Rotherham

Safeguarding Adults Board

Safeguarding Adults Review

‘David’

Overview Report

[Final DRAFT for SAB v130121]

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Contents

Executive Summary

1. Introduction

1.1. This review considers the sad circumstances of the death of 'David' who died in 2020.

1.2. David was a man in his sixties of white British ethnicity. He was known to a number of agencies. He was alcohol dependant and this impacted on his ability to care for himself. Concerns about David's self-neglect had been identified from 2015 but became more severe from 2017. David's family had a high level of involvement and were deeply concerned about him, regularly seeking help from agencies.

1.3. David had four hospital admissions from 2017 until his death, all as a result of self-neglect. In January 2019, David was admitted to hospital in a hypothermic and malnourished state, with severe pressure sores. He was discharged to a nursing care home where he made a good recovery. After a period of reablement, David obtained a new tenancy and his support ended.

1.4. Eight months later, David's family again raised concerns about his severe self-neglect and asked for him to receive support. Their understanding was that David was provided with home care support but this was not the case.

1.5. Two months later, David's neighbour found him on the floor. His brother believed he had been there for three days. David had not had any involvement from any agency for the last seven weeks. His family had not been able to visit due to Covid pandemic restrictions. David's condition was very poor. He had not been eating or drinking and his body was covered in sores. He was admitted to hospital where he was in resuscitation for several hours but sadly, he died.

1.6. This review examines learning for agencies in working with adults who self-neglect. It considers how agencies worked together and whether there were potential opportunities to avert the tragic circumstance of David's death.

2. Summary of the Learning Points from the Review

Summary of Key Learning Points	
i	Supporting adults who self-neglect presents significant challenges, particularly where the adult has the mental capacity to make decisions but is resistive to care. Duty of care requires practitioners to balance respecting the person's rights to make decisions (even though those decisions may appear unwise), whilst taking reasonable steps to continue to try and engage the person proportionate to the risk they present.

	Recent research of national Safeguarding Adult Reviews[1] (SAR) found that self-neglect was the most common type of abuse or neglect that led to the SAR being held. Research also highlighted the strategic and operational structures that support best practice in self-neglect.[2] In Rotherham, these factors were under-developed. There was no policy, procedures or tools to guide agency responses. Self-neglect was not managed as a Care Act Section 42 Safeguarding Enquiry. Alternative multi-agency processes were available but were not used and there was limited availability of resources required to support people with complex needs.
ii	The review evaluated responses by agencies against best practice factors.[3] There was evidence of good practice; individual practitioners being responsive and taking extra steps to try and engage with David and address his needs. Best outcomes are achieved through building up relationships and using this to understand the adult, work at their pace and negotiate small changes. David had very limited continuity of care and insufficient in-reach to achieve change. There were multiple services involved with David and multiple transfers of care. David's complex needs called for tight coordination of care, bringing the multi-agency system together to work with David and support his family. Coordination of care was severely lacking, both within and between agencies. David was consistently assessed as having the mental capacity to make decisions regarding his care and treatment. Staff assessed that he was making unwise decisions – not uncommon where there is alcohol dependence. However, David had repeatedly demonstrated he was not always able to follow through on decisions he made. This lack of executive capacity did not give any legal authority for agencies to act without his informed consent but should inform the risk assessment. There was a lack of robust risk assessment and risk management relating to his self-neglect. Risk assessments needed to take account of the whole picture, recognising David's history, drawing on multi-agency and family perspectives as well as David's representation of his needs. There were seven safeguarding adult referrals made. Responses to those referrals appeared to take an episodic approach without due regard to the relapsing and remitting pattern of David's self-care, or recognising the severe nature of his self-neglect. Consequently, the support that was put in place was not sufficient to address his risks.
iii	Rotherham has made a number of improvements in the period following David's death including restructuring within Adult Social Care and introducing new policy

[1] Local Government Association: Analysis of Safeguarding Adult Review April 2017- March 2019; Executive Summary October 2020

[2] SCIE (2014) *Self-neglect Policy and Practice*, Available from: http://www.scie.org.uk/publications/reports/69-self-neglect-policy-practice-building-an-evidence-base-for-adult-social-care/ [Accessed: November 2020]

[3] Ibid

	and procedures for working with self-neglect. The RSAB will need to seek assurance that these developments are making a tangible difference to how agencies work together with adults who have self-neglecting behaviours.

• Summary Conclusion

2.1. Research has highlighted the challenges of working with people who self-neglect and the factors that are most likely to give successful outcomes.

2.2. The review highlighted some good practice by individual practitioners but multiple opportunities for learning regarding coordination of care, risks assessment and multi-agency working.

2.3. It is not possible to determine whether these measures would have averted the sad circumstances of David's death. David may still have been unable to overcome his self-neglecting lifestyle. Nonetheless, the lessons highlighted within this review are important to help practitioners apply best practice and to be supported by Rotherham Safeguarding Adult Board in making a difference in the lives of adults who self-neglect.

2.4. Rotherham Safeguarding Adult Board and its constituent agencies have made a number of recent improvements in relation to self-neglect. The recommendations aim to support these developments.

Recommendation
The RSAB has recently launched new self-neglect policy and procedures. Following this implementation phase, the RSAB should carry out assurance activity to evaluate the difference that these procedures have made. This assurance should include: 1. Audit of front-line staff and their knowledge of the new procedures and referral routes 2. Feedback from front-line staff regarding strengths/weaknesses of the new procedures and impact on their levels of confidence in working with self-neglect **3.** Carry out some qualitative sampling of self-neglect cases to evaluate a) the quality of multi-agency practice b) outcomes achieved for adults in accordance with Making Safeguarding Personal c) support and involvement of carers The sampling should include cases that would be assessed as Level 2 and Level 3 under the procedure risk assessment guidelines (Appendix 1). 4. The training that is available to staff to improve their competence in working with self-neglect and their application of the new procedures 5. Availability and access to specialist resources such as the Complex Lives team to test capacity to meet the needs of people in the highest risk circumstances

Main Body of the Report

3. Context of Safeguarding Adults Reviews

3.1 The Care Act 2014 requires Safeguarding Adults Boards (SABs) to arrange a Safeguarding Adults Review (SAR) if an adult (for whom safeguarding duties apply) dies or experiences serious harm as a result of abuse or neglect and there is cause for concern about how agencies worked together. This SAR is conducted under section 44(2) of that Act.[4]

3.2 Rotherham Safeguarding Adults Board (RSAB) commissioned an independent author to carry out this review. The independent reviewer is Sylvia Manson who is wholly independent of RSAB and its partner agencies. Sylvia has a professional background in mental health social work and held senior management roles within Health and Social Care as well as leading regional and national development work. She is well experienced in carrying out statutory reviews as well as quality improvement work across Health and Social Care and with Safeguarding Boards.

3.3 The purpose of SARs is '[to] *promote as to effective learning and improvement action to prevent future deaths or serious harm occurring again'*.[5]

3.4 A SAR enables all of the information known to agencies to be seen in one place. This is beneficial to learning but the SAR also recognises that this benefit of hindsight was not available to individual practitioners at the time.

3.5 The Department of Health's six principles for adult safeguarding should be applied across all safeguarding activity[6]. The principles apply to the review as follows:

Empowerment:	Understanding how the service users were involved in their care; involving those close to the person in the review.
Prevention:	The learning will be used to consider prevention of future harm to others.
Proportionality:	Understanding whether least restrictive practice was used; being proportionate in carrying out our review.
Protection:	The learning will be used to protect others from harm.
Partnership:	Partners will seek to understand how well they worked together and use learning to improve partnership working.
Accountability:	Accountability and transparency within the learning process

[4] Care Act 2014, Section 44(2) relates to when an adult has died https://www.legislation.gov.uk/ukpga/2014/23/section/44/enacted
[5] Department of Health, (2016) *Care and Support Statutory Guidance Issued under the Care Act 2014*
[6] Ibid

4 Terms of Reference and Methodology

4.1. Terms of Reference

4.1.1. The review is focusing on the period from 2015 when David first became known to Adult Social Care until his death in 2020. The specific areas of enquiry are as follows:

