West Sussex Safeguarding Adults Board

Thematic Safeguarding Adults Review

Claire Foreman
Final Version | March 2021

Contents

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1. Foreword

1.1 West Sussex Safeguarding Adults Board (the Board) has today published a Thematic Safeguarding Adults Review (SAR) that looked into the circumstances surrounding the death of three adults in West Sussex. In agreement with their families and in considering the privacy of the adults, we refer to the three adults concerned as Mrs DP, Mr AJ, and Mr RC.

1.2 The Board wishes to extend its sincere condolences to the families, friends and carers of Mrs DP, Mr AJ, and Mr RC, and to both assure that lessons have been learnt and systems changed and improved, as a result of this review.

1.3 Serious Incident Reviews were completed for all three cases prior to the SAR and, all highlighted concerns about the specific operational circumstances and effectiveness of the adult safeguarding system in WSCC. Given that there were similar issues and themes across the 3 cases a SAR focusing on themes has been undertaken.

1.4 The purpose of a SAR is not to reinvestigate or to apportion blame but to establish where, and how lessons can be learned and services improved for all those who use them and for families and carers.

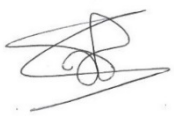
1.5 This Review looks at the incidents leading up to the deaths of Mrs DP, Mr AJ, and Mr RC, and examines the actions of various agencies that had been involved to reduce the likelihood of a similar events happening again in the future.

1.6 The Review highlights areas for learning, and recognises the immediate actions taken by Statutory Agencies prior to the Review. This evidences that involved agencies made changes to procedure and practice without delay and, preceding the outcome and recommendations from this Review.

1.7 The Review highlights key themes in the areas of making safeguarding personal; health optimisation; compliance with Policy and Procedure; recognising and working with self-neglect and, assessing and managing risk.

1.8 The Board and the SAR Subgroup, which reports to the Board, will monitor progress on the implementation of all recommendation through receiving reports from all agencies involved in working with Mrs DP, Mr AJ and; Mr RC, that reflect progress on their continued action plan to reduce risk and ensure that the necessary policies and procedures continue to improve.

1.9 The Board will also ensure the learning from this review is widely disseminated widely and that the outcomes of the learning will lead to improved services in West Sussex.



Annie Callanan, Independent Chair

2. Introduction

2.1 During the period between the last 2 weeks of May and the first 2 weeks of June 2019 there were 3 adults known to WSCC Adult Social Care, who were having current contact with the Local Authority and who sadly, unexpectedly, died: DP on 8th June 2019, AJ on 4th June 2019 and RC found deceased on 24th May 2019.

2.2 Following these deaths in May/ June 2019, WSCC commissioned an internal joined-up serious incident review (SIR) of these adults and the circumstances leading up to their deaths. A final report of the review was issued in August 2019. The report did consider how effectively agencies were responding to their duties under the Care Act 2014, implemented in 2015 1, (which are detailed within the Sussex Safeguarding Adults Policy and Procedures edition 4, May 2019 2). Each of the 3 cases related to an individual member of the public and all of the cases had other agency involvement. There have been thorough chronologies prepared by the local authority that indicate there were a number of similar concerns about the inter-agency working arrangements and responses by a range of agencies.

2.3 The SIR findings for the 3 cases were presented to the SAR subgroup in September 2019. The Safeguarding Adults Case Review subgroup agreed that the referral should be made for a thematic safeguarding adult review. The Chair of the subgroup made a recommendation to Annie Callanan (SAB Independent Chair) which she approved in October 2019.

2.4 At that time, there were likely, consistent themes emerging across the cases by agencies involved that could usefully be drawn together and identified as learning for change needed to improve system-wide safeguarding adult practice and procedure in West Sussex as well as specific learning for individual agencies. This Safeguarding Adults Review does also reflect any progress that has been made since then in response to these cases to improve system-wide safeguarding adult practice.

3. Context of Safeguarding Reviews

3.1 Under Section 44 of the Care Act 2014, Safeguarding Adults Boards (SAB) must arrange a Safeguarding Adults Review (SAR) if:

> There is reasonable cause for concern about how the SAB, member of it or other persons with relevant functions worked together to safeguard the adult and the adult dies as a result of abuse or neglect, whether or not it was known or suspected before the adults dies (s44(2))
>
> OR'
>
> If the adult is still alive and the SAB knows or suspects that the adults has experienced serious abuse or neglect (44(3)).

3.2 In addition, SAB's are free to commission a SAR in any other situations where it is thought there is valuable learning for the partnership (s44(4)).

3.3 A key principle for completing a SAR is to ensure there is a culture of continuous learning and improvement across the organizations that work together and the approach taken to the reviews should be proportionate to the scale and the level of complexity of the issues examined.

4. Background to Thematic Review

4.1 The evidence gathered for the cases indicates the deaths all involved potential safeguarding issues, whether identified or not and whether or not they were under section 42 enquiry.

4.2 From the information gathered from local authority records alone it appeared that agencies involved in the three cases could have worked more effectively together to protect the adults involved. The evidence collected for the SIR clearly demonstrated useful insights into the way organisations were working together on safeguarding, risk assessment and management and the improvements that may be needed.

4.3 The evidence gathered for the SIRs showed that there were clear gaps in putting the person at the centre of activity and understanding how the safeguarding adult procedures and making safeguarding personal could enhance outcomes. In recognition of adult safeguarding being everybody's business, there needed to be a system-wide understanding, sharing and analysis particularly in relation to managing pressures in organisations where a multi-agency response to a case of abuse or high risk is needed. WSCC has been leading such a review and where specific actions have been taken and progress made, these are reflected in the analysis.

4.4 This thematic SAR will support ongoing work and ensure the particular experiences for the 3 people are fully explored and taken into account. The aims of the Safeguarding Adults Review are to improve the safety and wellbeing of adults at risk and for improvements to provide a legacy to the three adults.

4.5 The objectives of the review, to meet these aims, are for agencies to work together in a spirit of openness, jointly with family and close representatives, to develop fuller pen pictures of the three adults, an understanding of the facts, a thematic analysis, findings, recommendations and actions.

5. SAR Process and Scope

5.1 The three cases all highlighted concerns about the specific operational circumstances and effectiveness of the adult safeguarding system in WSCC area particularly during May and June 2019 and it is likely that root causes and learning from this SAR will be very similar to that already highlighted in the WSCC internal SIR report. Therefore, rather than repeat the same review process highlighting very similar issues and learning for each case, it was recommended that a bespoke thematic Safeguarding Adults Review be undertaken in response to the three cases.

5.2 However, in order not to lose sight of the key issues and learning for all agencies involved in the cases, this SAR encompassed a review of the information and internal investigations from other agencies involved for each case, in addition to those already completed by WSCC, to ensure that any additional identified issues and learning were factored into this review process.

5.3 This Safeguarding Adult Review was conducted using a blended methodology using Individual Management Reviews and questionnaires for each case, which reflected on multi-agency work systemically and aimed to answer the question: why things happened? This included compilation of chronologies and completion of case audits against specific questions by the individual agencies involved.

