Overview Report

# Rotherham Safeguarding Adults Board

# Safeguarding Adult Review

## ‘**The Painter and his son’.**

Kate Spreadbury July 2021

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## Introduction

1.1 This Safeguarding Adults Review (SAR) is commissioned by the Rotherham Safeguarding Adults Board (RSAB) in response to the circumstances surrounding the deaths of Sam and his son Ben.

1.2 Sam was born on the 29th January 1927 and died at the age of 91 years. His body was found at home on the 24th April 2019. The cause of his death has been established as:

*1a Bronchopneumonia and Ischaemic Heart Disease (Coronary artery atheroma) and 2) Diabetes Mellitus, Polycythaemia*

His son, Ben, was born on the 9th September 1958 and died at the age of 61. His body was found at home on the 20th April 2020. The post-mortem examination concluded that Ben had died some months previously, the cause of his death could not be identified and is recorded as '*unascertained*' on his death certificate.

1.3 Pen Picture including demographic details.

Both Sam and Ben are white UK males, both heterosexual. Their religion is not known. Both lived in an owner-occupied home in their joint names. Ben had always lived with his parents. His mother married Sam, her second husband, bringing a young son and daughter to the marriage. Sam is described as '*a lovely man, a hard worker and good provider, he was caring and kind*'.

Ben always lived with his mother and father. He was the youngest child in the family and described by his sister as a '*quiet lad with a dry sense of humour. He never seemed to age or grow up, a Peter Pan. He had friends at school but not when he was an adult. He worked in the steelworks, leaving this job after an accident at work which left him with a back injury'*.

Ben was close to his family, his sister lived nearby, and he spent time with his father, both loved football and enjoyed greyhound racing. His mother was diagnosed with leukaemia and his sister reports that Ben took over household chores and supported his mother, *'he took her to hospital appointments. He did all the housework. He couldn't iron and would send his shirts out to the dry cleaner so they were neatly pressed. He kept the house and himself clean, he was 'particular'.''*

Sam and Ben were both very distressed by the death of Sam's wife/Ben's mother in 2011. Sam was 84 years old at the time, his step - daughter says that '*My Dad seemed to go downhill quickly after that. He looked frailer, he used to ask where Mum was, he didn't seem to recognise she had died. I don't know if this was deep grief or dementia*'. Sam experienced depression before and after his wife's death.

Ben already seemed depressed after his work-related injury, after his mother died he became more anxious.

According to his sister, in adulthood Ben had no friendships and no relationships until he met 'Z' who appears to have 'moved in' with him and his father around 2013. The relationship between Z and Ben resulted in the breaking of the connection between Ben and his stepsister which had been stretched as Ben coped with his mother's final illness and death.

1.4 This review is conducted in accordance with section 44 of the Care Act 2014 and the Rotherham Safeguarding Adults Board procedures. Section 44 (i-v) of the Care Act 2014 stipulates that a SAB 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 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) An (*sic*) 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).*

*(5) Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to— (a)identifying the lessons to be learnt from the adult's case, and (b) applying those lessons to future cases.*

The decision to undertake a SAR with respect to Sam was made in January 2020. Sam had died in unusual circumstances whilst closed to adult social care and without care and support for some weeks before his body was found. Ben was supported by various agencies in the year before his death. In the light of Ben's death in or around April 2020 an extension was added to the existing SAR terms of reference in September 2020 to include the circumstances around his death within the SAR.

The lead reviewer was commissioned in May 2020 and the SAR activities regarding Sam commenced on this date. The addition of a second subject to the SAR in September 2020 and the pressures on organisations during the 2020 pandemic has meant that the statutory

guidance to '*complete a SAR within a reasonable period of time and in any event within 6 months of initiating it*' (DHSC 2020 14.173)[1] has not been possible.

## 2. Terms of Reference

2.1 Timeframes considered by this SAR:

for Sam, the time in the SAR scope was 2012 when he was assessed for care and support until December 2019, eight months after he was found deceased.

for Ben, the timeframe was January 2016 when he was acknowledged as the carer for his father and April 2020 when his body was found.

From the evidence collected and analysed for Sam's SAR, it is believed that the key questions to ask with reference to Ben are:

***How did agencies work together to support Ben?***

***Were there challenges and barriers to understanding his needs and responding to them?***

## 3. Methodology

3.1 The methodology used in this review seeks to promote a thorough exploration of the events prior to the death of both men, whilst trying to avoid the bias of hindsight or outcome which can obscure the understanding and analysis of important themes. Agencies work within complex circumstances, and a systemic approach to understanding why people behaved as they did, and why certain decisions were made, is essential if learning is to be derived from the Review.

3.2 Activities undertaken during the Review process have included: collation of chronologies, individual agency reports, examination of documentation as appropriate, identification of key episodes, exploration of these episodes and the lead reviewers' initial findings through two learning workshop events with the agencies and personnel involved with both subjects. Some of the individuals who worked with Sam or Ben were interviewed by the lead reviewer. The lead reviewer also had access to the bundle of evidence submitted to the Coroner regarding Sam and Ben's deaths.

3.3. The SAR activities have been supported by a Panel of senior managers from the agencies involved.

3.4 The following agencies have contributed to the Review:

[1] Care and Support Statutory Guidance: updated 24 June 2020. Accessed at https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

For Sam:

- Rotherham Metropolitan Borough Council (RMBC) Adult Social Care, Housing and Public Health. (Assessment Team.)
- Rotherham Metropolitan Borough Council Adult Social Care, Housing and Public Health. (Safeguarding)
- The General Practitioner surgery.
- Rotherham NHS Foundation Trust (Community)
- Rotherham NHS Foundation Trust (Community Occupational Therapist)
- The Domiciliary Care provider agency
- South Yorkshire Police
- NHS Rotherham Clinical Commissioning Group

For Ben

- Rotherham Metropolitan Borough Council Adult Social Care, Housing and Public Health. (Assessment Team.)
- Rotherham Metropolitan Borough Council Adult Social Care, Housing and Public Health. (Safeguarding)
- The General Practitioner surgery
- Rotherham, Doncaster, and South Humber NHS Foundation Trust (RDaSH)
- Rotherham NHS Foundation Trust (Community)
- South Yorkshire Police
- NHS Rotherham Clinical Commissioning Group

3.5 The family of Sam and Ben have contributed a great deal to the SAR process via interviews. They have also attempted to submit additional documentary evidence to the Review, but their solicitor has experienced some challenges related to COVID restrictions and at the time of writing no documentation has been received.

## 4. Key Events and Analysis

Both Sam and Ben had a number of health conditions which required regular monitoring and medication. Sam had type 2 diabetes, described as 'uncontrolled'. At the beginning of the time considered by this SAR Sam had lost weight and was experiencing mobility difficulties following a stroke in 1998. Sam had also been diagnosed with depression, pernicious anaemia, ischaemic heart disease, secondary polycythaemia, chronic obstructive pulmonary disease and had a myocardial infarction in November 2015.

Ben had a number of health conditions including depression, hypothyroidism[2], ulcerative colitis[3], secondary polycythaemia[4], and cobalamin (vitamin B) deficiency and needed regular medication. Ben had neglected his own health for some time, he did not attend hospital appointments or routine blood tests- important to monitor hypothyroidism and polycythaemia. Ben did not pick up prescribed medication for his medical conditions. Ben is reported to have drunk alcohol heavily after his father's death, although his use of alcohol did draw comment from professionals who knew him prior to his father's death.

Professionals who knew Sam and Ben in the years considered by this SAR report that Sam was 'good *natured, he looked at Ben to answer questions that involved memory of complexity'* '*always laughing, joking, talking about the horses'*, they were '*very private people*.' Ben was '*eccentric, well intentioned, needed lots of reassurance, was he doing it right? Was there more that he could do*?'

## 4.1 2012 to 2015

Sam needed support with meal preparation and daily tasks but was described by RMBC adult social care (ASC) as getting full support from his son who was his '*main carer'*.

At the beginning of 2012 Sam had regular reviews of his diabetes, depression, and heart related issues at the GP surgery. Sam did not attend hospital appointments, missing regular specialist checks and diagnostic procedures. Sam's lungs began to be of concern in mid-2013 and he was also diagnosed with polycythaemia, although his notes were confused with his son's notes who also had the condition. Father and son were not proactive in following up support but appeared to be coping and generally compliant with medical care.

In early 2015 the GP noted Sam's deteriorating mental functioning although he refused to have a dementia screening test. For most of this year Sam continued to come into the surgery and was recorded by the GP (July 2015) as *'doing well with the aid of his son'*.

On the 1st December 2015 Sam was admitted to hospital having experienced a heart attack. He was 88 years old. He was discharged three days later, the hospital did not view his discharge as complex or requiring a care and support needs assessment, his son was thought to be managing Sam's needs, there was no need for Sam to climb the stairs as he slept downstairs and both father and son did not want support.

