BK Desktop Review Learning Briefing

About BK

BK was a 65-year old man who was sadly, found deceased at his home, and it was suspected that he had been deceased for around 8 weeks although the coroner advised it was not possible to give a precise timescale. Little is known of BK's history; he was estranged from his family and had no known local friends. It would appear that he was a solitary man, with possible difficulties with reading and writing, minor health issues and a minor physical disability. He had not been known to West Sussex Adult Social Care.

However, there had been concerns prior to his death regarding BK's ability to manage his personal care, a lack of money to buy food and electric and, concerns regarding rent arrears.

The West Sussex Safeguarding Adults Board (WSSAB) commissioned a Desktop Review which examined the actions of involved agencies to identify learning and actions to reduce the risk of BK's circumstances reoccurring in the future.

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

Learning for you to take forward in your practice:

- Knowledge and implementation of the Mental Capacity Act
- Implementation of the Care Act 2014
- Safeguarding Practice
- Multi-agency working
- Staff Management and supervision
- Professional Curiosity

Resources you can use to ensure your practice is current and reflects learning from this case:

- Mental Capacity Act
- Care Act
- Pan-Sussex Safeguarding Policy and Procedure
- Self-neglect Briefing
- Professional Curiosity Learning Briefing
- Escalation Policy

For cases where an individual is putting themselves or others at significant risk by refusing services and all options have been explored and, the level of risk is still high, a referral to MARM should be considered.

Questions to ask yourself in relation to the recommendations

The Review's recommendations have been developed into an action plan, which will be monitored to seek assurance that these have been implemented. In summary, these are the areas of practice that require consideration:

Compliance with policy, procedure, and process:

- Are you confident your practice complies with the Mental Capacity Act including, assessing mental capacity for each decision required for those who self-neglect?
- In terms of making safeguarding personal, do you ensure that any safeguarding concerns reported involve the person and/or includes their wishes?
- Are you aware of the Escalation Policy and how to implement this?
- Does your supervision enable you to reflect on your practice and, includes managers appropriately questioning practice where required?
- Is there robust and defensible decision making of closing self-neglect cases where risk remains or is unknown.
- Are you aware of the need for professional curiosity and, are you confident that you consistently practice this?

Referrals and assessment

- Are you consistently referring to Social Care when needed?
- Are you involving Independent Advocates if required?
- When you identify possible self-neglect, are you ensuring that appropriate onward referrals are made?
- Are you ensuring that contact is maintained with cases of possible self-neglect while they are awaiting consideration in any multi-agency forum?

Information sharing and dissemination

- Are you informing partner agencies, particularly in the voluntary and independent sectors, of services and support provided?
- Does your agency have robust methods to disseminate information effectively, particularly in relation to the process for raising safeguarding concerns?