Terms of Reference
1. To consider the effectiveness of responses to David's needs i. What was the quality of agencies' assessments and interventions in responding to David's needs? ii. What were the quality of risk assessments undertaken? Was the response by agencies appropriate and proportionate to the nature and degree of risk? iii. What steps were taken to enable and empower David to improve his wellbeing? How was Making Safeguarding Personal demonstrated in the care and support offered including consideration of mental capacity? iv. Were David's family and friends appropriately involved in the arrangements for his care? v. How well did agencies consider equality and diversity and adapt intervention accordingly?
2. To consider how effectively agencies worked together i. How responsive were agencies to concerns raised? Were there missed opportunities that prevented or delayed a timely response (by single or multi-agency) to respond to any concerns raised? ii. How effective was multi-agency working in communication and coordination of care? iii. How did multi-agency responses to David benchmark against best practice in self-neglect?
3. To consider the systems in which services operated and how this supported or detracted from care provided i. Was relevant legislation, guidance, policies and procedures followed by staff involved in the process? ii. Were policies and procedures adequate in supporting staff to provide effective care and support? iii. Were there any organisation or wider systems factors that impacted on providing effective response to David. (for example, organisational structural changes; staff capacity; access to adequate resources; organisational resilience; impact of Covid 19 pandemic)
4. To identify learning i. Was there evidence of positive practice by the agencies involved? ii. What needs to change to improve future responses to self-neglect?

iii. What are the learning points from this review and recommendations for single agencies and the partnership that will strengthen multi-agency working and reduce the likelihood of a similar situation occurring in the future?

4.2. Methodology

4.2.1 The methodology applied for this SAR combined a chronology from each agency with a reflective learning event to draw out further detail with the agencies involved.

4.2.2. Understanding the experiences of those receiving support from agencies is central to learning. The independent author is grateful to David's brother for his help in understanding David and providing his family's perspectives. His views are referenced within this report.

4.2.3. The privacy of those involved has been protected. The pseudonym of 'David' was agreed with his brother. Some information and dates within the report have also been deliberately generalised to protect the confidentiality of those involved.

Participating Agencies and Context of Involvement	
Rotherham Metropolitan Borough Council Adult Social Care, Housing and Public Health. (RMBC)	RMBC- Adult Social Care were first involved with David in 2015. Referrals were made to Adult Social Care for care and support and through Safeguarding Adult referrals. David was also provided with two episodes of reablement services RMBC -Housing were first involved in 2014 when David was at risk of homelessness. Housing assisted in looking for alternative accommodation following a period in private accommodation. David had a Council tenancy from July 2019. Income services were also involved due to arrears.
General Practitioner via Rotherham Clinical Commissioning Group	David was in regular contact with his GP Practice. During the scope period David was registered with the same GP. However, while resident in a nursing care home, he was temporarily also registered with a practice (GP2) linked to that nursing care home.
Rotherham, Doncaster and South Humberside Trust (RDaSH) Mental Health and Substance Misuse services	RDaSH Mental Health Liaison team attended David while he was in hospital in 2019 but he declined assessment and had no further involvement. David had previously had some involvement with RDaSH alcohol services but outside the scope period.
Rotherham NHS Foundation Trust (TRFT)	Known to TRFT from November 2016 under District Nursing service. He also received care from inpatients services, Dermatology, Alcohol Liaison, Speech and Language Therapists and the Dietician.
Nursing Care Home	David was resident between Jan – May 2019 having been discharged there from hospital.

5. David and the Background for this Review

5.1. David was a man of white British ethnicity. He was in his sixties when he died. David's brother provided some insights into his life.

5.2. David had worked as a butcher and then in steel works. However, in 2010 he developed throat cancer which though successfully treated, meant he had difficulty eating and this affected his quality of life.

5.3. David had been in a long-term relationship and was the father of a young child. However, in 2015 the relationship ended. David identified that this was due to his problematic drinking. His brother recalled David's alcohol dependency dating back to 2004. He felt there was no specific reasons for this but thought drinking had become habitual for David.

5.4. When David's relationship ended, family report his drinking became much worse. He was at risk of homelessness but secured a private tenancy. This was a three bedroomed property and was across the road from his GP Practice. David was supported by his mother and by both his brothers and their wives. They worried greatly about him as his living conditions and health deteriorated.

5.5. David had significant health needs, including Chronic Obstructive Pulmonary Disease; eczema and asthma. He also had severe cellulitis and skin damage associated with his high alcohol use and self-neglect. From 2015, David had four admissions to hospital, all related to self-neglect. Following one admission, he was discharged to nursing care and then reablement supported accommodation before being provided with his own council tenancy.

5.6 Family felt that David not always easy to help. He did not want to give up drinking alcohol, would forget appointments and not always follow through on care and treatment. Professionals repeatedly confirmed that David had capacity to make decisions about his care and support. However, family believed he needed daily support and could not understand why carers were not going into his home to support him.

5.7. Family had provided David with high levels of support however this had had to reduce due to other caring commitments. Contact in the later months of David's life was also reduced due to the Covid pandemic restrictions.

5.8 Ten months after David moved into his own tenancy, his neighbour found him on the floor. He had been there for three days. David had had no contact or support from any agency in the seven proceeding weeks. David's was in a dire condition as a consequence of severe self-neglect. He had multiple infected pressure wounds, severe excoriation around his buttocks and thighs and his feet were encrusted with faecal matter. David had not been eating or drinking. He was admitted to hospital but sadly he died soon after. The death certificate cited bronchopneumonia and secondary urosepsis and chronic pyelonephritis.

5.9. This review examines the circumstances leading up to David's death and how agencies worked together to try and meet his needs.

6. Summary of Key Events

6.1. This section sets out key events including interactions by agencies. Section 7 then provides analysis of these events and identifies learning.

6.2. In **2015**, David attended his GP with problems with his skin. They also discussed his relationship ending and his drinking. His GP made a safeguarding referral to RMBC Adult Social Care for support and possible rehousing. Social Care spoke with drug and alcohol services who knew David but needed his consent for a new referral. Social Care referred onto the RMBC Vulnerable Persons Team (VPT). On visiting David, the VPT view was that his home environment was in a reasonable state. David declined an assessment, saying his family and GP were helping him but did allow VPT to contact Housing and visit again. The VPT tried to see David on five further occasions without success so ended their involvement, notifying his GP.

6.3. During **2016**, David was treated for recurring cellulitis. He had some care from District Nurses (DN) but could manage independently. David attended Housing Services as he felt his private tenancy was too big for him. However, he didn't follow through in completing the medical form and made no further contact.

6.4. During **2017**, David regularly saw his GP due to recurring cellulitis. He was not taking treatment consistently but told his GP he was reducing his alcohol intake.

6.5. In **November 2017,** David's brother spoke with the GP Practice Nurse. He told her David was not coping and not eating although David denied this. The Practice Nurse made a home visit. David was struggling to get upstairs. Beer cans were scattered around. David admitted to excessive drinking but did not want to stop or to receive help from alcohol services. The Practice Nurse referred to DNs for an urgent continence assessment. David had refused to go to hospital for specialist treatment.

6.6. David's brother referred him to Adult Social Care. David's brother was worried he would die due to poor health, non-concordance with treatment, significant weight loss and not being able to operate his heating.

6.7. Social Care confirmed David was not known to mental health services. They discussed options with David's brother such as crisis team and a GPS phone but David was not consenting. David's brother planned to persuade him to go into hospital. The Social Care worker raised a self-neglect concern to their RMBC Safeguarding Adult Team (SAT). The SAT discussed the referral with the VPT and a referred onto the RMBC Social Care Locality Team.

6.8. A duty Social Worker visited David two days later. David's brother and wife were present. The home conditions were very poor with evidence of David's double incontinence around the house. David was drinking heavily to try and dull the irritation from his infected legs. He was

wrapped in a blanket, with an electric fire and was smoking. DNs had left a note on his front door – David had missed their visit as he did not use the front door.

6.9. David was persuaded to go to hospital. His admission records noted self-neglect. David also had eczema.

6.10. The Locality duty Social Worker liaised with the Hospital Social Worker and with the VPT. They also spoke with family about David's fire risk, suggesting a fire check of the property and that David could be provided with a fire- retardant blanket. The family's recall was that the Social Worker had agreed to follow this up.

6.11. The Alcohol Liaison Team (ALT) saw David in hospital, having been referred by the DN. David declined any support from ALT.

