Safeguarding Adults Partnership Board Practitioner Briefing

Safeguarding Adult Review - Arthur

What is a Safeguarding Adult Review (SAR)?

The Care Act 2014 statutory guidance says that a Safeguarding Adult Board must arrange a SAR when the following criteria is met:

- When an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

- If an adult in its area has not died, but the SAB knows or suspects that the adult has experienced serious abuse or neglect.

This SAR was undertaken on a male who we shall call Arthur, to respect his anonymity. The SAR was initiated whilst Arthur was alive and it was reported that he neglected his own health and wellbeing, and appeared to have hoarding behaviours. The referral, for a SAR, concluded that Arthur was a "vulnerable adult" with limited mobility, who had suffered significant harm due to potential neglect to his wounds.

In the case of Arthur all agencies were required to provide Independent Management Reviews (IMRs) and a chronology of their involvement with Arthur. In addition, a practitioner's event took place which explored key episodes and events within the timeframe being reviewed by the SAR enabling professionals to talk through their experiences in a safe and learning environment.

Changes since the SAR for Arthur

- During early 2019 Multi-Agency Risk Management (MARM) Guidance was developed and launched within workshops across the region. 137 professionals attended the workshops. The **Multi Agency Risk Management Guidance** sets out a co-ordinated, multi-agency response designed to protect adults deemed most at risk to ensure that any significant issues raised are appropriately addressed. It seeks to provide frontline professionals with a framework to facilitate effective working with adults who are at risk; where that risk may lead to significant harm or death and the risks are not effectively managed via other processes or interventions.

- Workers are encouraged to have regular meetings or 'huddles' regarding cases where there are safeguarding concerns to look at risks and how to work effectively together with the adult at risk.

- Self- Neglect and Hoarding multi-agency training has been developed and designed and is available through the Safeguarding Boards Training Brochure. Lived Experience of the Adult at Risk workshops were cascaded across the region earlier this year. 71 professionals from a variety of agencies attended. Arthur's case study was used as an exercise for ascertaining what the safeguarding issues were, what the roles of responsibilities of professionals should be and how agencies could work together to

minimise risks and safeguard the adult at risk. A task and finish group is being set up to develop practitioner guidance on the lived experience of the adult at risk.

- Over the next few years, Making Safeguarding Personal and embedding the learning from SARs (including Arthur's SAR) are priorities, for the Adult Safeguarding Partnership Board.

- Each agency involved within the SAR have a number of recommendations to action within their organisation. An Action Plan of the recommendations for Arthur's case is reviewed and revisited at the Safeguarding Adult Review Subgroup.

Background

Very little was known about Arthur's life until after the completion of the Safeguarding Adult Review. Arthur was 60 years old and lived alone in a first floor housing association flat. He was registered as disabled, having type 2 diabetes and a below the left knee amputation. He had limited mobility and used a wheelchair, which was stored in a hall cupboard for outside use as it was too big to use around the flat.

Arthur was generally isolated and did not see many people apart from those agencies working with him and a friend, who was his neighbour. His neighbour characterised him as a 'cantankerous, angry, miserable and embittered bloke' but also described a mutually supportive relationship.

Arthur's case is a complex one and involved a number of professionals working with him. He spent a number of times in hospital with regards to his amputation site becoming infected, swollen and on one occasion maggot infested. Whilst in hospital Arthur was generally compliant and his health improved and he was discharged back home. District Nurses visited Arthur to change his dressings and the General Practitioner (GP) was often contacted and completed home visits when Arthur's health deteriorated. Ambulance practitioners attended the home to take Arthur to and from hospital on occasions. Occupational Therapists visited and made referrals for a commode and a different wheel chair for Arthur so he could get around the flat. The Fire and Rescue Service also visited as there were hoarding concerns regarding Arthur living in a flat that was cluttered, that he had been smoking and using candles to give light in his home. Housing Officers visited, with regards to his hoarding and one was allowed in whilst another was told to 'go away'. Most of these professionals noticed that Arthur had been using empty milk bottles as a toilet and that the flat was scattered with belongings and furniture.

Each professional agency had various bits of information regarding Arthur's mobility, though they were often at odds to each other as to whether Arthur was mobile and able to get around and in and out of his flat. At the time of the referral to complete a Safeguarding Adult Review, Arthur is reported as having expressed a wish to move to alternative housing, but for most of the time covered within the SAR he expressed a strong wish not to move.

There were a couple of referrals to Adult Social Care, once Arthur had said yes to the professionals raising their safeguarding concerns with him, but when social care contacted him by telephone he would refuse their help. Arthur missed outpatient health appointments scheduled at the hospital and with his GP. On one occasion his case was closed by the District Nurse when he said that had managed to get out with friends and in response he was advised to see the practice nurse at his GP surgery in order to get his bandages changed.

Arthur appeared to some professionals as being exasperated at particular services that he felt should have helped him when he first had his leg amputated and at the wheel chair service for their lack of action. To an occupational health professional he asked them to just 'give me a gun' indicating how frustrated and [maybe] distressed Arthur really was.

