sup>4</sup> Section 2 of the Mental Health Act allows compulsory admission for assessment or assessment followed by treatment and can last up to 28 days <https://www.mind.org.uk/legal-rights/about-sectioning>

<sup>5</sup> Diogenes Syndrome also known as Senile Squalor Syndrome is a disorder characterised by extreme self-neglect, domestic squalor, social withdrawal, apathy and lack of shame <https://www.bgs.org.uk>

When the ambulance arrived at 16:40 to convey Adult E to hospital the 'true extent of his poor physical condition became apparent'. The paramedics removed his socks and jogging bottoms which were stuck to the skin with faeces and urine, his legs and feet were very swollen. He had moulded to the sofa and it was difficult to transfer him to a wheelchair as he could not move forward. His skin appeared to be stuck to the sofa and blood dripped down his legs which may have been from skin breaking or from another source. Paramedics were asked to take Adult E to ED as a priority over the admission for his mental health Section 2 admission. AMHP contacted the GP to express concern at the poor state of his physical health and delay in getting him physically assessed or treated. AMHP stated that in her view the mental capacity act or inherent jurisdiction through the Court<sup>6</sup> of would have been more appropriate routes to address these issues.

The AMHP spoke with nurse in charge at ED and the Mental Health Liaison Team to explain that Adult E could not be returned home as there was not sufficient support in place and he was 'liable to be detained'.

At 22:00 Adult E was declared medically fit and could be transferred from the ED to a mental health ward. The Emergency Duty Team (EDT) agreed that Adult E could be transferred to bed on a mental health ward. Adult E was transferred by ambulance with a Liaison Mental Health Team worker to ensure safe discharge.

22.10.2019 16:35 ED staff made aware that Adult E had been discharged from ED with extensive pressure sores from his shoulders to his feet. He had no dressing in place despite spending the previous evening in the ED. Following discussions with the medics and bed managers it was arranged for Adult E to be transferred to AMU for further medical treatment. Both he and his sister were informed of this plan, who were both in agreement and Adult E was discharged from his section 2 and admitted to hospital for treatment of his physical health needs.

22.10.2019 17:19 A full medical history and background to self neglect was documented in ED. Multiple areas of pressure damage present to buttocks. Left buttock recorded as category 3 (4x4cm). Right buttock unstageable. Left shoulder unstageable. Other areas of redness and excoriation of the skin caused by scratching. Impression, infected pressure ulcers.

Safeguarding Adult referral completed in ED. Medical illustrations were requested as it was reported there was too much skin damage for ED staff to photograph. Collateral history was taken from family; sister had tried to get help for him to no avail until recently when she put in a complaint to the GP where he was transferred

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<sup>6</sup> Adults who are vulnerable but who have capacity are outside the jurisdiction of the MCA 2005. The High Court can use its inherent jurisdiction to intervene to protect vulnerable adults who might be at risk of significant harm or exploitation <https://uk.practicallaw.thomsonreuters.com>

to ED for a mental health assessment. Appropriate medical plan put in place, Adult E admitted to AMU.

22.10.2019 Adult Care received Safeguarding Adult referral from NWAS staff.

05.11.2019 Mental Health Practitioner attended acute hospital ward where Adult E was receiving care following referral for MHA assessment again. The AMHP documented that Adult E had been admitted with infected pressure ulcers and scabies and was still being barrier nursed at this time; the general consensus was that this neglect was secondary to mental illness.

Adult E was assessed as being pleasant but minimised any concerns that were raised with him, he denied any issues at home, denied self neglect and denied being incontinent. He reported his mood was 'ok' he denied feeling depressed or low in mood, he had affect but this was reduced but not blunted. Adult E stated he did not think he required any input from Mental Health Services and did not want follow up when he was discharged from hospital. He denied any thoughts to harm himself and had no thoughts of wanting to harm others. He denied any psychotic symptoms, and did not appear to be responding, there was no evidence of thought disorder and did not appear perplexed. He denied any issues with sleep, appetite, motivation or concentration; he did have food and drink next to him at the time of the assessment. Adult E stated he drank 4 cans of lager a day.

An Abbreviated Memory Test (AMT) was completed and Adult E scored as 8/10. At time of assessment it was noted that Adult E lacked capacity and was being treated under a Deprivation of Liberty (DOLS<sup>7</sup>). However at the time of the assessment, he was able to understand weight up and relay information. The AMHP documented that this would need further exploration as Adult E did minimise and deny everything placed to him and this would need further discussion with his Sisters.

He advised that Adult E be discussed in the following morning's MDT and to be reviewed by a Consultant Psychiatrist prior to discharge as Adult E had been detained under the Mental Health Act, he was also refusing any input from community services.

06.11.2019 Consultant Psychiatrist reviewed Adult E after discussion in Liaison Mental Health Team MDT. Adult E was noted to have had at least a 15 year history of alcohol dependency and misuse. It was noted that he was thin and cachexic<sup>8</sup> with a dishevelled beard, his dental hygiene was poor and he had contractures in both his knees.