5.4 From the chronological evidence gathered and reviewed in the SIR, particular scoping periods in this review were applied for each individual to ensure that events and involvement leading up to the May / June period 2019 were also considered where relevant. These periods are as follows:

- Mrs DP: May and June 2019 (with any further information relating to the Section 42 enquiry even if after this date included)
- Mr AJ: August 2018 to June 2019
- Mr RC: January 2018 to May 2019

5.5 In detail, the methodology involved clear steps, comprising:

a) An initial meeting with the WSSAB SAR sub-group to agree the terms of reference;
b) Independent Management Reviews (IMRs) requested for relevant agencies involved with the 3 cases, other than WSCC Adult social care (WS ASC) who had already prepared extensive chronologies and who remained involved in the bespoke SAR panel;
c) Letters and communication with the representatives (families / friends) of the three individuals inviting them to participate in the review;
d) Scrutiny of IMRs / chronologies and relevant records by the reviewer;
e) Telephone interviews with one family member (Case AJ) and individual telephone consultations with IMR authors from agencies involved to clarify their views and initial learning identified;
f) Completion and circulation of draft overview and executive summary reports for discussion with a bespoke SAR panel of agency representatives for comment, clarifications and any amendments;
g) Planned development of learning tool e.g. VLOG
h) Holding a review outcome meeting and presentation to the WSSAB SAR Sub-Group and the WSSAB.

5.6 The review recognised good practice and strengths that can be built on, as well as things that needed to be done differently to encourage improvements. It also takes note of, and presents, the WSCC led progress that has already been made to improve the systems, processes and practice from learning of these cases. This review was a proportionate, collaborative and an analytical process, which actively engaged all agencies involved in the SAR and the convening of a bespoke SAR panel.

5.7 The Department of Health's six principles for adults safeguarding should be applied across all safeguarding activity. Department of Health (2016 Care and Support Statutory Guidance Issues under the Care Act 2014)1 The principles will be considered throughout the SAR as follows:

- Empowerment: Understanding how the adults were involved in their care; how their representatives are involved in the review.
- Prevention: The learning will be used to consider how practice can be developed to prevent future harm to others.
- Proportionality: Learning from the consistencies and important differences across the 3 cases to inform a single set of recommendations.
- Protection: The SAR process, learning and recommendations will be used to protect others from harm.
- Partnership: The SAR will give consideration to how well partners are working together in West Sussex and their cooperation with the review process; make recommendations.
- Accountability: The WSSAB will be responsible for holding the safeguarding system in West Sussex to account for making the necessary improvements.

6. The 3 Adults and their circumstances

6.1 This section provides a summary of the 3 adults who are the subject of this review. It includes the key events primarily in the May / June 2019 period when the unfortunate deaths occurred and highlights the similarities and differences in their circumstances through use of 3 domains used within the article by Suzy Braye, David Orr and Michael Preston-Shoot re: good indicators of self-neglect 7 . This approach to the comparative data allows the WSSAB to understand more about the individuals' journey, the professionals working with them and the partner agencies and provides a helpful framework for the underpinning themes emerging from the evidence.

6.2 DP (92): DP had a diagnosis of severe dementia (advanced stage) and lived at Silver Court Nursing Home, East Grinstead from 8/8/2016, initially funded by WSCC under a 12-week property disregard and then self-funded. She remained there until 31/5/2019 when her son moved her to Charters Court Nursing home, East Grinstead, after she suffered unexplained injury and safeguarding concerns were raised at Silver Court. She later died on 8th June 2019 in East Surrey Hospital.

6.3 During the night of 20th May 2019, whilst administering routine care, staff noticed DP had bruising in the immediate vicinity of her vagina and anus. As a result, DP was seen by a GP who stated, the unusual distribution of bruising could not readily be explained or accounted for and raised a safeguarding concern with WSCC adult safeguarding. The Silver Court deputy manager also raised the safeguarding concern informing Sussex Adult Social Care, the Police

(21/05/19) and next of kin, her son. However, no immediate action (within the next 2 days) was taken by the respective agencies receiving those referrals to determine the risks, the welfare of DP and other residents, preserving evidence and obtaining any necessary forensic evidence or indeed even being clear about any S42 investigation or who was leading it.

6.4 On 23rd May both the home and son were in contact with WS ASC safeguarding disappointed by the delay in actions, possible loss of forensic evidence and why the police had not been in contact. A Lead Enquiry Officer (LEO) was assigned by ASC and contact made with the son, the home, and the police who ASC suggested make a visit to the home and take the lead in the investigation. The home shared their interim safeguarding plan for DP which had been put in place since the safeguarding concern was raised.

6.5 After the significant delay, the police commenced their investigation into the cause of these unexplained injuries on 24th May 2019 and attended Silver Court Nursing home on 25th May 2019. No assessment visit was made to the home by ASC.

6.6 The GP reported to the police, when they contacted her on 23rd May, that she did not take any forensic evidence when she examined DP on 21st May as she was not forensically trained. There were 3 further GP contacts made at this home in DPs last few days there, including 2 visits by other GPs, where constipation management and a chest infection was discussed and prescribed for and recognition of the need for possible end of life care due to DP deterioration in health. The patient's son expressed his concern about his mother being seen by different GPs and informed one of the doctors he was going to permanently moving his mother to Charters Court. The son and the home remained frustrated at the lack of response by the statutory agencies.

6.7 Enquiries by the police with the staff subsequently indicated a likely explanation had revealed itself when on 22nd May 2019 as DP was observed using her own hands in the injured area to alleviate the symptoms of constipation. This behaviour was also witnessed on 23rd May and DP was given treatment for constipation and visited by community nurses over the following two days to assist with this. The inquiry revealed that, DP had a propensity to fall (police officers in attendance observed such an event) and coupled with her medication this culminated in DP having incurred injuries namely bruising and fractures. The police inquiry considered health & safety compliance, statutory and common law neglect and sexual offences. Officers consulted the GP regarding the observed behaviour of DP in relation to the concerning bruising and the GP commented that this provided a satisfactory explanation for the injuries. WSCC Adult Social Care didn't visit until 14 days later.

6.8 The son and the home continued to be frustrated at the response by the statutory agencies, and the son did move his mother to an alternative care home, Charters Court, on 31/5/19.

6.9 During this investigation, the Manager of Charters Court Home said that when DP arrived at Charters Court home on the 31st May she had been transported by private taxi arranged by her son. She had been transported without any assistance in the taxi, and her son had travelled in his car following her to the

new home. The home Manager explained that DP had displayed upset and distressed behaviours and she had advanced dementia. Staff at Charter House Care Home reported that after an unsettled night on the 6th June, staff were concerned about DP's unresponsiveness and an ambulance was called. The investigation established that despite a safety plan to prevent falls, DP suffered a fall on 2nd June where bruising to her ribs was observed by staff.

6.10 On 7th June 2019 East Surrey Hospital informed Sussex Police that DP had been admitted in a critical state with suspected injuries; fractured first & second vertebrae, recent rib fractures and multiple bruising and Sussex police commenced an investigation. This further safeguarding concern was phoned through to WS ASC safeguarding by East Surrey Hospital and on receipt of this further referral, the OOH WS ASC service manager who then reviewed information about the other Safeguarding enquiry underway, ensured WS ASC social workers immediately visited both homes and collected documentation. These records and body maps did give more detail to the possible cause of the injuries and DP needs.

6.11 On 8th June 2019 DP died. The police made a request for a Home Office forensic pathologist to conduct the autopsy. The autopsy being a more invasive investigative process than x-rays, concluded that there was no causal link between the injuries discovered and death, there was no evidence of neglect. After the toxicology result the pathologist recorded the cause of death as; Pneumonia and Congestive Cardiac Failure and Coronary Heart Disease.

6.12 **Addendum**: There were two specific Section 42 enquiries undertaken in relation to DP following the GPs assessment and concern raised on 21st May 2019 and the concern raised by East Surrey Hospital A+E on 7th June 2019. Both concluded that no abuse had taken place.