Sam was seen by his GP at home twice in December. Ben was having great difficulty in coping with his father's weakened state, the GP noted on the 17th December that Sam was unkempt, smelt of urine, was unshaven and dressed in stained clothing. He was very unwell and immobile. Ben may have had difficulties for a longer period, he had stopped monitoring

[2] Hypothyroidism: or 'underactive thyroid'. See Underactive thyroid (hypothyroidism) - NHS (www.nhs.uk)
[3] Ulcerative Colitis. A long-term condition where the colon and rectum become inflamed. See Ulcerative colitis - NHS (www.nhs.uk)
[4] Secondary polycythaemia – see under Polycythaemia - NHS (www.nhs.uk)

Sam's bloods, he had 'lost' the machine and claimed that nurses were supposed to sort this out but had not contacted him. The GP called an ambulance on 17th December 2015 and Sam was admitted to hospital, dehydrated and with a lower respiratory tract infection, he was discharged on the 24th December. On the 30th December Sam was back in the hospital Emergency Department, he had breathing difficulties and was hypoglycaemic, he was weak and confused but this resolved after his blood sugar returned to normal levels. He was discharged home without admission.

**4.2 Comment:**

Sam was becoming frail and Ben was struggling to cope as his father's carer. He had a strong relationship with the GP surgery which was diligent in attending to Sam's health needs.

Ben's sister notes that Ben found being his parent's carer very stressful and his 'personality changed' whilst his mother was ill, he went from being a '*lovely easy going'* man to a '*bad tempered withdrawn*' man.

## 4.3 January 2016 – December 2017

**Description**

Following Sam's discharge from hospital Ben visited the GP and said that he needed support to care for his Dad. The GP made referrals to the domiciliary physiotherapist, ASC, and Rotherham Community Action. There is no record of the referral being received by ASC.

Sam was admitted again to hospital on the 1st February. He was hypoglycaemic, the cause was recorded as not eating. This time he was viewed as 'complex' and referred to ASC for an assessment of his care and support needs. Ben said that he was prepared to care for his father at home providing he had the support to do so. Sam was presumed to have the capacity to make decisions about his own care and accommodation and was clear that he wanted to go home and not into a rehabilitation placement. A support plan was put in place to 'facilitate discharge', it was not a detailed plan, but this is acceptable practice to facilitate discharge. No consideration of Ben's needs as a carer was recorded. It may have been offered and declined but it is reported that at the time carer's assessments were not well explained and if declined rarely followed up and offered again.

No further assessment or review of Sam's care and support needs took place once he had returned home. There was no further assessment or a review of this support plan at any time in the subsequent three years despite Sam having a large and costly amount of support, two carers for 30 minutes four times a day and numerous reports about Ben struggling to support this father.

The care agency began working with Sam on the 22nd Feb 2016.

Sam was now sleeping upstairs in a low double bed upstairs with a television at one end. The care provider was immediately concerned that the bed was too low for carers to safely support him. The agencies' initial assessment was that the situation was '*high risk due to inappropriate bed'*. They referred their concerns about the bed to the RMBC Community Occupational Therapist (OT) service, their observations that Ben was '*overwhelmed*' were also directed to Sam's allocated social worker, but no carers assessment appears to have taken place as result of these concerns.

At the end of March Ben cancelled the carer's lunchtime visit, saying that he was taking him to a hospital appointment, but did not admit the carers for the teatime or night-time call. Ben had previously refused a key safe. Police, ambulance, and the fire brigade were called and the out of hours social care team informed as there was a concern that Sam had been alone, without food or drink, all day. Ben returned at 9.40pm, he had evidently been drinking alcohol.

Sam's allocated social worker recorded this as a safeguarding concern and visited the house two days later, meeting with the care provider manager and presumably the family. During this time period safeguarding concerns about an individual were addressed by locality teams. Neither the provider nor ASC have made any record of what transpired at this meeting. ASC has recorded however that the provider expressed concerns about the son's ability to care for his father, he '*means well but may have a learning disability'.*

By the end of April it was understood by health professionals that Sam spent 24 hours a day in a double bed with a foam mattress and slatted base. The pressure mattress provided was not being used. District nurses visited weekly until the beginning of May and assessed Sam for pressure area vulnerability, Sam did not develop any significant skin issues.

Sam was referred to a Community Matron by his GP as he had '*multiple complex medical conditions*.' He continued to be seen by the community physiotherapist and on the 8th August an OT made a visit to the house with the community physiotherapist. Sam was frail, he experienced low oxygen saturation on completing physio exercises, he was tired out and the OT recorded some cognitive issues but did not undertake a mental capacity assessment with regard to any specific decision making. Sam agreed to a mattress variator with a rail for a double bed and the OT gave the home carers advice on changes to his routines that may help with mobility. The GP visited twice in August as Sam had a chest infection.

By the end of August the carers were finding it very difficult to transfer Sam, even with a Samhall turner and the mattress variator. The provider manager referred again to the Community OT asking for an urgent visit. They were clear in their referral that Sam was sleeping with his son who was declining to facilitate a separate bed.

This information was also sent to an ASC locality team and resulted in a duty social worker telephoning Ben the next day but not allocation to a social worker for a visit or follow up.

Ben agreed with the social worker over the phone that his father would move to the single bed with pressure mattress that night, but when the carers arrived he refused to do so, saying that moving his father was distressing for him. The carers noted that Ben was discouraging his father from complying. The Community OT visited on 6th September, noting the same type of interaction '*Son was clear that he did not want his father to be distressed. As we were leaving the room Ben got on the bed next to his Dad. Lying next to him with his face close to his Dad's Ben said to his father; remember you don't want to be in that small room, it'll kill you if you go in there. Whilst talking to his Dad Ben kept touching/rubbing his Dads face in a repetitive manner with his fingers that appeared like a gentle prod and holding his Dads chin to turn his face to look at him*.'

In the event, the Community OT was able to work with the carers and find a way to enable them to care for Sam in the double bed. The OT did not report any concerns about the son's influence over his father to the ASC locality team or via a safeguarding referral.

The Community Matron closed her involvement in November 2016, describing father and son as being distressed and '*tearful*' at her departure. Sam continued to have support from his carers four times a day. Community nurses visited on a two to three monthly basis; on a few occasions they were not able to access Sam but were able to gain access within 24 hours. In August 2017 community nurses noted that Sam slept with his son in the double bed and preferred to do so, and that Sam had the mental capacity to make the decision to remain in the double bed. They continued to check for pressure areas and attend to Sam's ears, Vitamin B12 injections etc.

Sam experienced frequent chest problems and his GP observed that his son was very anxious about this, fearing another hospital admission. From late 2016 onward Ben was in very frequent contact with the GP, requesting home visits after his father coughed or appeared unwell. At times, the GP would attend but find that Sam was well, Ben's anxieties meant that he needed frequent reassurance from health practitioners.

The care provider made a safeguarding concern referral in December 2017 after arriving one morning to find Sam shaking, his son had shouted at him. Sam took one of the carer's hands and said he wanted '*to get out of there and go into care'*. Ben is alleged to have said that Sam would not get his 'Marks and Spencer's dinners if he went into a home, but to have made no response when his father said he had shouted at him. The concern was passed onto the Safeguarding team the same day, but no face-to-face visit was made. Due to the Christmas holiday no further contact was made with the referrer or family until January 4th when the care provider was contacted and said no further concerns had arisen. The case was closed, the family not seen.

### 4.4 Analysis

Sam was discharged from hospital in February 2016 with a large care and support package funded via a managed direct payment. It is understood that since this time an integrated hospital discharge team has been put in place that covers local and out of area hospitals and would review Sam's support ten days or so after admission. Sam's needs were not reviewed at any point during the three years he was supported by carers. At the time of the first Learning Event participants reported that it was still a struggle for ASC to review care and support arrangements and are unclear on how the Reviewing strategy is progressing. Many local authorities struggle to fulfil their duties under s27 of the Care Act 2014 as pressure to assess and arrange support leaves those already receiving support in a 'less urgent' category. Reviews can be planned or unplanned and provide an opportunity to not only explore whether the person's needs have changed but also whether family carers are struggling or whether there are safeguarding concerns (DHSC 2020 13.11)[5]. Plans can be made with the person and the other agencies involved. There are useful indicators within statutory guidance that are used to identify the proportionality of approach in a planned review, these can also be used when considering prioritising a review, i.e. the person's circumstances, the value of the personal budget and any risks identified (DHSC 2020 13.16)[6].

At several points during 2016 – 2017 there were indicators that Sam's needs were changing, that his family carer was struggling and that there were risks to Sam's wellbeing and safety.