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<sup>7</sup> Deprivation of Liberty Safeguards (DoLS) is an amendment to the Mental Capacity Act 2005. DoLS ensures people who cannot consent to their care arrangements in a care home or hospital are protected if those arrangements deprive them of their liberty <https://www.scie.org.uk/mca/dols/at-a-glance>

<sup>8</sup> Cachexia is a wasting disorder that causes extreme weight loss and muscle wasting and can include loss of body fat <https://healthline.com.health.cachexia>

Adult E was asked and was able to give an account of his life over the last 5 years however was not able to recall events leading up to his admission into hospital. Adult E was assessed as apathetic and struggling with retaining information during the assessment, he denied any thoughts of self harm or harm to others, he denied any psychotic symptoms and had limited insight into his difficulties. The Consultant wrote to Adult E's GP and stated that Adult E would be subject to a best interest meeting for discharge planning but 24 hour care seems to be a safer option than home care.

## **6 Views of the sisters of Adult E**

The independent author of the report spoke to Sister Z on 2 occasions the first on the 11<sup>th</sup> February 2021 and again on 22<sup>nd</sup> March 2021 to gain an insight into the sisters' perceptions of how agencies worked with them and their brother over the time frame of the report. Sister Z agreed that both she and her sister were of the same views, and any information she shared with the independent author could be taken as being from both sisters Y and Z. On the second occasion on the 22<sup>nd</sup> March the independent author wanted to confirm that both sisters were satisfied that their views had been recorded accurately which they confirmed with one amendment.

Sister Z began by explaining that it was their opinion that all the staff that were engaged with their brother over the time frame of the review were nice people trying to do their best but were largely ill equipped to deal with the situation they found themselves in. Sister Z explained that her brother had been a heavy drinker for a considerable period of his adult life and that this had had a negative impact on his marriage which resulted in a separation from his wife. This event followed by the death of their mother they believe resulted in a marked decline in their brother's mental and physical health and wellbeing. Both felt their brother's history of heavy drinking and the impact this was having on his mental health and mental capacity was not fully considered by professionals. He had also previously had a fall and spent time in a rehabilitation unit after suffering a bleed on his brain in 2008.

Both sisters made repeated attempts to get services engaged with their brother but felt exasperated by the lack of challenge by professionals to their brother's statements when there was both previous documented and current physical evidence that pointed to the statements their brother was making were either implausible or untrue. They felt that had more formal mental capacity assessments been carried out and documented this would have provided the evidence professionals needed to act sooner in their brothers best interests. There is evidence in the chronology that staff were undecided about Adult E's mental capacity, the mental health and wellbeing practitioner states 'might have to respect this decision' (page 15 of the report) and the Social Worker who documents 'appears to understand' during the process of assessing Adult E's formal capacity over 3 assessment visits this one on 16.07.19 (page 13 of the report).

Sister Z explained that she and her sister felt their brother was embarrassed to talk about his hygiene and toileting needs and would rather talk about anything else rather than address questions about this. They felt he would accept care to stop conversations and then dismiss the care offered stating to staff that his sisters would help him, or he would do it later when in reality his sisters were unable to help due to their own commitments, and there was evidence to demonstrate that Adult E would not do what he said he was going to 10.07.19 (page 12 of the report), 12.09.19 visit by Mental Health and Wellbeing Practitioner (page 15) and MDT meeting 07.10.19 (page 16) of the report respectively.

When conversing with Adult E both sisters felt professionals noted that he appeared embarrassed and evasive when questioned about personal hygiene and toileting and this wasn't explored in sufficient detail. Both sisters were concerned that their brother was being left to sit in urine and faeces all day and night, was becoming increasingly frail and unable to stand from a sitting position. They reported that he was bleeding anally and had not eaten for 6 days on 12.09.19 (page 15 of the report) but that this information did not prompt a same day visit to confirm or diagnose the problem. They also felt that there was a lack of professional curiosity when informed that Adult E was scratching at his skin in the context of prolonged poor personal hygiene.

Both sisters were left feeling that they struggled to get professionals to come together to properly assess their brother and listen to them as his sisters who knew their brother better than any of the services involved. They believe that had his alcohol use and depression been taken into full consideration his mental capacity could be more accurately assessed. The District Nurse appeared to be focussed on their brother's foot and made little attempt to gain his consent to examine his sacrum despite knowing he had pressure ulcers and was incontinent of both urine and faeces. The GP surgery sent letters requesting that Adult E attend the practice for medical review even though they were aware he was physically unable to do so. It wasn't until a threat to make a formal complaint against the practice that both sisters felt their concerns were properly listened to.

Adult E's sisters felt the care agency staff did their best to try to engage their brother with the support they offered and did alert professionals to their concerns over his lack of engagement with them and both sisters acknowledge that the home environment was not pleasant, with a strong odour of urine and faeces and flies present. They noted that there was a blood stained incontinence pad on 07.10.19 and communicated this promptly (page 16 of the report). Adult E explained that this was due to a cut to his hand and this explanation appears to have been accepted despite there being no evidence of physical trauma to either hand. This was reported to the GP but again no action was taken.

When finally admitted to hospital on 21.10.19 their brother was found to have significant untreated pressure ulcers to his sacrum and back and scabies, an

infection of his skin. Both sisters felt that action should have been taken earlier to address their brothers physical and mental health needs, moving beds downstairs, replacing chairs and carpets were peripheral matters that they were happy to support but were not addressing the root cause of their brother's problems.