6.12. David was in hospital for five days before discharging himself. He was deemed to have capacity for this decision. Hospital Social Worker had not completed a Care Act assessment but were concerned his home needed a deep clean. The plan had been for David to go to his Mother's address temporarily but he returned home. The discharge plan was follow-up by outpatient dermatologist; DN services to visit three times a week with carers from the reablement team twice a day.

6.13. David was also allocated a Social Worker from the Locality Social Care team. They visited David three times over the next few days, seeing him with his family who had been visiting daily since his discharge. Conditions in his home remained very poor due to self-neglect and damp. David continued to drink alcohol. He agreed to home care but would not change accommodation unless to his own one-bedded flat.

6.14. The Social Worker plans and actions were as follows:

- Referral to reablement services
- Plan to carry out a full Care Act assessment
- Referred for Occupational Therapy (OT) assessment for mobility aides.
- Spoke with David's landlord about conditions of flat and agreement to fit a key safe.
- David brother was contacting fire service for safety checks
- Contacted Housing to enquire about progress of application – (no information shared without David's consent)

6.15. The Social Worker also contacted the DNs as David did not have a commode one week after discharge. The Social Worker and DN's discussed David needs and risks. The Social Worker confirmed that DN's should use the back door rather than front door – this being the reason they were getting no response.

6.16. **In December 2017** David was visited by the reablement service accompanied by an OT. (The records indicate that a key safe was fitted, however family report this was incorrect and a key safe was never put in place.)

6.17. The enablement service was to provide six weeks post-discharge support. One week into this period, the carers called GP Out of Hours. David was unwell and was drinking.

6.18. The Locality Social Worker ended their involvement having been involved for two and a half weeks. Their expectation was that the Enablement Service would refer David to Social Care if required following their six-week period of support.

6.19. However, two weeks later, David's brother contacted Social Care, concerned as David was not receiving any care. It transpired that the Enablement Service had not been visiting for two weeks, mistakenly believing David was in hospital. Calls were reinstated.

6.20. DNs had seen David two days prior to this. David was drinking heavily. He declined to have his legs checked or to have bandages on as he wanted to wear shoes. He was able to apply creams himself and was discharged by the DN service.

6.21. Reablement care was reinstated but ended in mid-**January 2018,** the end of the 6-week post discharge period**.** The service requested a Care Act assessment for David. A duty Social Worker visited David later that month and his family were present. David restated his wish to move house. He acknowledged his alcohol dependence and was trying to cut down intake. The Social Worker recorded that no care package was required but that David wanted support with Housing and access to health. A referral was made to the voluntary sector by a social worker. There are no records relating to the outcome from this.

6.22. During **February – June 2018,** David was seen periodically at his GP Practice for treatment of his legs. By **July 2018** he was showing obvious signs of neglect again and had no Social Care support. The GP referred to RMBC Safeguarding Adults requesting urgent assessment. It referenced, '*this as a strong referral letter'*, and stated '*unless rehoused in secure surroundings one day likely to be found deceased*' The GP arranged a follow up visit the next day by their Health Care Assistant who reported back on the poor home conditions.

6.23. The GP spoke with David's brother, informing him of the RMBC safeguarding referral. The GP also made referrals to the Community Matron, Dietician, District Nursing Services. Two days later an MDT meeting was held in surgery regarding David. A Social Worker in attendance was due to advise on outcome of latest referral and feedback.

6.24. Three days after the GP's safeguarding referral, a duty Social worker visited David. David reiterated his wish to move. The Social Worker observed his home needed a deep clean. David agreed to a re-referral to the VPT to assist with housing move, help him with his living environment and to engage in alcohol support services. (the GP was not informed of this outcome.)

6.25. The Social Worker also contacted the DN care coordination centre, worried about the condition of David's legs. DN's visited David and described his home conditions as utter squalor. David was described as unkempt and with a strong odour. He appeared malnourished and was struggling to swallow. He was unable to describe what medications he was prescribed. David was struggling to mobilise due to pain in feet. He was unable to go to the shops but had food in the house. David was not going upstairs, sleeping in a chair. A Waterlow assessment[7] highlighted him to be at high risk of pressure ulcers. The DN spoke with Social Care who confirmed

[7] Waterlow is a pressure ulcer risk assessment/prevention policy tool commonly used in the UK

they were involved. The DN also made a safeguarding adult referral and referred David to dietetics and ALT. They liaised with the GP and agreed DN's would visit David twice weekly.

6.26. A duty Social Worker carried out a further visit a week later. David was asleep in a chair, intoxicated and with a lit cigarette in his hand. His property was in a better state with rubbish bagged up. The Social Worker spoke with David's brother who mentioned a previous Social Worker had planned to get a fire-retardant blanket due to fire risk.

6.27. DN's visited again the next day – David required hospital admission due to the poor condition of his legs. They noted the need for multi-disciplinary team (MDT) before he was discharged, and that David could not be returned to that environment. The DN sent in a safeguarding referral to RMBC. This was screened by RMBC safeguarding team eight working days later.

6.28. This hospital admission in **July 2018** lasted for two weeks. During that time, David saw a dietician. He was also assessed by the ALT on three occasions. David's view of his circumstances was very different to the view of others. He had no obvious signs of alcohol withdrawal and was given brief intervention advice.

6.29. A Social Care assessment was that David did not need reablement services as he appeared to be independent with personal care. David did not feel there were any safeguarding issues but did recognise he needed support. However, he did not wish to remain in hospital to await an MDT meeting, nor did he want assistance from Age UK. David's mother had agreed to help him get his property sorted out and family were also supporting him in rehousing.

6.30. David was discharged after a two-week admission. (**August 2018).** On his discharge, DN's visited but as they got no response after the first two attempts, David was advised he could see the GP Practice Nurse. David was also due to have follow up by dermatology, speech and language therapy and dieticians. David was discharged from the Dietician following non-attendance. He was also discharged from the Speech and Language Therapy service having not responded to their letter.

6.31. David's brother contacted Social Care again in **September 2018**. He had not been able to see David for a month but when he visited, David was in a poor state – he had lost a lot of weight and been unable to get to the toilet resulting in urine and faeces around his living area. David's brother had rung the GP to ask for help in lifting him but been advised to call for an ambulance. The following day, David's GP rang the brother for an update.

6.32. David had not been admitted to hospital but the ambulance service had contacted Social Care, concerned about self-neglect. A duty Social Worker carried out a wellbeing check whilst awaiting the VPT visit. The property was in poor condition with electrics blown and damp. David was advised to attend Housing. The Social Worker did not feel there was evidence of self-neglect. David said he would accept support from VPT, deep cleaning services and physiotherapy. The Social Worker did not identify any safeguarding issues and David did not wish to involve safeguarding. A referral was made for a deep clean quote; and to the GP for a physio assessment.

6.33. The Social Worker's view was that it was unclear whether Care Act criteria were met but that there were environmental needs. The plan was for VPT to carry out an assessment with no

further action to RMBC safeguarding other than to offer a joint visit with VPT. David told the Social Worker that he had no phone and any visits needed to be after 2pm; to go round to his back door as he could not hear the front door.

6.34. A Social Worker from the VPT visited David two days later. This was in the morning and they got no response. They spoke with David's brother and agreed a further visit. However, a further two appointments were also unsuccessful. David did however attend Housing services during September, saying he was sleeping in a chair and unable to bathe. The Homelessness Officer completed a housing application.

6.35. During **October 2018**, David's GP tried to phone him to check how he was. David had not engaged with dermatology, dieticians or surgery. The GP had no reply to messages left.

6.36. During October, David was seen by the VPT social worker at their office, accompanied by his mother. A Care Act assessment was initiated. VPT also assisted with a housing application, completed at a follow up appointment. The VPT Social Worker attempted to contact David throughout **November 2018** to complete the Care Act assessment but was unsuccessful. They liaised with his family.

6.37. David was admitted to hospital in **January 2019.** His friend had phoned for an ambulance. Records documented severe self-neglect. There were beer cans over the floor, David had no heating in the home was hypothermic. He was malnourished and blood results deranged. David had not seen anyone for three weeks. Records describe his socks being 'glued' to his feet with a putrid smell. David also had leg ulcers and pressure ulcers to his sacrum. He was commenced on Pabrinex[8] and antibiotics. The hospital wrote to David's GP informing of self-neglect concerns. Hospital also submitted a Safeguarding referral to RMBC.

6.38. The VPT Social Worker was not aware of David's admission, nor of the safeguarding referral. They had tried a further home visit in January, two days after David's hospital admission.