The inappropriate low bed created risks to both Sam's and his carers safety. The creativity of the community OT and commitment of the care provider kept this arrangement going but there were frequent struggles to maintain the care and support arrangements. Ben's odd and potentially controlling behaviour witnessed in September 2016 added to concerns about the use of this bed and created doubt about Sam's ability to exercise his own judgement and decision making about his own safety and wellbeing. The care provider continued to be concerned about the impact Ben's behaviour was having on their ability to support Sam and were diligent in reporting these concerns to ASC. The care provider also reported concerns about Ben's ability to care for his father and the stress that he was experiencing.

Through this period two safeguarding concerns were received. One concern (March 2016) did result in a face-to-face meeting at the family home with the care provider in attendance. There is no record of this meeting however, and no follow up or monitoring arrangements

[5] Care and Support Statutory Guidance: updated 24 June 2020. Accessed at https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

[6] Care and Support Statutory Guidance: updated 24 June 2020. Accessed at https://www.gov.uk/government/publications/care-act-statutory-guidance/care-and-support-statutory-guidance

for any resultant safety plan. The second safeguarding concern (December 2017), and the care provider's report that Ben was refusing to facilitate his father to move to a single bed (August 2016), were responded to via telephone calls only. The OT's experience of Ben exerting control over his father was not reported as a safeguarding concern.

At the time of the December 2017 response to the safeguarding concern all safeguarding decision-making and enquiry activity was undertaken by a specialist safeguarding team with a safeguarding decision maker at the front door point of access to local authority adult social care. At the time there were staff shortages in ASC and duty systems were extremely busy. The expectation was that the staff would gather information, risk assess using multi agency information and make phone contact with the person as necessary. Risk was not recorded on a distinct form but often in case notes which made it hard to find at a later date. In this case only one agency, the care provider, appears to have been consulted and historical information in case notes were not used. If consulted, primary care colleagues may well have advised their observations about Ben's anxieties and stress, the OT may have disclosed Ben's concerning behaviour.

The RSAB had participated in the national Making Safeguarding Personal (MSP) temperature check (2015/2017)[7] and found that they were doing well in terms of MSP approaches and practice. Both the care management and adult safeguarding practice in this case does not reflect a person-centred approach. Sam's voice is hard to hear. His concerns about Ben's behaviour, the support Ben gives him and the life he would like were not ascertained.

RMBC has since changed the delivery of its' adult safeguarding duty, a front door team has a decision-making function, but cases are held in community social work teams with embedded safeguarding specialists. There are two Quality Assurance officers who look at trends and themes. There are 'safeguarding clinics' for advice. Teams continue to be a very busy.

Both men appear to have felt a strong connection with the community matron, and to be despairing at her departure. They were also very engaged with the GP surgery, seeing them as the first port of call for any concerns. Although the surgery was supportive Sam was attended by different GPs and it was hard to build a long-standing relationship. The contribution of health colleagues to a review of Sam's care and support needs or safeguarding enquiry would have been invaluable. Community health staff presumed that Sam had capacity to decide to sleep in the same bed as his son. Inter-agency communication in November 2016 may have identified an element of duress, possibly arising from Ben's emotional state of overwhelming anxiety.

[7] https://www.local.gov.uk/our-support/our-improvement-offer/care-and-health-improvement/making-safeguarding-personal/msp-development

In the absence of a multi-agency plan the care provider was left to make decisions about Sam's safety and to try to alert other agencies when risks became too high.

## 4.5 2018

**Description**

On the 7th March 2018 the care agency contacted the ASC front door for advice as Ben would not let carers change his father's bedding. The care provider manager met with Sam and Ben the next day and reported back to ASC that he had advised the son that the carers must be allowed to change the bedding, it smelt of urine and there was a risk of infection to Sam who had not had a wash for five days, carers must be permitted to give him a strip wash.

The care agency manager told the ASC front door wellbeing advisor that the carers were not permitted to enter any other room in the house, only the bedroom where Sam lay, all the other doors were shut. The next day the care provider manager reported to ASC that Ben would not give them a bowl or water to wash Sam, and they were not permitted to get this themselves. These calls do not appear to have been analysed or overseen by any ASC manager and resulted in no action.

The frequency of Ben's requests for GP home visits and phone calls increased during 2018. Sam was seen in January and February at home by his GP. Paramedics attended him in March 2018 when he also had three GP home visits, recovering from a chest infection with antibiotics. Sam's mobility declined again, the care provider referred to the Community OT in May 2018 as he could no longer stand, and transfers were proving impossible. The OT assessed and provided slide sheets, noting that it was impossible to raise the double bed height.

GPs made three home visits and had numerous telephone calls with Ben in July 2018. The GP observed signs that Sam was being neglected, he smelt of urine as did the room and house, and his fingernails were dirty. His diabetes needed better control and he had a bacterial infection; the GP planned to stabilise Sam's diabetes in the hope that this would give him more physical strength and improve his quality of life. The GP referred him to the community matron for support with diabetes and also mentioned 'significant neglect'. The GP did not make a referral to the adult safeguarding team regarding his concerns about Sam's neglect. His condition was not deemed as complex at that time and so the community matron declined involvement whilst district nurses visited to take bloods to review Sam's diabetes.

Carers were concerned that Sam was grey and ill on the 12th August and advised Ben to call a doctor, Ben declined although Sam said that he wanted to see a doctor. The care agency reported this to out of hours social care as it was a Sunday. Out of hours phoned back to check on events and were advised by the care provider that Sam was looking better. This

event was added to Sam's ASC notes and an assumption was made that Sam had gone to hospital. No contact was made by ASC with the family to ascertain what the situation was or to check that Sam could access medical care without Ben's interference.

Sam became increasingly frail and was sleeping much of the time. The GPs were concerned that Ben was not coping with his father's decline, he could not accept this and needed a great deal of reassurance. GPs made five home visits from August onward and had frequent telephone discussions with Ben. On the 9th November 2018 the GP had a conversation with Ben, asking him to think about Sam's end of life, a 'Do Not Attempt Cardiopulmonary Resuscitation' order and about Sam spending his last days at home. The carers called an out of hours GP on the 18th November and Sam's GP followed this up with a home visit the next day. This was the last time a GP saw Sam although Ben did telephone the surgery on the 12th December, agreeing to 'keep an eye on' symptoms and phone back as needed.

The care agency reduced calls to Sam to three a day on the 4th December, it is not known why but may be that with his continuing decline there was less the agency needed to do to meet his needs.

**4.6 Analysis**

In July 2018 the GP identified that Sam appeared to be 'neglected' but did not make a safeguarding concern referral, instead referring to the community matron for assistance, the same community matron who had a strong relationship with the family.

GPs are reported to regularly make adult safeguarding referrals in Rotherham and on interview with the lead reviewer the GP surgery practice manager and a GP could not think of a reason why a referral was not made. They are and were very aware of safeguarding responsibilities but feel that GPs have continual emphasis on child protection in training and activities, and that adult safeguarding is still seen as an 'add on' especially in GP pre-qualification training. GP practices in Rotherham are encouraged to follow the requirements of the Intercollegiate Documents for meeting training competencies. The NHS Rotherham CCG reports that they have incorporated both adult and child safeguarding topics in protected learning time activity, and that additional training sessions have covered adult safeguarding related topics including domestic abuse, chaperoning, using the Mental Capacity Act and Best Interest decision making, and supporting perpetrators. Links with the General Practice Speciality Training Programme in Rotherham mean that since 2016 there has been both adult and child safeguarding sessions provided for all GP trainees.

A safeguarding concern referral at this point may have led the ASC decision maker to re-visit the care provider's concerns of March 2018. These concerns had been recorded but were not notified or discussed with a manager for advice. These and the refusal of Ben to call a GP in August 2018 show a pattern of total control over his father's life. Care and support activities and medical attention all had to go through Ben. Sam cannot be seen in Ben's

absence, there is no key safe, and appointments have to be made with Ben. Lack of ASC review or management oversight and a lack of partnership working between health and social care colleagues led to the significance and impact of Ben's control over his father going unexplored and unchallenged.

At this point Ben's anxieties appear to overwhelm him and, potentially after contemplating his father's death in November 2018, he disconnected from the GP surgery who had held a key role in maintaining the wellbeing of both father and son and in responding to any decline in Sam's health at home.

Throughout the 2016 – 2018 time period we can observe a lack of professional curiosity in both individual agencies and in partnership working. Each referral or incident appears to be treated as a separate concern, there is no evidence of review of historical information or information sharing between partners to explore what may be happening within this family or to identify accumulating risk. As Sam became frailer, and Ben more anxious, the risk of being unable to meet his care needs escalated, but the situation may have become 'normalised' in the minds of those working with Sam. Primary health workers and the care provider noted the unusual sleeping arrangements and permission to enter only one room in the house together with Ben's increasing anxiety and need to control, but did not enquire as to what the meaning of these behaviours might be or find ways to respectfully challenge, even when they impeded efforts to meet Sam's care and support needs. Evidence from SARs and SCRs (Thacker et al 2019[8]) suggests that a practitioner's ability to demonstrate professional curiosity can be hindered through pressure of work or complexity of cases. Partner agencies at the learning review were not convinced that they had any 'right' to exercise professional curiosity as they were 'guests' in people's houses and must respect their privacy. The concept of duty of care may help in exploring this thinking. If Ben had some informal support in fulfilling his role as a carer both Ben and Sam might have avoided the psychological stress they experienced in the last three years of Sam 's life.