## **7 Analysis of Practice and Learning Themes**

In line with the terms of reference for this safeguarding adult review there have been a number of themes for learning which have been taken from the combined agency chronology, the Review Panel Meetings and the practitioner Learning Event, the themes include:

6.1 Compliance with RBSAB's policy and procedure

6.2 Interagency working and information sharing

6.3 Care co-ordination, roles and responsibilities and whether they were understood by others involved

6.4 The timeliness of interventions for Adult E

6.5 The quality of assessments undertaken on Adult E

6.6 Review or recommendations and action plan from an earlier review to see if the lessons learnt were disseminated effectively and recommendations from that review were implemented

6.7 Identify any further actions required by RBSAB and its partners to promote learning and support improvement to systems and practice in future

### **6.1 Compliance with RBSAB's policy and procedure**

**6.1.1** Following the introduction of the Care Act 2014<sup>9</sup> Chapter 14 section 14.2 describes that safeguarding duties apply to an adult who:

- Has needs for care and support (whether or not the local authority is meeting any of those needs)
- Is experiencing, or at risk of abuse or neglect
- As a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect.

14.13 sets out the six key principles that underpin all adult safeguarding work:

- Empowerment – People being supported and encouraged to make their own decisions and informed consent
- Prevention – It is better to take action before harm occurs

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<sup>9</sup> Chapter 14 of the Care Act 2014 sets out safeguarding responsibilities <https://www.scie.org.uk/care-act-2014/safeguarding-adults>

- Proportionality - The least intrusive response appropriate to the risk presented
- Protection – Support and representation for those in greatest need
- Partnership – Local solutions through services working with their communities
- Accountability – Accountability and transparency in delivering safeguarding

13.15 Making safeguarding personal means it should be person-led and outcome focused. It engages the person in a conversation about how best to respond to their safeguarding situation in a way that enhances involvement, choice and control as well as improving quality of life, wellbeing and safety.

14.17 Describes neglect as a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding. It should be noted that self neglect may not prompt a section 42 enquiry. An assessment should be made on a case by case basis. A decision on whether a response is required under safeguarding will depend on the adult's ability to protect themselves by controlling their own behaviour. There may come a point when they are no longer able to do this without external support.

6.1.2 The RBSAB Multi- Agency Safeguarding Policy and Procedures that cover the time frame for this review are Version 8 and compliant with the Care Act 2014, last updated in July 2019. What is abuse and Neglect?<sup>10</sup> Covers self neglect and refers to separate Practice Guidance which is available on the RBSAB's website. This Practice Guidance was published in January 2019. The RBSAB also has a Self Neglect and Hoarding Policy Published February 2018. At the Practitioners Learning Event some practitioners, but not all, stated that they were aware of this document and had seen it. Despite some practitioners not being aware of this document they generally followed the principles set out in the Policy for managing self neglect as evidenced in the combined chronology.

6.1.3 During the time frame for this review Adult Care received a total of 6 Adult Safeguarding referrals in relation to Adult E and self neglect. 4 of these were submitted by NWS between 19.06.2019 and 21.10.2019, the 5<sup>th</sup> was completed by District Nursing staff on 17.07.2019 and the 6<sup>th</sup> by hospital staff during Adult E's last admission on 22.10.2019.

6.1.4 It would seem that Adult Care did not treat all of these safeguarding referrals as 'safeguarding' for the purposes of following the RBSAB policy and procedures. Some were treated as 'care concerns' which meant that action was taken as a result

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<sup>10</sup> RBSAB Multi-Agency Policy and Procedures 3.2.11 Self Neglect page 21  
<https://rbsab.org.professionals/multi/agency-policy-and-procedures>

but that there were no 'formal' multi agency safeguarding enquiries or meetings convened under procedures.

6.1.5 This was a missed opportunity to make more formal recording of multi-agency actions and outcomes for what professionals felt was a capacitous adult when putting together any risk assessment and mitigation plan. There were regular conversations and meetings held to discuss agencies concerns about Adult E and his self neglect, GP surgery MDT meeting, and District Nurse huddle meetings being examples; however these did not sit under safeguarding procedures. As such there was a missed opportunity again to document the various risks that Adult E's lack of engagement posed to his physical health and well-being, what mitigation could be lawfully put in place to encourage him to engage, and who was best placed to continue to be responsible for attempting this. A multiagency risk assessment and plan may have helped practitioners and carers have a clearer focus on actions and would have supported defensible decision making.

6.1.6 The decision not to proceed with a section 42 enquiry of the RBSAB Multi-Agency Policy and Procedures<sup>11</sup> states that a record must be made stating the reasons and that the referrer must also be informed of the decision in a timely way, the reasons for it and information given about any alternative services which have been offered. There is no documentation provided to inform this review that NWSAS were informed of the outcomes of their 4 adult safeguarding referrals by Adult Care.

6.1.7 Multi-Agency Risk Management protocol (MRM)<sup>12</sup> can be considered to facilitate effective multiagency working with adults who are deemed to have capacity and who are at risk of serious harm or death through self-neglect, risk taking behaviour or refusal of services. This framework was not considered by practitioners at the time of working with Adult E however at the Practitioners Learning Event staff had reflected on this and felt that perhaps managing Adult E under the MRM would have provided professionals involved with the structure to formulate an action plan identifying appropriate agencies responsibility for any actions. It provides a mechanism for review and re-evaluation of the action plan. See Appendix 1

## **6.2 Interagency working and information sharing**

6.2.1 As stated above the MRM protocol was not followed however the reviewer has been provided with evidence to support multi-agency working was in place which included MDT meetings and District Nurse huddle meetings. Where possible these meetings included Adult E and his sisters, where it was not possible for his sisters to attend in person they were given the opportunity to join over the telephone, and when this was not an option prompt feedback to Adult E and his sisters was provided.