6.39. David was in hospital on this occasion for eleven days. During the admission, David was seen again by ALT. He had no signs of alcohol withdrawal. David stated his intention to remain alcohol free once discharged home but with the occasional drink. David was given advice. David was also referred to the Nutrition and Dietetics service. David was referred to the RDaSH Mental Health Liaison Team due to concerns about low mood and self-neglect. The team attended to attempt assessment but he declined to engage.

6.40. During the admission, the VPT support worker contacted Housing services about David's housing application. The application had not been activated. Housing and the Hospital Integrated Discharge Team liaised regarding discharge options. David was discharged from hospital to a Nursing Care Home (a step-down bed for Winter Pressure)**.** Family contacted Social Care to ask for a reassessment of David's needs before he was discharged.

6.41. David remained at the nursing care home for four months. He was temporarily registered with a new GP Practice (GP2). He had follow-on care from this GP, dieticians, OT, tissue viability

[8] Injection rapidly correcting severe depletion or malabsorption of vitamins B and C, particularly in alcoholism

nurses and dermatology. David remained alcohol free during his time at the care home and his physical health improved considerably – increasing weight by 7 kilos and improving his mobility.

6.42. During his stay, Housing and the Integrated Discharge Team (IDT) Social Worker continued to work together to consider different options for David's accommodation and support. A Care Act assessment was completed.

6.43. The Housing Occupational Therapy Manager was concerned that David would not manage an independent tenancy and would deteriorate to the same state as when admitted to hospital. Their view was David required Extra Care Housing. However, the Housing Association declined to accept David, due to concerns about his historic risky behaviours**.** This decision was challenged by the Housing Occupational Therapy Manager, but it was not over-turned.

6.44. David was discharged in **May 2019** to reablement supported accommodation –a six-week placement to assess how David would manage independent living**.** On leaving the care home, David's temporary registration with GP(2) ended. Though David had remained registered with his original GP, there are no records of any further contact between David and his GP until March 2020.

6.45. A Social Care worker visited David at his supported accommodation in **June 2019**. He was well-presented, managing nutrition, personal care and keeping his property clean. His legs had improved and he had been able to go out for walks with a stick. The worker talked to him about extra care housing and that he could lapse in his own tenancy – they felt he needed extra support. However, David maintained he wanted his own property. He had recently attended Housing services, worried he may be homeless at the end of his six-week stay.

6.46. In **July 2019**, David accepted the tenancy of a Council bungalow. The Social Worker from the IDT visited him at his new bungalow. He was waiting to move in but was already in arrears as Housing Benefit had not been applied for.

6.47. **In August 2019** The IDT Social Worker concluded David had made a very good recovery and didn't need any homecare support. They ended their involvement**.**

6.48. By **September 2019,** David's rent arrears were accruing. An Income Recovery Officer visited David at home. David had thought Universal Credit paid his rent. A direct payment was set up and a monthly repayment plan made. The officer did not have any information about David's history but made a note that he was vulnerable.

6.49. The Area Housing Officer carried out a 'Welcome visit and Tenancy Health' in **October 2019.** The property was deemed to be in good condition. However, David still did not have his benefits in place. He was referred to the tenancy support team who attempted two home visits without success and ended involvement.

6.50. In **March 2020**, David's sister-in-law contacted Social Care. David had deteriorated severely. David''s sister-in-law described him as shocking in appearance – very thin, malnourished with

dirty clothes and odour. His house was described as in disrepair and he was thought to be in debt. He had blistered feet but would not see his GP.

6.51. The Social Worker spoke with the Housing Officer. They saw David a few weeks ago but he came outside to talk. The Social Worker understood David was still registered with the GP he was with at the care home (this was not the case) and had not been seen recently.

6.52. The Duty Social Worker carried out a home visit two days later. They recorded that David was unwilling to wash or dress without prompting. He was not eating sufficiently or engaging with health services. He had high levels of debt and was alcohol dependent. The duty social worker made a referral to tenancy support due to his debts, updated the GP and requested they refer him to the Social Prescribing Service. The Social Worker spoke with David's sister-in-law who felt ongoing support was needed.

6.53. David's sister-in-law called Social Care again ten days later. She felt the level of support was not sufficient and that David needed daily personal care. David was waiting allocation in one of the Social Care Locality teams. David's sister-in- law also contacted the GP Practice Nurse with concerns about David, describing him as living in squalid conditions again. David's brother was trying to support him but was getting very stressed. The GP Practice was contacted for input.

6.54. The Housing Financial Inclusion Officer phoned David to help complete an application for funding from a trust. They also helped him set David up an email account -David had no internet skills, no email address and no computer.

6.55. David's sister-in-law rang Social Care again a few days later, requesting daily support. The GP Practice Nurse also rang Social Care to request an urgent assessment. Social Prescribing were not visiting due to Coronavirus. The information was forwarded to the Social Care Locality team where a referral was awaiting allocation. The Practice Nurse also referred David to DN's, asking for assessment of his legs. This was arranged for the following day. The DN care coordination centre advised family that David must be in otherwise the DNs will not visit again.
DN's planned to visits David again a fortnight later - **April 2020**. There is no documentation that this visit occurred.

6.56. In mid **May 2020**, David's allocated Social Worker tried to contact him but had no response. The Social Worker spoke to his sister-in-law but they had not seen David for some time due to the Covid pandemic restrictions. The sister-in-law thought David would not be coping well as he constantly neglected himself. He often would not answer phone calls as he misplaced his phone. The Social Worker agreed to speak to his GP and then update her.

6.57. The next day**,** David's neighbour called an ambulance having found him on the floor. The neighbour usually saw David every day on his scooter but hadn't seen him recently. David had been on the floor for three days. David was admitted to hospital. He was suffering from severe self-neglect, multiple health conditions, maggots in his groin, feet encrusted with faecal matter and pressure damage with severe excoriation across buttocks and thighs. He was in resuscitation for several hours.

6.58. The ambulance service and hospital both submitted a safeguarding referral to RMBC. It was passed through to the Social Care Locality team who attempted to contact David's family. David died in hospital, six days later.

7 Analysis and Learning

7.1. Context

7.1.1. The term 'self-neglect' covers a wide range of behaviour. It includes people, either with or without mental capacity, who demonstrate:[9]

- Lack of self-care – neglect of personal hygiene, nutrition, hydration and/or health, thereby endangering safety and wellbeing, and/or
- Lack of care of one's environment – squalor and hoarding, and/or refusal of services that would mitigate risk of harm

7.1.2. Research has highlighted the significant challenges that individual practitioners, agencies and safeguarding partnerships have in responding to self-neglect.[10] A recent review of Safeguarding Adult Reviews in England occurring between 2017 - 2019[11] highlighted that self-negect was the most common type of abuse or neglect that had led to the SAR being held i.e. self-neglect was the reason the adult died/serious harm in 45% of all reviews.

7.1.3. Responding to self-neglect is particularly challenging where the adult has the mental capacity to make decisions but is resistive to care. Duty of care requires practitioners to balance respecting the person's rights to make decisions that others may view as unwise, whilst taking reasonable steps to continue to try and engage the person proportionate to the risk they present. Such approaches are part of the national safeguarding agenda, Making Safeguarding Personal.[12]

7.1.4. The Care Act 2014 statutory guidance does reference self- neglect as a type of abuse. [13] However the guidance states:

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[9] Definition: 'Self-Neglect', SCIE (2014), *Self-neglect Policy and Practice: Building an Evidence Base for Adult Social Care*, Available from: http://www.scie.org.uk/publications/reports/69-self-neglect-policy-practice-building-an-evidence-base-for-adult-social-care/ [Accessed: November 2020]

[10] Ibid.

[11] Local Government Association: Analysis of Safeguarding Adult Review April 2017- March 2019; October 2020

[12] SCIE Making Safeguarding Personal https://www.scie.org.uk/care-act-2014/safeguarding-adults/safeguarding-adults-boards-checklist-and-resources/making-safeguarding-personal.asp [Accessed October 2020]

[13] Care and Support Statutory Guidance (updated June 2020) Ch14, Available from: https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance [Accessed: November 2020]

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.

Care Act 2014 Statutory Guidance Ch 14.17

7.1.5. Historically, Safeguarding Adult Boards and Local Authorities have had different approaches to managing self-neglect. Some areas managed self-neglect under their Safeguarding Adults procedures whereas other areas determined that Safeguarding Adult procedures should be reserved for abuse or neglect perpetrated by a third party with self-neglect being managed as compex care through alternative multi-agency arrangements.