The Experience and Analysis of DPs journey during May and June 2019: The Adult, DP, and her experience

6.13 There is no evidence from the management reports prepared during this review, as well as for the SIR, that DP and her health and wellbeing was at the centre of the safeguarding process, actions taken, and outcomes achieved. Safeguarding was not made personal.

6.14 There needs to be consideration and acknowledgement of the likely impact on DP of her care journey during the last 2 weeks of her life and how her needs were being met – especially without a voice and ability to communicate what she wanted to happen and living in the final stages of dementia. What we know from her care records is that she was unwell with recurrent infections, constipation, poor skin integrity, falling, often sleepy then awake overnight calling and distressed – and in need of end of life care. There were almost daily calls by the home to the GP and NHS 111 asking for assistance. Despite this contact there was no health or social care practitioner taking a lead with continuity of support and planning end of life care towards meeting holistically her deteriorating physical and mental health needs.

6.15 The GP management review of this case says the GPs have maintained an open dialogue at all stages of her care with her next of kin: her son. However, the son

refused to engage with the home once the safeguarding investigation started and all communications were through the GP surgery which could have been avoided if a prompt and timely response was made by the agencies with skills to work with family concerns and fears in safeguarding investigations. The home found the son's behaviour difficult towards colleagues and towards his mother.

6.16 Questions were raised by the home about whether her son (with Power of Attorney) was making decisions in her best interests – particularly about moving her to another home when she was so poorly and in the context of her distressed state. However, there was no professional assessment, consideration or intervention given to the home or the next of kin about DPs possible rights and best interests in these circumstances, or options explored for use of the Mental Capacity Act 2005.

6.17 The welfare of DP and other residents were not given priority (alongside potential criminal / evidence preservation) as per the Safeguarding adult procedures on the 21st May 2019, and no one from ASC social work visited DP/the home until 18 days later or escalated concerns. Relevant information was not collected in a timely way from the home to inform the potential risk to other residents or DP and no regard given to an existing Safeguarding enquiry at Silver Court.

6.18 The agencies all noted that DP had dementia and did not have the mental capacity to understand and provide information about her wishes and experience and relied on the next of kin as her advocate and decision-maker about how her needs would be met, including a response to potential safeguarding allegations. Silver Court home staff knew DP well as she had lived there for 3 years and until this safeguarding referral, the next of kin had been satisfied with his mother's care there.

The Team around the adult: Safeguarding procedures were not followed

6.19 In the homes opinion from the onset of the enquiry, whereby the GP made reference to a potential sexual assault, consideration needed to be given for a forensic examination to have been carried out and if not, explicit, timely decisions and recording of why this was not seen as necessary. The GP making the original referral did not progress the discussions with the police about ensuring these were done or query whether they should, and was not invited to multi-agency discussions as they did not take place nor were decisions made about the scope of the enquiry to include this.

6.20 The allegations were not made explicit and different information re the potential safeguarding allegations were given to the son and the home whereby the GP used the term sexual assault to the son. The approach to the investigation was disjointed and uncoordinated through: a) poor sharing and recording of accurate, timely and clear information between key safeguarding agencies, the home and next of in, after the initial safeguarding referrals were made; and b) the gap in management oversight to ensure a timely and appropriate safeguarding procedure was followed. What ensued was a very distressing and undignified end of life care pathway. Silver Court Home reflected that this particular investigation was very difficult for them and although they were quite accurate in their reporting and responding with a safeguarding plan for DP, they were not

supported by the timeliness, activities and disjointed approach to the investigation by the other agencies involved.

> *'Safeguarding meetings may be the best way to ensure effective co-ordination of different aspects of an enquiry that relate directly to the adult or decisions that affect them'* [2]

The organisations around the team: The Safeguarding system and priority in West Sussex

6.21 The lack of a timely response by ASC and the police led to the son becoming increasingly frustrated, making unsupported / untested decisions with no social work involvement or consideration by social workers. This led to DP being moved twice when she was very unwell, frightened and in need of appropriately planned palliative care. The delay in the police and WSCC ASC responding could therefore be considered to have a detrimental bearing on the outcome and does not appear to be commensurate with the Sussex Police Safeguarding Adults policy & procedures regarding the priority of the first responders to safeguard the victim (and assess and protect possible risks to others) and establish if a criminal offence had been committed.

6.22 Initially the delayed response by Sussex Police to a potential allegation of assault appeared to arise from a lack of recognition that the original call required a response to establish if a criminal offence had been committed and a misunderstanding that the local authority were leading enquiries. Some delays that followed were reported to be as a direct result of lack of resources available and inter departmental consultation on the appropriate responders. The situation was rectified promptly on the receipt of further information. As soon as the Detective Inspector took ownership of this investigation on 24th he immediately recognised that there had been a delayed initial response by Sussex Police, and commissioned an internal review of the processes to ensure this was examined for any urgent learning. He also recognised the need to ensure that DP's son was fully updated on the response and took personal ownership of this.

6.23 The particular WSCC operational circumstances said to have been reported to senior managers at the time included Community Team staff absences, managing Safeguarding concerns and enquiries on duty as unable to allocate, working with other high risk Safeguarding concerns and trying to process and assess the risks associated with bulk SCARF (single combined assessment of risk form) downloads.

6.24 The recording by ASC staff was not timely, had gaps in defensible decision-making in relation to their actions, police decisions, DP health and family involvement, and showed little regard for the health and well-being of DP. The gathering of information for the SIR and the IMRs completed for this SAR did bring more accurate detail to some actions, outcomes, and timelines.

6.25 AJ (60): AJ lived in a chalet park home. He became known to WSCC Adult Social care in August 2018, when he was admitted to St Richards Hospital and was allocated a Social Worker. He had a diagnosis of Multiple sclerosis. His ex-wife remained supportive and at the time he deceased, he was under the care of the

Multiple Sclerosis (MS) nurse and his GP. He was on the proactive care caseload as he was considered to have complex needs and his caravan accommodation unsuitable for his needs.

6.26 Following hospital admission in August 2018, Care Act and OT assessments were made with a focus on alternative accommodation. AJ stayed self-funding in residential care while considering housing options. He returned to his chalet home in January 2019 after no progress was made with suitable alternative accommodation and his dislike of his care home and costs. Requests were made for further Care Act and OT assessments by the MS nurse to support him there as it was recognised that the accommodation was not particularly adapted to suit his physical needs. However, limited contact was made to achieve outcomes from these and WSCC ASC closed the case by early March after receiving no response from AJ to their phone and letter contact, and despite the MS nurse remaining concerned about how he was managing. His last contact with the MS nurse was by telephone in April 2019 when AJ stated he wanted no further help with care. He was seen at the GP practice by practice nurses approximately 10 times from March until early May until his ulcerated legs had healed.

6.27 There were GP consultations on 17th and 20th May in response to AJ's reported dizziness and unsteadiness on feet linked to his medication. The GP had a long conversation about the pros and cons of the recommended medication. AJ decided not to continue with Beta-blockers and GP was happy that AJ had the capacity to take such a decision. The GP wrote to AJ's Cardiologist to advise them of this decision and enquire whether they wanted to make a further change to his medication.

6.28 NHS 111 (service provided by SECAmb) were contacted by the son of AJs neighbour on 2/6/19 as he had become aware that AJ had become ill and after attending him, needed help. The result of the NHS 111 assessment on speaking with AJ was he turned down the offer of going to hospital but did report symptoms suggestive of acute cardiac failure, fatigue and weakness and swelling in the legs. The outcome and action taken by NHS 111 was 'Speak To A Primary Care Service Within 2 Hours' and there was an electronic referral to the IC24 out of hours clinical service. AJ also consented to a safeguarding referral to WSCC ASC for assessment of needs and help with risks of self-neglect at that time. During a call from IC24, 9 hours and 58 minutes later, AJ played down his symptoms, stated he was feeling a lot better than before, able to mobilise with a stroller, unlike before the only medication that worked for his lower back and leg pain was Ibuprofen. He requested his pain management be sorted out properly for him. He was advised to speak to his multiple sclerosis nurse or GP.