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<sup>11</sup> RBSAB Multi-Agency Policy and Procedures 12.10 Decision not to proceed with a section 42 enquiry page 81 <https://rbsab.org.professionals/multi/agency-policy-and-procedures>

<sup>12</sup> RBSAB Multi-Agency Policy and Procedures Protection Actions 12.14.3 MRM page 87 <https://rbsab.org.professionals/multi/agency-policy-and-procedures>

6.2.2 NWAS staff complete a patient report form (PRF) which is handed to ED staff on transfer of the patient's care to hospital staff, a review of these documents all record that an Adult Safeguarding referral had been made. There has been no evidence supplied to the review author that the hospital staff were aware of these referrals or had given them consideration prior to the hospital discharges of Adult E on 29.06.19 from a ward and 16.07.19 from ED.

Whether this information had documented in the hospital records of Adult E and been considered it is difficult to establish whether this would have had any bearing on the hospital discharges is difficult to establish. The hospital discharge on 05.04.2016 prior to any safeguarding referral being made appears to have been a co-ordinated one between Health and Social Care with the first episode of reablement from STARS team being put in place.

6.2.3 The hospital discharge on 28.06.2019 following the second NWAS safeguarding referral being submitted is less easy to evaluate as a safe discharge. The reason for admission was noted to be self neglect, ED staff considered involving Adult Care but Adult E stated he could manage well and his sister lived next door. There was little professional curiosity in relation to how he was managing well but also self neglecting and had pressure ulcers.

6.2.4 The hospital discharge co-ordinator documents from the ward records that Adult E was self caring and independent. It is difficult to see how this conclusion was made given the background to his admission and his physical presentation being described as unkempt. There was no attempt to corroborate what Adult E was saying by making contact with either of his sisters. Adult Care were not directly contacted to note what information they knew about Adult E in respect of his 'self neglect'. On 27.07.2019 page 8 of the report is it evident that Adult Care held information about Adult E's home circumstances. A discharge MDT might have highlighted the self neglect concerns following the NWAS safeguarding referral. 6.2.5 His alcohol intake was discussed but he declined a referral to alcohol services, these services usually only accept referrals if the person is willing to receive support. Learning from tragedies an analysis of alcohol related Safeguarding Adult Reviews<sup>13</sup> makes a number of recommendations following 41 reviews, 3 of the recommendations are linked to the need for greater national guidance about alcohol related risk and applying thresholds to people who self neglect due to alcohol misuse. They also recommend the commissioning of more 'assertive outreach' service models. There is also a recommendation that the Mental Capacity Act 2005 should also be amended to include specific guidance for working with individuals' with alcohol misuse or dependence, especially when they are likely to have complex needs. On 24.06.19 during a home visit by the GP Adult E stated that he drank 29 units of alcohol a week (DoH recommendation is 14 units for an adult). On 27.06.19

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<sup>13</sup> Learning from tragedies: an analysis of alcohol-related Safeguarding Adult Reviews  
<https://alcoholchange.org.uk>

(page 8 of the report) his sister also felt he hydrated himself with alcohol and nothing else.

6.2.6 The District Nurse huddle meetings are inclusive of staff from both Health and Adult Care, since this review was commissioned the invitation to participate has been extended to include staff from STARS and home care providers. This is a positive step which will allow for agencies to have a better understanding of the person as a whole.

6.2.7 On the 16.07.19 when seen by the Social Worker Adult E stated his reluctance to engage was due to it making him feel useless and desperate. He acknowledged that he sat on his sofa all day and slept on it at night. In recognition of the furniture's poor state Adult E did agree to have this replaced. On the same day Adult E later saw the District Nurse who discussed with him his reduced mobility, Adult E appeared to give his consent to moving from his home to a rehabilitation placement to improve his mobility; however this potential to assess Adult E's health and wellbeing away from his home environment and without access to alcohol was taken no further and the opportunity was lost.

6.2.8 From the combined chronology it is clear what a number of support agencies were asked to engage with Adult E by statutory agencies. Focused Care were asked to engage with Adult E and the Mental Health and Wellbeing Practitioner was also seeing Adult E, this individual continued to engage with Adult E even when he appeared ambivalent to their offer of support. This positive practice demonstrates the recognition that it takes time to build up relations with people to gain their trust, and willingness to engage.

6.2.9 When the STARS provision was discontinued there was no opportunity to discuss with the service how they might still persevere in trying to get Adult E to accept their support. This withdrawal of service meant that Adult E was without a support package for 2 weeks in July 2019. The service did however report their concerns to the District Nurse and GP requesting a medication review. STARS service now receives additional training in working with people who self neglect.

6.2.10 During July 2019 Adult E appeared to be engaging well with Adult Care and Health staff and gave his consent to have old carpet and furniture removed and replaced with his family's support. This again can be seen as a positive outcome which resulted in Adult E's home environment being improved over the short term.

### **6.3 Care co-ordination, roles and responsibilities**

6.3.1 The care co-ordination role sat largely with Adult Care with appropriate input from the District Nurse and GP staff. There was recognition that other services might be able to provide support such as Focused Care and the Mental Health and Wellbeing Practitioner. STARS and a home care agency were put in place to assist

Adult E when he consented to this however he soon disengaged with the care they were offering.

6.3.2 Roles and responsibilities seem to be largely understood by those involved, not all prearranged joint visits were able to be conducted as planned but there was good evidence of prompt communication between agencies when this wasn't possible, and Adult E and both his Sisters were regularly updated.