7.1.6. In 2015, research into self-neglect was published by the Social Care Institute for Excellence (SCIE).[14] This research highlighted

1. Organisational factors: the wider systems and processes required to support partnership working in self-neglect.
2. Practice factors: approaches by professionals and agencies to achieve the best outcomes for people who self-neglect

7.1.7. This review draws on this research to benchmark and analyse the effectiveness of multi-agency responses to David. Section 8 then discusses changes that have recently been put in place in Rotherham.

7.2. Organisational Responses to Self-Neglect in Rotherham

7.2.1. The SCIE research identified the following organisational factors that enable effective multi-agency responses to self-neglect.

Organisational Factors to Support Practice in Self Neglect
1. A clear location for strategic responsibility for self-neglect
2. Data collection on self-referrals, interventions and outcomes
3. Clear referral routes
4. Systems in place to ensure coordination and shared risk management between agencies
5. Time allocations within workflow patterns that allow for longer-term supportive relationship-based involvement
6. Training and practice development around the ethical challenges, legal options and skills involved in working with adults who self-neglect

[14] SCIE (2014) *Self-neglect Policy and Practice*, Available from: http://www.scie.org.uk/publications/reports/69-self-neglect-policy-practice-building-an-evidence-base-for-adult-social-care/ [Accessed: December 2017]

7. Supervision systems that both challenge and support practitioners

7.2.2. In Rotherham during the scope period the organisational systems for self-neglect were not well developed. There were no multi-agency policy or procedures in place for self-neglect.

7.2.3. This absence of guidance meant that there was not a shared understanding of how agencies should work with self-neglect. The pathway for responses by agencies was not clear. There were no assessment tools to help identify and assess the severity of self-neglect or to flag when threshold may be met for referral onto Adult Social Care.

7.2.4. When concerns were referred through to RMBC Adult Social Care, the RMBC policy at that time was that self-neglect would not be managed by the Safeguarding Adult Team (SAT). RMBC referred on to a Vulnerable Adults Team or to the Locality Social Care teams.

7.2.5. As noted in section 7.1, the Care Act does not require self-neglect concerns to be managed as a Care Act section 42 safeguarding response.[15] However, in the absence of this there did not appear to be a robust alternative process to deliver the coordinated, multi-agency response required.

7.2.6. There was a Vulnerable Adults Risk Management (VARM) Framework that had been in place since 2014.[16] The framework is intended for use in circumstances where:

> • *Where an adult has capacity to make the decision(s) that is creating significant concern for agencies about the adults safety and/or wellbeing (risk of serious injury/death)*
>
> *And*
>
> • *The risk arises from the individual's refusal to engage with services and/or self-neglect in one or more areas of their lives*
>
> *And*
>
> • *Where existing agency involvement have tried and been unable to resolve the issues.".*
>
> **Rotherham VARM Framework**

7.2.7. In relation to David, this VARM was not used and the reasons are not clear. However, the reviewer was informed the VARM was Chaired by Police and tended to be used for people who came to the attention of the Police (although this is not set out in the framework). David did not come to the attention of the police.

[15] The Care Act 2014, Section 42 (2) requires a local authority to make statutory enquiries, or cause others to do so, where it has reasonable cause to suspect that an adult with care and support needs is experiencing, or is at risk of, abuse or neglect and as a result of those care and support needs is unable to protect themselves from abuse or neglect. The Care Act confers duties of cooperation on others

[16] Rotherham Vulnerable Adult Risk Management (VARM) Framework 2014 https://moderngov.rotherham.gov.uk/documents/s97171/VARM [Accessed November 2020]

7.2.8. There was also a Community MARAC (multi-agency risk assessment conference) but this was primarily for use where people had multiple avoidable attendances at Emergency Departments, so called 'frequent fliers' - David did not present to services in this way.

7.2.9. The review heard that there had been some training provided on self-neglect but this was well-over-subscribed. Without policy, clear referral routes and established multi-agency processes, it would also be challenging for practitioners to put their training into practice.

7.2.10. The RSAB does receive basic data on self-neglect. However, without clear multi-agency pathways for self-neglect, it is questionable whether this data provides a true picture on prevalence or severity of self-neglect in Rotherham. Socio-economic factors in Rotherham[17] such as higher levels of deprivation; poverty, homelessness and alcohol use, are likely to result in higher prevalence of complex needs including self-neglect.

7.2.11. The SCIE research identified how time-consuming working with self-neglect can be. Practitioners needed time and resources to work more flexibly and over longer timeframes. RSAB did have a Vulnerable Adults Team in place. In 2018, this consisted of five social workers and 0.5 support worker. However, where data on self-neglect is limited, it is more challenging for RSAB partners to make strategic plans to allocate multi-agency resources adequate to meet needs of the population.

[Recommendation]

7.2.12. The following section explores what this lack of systems meant for David.

7.3. Practice Responses to Self-Neglect

7.3.1. The SCIE research identified the following practice factors as achieving best outcomes for people who self-neglect:

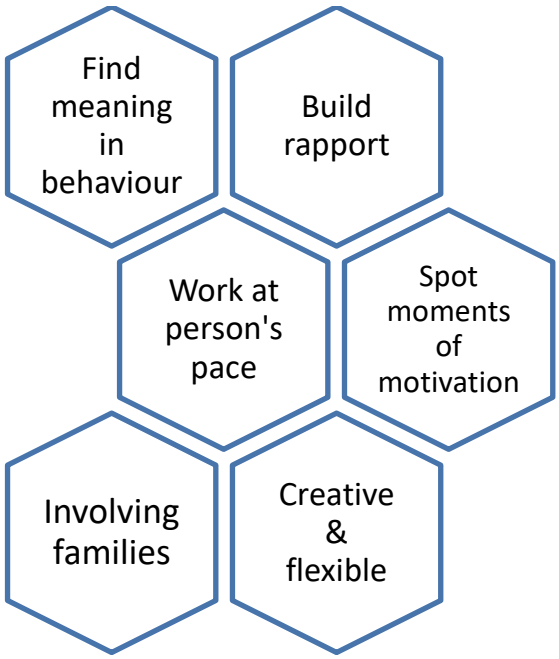
Practice Factors Most Successful in Self Neglect
1. Time to build rapport and a relationship of trust, through persistence, patience and continuity of involvement
2. Trying to 'find' the whole person and to understand the meaning of their self-neglect in the context of their life history
3. Working at the individual's pace, but spotting moments of motivation that could facilitate change, even if the steps towards it were small
4. Understanding the nature of the individual's mental capacity in respect of self-care decisions
5. Having an in-depth understanding of legal mandates providing options for intervention
6. Being honest, open and transparent about risks and options

[17] Rotherham Health and Wellbeing Strategy http://www.rotherhamccg.nhs.uk/Downloads/Our%20plan/Rotherham%20Joint%20Health%20and%20Wellbeing%20Strategy.%20Designed%20version.%20FINAL.pdf [Accessed November 2020]

7. Creative and flexible interventions, including family members and community resources where appropriate
8. Effective multi-agency working to ensure inter-disciplinary and specialist perspectives, and coordination of work towards shared goals.

7.3.2. The responses by agencies is considered against clusters of these best practice factors.

- Building and Using Relationships; Creative Approaches to Facilitate Change



7.3.3. Research highlights the importance of building therapeutic relationships and using those relationships to understand the person and the reasons for their behaviours. It highlights the importance of working at the person's pace, being creative and using moments of motivation to engage in change.

7.3.4. David had a multitude of professionals and services working with him at different times. The reviewer counted in excess of twenty-two different services and teams from across Health, Social Care and Housing. Within those services, there were many different professionals and multiple transitions of care.

7.3.5. David's GP practice was probably the most consistent professional relationship that he had. David lived across the road from the surgery and this appears to have helped their knowledge and engagement with him. There were repeated good practice examples of the GP Practice going 'above and beyond' - checking on his welfare, visiting him at home; linking in with his family and trying to engage David in care. There is good evidence of holistic care – talking through David's emotional wellbeing as well as treating his physical health conditions and referring him for support.