## 4.7 January 2019 – April 2019

**Description**

Community nurses struggled to contact Ben in January 2019 but were able to see Sam on the 30th January 2019. He was noted to be immobile and unable to change his position in the bed. He was said to be '*cheerful*' and to be able to make '*considered choices'* but with limited understanding of his health condition. He declined to have pressure areas checked but accepted a vitamin B12 injection.

[8] Thacker, H; Anka, A and Penhale, B (2019) 'Could curiosity save lives? An exploration into the value of employing professional curiosity and partnership work in Safeguarding Adults under the Care Act 2014'. The Journal of Adult Protection Vol. 21 No.5 pp252-267

The care agency contacted ASC on 30th January to ask for an urgent OT assessment as it was proving impossible to care for Sam in the double bed. Carers were injuring their backs and Ben was attempting to manoeuvre his father in an unsafe manner. The community OT visited on the 6th February and recommended that Sam have a hospital bed. Sam refused this and wished to remain in the double bed. The OT passed this information onto the appropriate social work team, describing the double bed as putting both Sam and his carers at risk from unsafe manual handling. The OT stated that this had been discussed with both father and son who had both refused the hospital bed and that there were '*no capacity concerns'* at that time. Given the risk that the care provider would have to stop caring for Sam, son and father had told the OT that they would manage without carers. The OT requested an assessment /review of Sam's care and support needs with a view to sourcing an alternative care package or '*discuss option of direct payments to allow client to choose his own carers to care from the low bed'*.

The care provider manager contacted ASC, expressing concerns that Sam may be neglected if left in the full care of his son and offering to meet with a social worker at the house. The social worker attempted to gain entry to the house independently but was unsuccessful. The plan was to review Sam's care and support needs. The care agency was asked to arrange a time for the social worker to return but after consulting with Ben the carers reported that he was not prepared to accept a visit from the social worker that day '*it was not convenient'* and he saw no point in discussing things further, he was not concerned about how he was going to care for his Dad. The social worker recorded that the care provider said they had no concerns about Sam's capacity, appearance or living conditions, but he did sometimes '*choose to decline'* to have a wash.

It was agreed by ASC that the care provider would end their support on the 10th February. There is no evidence of any contact with primary health colleagues to either gather information or to inform health colleagues of this decision.

The care provider continued to attend Sam after the 10th February. The provider told ASC that they had concerns about Ben's ability to care for his father long term, his support was not safe. They thought this should be reported as a safeguarding concern. ASC recorded that the provider was told that the support should have ended the previous day, noting that the care provider *….is concerned regarding sons' long-term ability to provide sufficient care to Sam and whether this should be reported as safeguarding. I advised that no harm has come to Sam yet and there is no reason at this present time to suspect harm will occur although it may be seen as an unwise decision.* It is unclear whose unwise decision this was thought to be.

The family were written to by ASC advising them of their options and urged to contact the single point of access before the 15th February should Sam require a care and support needs assessment. When no response came from Sam and Ben the case was closed to ASC.

**4. 8 Analysis**

Ben had suddenly dropped from very frequent contact with the GP surgery to nothing at all. This went unnoticed which appears surprising until both the location of the surgery, working practices and nature of the long-term conditions list are considered. The GP surgery covered the area where the family had lived some years previously, but Ben's parents had remained on the GP list as they were satisfied with the service. Because the surgery was out of area there were complications relating to which acute trust, community teams etc. the family used. It was a twenty-minute journey by car between the family home and surgery, but another local surgery was only half a mile down the road. In addition, the surgery used by the family was a branch of the main GP surgery, the same GP might not attend the branch for some weeks, different GPs spoke with Ben or attended Sam and may not have realised over the months that Ben had stopped calling. Sam was on the Long-Term Conditions (LTC) list and as such should be kept under 'regular and on-going review' and have a lead GP. In practice however it is hard to pick up on sudden changes, GP surgeries work within a culture of approach from the patient and the lack of contact may be missed when looking at a range of patients who are in contact and presenting needs. This is an on-going practice problem, and immensely challenging. The LTC contract is about taking a proactive approach – how can GP surgeries do this in practice? Health colleagues reported at the learning event that there is a surgery in Rother Valley South who have employed a nurse to follow up patients who have not been in touch or responded to letters. The lead reviewer has also encountered a similar approach in Herefordshire (Herefordshire SAB 2018)[9].

Lack of review over the previous three years meant that ASC had no clear idea of Sam's care and support needs, or whether Ben could meet them. The care provider did know the family well, having supported Sam for three years. They had grave concerns about Ben being able to meet his father's needs and made these clear, but their views were discounted without any attempt to assess Sam's care and support needs, hear his thoughts, or ensure that he did indeed have capacity to make the decision that would result in the loss of care and support, and that he was not under duress. The care provider's views were given little weight in the decision making which raises a question about respect and understanding of their role as colleagues in the local safeguarding partnership. The care provider manager offered to meet with the social worker at the family address, but it appears that the social worker attempted to visit alone. The decision to withdraw Sam's care does not take account of the previous history of concerns about Ben's behaviour or care of his father which were documented in Sam's case notes. Participants at the learning event explained that it was not common practice to look into the case file history when dealing with a situation on duty. Given the provider's concerns about the decision should the case have been allocated to a social worker?

[9] https://herefordshiresafeguardingboards.org.uk/media/7281/sar-may-final-anonymised.pdf

The use of the idea of 'unwise decision' does indicate a fairly common misuse of the Mental Capacity Act principles, applying these to capacitated adults rather than to adults who lack capacity. There is indeed no such right as 'the right to make unwise decisions', '*at least to be spelled out of the MCA: the MCA, rather, provides a person cannot be taken to be unable to make a decision merely because they make an unwise decision. That the decision is unwise may well be a trigger to investigating whether, in fact, they have capacity to do so'* (39 Essex Chambers 2019)[10] .

A recent judgement in the High Court [11]reminds us that reliance upon the presumption of capacity and the 'right' of individuals to make unwise decisions cannot in itself discharge public bodies of their safeguarding duties or indeed their duties under s11 of the Care Act.

Finally, numerous SARs (Preston Shoot et al 2019)[12] illustrate the dangers in misusing the principles of the MCA 2005 in this way. The question needs to be reframed, not '*is this an unwise choice that this person has a right to make*' which leads professionals into a position where they have no mandate or options to help, but '*what has led this person to make such a decision*?' Participants at the learning event report that they now have ready access to legal advice. They would welcome more understanding of concepts such as duty of care and the duty to uphold Human Rights (Human Rights Act 1998). Practices informed by professional curiosity, trauma informed responses and awareness of the impact of emotional distress on adults, mental health issues - for example Obsessional Compulsive Disorder, non-neurotypical presentations – in particular autism which we discuss below - how duress and control (coercive and non-coercive) present. Consideration of the how and why are all helpful in understanding the context of adult's decision making.

In making the decision to close Sam's case without review ASC did not consult partner agencies who may well have contributed to the decision making and the assessment of the risk of withdrawing care. Primary health colleagues were completely unaware that the care provider had withdrawn and indeed continued to predicate their thinking about Sam's safety and health on the belief that he was still being supported three times a day by two carers.

RSAB does have a published Escalation and Resolution policy[13]. It is important to ensure that all agencies, including care providers, are knowledgeable and confident enough to use it.

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[10] Summary of Southend on Sea v Meyers at https://www.39essex.com/cop_cases/southend-on-sea-borough-council-v-meyers/#_ftnref2

[11] Southend-On-Sea Borough Council v Meyers [2019] EWHC 399 (Fam) (20 February 2019) at https://www.bailii.org/ew/cases/EWHC/Fam/2019/399.html

[12] Preston-Shoot, M; Braye, S; Preston, O; Allen, K; Spreadbury, K; ( 2020) 'Analysis of Safeguarding Adult Reviews 2017-2019: Findings for sector-led improvement' LGA at; https://www.local.gov.uk/sites/default/files/documents/National%20SAR%20Analysis%20Final%20Report%20WEB.pdf

[13] http://www.rsab.org.uk/downloads/file/38/escalation-and-resolution-policy-sept-2019

## 4.9 April – May 2019

**Description**

Sam's estranged stepdaughter contacted both the care provider and ASC in March 2019 as she had heard that care had ended. Neither would give her any information about her father's situation citing his confidentiality as a reason. She was not asked why she was concerned about her father's care.

