West Sussex Safeguarding Adults Board
Making Safeguarding Personal

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Executive Summary: Desktop Review in respect of BK

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1. Introduction and overview

1.1. This is an executive summary of a Desktop Review, undertaken by Independent Reviewer, Pete Morgan. The West Sussex Safeguarding Adult Board (WSSAB) commissioned this Review following the death of BK, a 65-year-old man who was found deceased at his home on 5 December 2019. It was suspected that he had been deceased for around eight weeks. Prior to BK's death there were concerns regarding his ability to manage his personal care, a lack of money to buy food and electric, and concerns regarding rent arrears.

1.2. Following BK's death, West Sussex County Council (WSCC) commissioned a Serious Incident Review (SIR), which was completed in July 2020. The SIR identified that there had been long intervals in the time between visits by agencies and missed opportunities for multi-agency involvement. A referral was made to the WSSAB, who then progressed with a Desktop Review. The Review looked to establish any learning about the way in which agencies worked together to safeguard BK and produced recommendations for the WSSAB to take forward to seek assurance.

1.3. Involved agencies were West Sussex Adult Social Care; GP; Age UK; London & Quadrant Housing, and the Department of Work and Pensions.

2. About BK

2.1. Little is known of BK's history. He was estranged from his family. It is known that he had at least one daughter, however, for unknown reasons, had not been in contact with her for some time. The Coroner contacted his daughter in January 2020 when she offered the opportunity to contribute to the Review, however no response was received. It would appear that BK was a solitary man, with no known local friends. There is a suggestion that he had possible difficulties with reading and writing, minor health issues and a minor physical disability that required him to wear a calliper.

2.2. BK was found to have died of natural causes and his death cannot be causally linked to his self-neglect. The Reviewer concluded that it is, therefore, unlikely that different interventions by any of the agencies would have prevented his death. However, his quality of life during the last five months of his life could have been improved.

3. Areas of learning identified

3.1. The Review found that there was a lack of knowledge of policy and procedures regarding the Mental Capacity Act, the Care Act, and self-neglect, and a need for more effective multi-agency working, information-sharing, staff supervision and professional curiosity.

4. Recommendations

4.1. The Review period coincides with a period of change in safeguarding systems and processes. A number of changes had been put in place prior to the Review commencing; these have been summarised below.

4.2. The WSSAB should seek assurance that:

4.2.1. Adult Social Care is accurately informing partner agencies, particularly in the voluntary and independent sectors, of the services they can provide.

4.2.2. Partner agencies, particularly Adult Social Care, are enabling staff to identify and record possible cases of self-neglect and ensuring that appropriate on-referrals are made either to the multi-agency Safeguarding Procedures or the lower-level multi-agency forum.

4.2.3. Adult Social Care is effectively screening all safeguarding concerns on a multi-agency basis and in accordance with Making Safeguarding Personal.

4.2.4. Members effectively acting as conduits of information to their host agency or constituencies, particularly the voluntary and independent sectors, with particular reference to any changes to the process for raising safeguarding concerns, are effectively communicated with, with sufficient notice to enable them to revise their internal safeguarding procedures.

4.2.5. All Safeguarding concerns are effectively triaged and only signed off by an appropriate manager.

4.2.6. Systems are in place to link repeat safeguarding concerns and to enable referrers to update existing safeguarding concerns.

4.2.7. The escalation process within the Safeguarding Procedures is being effectively implemented.

4.2.8. Partner agencies, particularly Adult Social Care are encouraging staff to exercise "professional curiosity" in their interaction with adults.

4.3. An action plan is in place to seek assurance for remaining recommendations. These have been summarised below.

4.4. The WSSAB should seek assurance that:

4.4.1. Local housing providers' tenancy allocation procedures comply with the Mental Capacity Act 2005.

4.4.2. Partner agencies, particularly Adult Social Care, ensure that all cases of possible self-neglect have formal assessments of mental capacity.

4.4.3. Partner agencies are ensuring their staff, and those of services they commission, are trained and monitored to ensure they are implementing the Mental Capacity Act 2005 in accordance with the supporting Code of Practice, particularly section 2.11 re Unwise Decisions, correctly.

4.4.4. GP Practices are making appropriate referrals to ASC under the Care Act 2014 for section 9 and 10 assessments.

4.4.5. Adult Social Care is appropriately offering assessments under s9 and s10 of the Care Act 2014 and involving Independent Advocates under s67 of the Care Act 2014 when adults are having difficulty engaging with the assessment process.

4.4.6. Partner agencies, particularly Adult Social Care, are maintaining contact with cases of possible self-neglect while they are awaiting consideration in any multi-agency forum or procedures.

4.4.7. All referrals to Adult Social Care for possible self-neglect are referred either into the multi-agency Safeguarding Procedures if they meet the criteria of s42 of the Care Act 2014, or to the lower level multi agency forum if they don't.

4.4.8. Partner agencies, particularly Adult Social Care, have effective supervision procedures in place to enable staff to reflect on their professional practice and to enable managers to appropriately challenge that practice.

4.5. The Reviewer also identified good practice by individual workers and agencies and requested that this is recognised by the WSSAB. Areas of good practice have not been included in this summary, however, will be shared with the WSSAB as requested.