6.29 The safeguarding referral to WSCC that was made on 3/6/2019 by SECAmb, declared AJ had deteriorated and was not taking care of himself correctly. The referral said he was in a mess, currently in bed and in need of personal care. The caravan was reported to be in quite a state, where he had been struggling to do things for himself and kept dropping things. On 5/6/19 this was reviewed by an ASC community team manager as needing social care assessment and not appropriate for safeguarding. However, AJ passed away 3/6/19, found by a passer-by in a wheelchair, slumped over and cold. Confirmed deceased by ambulance attendance.

6.30 The cause of death was acute cardiac failure, ischemic heart disease, coronary artery atherosclerosis. Hypertension.

6.31 Addendum: The NHS 111 pathways assessment and clinician advice call has been audited by the provider, South East Coast Ambulance Service NHS Trust following a complaint which was received from the friend of the patient's neighbour who had attended AJ and facilitated his contact with NHS 111. The call was a 'Red Fail' meaning it did not meet the required standards both from the actions of the Health Advisor and the subsequent Clinical Advisor of the NHS 111 service. It is uncertain whether the call should have been passed to the out of hours service or should have resulted in a more urgent disposition.

6.32 Furthermore, the audit of the IC24 Advanced Nurse Practitioner's triage call to AJ from IC24 out of hours service on 03/06/2019, scored 57%, which falls below the audit threshold of 80%. A call back by IC24 within 2 hours was indicated, however a call was not made until 9 hours and 58 minutes after the case was passed to IC24, due to 'high demand on the service and high volume of calls'. In cases where the service is not able to meet times for calls and when the calls are about to breach, a non-clinical member of the team should carry out a 'comfort call' to the patient informing them about the delay and giving them advice of what to do if condition worsens. There were no comfort calls made. A conclusion of this investigation was 'had the patient accepted hospital admission when offered by NHS 111, or a face to face assessment been carried out by the out of hours service, it is possible this death may have been prevented'.

The Experience and Analysis of AJs Journey during May and June 2019:

The Adult, AJ and his experience: Emergency risk assessment not timely or accurate

6.33 Mr AJ remained close to his ex-wife after they separated, and she was able to contribute to this review as well as to the investigations noted above. She clearly expressed her wish that she would not want AJs experience to be repeated for anyone else, particularly in respect of no professionals visiting his home and the delay in IC24 calling from an expected 2 hours to 9 hours. She feels he should have been seen in response to the NHS 111 call on 2nd June 2019 recognising his vulnerability at that time. She knew he had stopped taking his specific heart medication and is frustrated that the IC24 practitioner could not get access to his case notes where this was recorded. She also queries why the MS nurse did not visit prior to this (and was not aware that the nurse had arranged with AJ to contact as required) and thought AJ didn't accept that his MS was getting worse as well as his heart condition. Following a visit to his home after he died, she reflected that 'if someone had seen the state of the place, they wouldn't have left him there'. She knew him as a very proud man and would declare himself 'fine' rather than accept help.

The Team around the Adult: Preventative, precautionary and sustained proactive approaches were missing in responding to possible self-neglect.

6.34 AJ had most contact with his primary care team in the 3 months before his death. There were no concerns about AJ's welfare noted by the practice nurses

during their time treating his legs at the surgery or by the GPs who reviewed his medication with him.

6.35 The role and involvement of the nurses and community adult social care staff could be questioned with the need to persevere in possible self-neglect cases where refusal of help should not be taken at face value by the agencies working with him but necessary relationships built and sustained, not least to monitor the progress of the disease, support with managing these changes where co-morbidities exist and understanding how they are managing. However, the MS and Community nurses considered that AJ had the capacity to make unwise decisions regarding healthcare. Certainly, for community services like Adult social care not using the opportunities with the referrals made to review how he was managing in his own home after April 2019, with face-to-face contact, was a missed opportunity.

The organisations around the Team

6.36 The wishes of AJ to maintain his independence were respected and there is evidence of good practice within the documented multi-disciplinary and multi-agency working in respect of AJ's health needs prior to the spring of 2019.

6.37 It is understood that the NHS 111 clinical advisers have access to GP Summary Care Records (but not to System 1 which GPs use ordinarily). The IC24 practitioner who responded to AJ on the 2nd / 3rd June 2019 did not have her NHS Smart Card activated and did not access all relevant information in her assessment. This is an important learning point and recommendation to improve information sharing and comprehensive assessment.

6.38 The vulnerable person Safeguarding alert referral generated by SECAmb (NHS 111) was not sent on the day of the call but a day later and was not dealt with in a timely way, nor was an out of hours referral to WSCC considered by SECAmb on the 2nd June 2019. It took a further 2 days to be processed by WSCC ASC across their care point 1 and care point 2 access points and the conclusion was that it was not appropriate to be taken through safeguarding but to be considered for a social care needs assessment. It is not clear why this was the outcome and what evidence, or information was used and what careful consideration was given to the risk of the self-neglect statement it contained. It was reported during the incident review that there was some pressure in WSCC ASC community team for duty where the volume of outstanding duty tasks had to take priority.

6.39 During the review of information held by WSCC, there were recording inaccuracies identified relating to specific actions, timelines, and detail about the Adults circumstances.

6.40 **RC (66):** RC lived on his own in Midhurst in a Housing Association flat from 2010. He had a physical disability following his left leg being amputated and was a wheelchair user. He had a history of alcohol misuse and self-and environmental neglect.

6.41 From mid-2017 onwards various contacts and were made between health, social care, police, fire and rescue services and housing agencies regarding his living

conditions, ability to meet his needs and concern about self-neglect. There were multiple social care teams involved in direct assessment and support planning with RC intermittently during this time including: OT, CRS, RAIT, PAT, Family Mosaic, ASC Community Team. Records suggest that ongoing support was offered, and RC was difficult to engage and often refused support. There is no record or suggestion that a multi-agency meeting was held at any point to discuss the key concerns being identified by individual agencies relating to his self-neglect, (this being the term often recorded on referral information), alcohol misuse and mental health needs or reference made to the Sussex Safeguarding Adult policy and procedures relating to self-neglect.

6.42 The prior recorded key events and involvement from agencies, other than WSCC ASC, shows some recognition of self-neglect and appropriate referrals made to safeguarding from the limited contact made. Of note though is the gap in primary care involvement from January 2018 and it can only be assumed that RC had no health reviews or medication reviews taking place from that time.

6.43 Health: The only involvement the GP had during this period was to react to concerns raised by the risk assessment (rehab) team in January 2018. A GP visit was conducted on the day and the patient admitted to hospital. Self-neglect was recorded on the assessment of RC at his home. The discharge letter reported a diagnosis of pneumonia and alcohol dependence with a referral to the alcohol liaison nurse. No follow up visit occurred after discharge, but the GP reported that this would not normally occur. They received no further information about concerns relating to RC between January 2018 and his death in 2019. A specific need for a medication review and health check was flagged to the OT working with RC after a joint visit with the PAT nurse adviser in December 2018 to carry out a needs assessment, as it was noted RC had not been seen by the GP for a year. There is not a record of this being actioned.