Sam's body was found late at night on the 24th April after district nurses became concerned that Ben had cancelled his father's vitamin B12 injection. Community nursing staff entered the house with the police. Sam appeared to have been dead for many weeks. Ben had last used a blood glucose measurement for his father's diabetes on 17th February 2019, six weeks of unused medication was found in the house. Ben had continued to sleep next to his father's body and there was evidence that he had continued to try to feed and care for his father.

A paramedic and out of hours doctor attended and although Ben was tachycardiac he did not need admission to a hospital, he also refused this and was thought to have the mental capacity to make this decision. Police submitted a concerns notification (a CID 70) to ASC and to the mental health service that night detailing that Ben had been sleeping, eating, and drinking in the bed where his father's body lay. His living conditions were described as "*extremely poor with rubbish throughout the house including used colostomy bags (sic*)". District nurses sent a safeguarding adults concern referral first thing the following day regarding Ben's self- neglect and potential for suicide, having found various possible means of suicide on the premises the previous night.

Ben was not arrested regarding his failure to report or register his father's death, he was initially thought to be 'too unwell' by attending police officers.

The mental health service attempted to follow up the CID 70 the next day by telephoning Ben. His GP and the surgery practice manager visited him on the 25th April, Ben admitted drinking alcohol 'heavily' and that he had taken no medication for some time. The GP and community heath staff ensured that Ben's basic needs were met and enquired after the possibility of support from his family which Ben declined. Ben permitted a look around the house:

*He allowed us to look around the house - the lounge had piles of letters and newspapers, and piles of large cardboard boxes up to the ceiling - they looked empty. The kitchen was unkempt. The corridors had piles of rubbish and filled bin bags. Ben has stripped the sheets off the bed, but he still slept in the same bed last night. The downstairs bathroom was in a state of disrepair. The big bedroom was also extremely untidy with piles of rubbish. The sheets were on the floor and the sheets and mattress were extremely stained.*

Ben agreed to the GP making a referral to the mental health community team and social services, the GP made these the same day, a community matron also followed up and offered a joint visit with a social worker as getting to see Ben could be tricky. Ben said he would attend the surgery for a blood test but did not do so.

Ben was visited on the 26th April by a number of professionals. Two Approved Mental Health Professionals (AMHPS) from RDaSH mental health service attended alongside social worker 3 and a community matron who knew Ben from past involvement. The mental health assessment concluded that Ben showed no evidence of a mental health disorder. It acknowledged that the "*situation which was strange and bizarre in nature requires a sensitive approach to engage the patient and build a trusting relationship which would enable a more robust assessment and help formulate a plan of action*." The service identified to deliver this by the AMHPs was Adult Social Care.

In addition to a full needs assessment AMHPs completed a Functional Analysis of the Clinical Environment (FACE) risk assessment, considered standard practice in these circumstances. This is a holistic assessment of risk and gives a subsequent risk formulation. The risk summary assessed risk of suicide and noted Ben's alcohol use and self-neglect. Ben admitted drinking alcohol since 2012 but did not feel his drinking was a problem. He said that he did not intend suicide as his father would not have wanted this. No role for mental health services was identified and the case was closed that same day.

Social worker 3 noted that Ben made no eye contact and appeared socially awkward. The first time she met him he was shaking and she wondered if this was acute alcohol withdrawal. He was pleasant but 'stand offish' and she felt conscious of being 'in his space'. He initially did not engage and it was thought that he must be experiencing trauma. He seemed embarrassed that he had let 'things get like this'.

Social worker 3 and the community matron offered Ben various options. In conversation Ben would say 'yes' to everything, but on deeper questioning had no idea as to where to start or what to do. He was offered support from Environmental Health to remove soiled furniture from the bedroom and to inspect the cooker and bathroom, support to purchase a new door and a referral to Age UK for help with arranging the funeral plan and finances. Ben was also offered respite at another location whilst the property was made clean and safe to live in.

Ben said he would prefer to sort things out himself. He agreed to see social worker 3 again but said she must make an appointment. After the visit the community matron and social worker also agreed that they would make another home visit to Ben the following Monday, would contact the police for an update on enquiries, and the community matron would ask the GP to visit to take bloods in order to restart Ben's medications. Both intended to discuss the involvement of mental health services further with their managers but there is no evidence of any action regarding further mental health referrals.

Arrangements were made for both the social care out of hours team and the district nurse out of hours team to visit Ben over the weekend, a district nurse did visit on the Saturday and called the police and ambulance as she could not gain entry. The police attended, finding Ben well, and submitted a further CID 70 to the local authority. It is unclear whether social care out of hours visited.

On the 26th April the Safeguarding Adults team decided not to progress the reported concerns about Ben under the s42 duty as he was an 'alleged source of harm' and this was thought not to be appropriate. However, a multi-disciplinary meeting was arranged for the 30th April. A representative from the police, together with social workers 2 and 3, adult care managers, two community matrons, two district nurses and the GP practice manager attended. Agreed actions included the GP to refer for a second mental health assessment, consultation with RMBC Legal services, referral to Speech and Language services for a comprehension assessment, and escalation of environmental concerns to environmental health. No further multidisciplinary meetings were held to monitor or review these plans. Ben was recognised as a person who was self-neglecting but care management was thought to be a more appropriate response. It should be remembered that this work took place eighteen months before the RSAB self-neglect policy was published which may have made a difference to the multi-agency response.

Despite Ben not being considered under the s42 duty an 'enquiry manager', social worker 2, was appointed. Social workers 2 and 3 worked closely together.

The GP recorded making a referral to RDaSH, but this referral is not noted by RDaSH in information submitted to this Review. Although the GP and community matron attempted to obtain Ben's bloods via local district nurses, this was not done as it was argued that Ben was not immobile and could therefore attend the surgery. Subsequently the GP and practice manager visited Ben at his home on the 9th May to obtain bloods, but he was not in and could not be contacted on the phone. They left a letter for him and, on the basis that mental health services had seen him, and he was thought to have capacity to make decisions about his own health, the surgery took no further action.

Social workers 2 and 3 continued to work with Ben. Introducing new people to Ben was difficult. Social worker 3 was concerned to go at his pace, it would be so easy for him to never be in or never answer the door. There was also a risk that he would get 'overwhelmed' if too much happened or too many new people arrived. The social workers were concerned that he had mental health issues but did not know what these might be. If Ben did not want to discuss a topic he would 'shut down' completely.

By the 2nd May Ben started to 'go away' frequently, sometimes saying 'with friends' and sometimes with an 'ex-girlfriend', Z. Social workers 2 and 3 were able to see him between these 'holidays' and continued to offer support, to try to make a relationship with Ben and

talk with him about his father and what happened before and after his father's death. ASC made a referral to the RDaSH community learning disability team who carried out a screening questionnaire on the 17th May, finding that Ben had no learning disability and therefore there was no role for their services.

The possibility of Ben having autism was in the ASC manager's mind when making the referral to the learning disability team, but the manager did not specify a request to screen for autism, assuming that this would be done as well as the screening requested – which was for a general learning disability. There was no consideration of the possibility of Ben's unusual behaviour and communication style being explained by the possibility of his being on the autistic spectrum in the RDaSH assessment as this had not been highlighted or requested.

Social worker 3 continued to follow up actions with other agencies and to find out information from police colleagues about whether Ben might be charged with an offence in relation to his father's death or not. She was told his case was 'active' by the coroner. Social worker 2 and 3 saw Ben three times in May 2019.

Toward the end of this period Ben's care and support needs were assessed. At this point his 'friends' had begun to help him clear up and he was assessed as '*independent with all his care and support needs and is therefore not eligible for support however reassured him that we can always offer advice and support if he requires*'.

Social worker 3 tried to connect Ben with the Coroner and also offered support with planning the funeral. Ben finally agreed to a visit from Environmental Health as the mattress his father had lain on was still in the property and had been contaminated with bodily fluids. Social worker 2 visited with an environmental health officer on the 11th June and accompanied the environmental health officer to remove the mattress on the 25th June. A fire safety check was arranged with South Yorkshire Fire Service but Ben cancelled this.

**4.10 Analysis**

Agencies working with Sam appear to believe that data protection legislation forbids interaction with family members. Indeed, Sam's stepdaughter should not be given information about him as a matter of course. But she could have been asked if she had any concerns about her father in the light of the withdrawal of care, and her concerns may have led to further contact with Sam and Ben.