6.3.3 The District Nursing service appeared to be focussed on their role in wound management of Adult E's foot. When visiting Adult E and requests were made to examine his sacrum and he refused, there is little evidence of further professional curiosity or documented assessment of his mental capacity by them to assess whether he had the capacity to understand the risk of damage to his skin. The GP who during the home visit on 24.06.19 noted possible scratch mark and pressure ulcers also took no action to actually review Adult E's skin. It cannot be too hard to imagine that someone who is largely immobile and doubly incontinent might have pressure ulcers on their sacrum even if the TVN referral made in June when Adult E was in hospital was not communicated to the community TVN Service due to an IT issue. This damage to Adult E's skin must have been significant in June for hospital staff to have felt a referral to the TVN was necessary at this point.

6.3.4 The District Nursing service have reflected that while there was engagement from MDT members making joint visits and having discussions with each other the MDT never actually came together as a group. Had they have done so there may have been the opportunity to work on a different approach with Adult E. As a result of this reflection they have now set up a weekly safeguarding meeting for staff to share concerns and highlight people to other health services and social care to ensure they follow policy and provide all necessary care. The District Nursing service are also sharing the care of Adult E as a case study and the lessons learnt across all their INT teams via a presentation at a future Performance and Quality Review Meeting.

#### **6.4 Timeliness of interventions for Adult E**

6.4.1 Interventions by agencies engaged with Adult E were based on his perceived capacity to consent to these without formal documentation supporting these assessments being recorded.

6.4.2 As 6.3.3 above there is no evidence of Adult E's pressure ulcers being monitored following his discharge from hospital on 29.06.19 despite being referred to tissue viability while in hospital, a review of this referral made using an automated system does not show why the referral to the community team was not actioned. This failed referral resulted in no TVN service in the community and the District Nursing team trying to gain Adult E's consent to review his pressure areas which he regularly declined. There were regular reports from home care staff that Adult E was frequently sat in urine and faeces from June to October. When he was finally

admitted to hospital on 21.10.19 he was noted to have multiple areas of tissue damage to buttocks and left shoulder which were graded as category 3<sup>14</sup>.

6.4.3 On 07.10.2019 a blood stained continence pad was found by carers and reported, Adult E stated he had cut his hand which was why there was blood on the pad although no evidence of a cut to his hand was noted. Adult Care contacted the GP surgery to request a home visit to examine Adult E's pressure areas but there is no evidence of this being undertaken. This again suggests a lack of professional curiosity and respectful challenge towards Adult E.

6.4.4 There appeared to be an opportunity in mid-July to move Adult E from his home to a rehabilitation unit as he appeared to consent to this however this does not appear to have been followed up and the action was lost.

6.4.5 Adult E's sisters regularly expressed their concerns about their brother's mental health to professionals from as early as 2016. The GP identified that Adult E was indicating no suicidal intent on a home visit on 04.09.2019 and a medication review was done, it was not until October 2019 that Adult E was prescribed antidepressant medication. There is no evidence provided to inform this review that the Mental Health and Wellbeing Practitioner who saw Adult E between July and October 2019 liaised directly with the GP about Adult E's mood and if a trial of medication would improve Adult E's engagement. This practitioner did manage to establish that Adult E had been a joiner in his working life and made efforts to try to encourage him to consider woodworking classes to help him engage with the community.

## **6.5 The quality of assessments undertaken on Adult E**

### **6.5.1 Mental Capacity Assessments**

The presumption that a person has capacity is fundamental to the Mental Capacity Act<sup>15</sup>. It is important to remember that the individual has to 'prove' nothing. The burden of proving a lack of capacity to take a specific decision always lies upon the person who considers it necessary to take the decision on their behalf.

It is evident from the chronology that no formal documented assessment of Adult E's mental capacity was taken on any of the occasions when he was in hospital, whether this was in ED or on a ward. The panel member for the Trust concludes that Adult E was definitely assumed to have capacity as he was able to communicate his choices and also understand the information given to him including his medication.

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<sup>14</sup> NHS Pressure Ulcer Grading Chart a grade 3 pressure ulcer injury demonstrates full-thickness skin loss <https://nhs.stopthepressure.co.uk>docs>PU-Grading>

<sup>15</sup> The Mental Capacity Act (MCA) is designed to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment. It applies to people aged 16 and over. Department of Constitutional Affairs, Mental Capacity Act 2005 Code of Practice, Published 2007

6.5.2 On 02.07.2019 the GP documented there were no concerns about Adult E's capacity although it is not clear what the decision Adult E was being made to make concluded that he had capacity. Following the refusal of Adult E to have his foot redressed the District Nurse attending also did not complete a capacity assessment on Adult E instead escalating this refusal to the doctor on return to the practice.

These are 2 potential missed opportunities to formally assess and document Adult E's capacity and allow for further evidence of his decision making ability. 12.07.2019 a District Nurse visited Adult E to dress his toe, at the huddle meeting on 15/07/2019 there is no evidence to support that the DN advised the huddle meeting that she had undertaken a formal assessment of Adult E's mental capacity and the completed assessment has not been shared with the independent author for the purposes of informing this review.

6.5.3 There is only one formal mental capacity assessment documented by Adult Care in respect of Adult E's mental capacity to make decisions about his personal care and treatment. This capacity assessment was conducted over the course of three visits to Adult E between 16.07.2019 and 23.07.2019. At the first visit Adult E's sister was present during the assessment and at the final visit a District Nurse was also present to support the process. Additional information was also sought by the practitioner from the BARDOC doctor who had visited Adult E and the STARS team manager.