6.44 Sussex Police had contact with RC on two separate occasions in 27 June 2017 and again in May 2019, 15 days before he was found deceased. The contact Sussex Police had with RC was confined to carrying out welfare checks requested by Careline staff. Observations, actions, and concerns were incorporated into SCARF / VAAR forms. In the second (May 2019) SCARF / VAAR submitted to West Sussex Adult Social Care, the MASH officer triaging the form identified that RC could be suffering from underlying mental ill health (the Care Act identifies that fluctuating capacity or impairment through mental illness / alcohol / drugs can be factors in cases of self-neglect) and ticked the box marked Mental Health & Health / Support which have an automatic Amber BRAG grading. This VAAR was promptly shared with Adult Social care. Sussex Police highlighted that self-neglect (physical / environmental) was evident on both police attendances and both VAARs identified that RC was in need of care and support. There is no information on police systems that this VAAR prompted any action by other agencies which is normal if no further multi-agency actions, involving the police, are pursued.

6.45 Housing: Hyde were RCs landlord with responsibility for collecting rent, providing repairs/other landlord services and ensuring regular testing of a pull cord system fitted into the flat that provided alarm monitoring via Careline. A safeguarding referral was made in October 2018 following a pull cord testing visit with concerns about number of wine bottles everywhere and the property being in a

poor condition. WS ASC responded after visiting to say they will be working with RC on issues and arranging a deep clean. This was followed up with ASC by Hyde in March 2019 with concern that the situation had not improved. ASC shared the dates of deep clean planned for April, with respite care for RC while in progress, and that the PAT team were involved as there were difficulties engaging with RC.

6.46 **The specific Adult Social Care involvement April / May 2019:** RC agreed to a care package following a Care Act assessment by a student social worker in March 2019 that included daily calls for welfare checks, support with laundry and managing his home. A request to set this up was sent to WSCC Adult Social Care brokerage. The Housing Association made contact with ASC in March as RC's wellbeing had been flagged up and information on his support plan needed to be shared ahead of any possible referral on to the enforcement team. The OT involved forwarded the support plan that was going to be implemented. There was no consideration at this time for a multi-agency planning meeting despite the range of presenting needs around RC's accommodation, health, wellbeing and care and support.

6.47 A deep clean of his flat was undertaken before the care and support was planned to start and in April 2019 he moved into respite while the clean took place. There were no records of the experience for RC of being in respite care or how he presented or managed his needs within the care home setting. RC's landlord requested follow up information from the SW about deep clean and also on-site visit with social worker to discuss fire risk concerns. The meeting scheduled for 25/4/19 did not take place as the SW was unable to attend. Further fire risk advice was mailed to ASC on 16/5/19 by the landlord following WSCC fire and rescue service advice received due to concerns that RC smoked and had restricted mobility.

6.48 On 2/5/19, as was the usual practice at the time, ASC closed the case to RC's allocated worker in the community team, as the case had been transferred to the brokerage team to set up the support plan. At this point no checking or liaison with the brokerage team was carried out by the community team to ensure that the support plan had in fact been set up or how RC was coping with it. On 9/5/19 the police visited RC following a care line activation and RC was found on the floor between the seat and handlebars of his mobility scooter. The flat was dirty with 30+ empty wine bottles. RC stated that he did not have any help from adult social services but could benefit from help and specifically a cleaner to help him manage the property; his son lived in Guildford and did not visit often and he had no additional support or friends or family.

6.49 The police sent a SCARF to WSCC ASC on 10/5/19 recording: self-neglect, the environment and RC as squalid, not eating, and unwashed. In the SCARF submitted to West Sussex Adult Social Care, the MASH officer triaging the form identified that RC could be suffering from underlying mental ill health (the Care Act identifies that fluctuating capacity or impairment through mental illness / alcohol / drugs can be factors in cases of self-neglect) and ticked the box marked Mental Health & Health / Support. This VAAR was promptly shared with Adult Social Care.

6.50 There was a delay in processing the SCARF on this open case in May 19 across ASC Care point 1(CP1) and Care point 2 (CP2), with no assessed need for a

discussion at handover nor regard to previous records recognising care was not set up. So, it was not until 6 days later on 16/5/19 that CP2 screened the SCARF and sent it back to CP1 for forwarding on as a contact open case to the community team. On the 23/5/19, 2 weeks after the police had seen RC, the SCARF was forwarded by CP1 to the community team.

6.51 Alongside this on the 22/5/19 the Disabled Facilities Grant documentation was completed for adaptations that had been assessed by the OT for RCs flat and the OT sent an appointment letter to RC for 28/5/19. When the OT visited on 28/5/19 she couldn't get in. A Neighbour said to the OT that RC had passed away a week ago but had not been found until the weekend by the police when they had complained about the smell.

6.52 The Community Team did follow up on the SCARF and discovered via the proactive care team information that RC had been found dead with a severely decomposed body, a likely date of death 24/5/19. According to the police Report of Death to HM Coroner and one of the officers that attended, RC's living conditions were in a poor state. There was an excessive amount of empty wine bottles on the floor and mouldy food was visible. It is not known how long RC had lain deceased. He was found to have died from Myocardial Fibrosis (heart failure), what appeared to be a pre-existing condition.

The Experience and Analysis of RCs journey during April and May 2019

The Adult, RC, and his experience: The absence of focus on RCs physical and mental health needs

6.53 RC was known to ASC for 22 months with monthly activity and involvement during this time. In terms of the WSCC ASC activity in this case the WSCC SA procedures relating to self-neglect were not followed, |the risks were not correctly assessed or escalated, plans not implemented in a timely way, and the health and wellbeing of RC not central to the process.

6.54 The ASC records for the 12 months prior to his death, indicate that he repeatedly stated his need for support in keeping his home clean and his ex-wife advocated this on his behalf and did engage with the OT about his fluctuating needs until the beginning of 2019. Indeed, RC was compliant with the arrangements made in the 3 months before his death for the deep clean (at his cost), his stay in respite to facilitate this and the agreed package of care to be set up on his return home. It was a missed opportunity that WSCC ASC brokerage did not implement the support plan and ensure it was in place and also, that the operating system in ASC did not have any checks and balances when cases were closed or cross-referencing when new referral information is received.

6.55 The records held within ASC indicate that a PAT nurse advisor assessment in December 2018 recorded the following: *'the squalid conditions that he is living in are putting his health at risk. I am concerned that his skin on his bottom may be sore, but he declined to let me have a look. His stump skin is intact, but he had a 2-inch skin tear on his left arm. The fly infestation in his flat is a health hazard'*. However, there is no further comment or action in relation to referral on to health agencies, or other medical investigations in relation to this, on records

reviewed. He was not in touch with his GP or primary care team during the last 18 months of his life and neither did the professionals working with him ensure that he accessed this. RC did not receive appropriate attention to his fundamental physical and mental health needs.

6.56 RC received good quality primary care responses at the time of his acute presentation in January 2018. With better communication about the concerns relating to his general health, primary care services may have been able to provide more support relating to his chronic medical problems. It is worth noting that RC had previously declined offers of help on occasions but during the last few months of his life, and with a sustained professional relationship from social work / OT / GP (if informed) working together, it is possible that his health and environmental situation could have been better. RC spent the last 2 years of his life, and passed away, in circumstances lacking compassion and dignity with his rights to appropriate care and safety denied.

The Team around the Adult: Lack of leadership and use of WS Safeguarding Adult policy and procedures in respect of self-neglect and/or multi-agency discussion and planning.