Agencies were naturally shocked by the manner in which Ben had kept his father's body and his failure to inform anyone of Sam's death. Some colleagues believed that Ben may have committed a criminal offence and were critical of the police's investigation of the situation. The police took some months to decide on the need for any action, taking account of post-mortem findings and discussing the way forward with the coroner. Some colleagues thought

that a charge under s44 of the MCA 2005 (ill-treatment or wilful neglect of a person who lacks capacity) should be considered, although no one had recorded an assessment of Sam's mental capacity. Colleagues also thought that a charge relating to prevention of a lawful burial should be considered – although a '*mens rea*' (criminal intent) is part of this consideration, and Ben appeared to be mentally unwell rather than have some other motive to keep his father's body with him. The potential for criminal action hung in the minds of professionals for a time and may have also concerned Ben who was waiting for months to be 'spoken with' by the police. Police colleagues have reflected that it is important to keep other professionals updated on investigations, they may feel ignored or unaware of the enquiries on going. Once the investigation is closed relevant staff from other agencies who have been helping or facilitating meetings need to know so that they can feed this back to concerned parties including victim and witnesses. There was no inquest into Sam's death as the coroner decided that they did not need one, they were satisfied with the pathologists' findings and the cause of death, Sam died of 'natural causes.' His death was not the result of neglect and there was no evidence of any external or internal injuries which may have indicated third party involvement in his death.

It is unlikely that thoughts about Ben's culpability influenced the agencies response to him. Certainly, multi-agency working in response to the immediate crisis was excellent in the week after Sam's body was found, with primary health, mental health and ASC colleagues working closely together.

However, in the absence of any multi agency framework to support partners to work together actions were not followed up, communication between organisations broke down, assumptions were made about what actions partners were taking and whether referrals were being responded to. The response to Ben became predicated on his eligibility for services rather than a person-centred approach to consider his needs and circumstances.

Ben's alcohol use was identified in the risk assessment undertaken by mental health services on the 26th April and both this and his self-neglect were noted as *'long standing problems'* which Ben did not recognise as problematic. Ben was also noted as neglecting his physical health. There was an opportunity to follow up on these observations subsequently, perhaps working jointly with ASC, rather than undertake an assessment during a crisis when Ben was still shocked. Further discussions would have been very helpful to social workers 2 and 3 who were left to try to make sense of Ben's behaviour and difficulties.

An ASC manager at the time recognised Ben's behaviours as potential indicators of Autistic Spectrum Disorder (ASD). This may have become more apparent if Ben's alcohol use or self-neglect were explored or may have been indicated if a screen for autism as well as general learning disability had been requested from the RDaSH learning disabilities team. Autism is not a learning disability, although people with ASD may also have learning disabilities many do not.

Participants at the learning event were not confident that they had adequate awareness of ASD. Understanding of ASD and how many adults may experience this is evolving in the UK. Research is currently focused on children with ASDs, with diagnostic rates doubling in school children in the last nine years[14]. The number of adults with ASDs in the population is unknown however, with people over 40 highly unlikely to have ever been diagnosed unless they also had a learning disability or mental health comorbidity. We may not know that we are working with a person with autism, but this information becomes pertinent when building relationships, understanding the person's thinking and problem solving and their individual vulnerabilities. The high frequency of anxiety amongst people with ASDs has been proposed as a principal reason for their use of alcohol or illegal drugs (Helverschou et al. 2019)[15]. Haruvi-Lamdan et al (2017)[16] believe that Post Traumatic Stress Disorder, as Ben may have experienced after his father died, can exacerbate certain ASD symptoms, for example, maladaptive coping strategies and reduced help-seeking. People with ASDs are also more likely to be exploited by others as they may struggle to understand another's motivation and intention[17] They may also self-neglect for a variety of reasons ranging from discounting aspects of their own care to avoiding contact with people or crowded/noisy situations. Research and awareness will add to what we know about working with people with ASDs in the future, but for now it will be wise to have awareness of how ASDs may present and influence a person's decision making with a known pathway to screening and specialist advice when needed.

Statutory guidance (DH 2015) [18] to support the 2009 Autism Act specifies that local authorities, Clinical Commissioning Groups and NHS Trusts should provide general autism awareness to all frontline staff in contact with adults with autism, so that staff are able to identify potential signs of autism and understand how to make reasonable adjustments in their behaviour and communication. Health and social care commissioners should be ensuring that the services they commission should also have access to autism awareness training.

[14] https://www.ncsautism.org/blog//prevalence-of-autism-spikes-in-uk-schools

[15] Helvershon, SB; Brunvold, AR; Arnevick, EA (2019) '*Treating Patients with Co-occurring Autistic Spectrum Disorder and Substance Use Disorder: A Clinical Explorative Study*'. Substance Abuse: Research and Treatment Vol 13 pp 1-10.

[16] Haruvi-Ladan, N; Horesh, D and Golan, O (2018) '*PTSD and Autistic Spectrum Disorder: Co-Morbidity, Gaps in Research and Potential Shared Mechanisms*' Psychological Trauma: Theory, Research, Practice and Policy; Vol. 10 No. 3 pp 290-299.

[17] https://www.theguardian.com/society/2014/jun/14/autistic-adults-abused-by-friends-survey

[18] Statutory guidance for Local Authorities and NHS Organisations to support the implementation of the Adult Autism Strategy (2015) DH find at https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/422338/autism-guidance.pdf

**4.11 Late June 2019 until April 2020**

By June 2019 social workers 2 and 3 were the only professionals involved with Ben. Social worker 3 made an unannounced visit on the 21st June as Ben was not answering phone calls. She managed to connect him with the coroner and discuss his father's funeral with him. The coroner told Ben that '*due to the nature of his father's passing he will need to be spoken to at a later date to clarify some facts'*. Social worker 3 reassured an anxious Ben that he would be supported through this.

On the 26th June social worker 3 visited Ben with a welfare officer to support him with funeral arrangements and benefits. Ben had been taking money out of his father's bank account and it was explained that he must not do this and would owe money. Sam's benefits had not been cancelled. The Funeral director attended and discussed the process and costs with Ben who said he was happy about the service but wanted to think it over. During the visit Ben spoke about going away over the weekend with his ex-partner, "Z".

Social worker 3 continued to try to find out if Ben would be interviewed in connection with his father's death and managed to talk with police officer 4 who explained that they were holding off interviewing Ben was because they were concerned about his mental health. There was a possibility that he would be interviewed regarding his father's death after the funeral.

Ben did not attend his father's funeral on the 23 July. After difficulties in contacting Ben social workers 2 and 3 made an unannounced visit on the 8th August. Ben was shaking again, he looked unkempt his hair was long and he was unshaven. He had not cleaned the boxes out of the property yet. On the other hand, he had a pizza in the oven and said that he was 'seeing someone' – Z. He did not elaborate on how he had met Z, and there was a possibility in the social workers mind that he was making this up to assure them that he was managing.

Ben said he no longer needed adult social care's support for anything else and agreed that the social workers would end their involvement. The social workers' observations about Ben's appearance and behaviour were reported back to the GP for information.

Ben and social worker 3 last spoke over the phone on 21st October, social worker 3 had made an unannounced visit earlier in the month but Ben was not in. In the telephone call social worker 3 explained that as he had not paid for the funeral and the funeral director had not been able to contact him, there would have no option but to refer to debt collectors. '*Ben did appear quieter on the phone so I asked if he could afford to pay it, he said he couldn't right away but could in a couple of weeks. I explained he just needed to communicate with the funeral director and could come up with a payment plan, he didn't need to pay it all at once. I advised him to contact them today to discuss. I also asked if he had contacted DWP and the bank to close his father's account to which he said he had. Ben said he didn't feel the need for*

*me to visit him but I said I would speak to him as an when I needed, or he could contact me if he was struggling'.*

Ben's body was found by the police on 20th April 2020 after a neighbour was concerned that she had not seen him for some time. He had been dead for some months. His body was very decomposed and the cause of his death could not be ascertained. There were however no signs that Ben's death was violent and the attending police officers found no suspicious circumstances in the house relating to Ben's death.

**4.12 Analysis**

Ben remained allocated to a social worker for some months so that support could be given to him, not only to recover from his father's death but in case he was interviewed by police. Social workers demonstrated good practice, working with Ben, observing his needs and reactions as best they could as well as using their professional curiosity to respectfully challenge Ben and try to understand his experiences. Unanswered telephone calls were followed up with unannounced visits, Ben could have no doubt that social workers were concerned about him and ready to support him.

Social worker 3 understood a great deal about Ben, that he could not go near the GP's surgery for blood tests, that the mattress needed to be removed when Ben was ready to let it go and that the risk to his emotional health by pushing him outweighed the health risk of it being in the house, that new people had to be introduced carefully into his life. Ben did talk about the last days of his father's life but appeared to have a 'blank' about the weeks following Sam's death. The social workers were concerned about his mental health, that something was 'wrong' but did not know what it could be. The professionally curious but respectful approach that the social workers took could have been usefully supported by access to partner agencies' expertise and further multiagency meetings. Toward the end of the period of ASC involvement Ben did not want to continue to be supported by social workers and without a rationale to continue contact ceased.

**4.13 Afterword**

Ben's sister went into his house the day after his body was found and became concerned about what was happening to Ben before his death. In her contribution to the review Ben's sister has told us that she found evidence that led her to believe that Z and her associates were exploiting Ben. Ben's bank statements showed that he had withdrawn £15,000 from his bank account to loan to a man who left an IOU in the house, '*I am going to buy a car with the £15,000 you loaned me I will repay you',* he also spent £1200 in lingerie and women's clothing shops during Christmas 2019. Ben had taken £30,000 equity release out against his home in late 2019/early 2020. There was no evidence in the house of what the equity release had been spent on. No new fittings or furnishings, no new car etc.

