West Sussex Safeguarding Adults Board
Making Safeguarding Personal

Learning briefing
Safeguarding Adults Review in respect of Colin

What do we know about Colin?

Colin was a 77-year-old man who lived in his own home with his wife, Doreen, their son, and Doreen's mother.

Colin was described by his wife as the solid foundation of the family; a man who was physically and mentally strong, who could turn his hand to anything. He was interested in joinery and cars and kept parrots and parakeets. Doreen described their relationship as long and happy, and shared that Colin had a special relationship with his son, characterised by a good insight into the challenges that he experienced.

Unfortunately, during their son's early childhood, Colin suffered a stroke, which led to Doreen taking on the role of Colin's carer for the sixteen years prior to his death. This was a difficult time for the family. Further to this, every member of the household had care and support needs, which contributed to a challenging environment.

What happened?

In October 2022 Colin was admitted to hospital. He died 18 days later, with a recorded cause of death of sepsis and multiple infected pressure sores.

At the time Colin was admitted to hospital, he was physically disabled following a stroke, with limited mobility. He was diabetic and had an increased risk for pressure ulcers. The primary issue recorded in the Safeguarding Adults Review referral was the deterioration of Colin's physical health in relation to pressure ulcers, in the wider context of self-neglect. Prior to his hospital admission, Colin's contact with services was primarily with the General Practitioner (GP), podiatry, community nursing, occupational therapy, and ambulance services. Services repeatedly recorded that Colin declined assessments, treatment, and equipment.

> **"There was an ongoing assumption of capacity in terms of the decisions that Colin made, thus his presentation and resulting situation can be considered as self-neglect."**
>
> **Anna Berry, report author**

What have we learned?

The Safeguarding Adults Review identified five key findings during the review of the circumstances leading to Colin's death. We'll explore those findings here.

Key finding 1: Legal literacy

Cases involving self-neglect can be extremely difficult for staff. They require an understanding of capacity, identified lifestyle choices, and risk, with often no legal basis for intervention. For this reason, it is paramount that staff understand the interface between self-neglect, and legislation, namely the Mental Capacity Act, and the Care Act. This is known as 'legal literacy'.

Key finding 2: Multi-agency coordination

To ensure effective multi-agency communication, risk assessment, and escalation as needed, staff must familiarise themselves with, and refer to, local self-neglect procedures. These provide a clear framework for managing self-neglect cases.

Key finding 3: Professional or concerned curiosity

Professional or concerned curiosity is a core responsibility for all staff across the health and social care sector. We must not be afraid to 'dig deeper' into areas where we feel we are missing information; this information can help to inform our assessments and support our decision-making.

Key finding 4: Family involvement

Family involvement, and seeking the views of the family unit, are important aspects of working with adults with care and support needs, especially where a family member has the role of carer. Staff need to have confident and courageous conversations with the adult, their carer, and other important family members.

Key finding 5: Making Safeguarding Personal

We know that the principles of Making Safeguarding Personal are central to all adult safeguarding work. Staff need to ensure that they never lose sight of this, and that they understand how to apply these principles into their practice, at every stage.

What do we need to do differently?

The report makes recommendations to share learning in order to improve practice across the partnership. To ensure your practice reflects learning from Colin's review, please support these recommendations by considering the following:

- Is your knowledge of key legislation up-to-date, namely the Mental Capacity Act and the Care Act? Do you understand how these legislative practices link in with self-neglect practice in West Sussex?
- Are you familiar with both the Sussex self-neglect procedures and the Sussex Escalation and Resolution Protocol? Do you regularly refer to these to support your practice?
- Are you routinely employing the principles of Making Safeguarding Personal and practising professional or concerned curiosity? Are these practices informing your decision-making when working with adults with care and support needs?
- Do you have a 'Think Family' approach to safeguarding? This includes ensuring that you are aware of the process for carers assessments, including identifying the need for carer assessments, and how to refer.

Where do we go from here?

> **"This review shines a light on the different ways that the system as a whole could have responded to self-neglect and worked with him and his family in a different way.**
>
> **It is likely that Colin would have experienced an improved quality of life […] if his overall care and support had been responded to in a more connected and multi-agency way using the range of legal powers available."**

Anna Berry, report author

You can continue your learning with the following resources:

- Access the Sussex Self-Neglect Practice Guidance for Staff and the Sussex Safeguarding Escalation and Resolution Protocol
- Access our multi-agency working learning resources
- Access our professional or concerned curiosity resources
- Access our language and terminology learning resources
- Access the Sussex Safeguarding Adults Policy and Procedures discriminatory abuse chapter