6.57 RC was known to ASC for 22 months with monthly activity and involvement during this time. In terms of the WSCC ASC activity in this case and the risks identified in SCARFs, safeguarding concerns and other risk alerts raised by other agencies, the WS SA procedures in respect of self-neglect were not followed, the risks were not correctly assessed or escalated, plans not implemented in a timely way, and the health and wellbeing of RC not central to the process.

6.58 There was a reported practice in community teams that if someone who is suspected of self-neglect is 'engaging with us' then there is no need to use the SA procedures. RC had periods of intermittent engagement and there were several missed opportunities to hold Multi-agency planning meetings and use the procedural framework to enhance outcomes. There were also concerns about his mental health and influence of alcohol misuse on his ability to make some decisions and self-care. '*In addition to the statutory duty to carry out a safeguarding enquiry under Section 42 of the Care Act, local authorities have a power to undertake a non-statutory safeguarding enquiry if it is proportionate to do so and will promote the adult's wellbeing and support a preventative agenda*' [2].

6.59 An innovation site initiative in 2018 within WSCC aimed to reduce the passing of people between disciplines, and the OT working with RC assumed a cross-discipline approach. However, this did not lead to a coordinated and appropriate response to his issues of self-neglect, his alcohol dependency or compromised physical and mental health needs within the context of Sussex safeguarding adult procedures during the whole period of the 22 month involvement by the OT. His outcomes did not improve, and the risks were not assessed within a multi-disciplinary context.

6.60 The roles and responsibilities of potential teams and services in the health, care and housing system were unclear, led to inappropriate referrals and delays and lack of ownership. The subsequent ASC community team student SW assessment was untimely and inadequate with regard to all the previous missed opportunities

in the records and the vulnerability of RC and his needs, despite supervisory oversight with this. The lack of implementation of the support plan in 2019, can only be described as a significant error, without effective checks in place.

6.61 There was no information to indicate that RC was at risk of abuse / neglect from a third party. Police opinion is that he did not meet the threshold for a S42 safeguarding enquiry. Taking into account WSSAB Safeguarding Thresholds and whether RC's situation should have been raised as a safeguarding concern, the information brought together in this review would indicate that he would meet the threshold due to his lack of self-care, chaotic substance misuse, multiple reports of lack of self-care, tenancy concerns, as well as the longevity and deterioration in these factors.

6.62 More effective information sharing between agencies and professionals may have signposted more effectively the need to have regard to the multi-agency Safeguarding policy and procedures and work together in an informed way with this case of self-neglect

The Organisations around the team: The blind spot in the system, addressing the cause.

6.63 Fundamentally, the safeguarding concern about RC and his self-neglect was well reported and referred by agencies and individual professionals over at least the last 2 years of his life. However, the WS system did not come together to address the issues and have regard to the SA procedures, where there are well documented approaches to be considered and referred to relating to self-neglect along with a growing body of research and evidence about best practice.

6.64 At the end of May at the time of the police SCARF submission, there was a reported backlog of work in relation to the number and volume of SCARF's in WSCC ASC. This led to delays in processing work in Care point 1 and Care point 2. This was not shared and supported across the safeguarding system and between key agencies, so the risks of delay were not known and assessed appropriately by referring agencies.

6.65 These operational circumstances in WSCC ASC also meant that the Community Team were closing cases to allocated workers after assessment once they were sent to brokerage for service set up. This meant that, along with brokerage not actually putting the care package in place, there was no follow up or ongoing checks and reviews of the outcomes of RC's intended support plan and he went without support at this crucial time.

6.66 Referrals were made by the housing landlord, for example, concerning RC and his self-neglect and poor environment but these could have been more vigorously chased up by the landlord and a multi-agency meeting arranged to ensure communication and actions completed to provide necessary support for RC and also, for the safety of other tenants in the block as there were known and shared fire risk concerns about RCs environment. At that time there were no triaging and feedback mechanisms or sharing of information about referral outcomes between WS ASC and housing.

6.67 From the housing landlord's point of view their policy and procedures were followed but they recognise that there are opportunities to work more collaboratively with other agencies despite not having specific powers or responsibilities that other agencies do with care and support. This review raised two queries that remain not fully explored: 1) The remit of Careline & Hyde Housing in responding to welfare concerns involving their clients / residents. 2) The type/location of Careline alarms. There has been a lack of available information to comment further in this review about the role of Careline alarms, responses,

6.68 + and types of devices, despite asking for an IMR contribution from the Careline service.

7. Thematic Analysis, Learning and Progress

7.1 The key themes that emerged from the review are considered under five key areas:

For the Vulnerable Adult:

1. Person-centred approaches and making safeguarding personal;

2. Health Optimization;

For the Team around the Adult:

3. Compliance with West Sussex Safeguarding Policy and Procedure;

4. Recognising and working with cases where there is Self-Neglect;

For the Organisations around the Team

5. Assessing and managing risks at individual, organisational and system levels.

7.2 To note, this analysis is based on information that has been made available and has the following key features:

- Available reports shared with the reviewer tended towards description of events rather than appraisal of what influenced practice.
- There have been gaps in evidence gathering following requests for this review from Charters Court care home, and the Careline provider for RC
- There are some inaccuracies and inconsistencies in the evidence provided and management reports, but these do not fundamentally alter the key themes, outcomes for individuals and basis of the recommendations.

Person-centred approaches and making safeguarding personal:

7.3 The person's voice, views and wishes, how these were discussed, and holistic plans developed with the individual and then taken into account in planning actions and the outcomes, were missing from recording and the management reports. In developing the chronologies for the cases, it seems that interventions lacked a person-centred approach. The work of professionals with individual vulnerable adults should lead to improving outcomes (including Safeguarding outcomes).The cases recorded lots of activity by professionals but with no difference / improvement made in outcomes for individuals, leaving a sense of failure in 'seeing the person'.

7.4 The activity should have included in a timely way:

a) Seeing the person (often enabling greater involvement in assessment and support planning processes) and recognising the lead professional health and social care worker role in advocating for the individual in this;
b) understanding and recording the persons story, history, care journey and how they want to live their life (after exploration of the options and what is possible);
c) legal rigour around the Care Act, advocacy and ensuring best interest, Mental Health Act and capacity assessments, Deprivation of liberty assessments and roles and responsibilities of attorneys.

7.5 In the cases of AJ and RC, where there were obvious concerns about self-neglect, many expressed views were taken at face-value with little discussion and progression and regard to underlying causes of their views at the time. This is despite there being a key health and social care professional having a relatively (beyond 1 year) long term relationship with each of them. In the case of DP, there was no obvious regard by professionals of what may be in her best interest during the safeguarding investigation.

Local learning and progress:

7.6 There have been Adult Safeguarding audits completed including 40 random cases of the new Adult Safeguarding Hub which demonstrates more robust and timely triaging of safeguarding. This supports review and practice improvements of person-centred approaches as well as how risks are being assessed and managed.

Health optimization:

7.7 There appeared to be little regard for holistic assessment of physical and mental health in each of the cases, and the impact of this on decisions made, especially in relation to capacity assessments and best interest decisions. For example, there should have been a holistic health assessment for RC including assessing capacity to make unwise decisions and intervening. A holistic assessment of DPs possible need for end of life care by a lead clinician assessing and coordinating her physical and mental health needs, at the time she was presenting very distressing clinical symptoms and harm, may have supported professionals to intervene in DPs best interests and work with her son to implement appropriate

care. For AJ, there is a key question in relation to the role of specialist nurses and visiting and seeing individuals who may be at risk of self-neglect when they have a known deteriorating condition and co-morbidities. In addition, a timely and accurate assessment of AJs health needs when he did engage with services may have led to a different outcome for him at the end of his life.