7.3.6. This important relationship was suspended while David's stayed in the nursing care home in early 2019 and was temporarily registered with a different GP. Once discharged from the nursing care home, the temporary registration lapsed although registration with his original GP Practice was automatically retained. There was then a lengthy gap when David had no contact with a GP. The reasons are not clear. David's health had improved considerably but on discharge, he was still on prescribed medication (ranitidine to protect the lining of his stomach and Calcium/vit D supplements).

7.3.7. It may well have been the case that David was not aware he was still registered with his original GP Practice. Whilst David was cognitively capable of checking his registrations and making appointments, his history clearly demonstrated he may require support and prompting to follow this through.

7.3.8. What is now known is that David deteriorated significantly in the intervening period between May 2019- and March 2020 when he came to his GP's attention again. This is a learning point in relation to discharge planning from step-down beds and for management of temporary GP registrations.

7.3.9. The effects of not complying with his medication would have been detrimental to David's health and wellbeing over a period of time, especially when combined with the poor diet and alcohol misuse that followed. Perhaps more significantly, this was a missed opportunity to identify early signs of relapse and to coordinate earlier intervention. The need for coordinated support is discussed further in the section below on multi-agency working.

7.3.10. Beyond his GP, David had very limited continuity of care by the same professionals. Social Care rightly promotes enablement and independence. However, working with self-neglect is often relational based and may well require flexibility in approach/working practice and longer-term involvement.

7.3.11. In Social Care at that time, community-based teams would transfer care if the adult was admitted to hospital. David's family commented that he never seemed to have the same Social Worker. Certainly, the chronology is filled with references to different parts of the Social Care system and responses by duty workers while awaiting allocation.

7.3.12. The Vulnerable Person's Team's (VPT) brief included working with people who self-neglect. However, the chronology indicates delays in allocation and that the team did not appear to be able to offer the continuity required or the degree of tenacious in-reach that was necessary. The gap of some weeks contact leading up to David's admission to hospital in January 2019 is an example of this (albeit that this was over the Christmas period with a reduced workforce). Had David had proactive involvement of VPT, they may have identified his lack of heating; malnourishment and skin breakdown that resulted in that admission.

7.3.13. It is evident from the chronology, that David had some periods of appearing to cope before lapsing once more into severe neglect. The Adult Social Care report indicates that this remitting and relapsing pattern was not clearly identified and responded to.

Discharge from the winter planning bed into [supported accommodation] and a period of rehabilitation was a positive experience, but from here [David] moved into his own council property. Given [David] past history, it was likely that without any ongoing support, he would slip back and start to self-neglect again. Missed opportunity, [David] should have been referred back into Vulnerable Persons Team to provide ongoing support and monitor him at home, signpost to other services etc.

RMBC Adult Social Care Report

7.3.14. The absence of a longer-term flexible engagement may be reflective of a wider-systems issue as referenced in 7.2. i.e. the need for adequate resourcing to work with people with more complex needs including self-neglect.

[Recommendation]

7.3.15. DNs provided a high level of support and David's family report positively on the care he received from the service. However, the nature of DN care is temporary. The service has informal arrangements for trying to provide a consistent nurse(s) where the person has more complex needs or presents challenges to engage with. However, there is no policy for 'keyworker' arrangements.

7.3.16. There were multiple occasions when professionals would visit David but get no response. On occasions, David made an active choice not to engage. However, on other occasions, it seems he missed appointments due to a lack of communication within and between agencies about the best means of contact. David had no computer or email address and regularly had no phone. He was known to have memory problems. There are at least two known occasions when David told professionals to call at his back-door (as he was not able to hear his front door) and the best time of day to call. This information does not seem to have been communicated across the system and recorded in agency care plans. This should have been in place as a reasonable adjustment in line with the Equality Act 2010.[18]

[Recommendation]

7.3.17. The consequence of this lack of communication was many missed appointments. It reinforced the view held by agencies that David was unwilling to engage – this was only partially true. In some cases, services ended their involvement. It is notable that David was due to receive a visit by DN's in March and April 2020. There are no records to indicate these visits occurred and there was no further contact before he died.

7.3.18. There were however many examples where professionals did take additional steps of contacting family members to check on David – this was seen by Social Workers, his GP Practice as well as DN's.

7.3.19. Overall, there was good engagement with David's family. There were many occasions when family contacted various services to express their concerns about David. Their perspective is that professionals were responsive to them. There were also many occasions when family were contacted and asked about their views as well as times when Health and Social Care professionals saw David with his family. There were examples of engaging family members in the

[18] Equality Act 2010 section 20 https://www.legislation.gov.uk/ukpga/2010/15/section/20 [Accessed November 2020]

care plan, for example, asking them to contact Housing and arranging for a fire safety check. This was positive practice but there is no record of collaboration to see how these plans were followed through. This would have flagged a miscommunication i.e. that the family and the social worker both believed the other party was contacting the fire service.

7.3.20. Involvement of family could have been improved through a more structured approach of using family group conference. Family group conferences have traditionally been used in Child Protection work however there is increasing evidence that they can be helpful in adult safeguarding.[19] Using this more structured approach could have enabled a more creative and coordinated plan as well as supporting the family in their very stressful role as carers for David and they would have valued this. There was no record of any carers assessment being considered. **[Recommendation]**

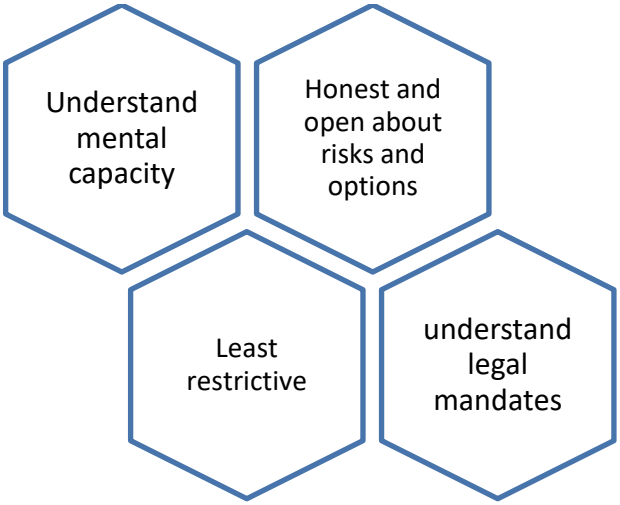
7.3.21. David's family recognised the adverse effect that alcohol had on his wellbeing and had frustration that David's would not seek support to address his alcohol dependence. The model of behavioural change is well established in alcohol and substance misuse services, recognising the person may be at different stages of the motivation to change cycle and that relapse is often part of this process.[20] David's family were probably best placed to identify windows where David may be more motivated to address his alcohol use and self-neglect. Attendees at the learning event reflected on the challenges of helping people overcome problematic alcohol use, the need to be realistic about what they can achieve and want to achieve. All agencies have a role to play in using opportunities where the person may be more motivated to change.[21] There was evidence of this by practitioners involved such as DN's; GP Practice and the hospital with referrals into Alcohol Services. Sadly, David was not at the stage of being able to follow this through.

7.3.22. David may well have had different views about what would help him most. Making Safeguarding Personal recognises the need to engage with the person on the areas that will be most important to their wellbeing. This is also key to assertive outreach approaches,[22] working to maintain engagement where a person may be resistive to change.

7.3.23. For David, getting his housing sorted out was a key factor and an issue he continually sought help with. Earlier, more proactive support in this may have had the benefit of improving his accommodation; giving him the chance to cope with a smaller property, as well as demonstrating to him the value of engaging with professionals.

[19] SCIE Safeguarding Adults: Mediation and Family Group Conferences 2012 https://www.scie.org.uk/publications/mediation/ [Accessed November 2020]
[20] World Health Organisation (2003) Intervention for Substance Use: Brief Intervention for Substance Use: a Manual for Use in Primary Care -Draft https://www.who.int/substance_abuse/activities/en/Draft_Brief_Intervention_for_Substance_Use.pdf [Accessed November 2020]
[21] NHS Health Education England; Making Every Contact Count https://www.makingeverycontactcount.co.uk/ [Accessed November 2020]
[22] Burns T, Firn M (2002) Assertive Outreach in Mental Health. A Manual for Practitioners. Oxford: Oxford University Press.

- Managing Risk within Legal Frameworks



7.3.24. Research emphasises the need to work consensually with the person but recognises the value of using legal frameworks to support change. However, legal levers were limited.