On the capacity documentation there is comprehensive documentation by the practitioner about what has led to you having doubts the person's ability to make the decision. When engaging Adult E in conversation at the first visit he demonstrated the capacity to discuss his earlier life and an awareness of his current living conditions. He was clear in his view that he had support from both his sisters and that he didn't need carers because he didn't need them. He gave unrealistic descriptions of how he used a zimmer frame to mobilise and how he showered using his upstairs bathroom, using two handrails to pull himself up the stairs to get there. Following discussions with his sister he agreed that a carer could come to assist him with washing in the morning if they came at a later time. He was reluctant to discuss toileting admitting that this was a problem for him but that he did not like the idea of a commode and acknowledged that he used incontinence pads but that these were not ideal. He also acknowledged that his skin was at risk of breaking down and that if this happened he would probably be taken to hospital again which was something he stated he wanted to avoid. The opportunity to reinforce to Adult E that his continued need to engage with support was the only way to prevent a hospital admission could have been more directly reinforced.

#### 6.5.4 Mental Capacity Act v Mental Health Act

Prior to Adult E's last admission to hospital there were discussions between professionals about whether Adult E had mental capacity and if this could be used to

transfer him possibly against his will to hospital, or whether he would be conveyed under the Mental Health Act. The GP believing he was suffering from Senile Squalor Syndrome felt a MHA assessment should be the priority.

The Approved Mental Health Professional (AMHP) disagreed with the GP in their view Adult E's immediate health issue was his physical health; as such he should have had a mental capacity assessment recorded and a best interest decision made to transfer him to the acute hospital for a full assessment of his physical health and instigation of treatment. The AMHP felt Adult E's mental health could then be assessed when his physical health was improved.

6.5.5 A term that is often misunderstood, in the context of the Mental Capacity Act 2005, is the 'material time', which is used at section 2(1) of the MCA *"For the purposes of this Act, a person lacks capacity in relation to the matter if at the material time he is unable to make a decision for himself in relation to the matter because of, or a disturbance in the functioning of, the mind or brain."*

Research has found that professionals in the health and social care sectors have artificially created a 'rule' that suggests 'material time' means only considering a person's capacity to make a specific decision at the time of the conversation with the person. This means they do not always consider observational real-world evidence from families, carers or professionals as part of the capacity assessment, even when this may be applicable to the decision in hand.

What constitutes 'material time' will depend on the type and nature of the decision that you are supporting a person with. Decisions can be:

- Decisional capacity (just in the moment);
- Executive capacity decisional and performative in their nature (ie application of information also takes place outside of the discussion).

A simple example of a decision which is only 'decisional' would be determining whether a person has capacity to consent to support with their personal care on that day, in that moment. In the context of Adult E's care, consenting to allow the District Nurse to clean and redress his toe. In this instance Adult E was supported to make a decision in relation to a 'task' that was happening in the here and now at the 'material time', and Adult E would not need to understand, retain, use or weigh this information any longer than the task required.

However in relation to Adult E's capacity, assessment necessitated not just 'decisional' consideration but also 'performative' considerations. The terms 'decisional' and 'executive' capacity are found in research but not mentioned in the MCA or the MCA code of practice; therefore practitioners should keep to the language of the MCA for recorded capacity assessments.

These terms are important though in contextual terms when practitioners want to explain the challenges of assessing a person's decision-making capacity when they can seemingly 'talk the talk' (decisional capacity) but cannot 'walk the walk' (executive capacity); especially when the ability to 'walk the walk' may be because of an impairment of, or a disturbance in the functioning of the mind or brain.

These terms came to the attention of health and social care practitioners with the publication of the 2011 Social Care Institute for Excellence paper Self-neglect and adult safeguarding: findings from research<sup>16</sup>The following extract perfectly articulates how the authors of this paper identified these issues:

*'Capacity is a complex attribute, involving not only the ability to understand the consequences of a decision but also the ability to execute the decision. Where decisional capacity is not accompanied by executive capacity, and thus overall capacity for autonomous action is impaired, 'best interests' intervention by professionals to safeguard well-being may be legitimate. Yet executive capacity does not routinely figure in capacity assessments, and there is a risk that its absence may not be recognised. There is concern too that capacity assessments may overlook the function-specific nature of capacity, with the result that apparent capacity to make simple decisions is assumed in relation to more complex ones.*

Adult E demonstrated frequently that he would agree to have care support but then repeatedly failed to engage with this stating he did not need this and was ok. If executive capacity had been considered Adult E could be found to lack mental capacity in the months prior to October 2019.

## **6.6 Reflect on the recommendations and action plan from an earlier learning lessons review to see if the lessons learnt were disseminated effectively and recommendations from that review have been implemented**

6.6.1 In the RBSAB report on Adult 2 published in June 2019<sup>17</sup> (Booth, 2019) following an earlier self neglect concern the author identifies that the MRM could have been used to support practitioners working with Adult 2 but because no safeguarding meetings had been held in respect of Adult 2's care this was not considered. The report author makes 4 recommendations for further action one of these centres around staff in all partner agencies having an understanding of:

- things that might lead to a refusal of service
- issues around mental capacity and in complex cases being able to call on support in making an assessment
- assessment of capacity should be recorded as a matter of routine

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<sup>16</sup> SCIE Report 46: Braye S, Orr D, Preston-Shoot M. Self-neglect and adult safeguarding : findings from research 2011 page 4 <https://scie.org.uk/reports/publications>

<sup>17</sup> Rochdale Borough Safeguarding Adult Board Adult 2: Booth J June 2019 <https://rbsab.org.uk>

- risks associated with self neglect and what measures have been put in place to make the person safer

6.6.2 The action plan linked to this report is being put in place at the time of this report and it is too early to state that all actions from the earlier report are now in place.