His sister also believes he had received an amount of compensation for an accident at the steelworks. Ben was however in considerable debt, he owed money to household services and council tax. He had not paid his father's funeral bill. She found letters from a bailiff to Z at Ben's address, Ben had paid Z's debts.

All of the family identity documents were missing, birth certificates, Ben's driving licence. Ben's wallet was missing together with his credit cards. There was no jewellery in the house, her mother's wedding and engagement rings, stepfather's wedding ring and Ben's signet ring were all missing. Ben had kept all his parents clothing and other possessions so it seemed odd to his sister that the jewellery and identity documents were missing.

Ben's sister reported these matters to the police who were unable to take any action as Ben had died. She has given a statement to the coroner regarding these matters. The lead reviewer has given a statement to the RSAB Business Manager to pass onto the RMBC safeguarding service with regard to the risk that might be posed by these people to others in a vulnerable position in the area. It is not known if any action has been taken in regard to these matters.

**Comment**

Ben was 'a private person' according to his sister and would not have divulged what was happening to him easily. There is no indication that agencies could have identified that Ben might be exploited by Z and her associates without Ben trusting them enough to tell them.

What we can do is to note that people who are isolated, have addictions, are self- neglecting, have autism, mental health issues or learning disabilities are vulnerable to being exploited. This needs to be noted in policy, guidance, and training.

## 5. Findings and learning points.

There were no specific areas of focus for the SAR in terms of Sam, but for Ben the areas of focus were: *How did agencies work together to support Ben? Were there challenges and barriers to understanding his needs and responding to them?*

### 5.1 Good practice.

As can be seen in the commentaries in section 4 above, there is much good practice to build on in this SAR. The Community OT service were creative in their adaptions to work around the 'unsuitable bed' whilst the GP surgery was very responsive to Sam's health issues and in supporting the anxious Ben. Primary care services worked consistently with Sam to keep him at home and maximise his quality of life. The care provider was diligent and responsible in highlighting their concerns about Ben as a carer and in their commitment to supporting Sam in increasingly challenging circumstances. Social worker 3 in particular demonstrates excellence in person-centred professionally curious practice over an extended period of

involvement**.** The assessments agencies undertook together with Ben in the brief period after Sam's body was found were timely.

**There are a number of areas where findings indicate that improvements are needed to build upon good practices and address areas where there appear to be significant gaps.**

**The findings below are arranged into the following domains:**

- Direct practice
- Inter-professional and interagency collaboration
- Organisational features affecting how practitioners and teams worked.
- SAB leadership, oversight, and governance.

### 5.2 Direct practice

#### 5.2.1 Person-centred approaches.

The care provider and primary health colleagues provided as person-centred approach to Sam as possible but were sometimes impeded in this by Ben's anxious or drinking behaviours. A person-centred approach by ASC via planned and unplanned reviews as well as safeguarding enquiries may have begun to enable all agencies to be able to hear Sam's voice and ensure that his wishes and views were amplified.
Ben's individual needs as Sam's carer, and potentially as a disabled person, may have been identified via carer's assessments and/or safeguarding enquiries.

The adult care social worker's approach to Ben after his father's death was person centred, but the lack of partnership working meant that other organisations defaulted to an eligibility criteria approach which left ASC without the expertise to fully understand and meet Ben's needs.

Helpful approaches to promoting person centred approaches could have included:
ASC face to face contact with Sam and Ben individually and together.
Advocacy for Sam had the Care Act duties been undertaken.
Person centred risk assessment and planning practices [19] [20].

**Learning Point 1:**
**The provisions of the Care Act 2014 promote a person-centred approach though the s9, s. 10 and s42 duties. In addition, the duty to provide advocacy (s67 and s68) support people who have substantial difficulty in being involved in decisions about their care and support**

[19] White, E (2017) '*Assessing and Responding to Risk'* in Cooper, A and White E (eds.) 'Safeguarding Adults under the Care Act 2014: Understanding Good Practice' London; Jessica Kingsley pp110-27
[20] Spreadbury, K and Hubbard, R (2020) *The Adult Safeguarding Practice Handbook;* Bristol; Policy Press.

**or safeguarding. In the absence of these legal frameworks it becomes difficult to be person-centred, or to support other organisations in this approach.**

**Learning Point 2:**
**Collaborative partnership working supports a person-centred approach to adults and their carers. Roles and responsibilities are appreciated and utilised, collective problem solving supports all working in situations where there are challenges in supporting adults and their carers.**

### 5.2.2 Professional curiosity.

Professional curiosity can be defined as

*'the capacity and communication skill to explore and understand what is happening with an individual or family. It is about enquiring deeper and using proactive questioning and challenge. It is about understanding one's own responsibility and knowing when to act, rather than making assumptions or taking things at face value'*[21].

Approaches to Sam lacked professional curiosity in terms of ASC's understanding of the context for concerns about his safety and wellbeing. At times there is reported to have been lack of opportunity to look up and use historical information because of lack of time/ workflow processes. The practice of recording risk information in case notes would have also impeded these efforts.

Attending agencies believed that respect for privacy precluded professional curiosity and they also had an underlying lack of confidence in using this approach. This created the potential for agencies to 'normalise' the relationship and circumstances of Sam and Ben in the face of Sam's declining health and Ben's escalating emotional distress.

Identified barriers to using professional curiosity to understand and challenge Ben's care of Sam also included an absence of managerial oversight, advice and challenge to decision making and time constraints on face-to-face contact.

ASC staff were using a professionally curious approach when working with Ben but could not explore their understanding fully without access to partner colleagues expertise to help them unpick some of the challenges they experienced.

[21] Norfolk Safeguarding Adults Board (2020) 'Professional Curiosity Guidance' issue 03 p2 at https://www.norfolksafeguardingadultsboard.info/assets/NSAB-GUIDANCE/NSAB-Professional-Curiosity-Partnership-VersionAPR2020FINAL04.pdf

Partner agencies working with Ben had no awareness of the possible underlying reasons for his behaviour, including ASD.

Practitioners can develop their professional curiously in a number of ways [22] including:

Attending good quality training to help them develop.

Accessing good management support and supervision that promotes professional curiosity.

Using empathy ('walk in the shoes') of the person to consider the situation from their lived experience.

Being diligent in working with the person and their family/network, developing professional relationships to understand what has happened and its impact on all involved.

Developing the skills and knowledge to hold difficult conversations.

**Learning point 3**

**Professional curiosity protects against a number of unhelpful assumptions when working with adults in risk situations. It can be promoted in a range of ways, including training and through supervision, and is underpinned by face-to-face contact with the adult and their networks, as well as relationships with partner agencies working with the adult.**

### 5.2.3 Legal literacy

The ASC response to Ben and Sam's refusal to change sleeping arrangements was ill-informed and perhaps not thought through carefully, but it does indicate an inaccurate perception of how the principles of the Mental Capacity Act 2005 might be interpreted in situations where people are reported to have the mental capacity to make a specific decision. A focus on the 'right' of capacitated individuals to make unwise decisions can preclude exploration of the rationale and context for decision-making and also leaves practitioners believing that they have no permissions to intervene to protect human rights or enact a duty of care.

**Learning point 4.**

**'Unwise decision making' by a capacitated adult should not result in case closure without further exploration of the rationale and context for the decision. It is important to carefully re-examine policies, procedures and practices to ensure that they are not based on this misunderstanding of legislation.**

Unwise decision-making can be a reason to explore a person's capacity to make that decision. Sam's GP and primary health staff had noted a decline in his cognition, there were aspects of his health that he was said to no longer be able to make decisions about (although this was never assessed), he was thought at times to possibly be under duress

[22] Norfolk Safeguarding Adults Board (2020) ibid.

from Ben. These factors, and the potential consequences of the decision to withdraw care and support, should have led to a decision by ASC to undertake an assessment of his capacity under the provisions of the MCA 2005.

Primary health staff commented from time to time that Sam had cognitive issues or had difficulty in understanding his own health condition. There are no examples that the lead reviewer can identify where health colleagues/OT should not have presumed capacity, however it must be noted that even when a person is compliant and accepts a course of action, if there are doubts about their capacity to make this decision an assessment should be undertaken and if they are not capacitated their best interests must be considered.

**Learning point 5.**

**All who work with adults must be confident about when and how to undertake an assessment of capacity under the provisions of the MCA 2005 and in how to use best interest decision making processes if the person does not have capacity at that time to make the specific decision.**

Staff at the 'front door' of both ASC and the care provider service were concerned about 'breaching confidentiality' by sharing personal data inappropriately. This relates to how we can work with concerned relatives in situations when we do not have the subject's permission to share their information. This does not preclude asking for information, Sam's stepdaughter knew that care had been withdrawn, without acknowledging that this was the case she could have been asked if she would be concerned about this and why. We can ask families questions without giving information. Front door staff can be given protocols to use to alert managers to an enquiry by a concerned relative so that these matters can be pursued with sensitivity and within the provisions of data protection legislation.