7.3.25. There was no evidence that David had any mental disorder and would have met criteria for compulsion under the Mental Health Act 1983. Nor did David's living conditions invoke action under environmental or community protection orders.[23] At the learning event, Housing discussed the potential to use powers within their tenancy contract alongside the supportive measures of tenancy support. However, there are no records that this was considered at the time.

7.3.26. The Health and Social Care records consistently demonstrate that David's mental capacity was considered. Records were made at specific points when David declined care confirming that he was capacitous. Consequently, decisions could not be made in his best interests under the Mental Capacity Act. There was also no evidence to indicate his decisions were hindered by coercion that may invoke the inherent jurisdiction of the Court (although this does not appear to have been considered).

7.3.27. Section 7.1. described the well-documented challenges of working with adults who have the mental capacity to make decisions but who are resistive to care and support. The Mental Capacity Act Code of Practice[24] refers to this as exercising 'the right to make decisions that others may view as unwise.'

7.3.28. Professionals as well as family can find it very difficult to accept when a person with capacity acts in a way that may put them at substantial risk. It can be difficult for families to accept limitations of legislation and that their wishes for a loved one's wellbeing may not be compatible with the person's choices. As David's family commented *'we couldn't see how anyone would want to live like that.'*

[23] Environmental Protection Act 1990; Anti-social Behaviour, Crime and Policing Act 2014.
[24] Office of the Public Guardian Mental Capacity Act Code of Practice 2007, Updated 2020 https://www.gov.uk/government/publications/mental-capacity-act-code-of-practice [Accessed November 2020]

7.3.29. For David, although he was assessed as having capacity to make decisions, his ability to follow through on alternative courses of action was often compromised, i.e. his executive capacity. This lack of executive capacity does not give others the right to make decisions or give legal authority to compel a person to accept care without valid consent. However, this inability to follow through on a decision should inform risk management.

7.3.30. At the learning event, attendees discussed the difficult balance of accepting a person's choices and rights to make 'unwise decisions,' whilst taking reasonable and proportionate steps to help them to explore risks and alternatives. This is reiterated in policy:

> *'Making Safeguarding Personal does not mean 'walking away' if a person declines safeguarding support and/or a S42 enquiry. That is not the end of the matter. Empowerment must be balanced for example, with Duty of Care and the principles of the Human Rights Act (1998) and of the Mental Capacity Act (2005). People must not simply be abandoned in situations where, for example, there is significant risk and support is declined and/or coercion is a factor.'*
>
> **ADASS Advice Note 2019**[25]

7.3.31. There were some good examples of professionals having discussions with David, helping him to consider risks arising from his living situation, his choices about independent living; his drinking and the occassions when he declined care and treatment. This was all positive (albeit expected practice) but the conversations related to different aspects of David's needs. What was not evident from any agency involved, was a comprehensive and formal approach to risk assessment and risk management across all elements of his self-neglecting behaviours. The lack of policy and guidance meant that there were no assessment tools providing a shared language and helping the different agencies to quantify the severity of the self-neglect.

7.3.32. Throughout the scope period, there were seven Safeguarding Adult referrals. These were from the GP Practice; DN's; ambulance; hospital and Locality Social Work team. Within these referrals, there were stark descriptions of David's self-neglect and, in one case, concern expressed that he may die. Had these referrals been managed as Care Act section 42 enquiries, this should have led to a robust multi-agency risk assessment and management plan to try and address professionals' and family's concerns as well as capitalise on David's strengths and assets. As it was, the referrals were diverted from the Safeguarding Adult Team through to other parts of Adult Social Care such as the Locality Team and Vulnerable Person's Team. There did not appear to be any formal risk assessments and only one Care Act section 9 assessment[26] was completed in March 2019. There is no record of a Care Act Carers assessment being considered.[27]

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[25] ADASS Advice Note: A Framework for Decisions on the Duty to Carry Out Safeguarding Adult Enquiries July 2019 https://www.adass.org.uk/media/7326/adass-advice-note.pdf [Accessed November 2020]

[26] Duty on the Local Authority to carry out a needs assessment to determine whether the adult has care and support needs and what those needs may be. https://www.legislation.gov.uk/ukpga/2014/23/section/9/notes

[27] Carers can be eligible for support whether or not the adult for whom they care has eligible needs

7.3.33. The lack of formalised risk assessment along with multiple transfers of care, also resulted in plans being lost or drifting. An example was the management of fire risk. David's circumstances put him at high risk of fire - limited mobility; smoker; cluttered house; alcohol; electric fire. This was identified in November 2017 when a duty Social Worker found him asleep, intoxicated, wrapped in blankets with a lit cigerette next to a fire. The plan was to ask family to organise a fire safety check and for the Social Worker to obtain a fire blanket. David's care was then transferred to other Social Care teams. There is no reference to the fire safety plan being followed through. The same fire safety concerns were raised in July 2018.

7.3.34. The lack of continuity of care also detracted from a worker gathering a cumulative picture of risk. Assessments carried out by Social Care duty workers appeared to take an episodic approach to risk assessment. Assessments appeared to rely on what David was telling them and observations at the time. The assessment also needed to take into account the collaterol history and David's questionable executive capacity. There was no reference to his patterns of relapse; severe self-neglect and the multiple hospital admissions as a consequence of his self-neglect. There was also limited evidence that assessments drew on multi-disciplinary perspectives or, more latterly, on the views of the family. Consequently, the plans put in place were largely a repeat of what had already been tried and were not adequate to meet David's needs.

7.3.35. Reviews need to be cautious about making judgements with the benefit of hindsight. However, David's extensive histroy of severe self-neglect was known. Professionals such as the Housing Occupational Health Manager had also identified concerns about how he would cope in independent living. He had been assessed as benefitting from Extra Care. However, when this was declined (by the Extra Care Housing Association and by David) the alternative care package that was set up in March 2020 was Social Prescribing.[28] While Social Prescribing has great value in linking people into services, it is a 'light touch' support. The Social Prescribing link worker was also not providing home visits at that time. Without additional input, a Social Prescribing response fell well short of that needed to address David's risks. The fact that this also coincided with a tailing off of DN services and a period of Covid lock down when family could not visit, compounded the lack of support.

[28] NHS England Social Prescribing https://www.england.nhs.uk/personalisedcare/social-prescribing/ [Accessed November 2020]

- Multi-agency Working

7.3.36. The absence of multi-agency working, care coordination and information sharing is highlighted as learning in the majority of Safeguarding Adult Reviews.[29] This review is no exception.

7.3.37. During the scope period, there were a significant number of agencies and professionals with some involvement in David's care:

ASC Safeguarding	ASC Community & VPT	Hospital Social Care	Occupational Therapy
Dieticians	Hospital	Ambulance	GP Practice
Enablement Services	District Nursing	Housing Pre-letting	Housing Post-letting
Dermetology	Alcohol Liaison	Mental Health	Speech & Language

7.3.38. Given David's repeated severe self-neglect episodes, there was a critical need for a coordinated multi-agency approach. This would bring together information and professional perspectives; access resources and expertise as well as offer a shared approach to risks assessment and management.

[29] Local Government Association: Analysis of Safeguarding Adult Review April 2017- March 2019; Executive Summary October 2020

7.3.39. There were pockets of effective joint working for example, between Housing and Social Care Integrated Discharge Team. There was also evidence of communication between different parts of the system such as DN's and Social Care; DNs and GP Practice. However, despite the number of services involved, at no time was there a multi-agency meeting that brought all the key services together.

7.3.40. There was one record of a multi-agency meeting being held in June 2018. This was convened by the GP Practice and through the Community Matron for long term conditions. It was good practice to convene this meeting however, there is little information known about attendees or the content of this meeting; whether there was a robust plan and contingency plan put in place. There is no evidence of this in the subsequent response to David.

7.3.41. There was also an intention to hold a multi-disciplinary meeting prior to David's discharge from hospital in July 2018. However, David discharged himself before this could be convened. The need for a multi-agency meeting was not followed up as part of transfer of care through to community services. Individual services then discharged David when he didn't attend and within two months, David had deteriorated once more.

7.3.42. It was apparent that communication within agencies as well as between agencies was lacking. There was evidence of this within Health, Social Care and Housing. The author of the RMBC Housing report highlighted learning for their service. David's history and vulnerability were well understood by their pre-lettings service. The Housing Occupational Therapy Manager was clear about his risks and had tried to advocate for David with Extra Care Housing. However David's risk profile was not transferred through to the post-lettings team. Had this been communicated, David may have received greater support by the tenancy support team and by the income recovery team in those important months of managing his own tenancy once more. Housing recognised this was a missed opportunity.