7.8 There were missed opportunities to involve and engage with community health care professionals in multi-agency planning both for self-neglect and end of life care.

Local learning and progress:

7.9 For Silver Court Care Home, the review conclusion by the home is that they have taken learning in respect of:

a) supporting people who have constipation triggers and implemented protocols to ensure a robust management of any concerns
b) all falls are immediately directed to a Health professional for consultation regardless of any evident injury or no injury.

Compliance with Safeguarding Policy and Procedure[2]

7.10 The review has highlighted gaps *at that time* in agencies working together effectively, without robust systems of referral and communication, to safeguard and promote the welfare of each of each of the three adults. The necessary actions were not always taken, information was not shared appropriately, and timescales not met during May and June 2019 to support satisfactory implementation of WSSA Policy. Each agency (and in some cases teams within an agency), and particularly WS ASC and community health organisations, failed to recognise and consider the need for multi-agency planning, risk assessment and the leadership role where risks and safety concerns were escalating. There was an over-reliance on referring between agencies via electronic transfer without discussion or feedback of outcomes when working with high risk situations.

There is, however, significant local learning and progress reported below.

7.11 A reflection from Silver Court Home, GPs and housing in relation to safeguarding practice in these cases was the need for better communication and transparency and also how to escalate concerns between agencies where actions are not completed, or updates provided. An effective timely plan for the enquiry and / or clear recording of the decisions regarding the timescale of the enquiry would also have been beneficial in the Case; DP. In addition it has been suggested that GPs are often not made aware of Safeguarding Adult referrals (and this includes self-neglect) and again indicates multi-agency planning and information sharing as needing to improve where it can enhance outcomes as well as comply with WSSAB procedures.

Local learning and progress:

7.12 The following key adult safeguarding system developments have been made since the Serious Incident Reviews to promote more effective and compliant use of, and work within, the Adult Safeguarding policy and procedures:

a) The creation of a single front door Adult Safeguarding Hub for West Sussex. The multi-agency safeguarding hub police supervisor is now co-located with a manager in adult social care which means that discussions regarding safeguarding referrals from the police or where there is a possible crime committed can take place as soon as they are received. This HUB approach to triage enables the police and ASC to quickly share any relevant additional history where there is a safeguarding concern and for conversations to take place regarding any next steps / escalation and how this will be achieved. The likelihood is that now there may have been a conversation about the cases which may have prompted further enquiries with adult social care and more timely and planned responses by agencies. The establishment of the safeguarding adult HUB has significantly lowered referrals.

b) The **WSSAB 'Safeguarding Thresholds: Guidance for professionals'** document (January 2020) [3] offers guidance about 3 categories of action in relation to Safeguarding which are:

Non-reportable, requires consultation, Reportable (meaning it is highly likely that the case will meet the criteria for a safeguarding enquiry). This sets out good examples of the types of key indicators across the three areas supporting each level of action. It will help all professionals consider what they do know and what they need to know about a vulnerable adult as well as what other information they need from other agencies in assessing potential risks, risk of harm and need for a Section 42 Enquiry.

The information gathered for the three cases in this review and at the point where a safeguarding concern was raised in the May / June 2019 period, suggest that both DP and RC would certainly meet the criteria for a safeguarding enquiry. This is, however, predicated on all known information having been shared across agencies at that time. In addition, for AJ, it could be considered helpful for the WS SAB partners to discuss whether the failure to arrange access to appropriate medical care and attention on the day and night before he died would have been a safeguarding concern in the context of knowing he had likely care and support needs.

c) There have also been other supporting developments to ensure more effective working which include: a professionals' consultation telephone line, a new online safeguarding referral form and a staff restructure within WS ASC.

d) The GP practice for RC emphasises the previous liaison social worker role may have helped if it had been maintained and that changes have been made to the way that MDT meetings are conducted to allow more flexible communication.

Self-neglect

7.13 'The Care Act 2014 formally recognises self-neglect as a category of abuse and places a duty of co-operation on all agencies to work together to establish systems and processes for working with adults who are self-neglecting. The Care Act emphasises the importance of early intervention and preventative actions to minimise risk and harm. Central to the Care Act is the wellbeing principle and focusing on decisions which are person-led and outcome focused. These principles are important considerations when responding to self-neglect cases'.[2]

7.14 The WS SA policy and procedures contained important information and support to professionals working with cases of self-neglect but there is little evidence there was regard to this for RC in particular or consideration given to AJ's vulnerability to self-neglect from the choice he made about his unsuitable accommodation, reluctance to engage and health status. It is a challenging area to work with but there was little curiosity shown by the professionals involved in how to improve engagement, what may work between agencies and multi-agency planning. Rather the emphasis was on who to refer to and service-solutions. The role of housing and Careline providers could have been pivotal in both cases in terms of their contribution to engagement with the adult, environmental risk assessment and management, as well as information sharing.

Local learning and progress:

7.15 *a)* The WSSAB Self-Neglect Briefing Note: Sussex procedures to support adults who self-neglect, Version 2, June 2020, sets out new updates to the self-neglect procedures within the Sussex Safeguarding Adults Policy and Procedures to take account of learning from Safeguarding Adults Reviews (SARs) involving self-neglect. The briefing sets out the key sections of the new Sussex Self-Neglect Procedures. The procedures provide a clear pathway to assist professionals from any organisation to work using a multi-agency approach when working with adults who are displaying self-neglecting behaviours.

b) To note: RC had care and support needs, which he latterly had self-acknowledged and these had rightly been shared promptly by the police. Current WSSAB Safeguarding Thresholds (January 2020)[3] states that only exceptional cases of self-neglect will trigger adult safeguarding – all standard interventions such as Care Management & Care Plan approaches should be considered first. Sussex Police was not aware if any of these interventions had been implemented in relation to RC. Therefore, agencies will need to improve communication and information sharing to make effective use of the threshold document and also maximise joined-up approaches to planning to make efficient use of their resources.

Assessing and managing risk at individual, organisational and system levels

7.16 'Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. It is about working together to support people to make decisions about the risks they face in their own lives and protecting those who lack the mental capacity to make those decisions' [2]

7.17 The outcomes of professional and organisational interventions were disappointing in all three cases. The identification and assessment of risks, timeliness of response, appropriate communication methods, discussion between agencies and leadership when risks were identified, was poor. In all 3 cases the presenting risks at the point of crisis were not articulated in reports reviewed and no evidence of exploration of these risks with the adults or their advocates.

7.18 A root cause analysis points to a system at that time where each agency was working in a vacuum, where key agencies were experiencing operational pressures and workflow processes between agencies did not ensure robust assessment of risk and information sharing. This created an environment where the decisions made, and actions taken, did not deliver safe outcomes at all levels: individual casework, organisational priority setting and multi-agency accountability for safeguarding policy and procedure.

7.19 In the SAR report, Adult E, February 2018,[8] recommendation 4 states: 'The West Sussex SAB seek assurance from West Sussex County Council that it has reviewed and revised the operation of Care Point One and Two to ensure that concerns are responded to in a proportionate timeframe, with the appropriate staffing levels and resources, and that it has initiated a management process to advise partner agencies of response times '. It is clear from the cases that there continued to be problems with the workflow in WS ASC in May / June 2019 and particularly in relation to the operation of referral, triage, and the volume of the single combined assessment of risk forms. The management action taken to address this perpetuated increased delay in other referral activity, leading to increasing unassessed risks, as well as case management whereby case closure was considered even when support plans had not been set up and delivered.