**Learning Point 6.**

**Front door staff can be supported in observing legal requirements on data protection in a way that enables dialogue with concerned others. Fear of breaching the provisions of the Data Protection Act 2018 should not be a barrier to listening to concerned families or friends.**

### 5.3 Inter-professional and interagency collaboration

The absence of partnership working is a key finding of this review. In answer to the question posed in the SAR extended terms of reference *'How did agencies work together to support Ben? Were there challenges and barriers to understanding his needs and responding to them?'*

we can see that agencies worked together well for a week after Sam*'s* body was found but the subsequent lack of partnership working between ASC, the GP surgery, RDaSH and the police meant that Ben's self-neglect and alcohol use could not be adequately addressed.

Significant decision making about safeguarding Sam and closure of his case was also not informed by partnership information sharing or discussions, particularly between ASC and primary health services. Concerns expressed by the care provider did not result in action or review of decision-making by ASC, although the OT service did respond in a timely manner and did encourage primary health staff to work closely with the care provider.

Aspects of partnership work that appear to need attention are:

Respect for and understanding about other agencies role and responsibility, particularly with respect to working in partnership with service providers.

Consulting with partners – via the statutory review process, when making decisions about the response to safeguarding concerns, when withdrawing care.

Partner's confidence and consistency in referring to adult safeguarding when concerned about neglect or harm, including reference to GP services.

The use of the RSAB Escalation policy by all partners, including service providers.

Using multi-agency forums or meetings to create plans and follow up on actions, to support, advise and challenge each other when working with difficult people/situations.

**Learning Point 7**

**Adult safeguarding, and all other responses intended to address risk, benefit from collaborative partnerships which share risk and contribute to problem solving.**

### 5.4 Organisational features affecting how practitioners and teams worked.

Pressure of work is a feature for all agencies involved with Sam and Ben. Every agency involved with this SAR will be concerned as to how organisational leadership, policies and working practices can support staff to work in as person centred and effective way as possible with the people they serve.

Strategies to manage the pressure of work, whether they are formally introduced by managers or informally adopted by staff, risk missing exceptional circumstances. This can lead to further pressure as preventable risks escalate into crises.

Work-flow management and the pressure of on-going work led to ASC during the 2016 – 2019 period of this SAR being unable to undertake planned or unplanned reviews, unable to

undertake face to face visits or utilise existing historical information, incidents which could have resulted in allocation or in an enquiry under the s42 duty were dealt with on a duty basis or 'screened out'. It is understood that ASC has spent a good deal of time reviewing and remodelling service delivery. It will be important to build in opportunities to mitigate against practices which do not support person-centred and professionally curious practice. The practice exhibited by social workers 2 and 3 with Ben would indicate that matters are improving although practitioners are still concerned about difficulties in undertaking reviews of existing care and support plans.

It is also important to create collaborative partnerships, finding that a person is 'not eligible for a service' should not be the end of the conversation with partner agencies who are still involved. Finding out what advice and support to colleagues is needed, or where an exception can be made to 'usual practice' builds partnerships that are ultimately time and cost effective as well able to deliver better services.

**Learning Point 8**

**Leaders in all organisations can usefully support mechanisms which identify exceptions to established practices and permit staff to either act on the need to work proactively with the person and their families, or to support partners by sharing information in a timely manner or giving advice and support.**

The working culture of GP practices is built on the understanding that the patient or their families will approach the GP. There is no time to develop or use mechanisms that are proactive in identifying missing or disengaged patients who may be experiencing poor health. Some GP surgeries have been able to employ a qualified practitioner to proactively follow up missed appointments and other indicators of disengagement in patients who are self -neglecting, frail or mentally unwell.

**Learning Point 9**

**Proactive responses are not guaranteed by a person being on a list or having an identified GP. To work against the prevailing working culture in very busy GP practices extra resource may need to be considered.**

### 5.5 SAB leadership, oversight and governance

RSAB did not publish a Multi-agency policy on Self Neglect and Hoarding until January 2020, outside of the time when agencies were working with Sam and Ben. Practitioners at the

learning events who are aware of this policy have described how their confidence and practice has begun to improve as a result of the new policy and guidance.

**Learning point 10**

**Effective responses to self-neglect continue to evolve and it is important to keep policies, procedures and guidance under review.**

## 6. Recommendations

6.1 Where agencies have made their own recommendations in their review of Sam and Ben, Rotherham Safeguarding Adults Board should seek assurance that action plans are underway and outcomes are impact assessed within those organisations.

6.2 Rotherham Safeguarding Adults Board should seek assurance that named agencies have addressed the recommendations in items 6.3, 6.4 and 6.5 below.

6.3 Rotherham Metropolitan Borough Council Adult Social Care is recommended to complete a strategy to enable the fulfilment of its statutory duties under sections 9, 11 and 10 of the Care Act 2014. Any Reviewing Strategy and supporting procedures is to contain mechanisms to identify people most in need of review in accordance with the Statutory Care and Support Guidance. (Learning Point 1)

6.4 NHS Rotherham Clinical Commissioning Group and Rotherham Metropolitan Borough Council are recommended to ensure that Autism Awareness training is available to and taken up by all frontline staff, including those in commissioned services. They are also recommended to ensure that routes for Autism related advice and support for practitioners working with people who do or may have ASD are identified and readily available. (Learning Point 3)

6.5 NHS Rotherham Clinical Commissioning Group and interested GPs are recommended to explore how proactive approaches to monitoring patients or carers at risk of disengagement can be utilised in a busy practice environment.
(Learning Point 9)

**These recommendations are for 'all RSAB Partners' and may need to be reported back to RSAB via subgroups or task and finish groups.**

6.6 All SAB partners are recommended to explore the confidence of their frontline staff and managers in using the provisions of the MCA 2005 and their understanding of the benefits to the person of using this legislation. Depending on the outcome of this exploration a multi-agency MCA awareness event may be useful. (Learning Point 5).

6.7 All relevant SAB partners are recommended to review their frontline practitioners and manager's understanding of the implication of making an 'unwise decision' and their confidence in exploring and responding to a range of explanations for unwise decision making. The outcome of the partner's review may contribute to a strategy to support 'Professional Curiosity 'in the workforce. (see recommendation 10). Partners are recommended to ensure that Policies and procedures do not mislead practitioners in understanding the implications of a person making an 'unwise decision' (Learning Point 4)

6.8 All SAB partners are recommended to ensure that both they and commissioned services understand how to communicate constructively with concerned family or friends in the light of the provisions of the Data Protection Act 2018 and when to involve managers for assistance (Learning Point 6).

**Recommendations for RSAB**

6.9 RSAB is recommended to attend to the nature of collaborative safeguarding partnerships in Rotherham. The RSAB will be supported in this work by the LGA suggested multi-agency framework on 'Understanding what constitutes a safeguarding concern and how to support effective outcomes' (2020)[23]. Particular attention should be paid to

- leaders supporting practical opportunities for frontline practitioners to share information, work together, to undertake risk sharing and problem solving.
- parity of esteem between organisations, including those who are commissioned. (Learning Points 2, 7 and 8)

6.10 RSAB is recommended to take steps to promote the development of 'professional curiosity' in all partners. The Norfolk Safeguarding Adults Board (2020) guidance [24] is a good starting point in implementing this recommendation. (Learning Point 3)

6.11 RSAB is recommended to review its' Multi Agency Policy for Self-Neglect and Hoarding in the light of the findings of this SAR. (Learning Point 10).

[23] Available at https://www.local.gov.uk/publications/understanding-what-constitutes-safeguarding-concern-and-how-support-effective-outcomes with particular reference to pages 39-41.

[24] Norfolk Safeguarding Adults Board (2020) 'Professional Curiosity Guidance' issue 03 p2 at https://www.norfolksafeguardingadultsboard.info/assets/NSAB-GUIDANCE/NSAB-Professional-Curiosity-Partnership-VersionAPR2020FINAL04.pdf

## 7. Glossary of terms used.

AMHP – Approved Mental Health Professional
ASC – Adult Social Care
ASD – Autistic Spectrum Disorder
CCG – Clinical Commissioning Group
CID 70 – Police notification to relevant agencies of concerns.
GP – General Practitioner (Doctor)
LTC – Long term Conditions
MSP – Making Safeguarding Personal
OT – Occupational Therapist
RDaSH- Rotherham Doncaster and South Humber NHS Foundation Trust
RMBC – Rotherham Metropolitan Borough Council
RSAB – Rotherham Safeguarding Adults Board
SAR – Safeguarding Adults Review