7.3.43. This example again reinforces the value of multi-agency working. Had this been in place, the coordinator would have been able to ensure all parts of the system were aware of David's risks and vulnerabilities and their contribution to the risk management plan.

7.3.44. Safeguarding Adults procedures establish the formal structure for multi-agency working. However, as noted in the above section, the referrals were not managed as section 42 enquiries. Lack of communication regarding outcomes from safeguading referrals was specifically flagged by the author of the GP report as needing to improve.

7.3.45. As identified in section 7.2. structures such as VARM and the community MARAC were not used either. It is not clear as to the reason why and whether the terms of reference for those meetings are well understood.

7.3.46. Practitioners often refer to the difficulties of getting partners' commitment to attend multi-agency meetings. It can feel an additional commitment in challenging times when agencies are having to do more with less resources. There is a need for the proportionate allocation of stretched resources. However, there will be some more complex and high risk cases that merit a more intensive response by all agencies. In such circumstances, multi-agency working is likely to deliver the most effective outcome for the person as well as the best use of resources.

8. What Has Changed?

8.1. This review was initiated within six months of David's death. However, within this time frame there have been a number of changes relevant to the learning.

8.2. The RSAB has launched self-neglect procedures. These provide guidance on identifying and assessing self-neglect including convening multi-disciplinary meetings and recognising when a referral through Safeguarding Adult procedures is indicated. The procedures include flow charts; lists of resources and tools to aide practice including quantifying levels of risk and associated actions.

8.3. The introduction of policy and procedures is important but it can take time to change front-line practice. RSAB will need to assure that launching the procedures is part of a wider package that incorporates training and supervision across partner agencies. The RSAB will also need to assure new referral pathways are known and used by all partners. Most significantly, the RSAB will need to test the quality of multi-agency response and understand how this has improved outcomes for people such as David.

[Recommendation]

8.4. RMBC Housing has developed an integrated IT system that will improve communication across all their services including information such as vulnerabilities and additional needs of tenants. The system is due to be implemented in October 2021. In the interim, RMBC Housing is recommending introduction of handover between pre and post letting services including the Area Housing Officer, to ensure effective support and multi-agency liaison for tenants with more complex needs.

8.5. RDaSH is developing a seven-minute briefing for mental health staff to improve knowledge and understanding of self-neglect. This was developed following learning from another incident. RDaSH includes self-negelct in their level 3 training and has developed a bespoke self-neglect training package which can be delivered to individual teams. TRFT has increased the size of their Safeguarding Adults Team and is able to provide increased support; guidance and training to staff in clinical areas. This is in addition to safeguarding champions across community and inpatient services. The CCG also has a 7 minute guide to share across primary care and will be sharing learning from this SAR across all practices with practical input in 2021.

8.6. RMBC Adult Social Care has restructured their service. Safeguarding Adult concerns are no longer managed by a separate team but are allocated directly into the relevant Locality Social Care team. The Locality Teams also continue to work with the adult if they are admitted to hospital rather than transfer care to Hospital Social Care team.

8.7. This is likely to be beneficial in providing continuity of care. It may also help safeguarding be integrated into wider work that supports the adult's wellbeing. However, RMBC will need to assure that these new arrangements deliver the quality improvements intended, particularly that the wider Social Care workforce have the rigour and expertise for safeguarding that was

previously held by a specialist team. There is now a safeguarding assurance team which provides, oversight, guidance and information on complex cases.

8.8 The author of the RMBC Adult Social Care report recognised that identifying and responding to self-neglect was an area of weakness for Social Care staff and that the workforce would benefit from self-neglect and hoarding training. The over-subscribed applications to self-neglect training commissioned by RSAB suggests this is also an unmet need for partner agencies. Adult Social Care also identified a need to strengthen use of supervision in self-neglect cases- evidence of decision making and case discussion with team managers recording the agreement of professional involvement.

[Recommendation]

8.9. RMBC Adult Social Care has also restructured their VPT into a new Complex Lives team. They attend biweekly tactical meetings attended by a broad range of partner agencies where complex cases involving self-neglect are discussed.
It is noted that the resources within this team remain limited (two social workers). This review has highlighted the additional resources and multi-agency response required to work effectively with people who self-neglect. Self-neglect can be a high economic cost as well as human cost – avoidable health conditions and hospital admissions; environmental problems including fire; costs incurred from missed appointments.

8.10. Time and resources spent can be a sound economic as well as ethical investment. It may be valuable for the RSAB partners to undertake further strategic work to better understand the prevalence of self-neglect within Rotherham and to re-evaluate the multi-agency resources needed to support successful implementation of the new procedures.

[Recommendation]

9. Conclusion

9.1. The review has examined the sad circumstances surrounding David's death.

9.2. David's alcohol use coupled with his poor physical health had a great impact on his quality of life and his ability to care for himself. David showed insight into his condition and there is no indication that he lacked capacity to make decisions about his care and treatment. He had periods of improvement but like many people with problematic alcohol use, he could not always sustain and act on his good intent to reduce his alcohol.

9.3. At times, David was resistive to accepting help from agencies despite understanding the risks of not accepting care. However, there were also many elements of care and support that David was prepared to engage with. The task for agencies was to capitalise on these opportunities, using relationships to build rapport and to coordinate a multi-agency response.

9.4. The review highlighted some elements of good practice. Professionals being responsive and taking the additional steps to try and work with David and his family.

9.5. However, collective responses fell short of best practice. There was an absence of comprehensive risk assessments that would see the bigger picture and identify recurrent severe self-neglect. There was also an absence of bringing together all the key agencies with David and his family to coordinate a care plan; set out clear expectations for all agencies and agree a contingency plan. Practitioners were not supported by systems to support effective multi-agency working.

9.6. It is not possible to determine whether these measures would have averted the sad circumstances of David's death. David may still have been unable to overcome his self-neglecting lifestyle. Nonetheless, the lessons highlighted within this review are important to help practitioners apply best practice and to be supported by Rotherham Safeguarding Adult Board in making a difference in the lives of adults who self-neglect.

10. Recommendations

10.1 Agencies identified learning points for their own service. The review has also highlighted learning for the RSAB partnership. The recommendations take account of improvements already made.

Recommendation
The RSAB has recently launched new self-neglect policy and procedures. Following this implementation phase, the RSAB should carry out assurance activity to evaluate the difference that these procedures have made. This assurance should include: 1. Audit of front-line staff and their knowledge of the new procedures and referral routes 2. Feedback from front-line staff regarding strengths/weaknesses of the new procedures and impact on their levels of confidence in working with self-neglect **3.** Carry out some qualitative sampling of self-neglect cases to evaluate a) the quality of multi-agency practice - , b) outcomes achieved for adults in accordance with Making Safeguarding Personal c) support and involvement of carers The sampling should include cases that would be assessed as Level 2 and Level 3 under the procedure risk assessment guidelines (Appendix 1). 4. The training that is available to staff to improve their competence in working with self-neglect and their application of the new procedures 5. Availability and access to specialist resources such as the Complex Lives team to test capacity to meet the needs of people in the highest risk circumstances

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Glossary

ALT Alcohol Liaison Team

ASC Adult Social Care

DN District Nurse

ED Emergency Department

IDT Integrated Discharge Team

MARAC Multi-agency Risk Management Conference

MDT Multi-Disciplinary Team

OT Occupational Therapist

RDaSH Rotherham, Doncaster and South Humberside Trust

RMBC Rotherham Metropolitan Borough Council

RSAB Rotherham Safeguarding Adult Board

SAR Safeguarding Adult Review

SAT Safeguarding Adult Team

SCIE Social Care Institute for Excellence

TRFT Rotherham NHS Foundation Trust

VARM Vulnerable Adult Risk Management

VPT Vulnerable Persons' Team

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About the Reviewer

The review report was written by Sylvia Manson, of Sylman Consulting. Sylvia is a mental health social worker by background and has many years' experience in Health and Social Care senior management and commissioning. Sylvia has held regional and national roles in implementing legislation and developing safeguarding policy, including as Department of Health, lead for NHS, developing the Safeguarding Adult Principles, now incorporated into the Care Act statutory guidance.

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