7.20 However, WS ASC, although a lead agency for Adult Safeguarding, is part of a safeguarding system and for this to be effective requires dialogue and information sharing beyond electronic form dispatch and assumption that someone else will address risks. There was no joined up leadership of the safeguarding system in particular to review the interdependencies of managing pressures of workflow between organisations. 'Availability of resources is not seen as an acceptable reason for delay where an adult is, or may be, experiencing abuse or neglect. There must also be clear and agreed local multi-agency escalation processes in place to address any delays should these occur.'[2]

7.21 There were gaps in recording of professional responsibility, including decision-making based on risk assessment, management oversight and escalation, as evidenced in DP (initial safeguarding concern and police / ASC response), RC (SW risk assessment, brokerage failure to set up support) and AJ (NHS 111 and iC24 triage and inclusions / missing information). The record needs to be the first reference point for anyone involved in the case (and between agencies) and as up to date and accurate as possible. For example, the safeguarding concern and designated LEO for DP was recorded days after the initial referral.

Local learning and progress:

7.22 a) There is a more joined up approach across 999 emergency and NHS 111 as the information systems now talk to one another, so information is shared.

8. Recommendations

8.1 This thematic review is being completed 15 months after the three adults died and the initial serious incident review was undertaken by WS ASC. There have been significant changes to the leadership at WSCC during this time. There has however, been consistent leadership of the Adult Safeguarding function within WSCC since the SIR and this has enabled much of the progress to be made in ASC learning and improvements in relation to compliance with policy and procedures, access across agencies, workflow and appropriate assessment pathways for adult safeguarding, as evidenced across the themes.

8.2 A system-wide response to the findings and recommendations is required which is accountable for delivery to the WSCC SAB. This will support the WSSAB to deliver its 3-year Strategy 2019-2022 [6] as well as continue to assess key learning and development needs for the West Sussex Safeguarding Adult system. It will also help individual agencies consider how their own safeguarding procedures are being implemented.

8.3 There is evidence that the requirement for a system-wide understanding, sharing and transparency to managing pressures in organisations where a multi-agency response to a case of abuse or high risk is needed, has been progressed and actions taken. However at an operational level, there will continue to be a need for both individual professionals working with a vulnerable adult and organisational managers, to be supported with a process of escalation and challenge where partners experience obstacles to things being actioned according to their understanding of the presenting risks. The new West Sussex system-wide Vulnerable Adults Panel, due to commence in November 2020, will support the development of this type of working.

8.4 There is no single agency that the thematic review has identified requiring significant improvement. Moreover, it is a contention that many of the elements where improvement is required are related to the interface where two or more organisations are required to work together across, and to offer appropriate challenge as necessary to improve outcomes for adults with high risks to their health, safety and wellbeing. *'Systems thinking is a way of exploring and developing effective action by looking at connected wholes rather than separate parts'.*

8.5 Therefore, this thematic Review makes the recommendations for WSSAB and requires WSSAB to seek assurance across and between agencies that the following are addressed:

1. **Strengthen front line practice, across agencies, in conducting holistic risk assessments**

- Professionals' use of risk assessment tools can be inconsistent. With this in mind professionals from agencies involved with safeguarding adults work should be trained specifically on identifying risk and conducting together a

holistic risk assessment, and specifically how this should impact on decision making.

- The supporting guidance must be developed to include how to conduct a risk assessment when the adult declines engagement and include the importance of communication and information sharing between agencies. The new non-engagement procedure will need to be monitored and evaluated for effectiveness in support of this.

- Just as with assessments including mental capacity assessments, the importance of regularly assessing risk at critical points should be considered best practice

2. **Engage and support housing providers (including housing support providers and assistive technology support providers), care homes and GPs to be full active participants in the safeguarding system**

- Two learning review events, or virtual online learning opportunities, are recommended where the 3 cases are explored within a reflective learning framework with participants from across agencies and levels

- Include housing, care home and GP representatives at WSSAB meetings and specifically in SAR bespoke panels where needed.

3. **Implement a multi-agency 'beyond auditing' approach**

- which invites individual workers from different agencies engaged with a live case to participate in live audits of their case work. It offers them an opportunity to 'learn on the job' supported by an internal or external expert supporting best practice. Start with cases of self-neglect.

4. **Establish a reference group of people who have lived experience of the WS Safeguarding adult system to regularly engage with the WSSAB and review whether WS Safeguarding Policy and Procedures are being adhered to and outcomes are being achieved through a person-centred approach.**

   Use the learning from SARs to underpin reviews, test out 'what good looks like' for the reference group members and use accessible ways to facilitate engagement.

5. **Set a clear policy and framework for how extraordinary operational pressures (across functions / service / agencies along the customer journey) are managed**

- Particularly when impacting on compliance with adult safeguarding standards, in terms of leadership, how and where decisions are made and concerns escalated, moving staff resources around, along with engaging across agencies for support.

6. **Regularly review and audit decision making and outcomes as to when a safeguarding concern is progressed to a Care Act 2014 section 42 enquiry,**

- especially in relation to the Adult Safeguarding Hub development and the thresholds guidance, how it is being interpreted and the resulting outcomes for individuals. The system will need to assure itself that the data trends on number of referrals and progression are reflecting the up-to-date level of concerns and presenting risks across West Sussex. Keep in mind the ability for Local Authorities to conduct a non-statutory enquiry when the adult would benefit from early intervention and ensure referral pathways are established and embedded. The pathway should focus on a timely multi agency approach.

- It is recommended for the Adult Safeguarding Hub development and leadership of improvements as to how Safeguarding is operating across the system in West Sussex, to widen triage at the Hub to include NHS community health representatives.

9. Glossary

ASC: Adult Social Care

CP1 (as at May 2019): CarePoint 1; this is the initial point of contact for the vast majority of enquiries in relation to Adult Social Care at WSCC. CP1 is staffed by Customer Service Advisors, who provide information and advice to simple queries but forward new requests for social care support or safeguarding concerns to CP2 for further assessment

CP2 (as at MAY 2019): CarePoint 2; this undertakes initial assessments of need and information gathering for all referrals including those for assessment and safeguarding concerns received by WSCC. It is staffed by trained Assessment Officers and qualified Social Workers and Occupational Therapists. In relation to safeguarding, its primary function is to ensure immediate actions have been taken to make a person safe where needed and to establish whether concerns are sufficient to require a Safeguarding Enquiry as mandated by Section 42 of the Care Act 2014

IMR: Individual Management Review

LEO: Lead Enquiry Officer for an adult safeguarding enquiry

MCA: Mental Capacity Act 2005

MDT: Multi-disciplinary team

OOH: Out of Office Hours

PAT: Prevention and Assessment Team

RAIT: Rapid Assessment and Intervention team

SAR: Safeguarding Adult Review

SCARF: Single combined assessment of risk form

SECAmb: South East Coast Ambulance NHS Foundation Trust

SIR: Serious Incident Review

VAAR: The Vulnerable Adult at Risk section of the SCARF

WSSAB: West Sussex Safeguarding Adults Board

10. References

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6. West Sussex Safeguarding Adults Board 3-year strategy 2019-2022

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11. Reviewer

Claire Foreman is an independent health and social care consultant and has previously held senior roles at Executive Director level in public and not-for-profit organisations including Adult Social Care. She was Chair of the Safeguarding Adults Board on the Isle of Wight, worked as a LGA Professional Lead Advisor - Safeguarding Adults Programme, to support the national implementation of the Care Act 2014, and has carried out detailed safeguarding inspections as an independent consultant. As an Executive Board member of Healthwatch Hampshire and Healthwatch Slough she gained experience of developing the role of the consumer voice in health and social care service development and delivery.