6.6.3 The actions from this report could be linked to the earlier report where appropriate to 'blend the action plans together'.

## **6.7 Identify any further actions required by RBSAB and its partners to promote learning and support improvement to systems in future**

6.7.1 See point 8

## **8 Good Practice**

The review has identified a number of good practices:

- There was good communication with Adult E's Sisters by agencies involved, they were given the opportunity to support their brother at visits by professionals and to give context and alternative facts which sometimes contradicted some of their brother's views, but assisted in helping professionals to see a fuller picture of their brother and his needs.
- NWS staff reported their concerns about Adult E's self neglect using safeguarding adult referrals to alert the Local Authority in line with their own internal, and the RBSAB's policy and procedures.
- There was consistent staff involvement with Adult E by the District Nurse and the Social Worker who worked hard with Adult E in attempting to get him engaged with support packages. Each reinforcing the concerns of professionals in relation to the risks he was exposing himself to.
- The identification of self neglect as a category of abuse is embedded well in the partner agencies of the RBSAB.
- The Home Care Agency staff reported their concerns promptly over Adult E's unwillingness to engage with them and continued attempts to support when the home conditions were poor.
- Staff did manage to gain Adult E's consent to make changes to his living arrangements and remove and replace soiled, damaged furniture, it may have been hoped that these changes would help Adult E see that he was not in a desperate situation.
- Care agency staff tried to support Adult E with male carers to see if this would lessen his embarrassment, particular around toileting.

Reflect on the recommendations and action plan from an earlier learning lessons review to see if the lessons learnt were disseminated effectively and recommendations from that review have been implemented

## 9 Practice Areas for Development

The following practice areas for development have been identified for consideration by the RBSAB partners:

- Gain assurance the adult safeguarding referrals made by NWS are acknowledged by the hospital staff and are communicated across the hospital when handover of patients occurs from one clinical area to another so that these can be considered by hospital staff as part of the discharge planning process.
- RBSAB partners to ensure their staff are aware of the Multi-Agency Risk Management protocol in relation to self neglect concerns and that they know how to refer a concern into this pathway.
- RBSAB partners to continue to educate their staff in the legal literacy around self neglect, particularly in relation to the Mental Capacity Act 2005, the Mental Health Act 1983<sup>18</sup> and the Human Rights Act 1998<sup>19</sup>.
- RBSAB partners to provide the Board with ongoing assurance that work to embed knowledge of the MCA and increase staff confidence in the documentation of mental capacity assessments in cases where self neglect is a cause for concern is being continued and compliance improved.
- Health staff should consider where a person's continued refusal to engage in a physical assessment is evident in relation to self neglect, and there is a significant risk to the person's health, a documented mental capacity assessment should be recorded and contribute to a risk assessment process.

## 10 Conclusion

Self neglect can be found in all areas of society and needs to be understood in the context of each individual's life experience. It is more usual for people to start to self neglect when they become mentally or physically unwell or older and frailer. The person concerned may recognise the term but may not wish to use it to describe their own situation. It can be the most challenging of all safeguarding concerns for practitioners to manage. The mental capacity of the individual must be considered with regard to their consent to have their care needs met and in the absence of the MCA 2005 dealing with the concept of functional and executive capacity practitioners are left assessing someone's mental capacity under the current legal framework, with consideration of executive capacity

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<sup>18</sup> The Mental Health Act is the law that describes what should happen when someone who is living with a mental illness needs treatment and protection for themselves /others. Department of Health Mental Health Act 1983: Code of Practice, published 2015

<sup>19</sup> Human Rights Act 1998 sets out the fundamental rights and freedoms that everyone in the UK is entitled to. Article 2 is the right to life; public authorities must take action to protect your life if it is in danger. Article 3 is the right to live life free from torture, inhumane or degrading treatment. Article 8 is the right to private and family life. <https://www.legislation.gov.uk/ukpga/1998/contents>

The report shows that only one agency involved in the care of Adult E has shared their formal assessment of Adult E's mental capacity. The conclusion of this assessment was that Adult E had capacity and had consented to have changes made to his home environment and to try a care support agency again if they arrived late morning. On review of Adult E's responses to some of the questions posed to him about washing and dressing and toileting he provided unrealistic answers which were not supported by the physical evidence in his home. This was a recurring theme that most care agencies observed when engaging with Adult E.

Given that Adult E had previously agreed to have support at home but only engaged with this for very short periods of time in the past it would have been appropriate to revisit Adult E's mental capacity more frequently. Most notably on 14.10.2019 it would have been appropriate to have formally reassessed Adult E's capacity when at that home visit he was observed to be slumped on his sofa in a semi clothed state. It is the Reviewer's opinion that at this point Adult E's physical health needs took priority over his mental health needs. If a mental capacity assessment and best interest decision had been made at this time it would have prevented the unnecessary transfer of Adult E from the ED to a mental health ward who were not able to treat his physical needs. Once these had been met an assessment of his mental health could have been undertaken at the acute hospital.

In their paper A brief guide to carrying out capacity assessment 39 Essex Chambers<sup>20</sup> cite the House of Lords Select Committee looking at the MCA as such 'Finally, the very act of deciding to carry out a capacity assessment is not itself neutral, and the assessment process can itself often be (and seen to be) intrusive. After all, to assess someone's mental capacity is to interfere with their right to respect for private life for Article 8 purposes. So you must always have grounds to consider that one is necessary. Conversely, you must also be prepared to justify a decision not to carry out an assessment where, on its face, there appear to be a reason to consider that the person could not take the relevant decision. Whilst the presumption of capacity is a foundational principle, you should not hide behind it to avoid responsibility for a vulnerable individual. In our experience, this can happen most often in the context of self neglect where it is unclear whether or not the person has capacity to make decisions.

In managing self neglect practitioners across Rochdale have access to the RBSAB Policy and Procedures, a Self Neglect and Hoarding Policy<sup>21</sup> and a Seven Minute Briefing in Self Neglect<sup>22</sup>. It is the reviewer's opinion that Adult E was largely

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<sup>20</sup> A brief guide to carrying out capacity assessments 39 Essex Chambers 2016 page 4  
<https://39essesx.com>mental-capacity-guidance>

<sup>21</sup> Rochdale Borough Safeguarding Adults Board Self-Neglect and Hoarding Policy 2018  
<https://rbsab.org.professionals/multi/agency-policy-and-procedures>

<sup>22</sup> Rochdale Borough Safeguarding Adults Board Seven Minute Briefing in Self Neglect  
<https://rbsab.org.professionals/multi/agency-policy-and-procedures>

managed in line with these documents by the practitioners involved in his care. Steps were taken by the majority of agencies working with Adult E to attempt to build up trusting relationships with him but these take time.

To support the work with Adult E who had complex needs and struggled to engage the reviewer concludes that having formal safeguarding procedures instigated early following the first safeguarding referral would have provided the framework to consider Adult E's capacity, and whether 'safeguarding procedures' were appropriate to allow for a multiagency risk assessment to be undertaken. In June 2019 practitioners believed Adult E had capacity to make the choices he was making, when the 3rd safeguarding referral was made in July this could have triggered the referral into the MRM process. This could also have been discussed and shared with Adult E and his sisters who clearly wanted to support their brother, and were active as far as possible in supporting him.

The report has identified a number of obstacles to improving practice some of which requires action at a national level and is beyond the scope of this review to action. Those improvements to practice that can be made locally should be monitored for completion by the RBSAB.

Adult E remains in a nursing home following his discharge from hospital in December 2019 and resides there under a Local Authority authorised DoL. His sisters visit him regularly, and his pressure ulcers have healed.

## **11 Recommendations**

1. That the Rochdale Borough Safeguarding Adult Board (RBSAB) receives assurance that partner agencies include in their MCA training presentations executive functioning and that there is a process in place to undertake an annual audit of compliance with the MCA 2005 which demonstrates year on year improvement and feedback to staff as appropriate which is presented to the Board.

2. That the RBSAB receives assurance via a statement of compliance by partner agencies Chief Executives (or equivalent) that staff have been made aware of the Multi-Agency Risk Management (MRM) process. This could be achieved by sharing a copy of the organisations adult safeguarding training presentation or learning briefing, that is used which evidences that the MRM meeting process is included allowing staff to understand its purpose; when a person with capacity is not engaging with services offered to support them in maintaining their health and wellbeing. The training presentation/ learning brief must include when cases should be escalated within their organisation for of submission into the MRM process.

3. That the RBSAB receives assurance via annual audit findings that the agency representatives at the MRM meetings have the necessary seniority and authorisation

to make decisions on behalf of their individual agencies when a case is presented, and that audit findings demonstrate evidence of meaningful actions to mitigate risk.

4. That the RBSAB receives assurance that adult partner agencies provide briefings highlights the importance of 'respectful challenge' when an individual who is clearly self neglecting makes responses that all the physical evidence before the staff member clearly contradicts. Staff should have the confidence to ask the individual to explain and physically demonstrate how they or others are meeting their care needs. Corroboration of support should be sought from their family/carers and documented.

5. That the RBSAB receives assurances that there has been a briefing by NWAS for all North West Local Authorities on their proposed referral form changes to enable the Local Authorities to differentiate between a 'safeguarding referral' and a 'care concern' so that this change in practice is shared with front line staff in both NWAS and the relevant Local Authorities.

6. That the RBSAB receives evidence that Northern Care Alliance have amended their audit template to capture if there has been a 'safeguarding referral' made by NWAS at the point care has been handed over to hospital staff or by ED staff on handover of care to a ward.

7. That the RBSAB receives documentation audit findings from NWAS that evidences that staff covering this geographical area handing over to hospital staff when they have made an 'adult safeguarding referral' using their new framework to allow this information to be considered when planning discharge from hospital.

## **12 Statement by the Independent Reviewer**

The reviewer, Michelle Grant is independent of the case and of Rochdale Borough Safeguarding Adult Board and its partner agencies.

Prior to my involvement with this Safeguarding Adult Review:

I have not been directly concerned with the adult or the carers and professionals involved with the adult, nor have I given any professionals advice on this case at any time.

I have no immediate line management responsibilities of the practitioners involved.

I have appropriate recognised qualifications, knowledge, experience and training to undertake this review.

The review has been conducted appropriately and with rigorous analysis and evaluation of the issues set out in the Terms of Reference

**Independent Reviewer**

Signature:

Michelle Grant

Name: Michelle Grant

Date: 30<sup>th</sup> April 2021

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