Sadly, Arthur, died in 2018 and his cause of death was recorded as cardiac arrest, peripheral vascular disease, hypertension, sepsis, type two diabetes and hyperosmolar hyperglycaemic state.

As part of the Safeguarding Adult Review his neighbour was able to give some insight into Arthur's life. He explained that Arthur did have a job and enjoyed that it allowed him to travel around the world but that he lost his job due to an industrial accident. At the time of his amputation he had lost his three bedroomed house and had to move all the contents into the one bedroomed flat. The neighbour reported that Arthur was only able to get out of his flat when his small group of friends helped to lift him in and out of the building navigating him through hallways and into the lift. Arthur was embarrassed about his legs and his incontinence.

Key Learning Points for Professionals

Self- Neglect

All of the agencies involved with Arthur were able to identify areas of Arthur's self-neglecting behaviours, though none ascertained from Arthur when his self- neglect started nor the reasons why. Many of the Professionals within Arthur's case lacked **'professional curiosity'** as to how and why he was living the way he was. A number of agencies failed to ask Arthur about his current life situation or his past life experiences.

No agency took the lead to co-ordinate assessments and planning for Arthur and no multi-agency meetings were held to discuss ways forward for working together to support Arthur. Instead agencies worked largely in isolation.

Arthur explained to some professionals that he had not been out of his flat for months, though his '**social isolation'** was never assessed nor investigated further.

Hospital Discharge

Discharge plans were clear but the referral processes for on-going home care were not followed through in every instance of Arthur being discharged from hospital. The Housing Association was not included within the discharge plan when there were concerns about his accommodation and his reluctance to move.

When discharging patients discussions and discharge plans should consider the suitability of the accommodation and home conditions. Key agency's working with the service user should be part of the planning process. Plans should also contain a case history of previous admissions including areas of concern such as self –neglect and a discharge checklist. The checklist and discharge plans should be completed for every patient case and recorded on file.

Working Together

There were highlighted some good areas of practice where the Housing Officer maintained contact with Arthur and liaised with the Fire and Rescue Service and the Occupational Therapist. However, each agency held bits of information about Arthur, his health, their observations of him and his living conditions, yet they all tended to work in isolation. This resulted in the agencies not having a holistic view of Arthur, his lifestyle or of his care and support needs.

Professionals when working with complex cases should have clear policies and procedures regarding agencies working together to safeguard the adult at risk. There needs to be clear communication between agencies. In Arthur's case **Multi-agency meetings** might have overcome this and may have led to greater engagement with Arthur and better outcomes by combining assessments and planning.

Disguised Compliance

Arthur was willing to speak with some professionals and to let them into his home environment but not with others.

Arthur may have been offering **disguised compliance** to some professionals for a number of reasons only known to Arthur and how he felt at the time. However, the practitioners involved in the case should have been '**respectfully uncertain'** and checked out with Arthur and with the other agencies what he was telling them. This may have changed initial assessments and planning by some agencies, avoided the closure of his case when he needed health provision and given a true picture of what was happening in Arthur's life.

An illustration of this was when Arthur stated, to some professionals, that he could leave his flat and to others that he had not left his flat for months. For those whom he told that he could leave the flat he was never asked how he could actually physically manage to do that. A **'show me'** approach might have indicated whether or not he could execute his stated decisions.

Policy and Procedures

Professionals should be aware of their agencies policies and procedures and know where to find them and how to access them. Practitioners should adhere to multi-agency policy and procedures for supporting people who self- neglect and for working with people who display hoarding behaviours. In Arthur's case, for some agencies the risk assessment indicator tool in the policy was not used when it would have indicated that a section 42 enquiry was appropriate and there was no consideration of whether his behaviour and lifestyle amounted to hoarding.

Safeguarding

Professionals should be aware of multi-agency policies on hoarding and self-neglect and follow procedures when this becomes a safeguarding concern. Agencies should consider a multi-agency approach as part of a safeguarding enquiry. (working together / multi-agency safeguarding meetings).

When there are repeated patterns of self- neglect and increased difficulties with everyday living or an escalation of risks; safeguarding referrals/meetings should be considered.

Mental Capacity

Arthur's mental capacity was never formally assessed; even though his behaviour and circumstances could have been considered reason enough (sepsis, infections and not coping) to question his decisional capacity. There was a lack of recognition that Arthur was unable to carry out his own good intentions at times which could have led to consideration of his executive capacity.

Some agencies may not have a statutory duty to undertake mental capacity assessments, as in Arthur's case. However, they may be the best placed agency to do so by virtue of their

knowledge of the person and of the question to be decided as to whether an individual does indeed have the mental capacity to take a specific decision at a specific time.

Professionals should use mental capacity assessments tools and be clear in their analysis and recording what elements of mental capacity are being assessed.

Assessment

*When completing assessments professionals should include an analysis of the person's history (service provision and life experience) that may include patterns, **risks** and **resilient** factors to inform the assessment and plan of support for the individual. Holistic assessments should involve other agencies, extended family and friends and the person involved.*

In Arthur's case, there was limited evidence of risk assessments being completed nor of evidentially supportive risk assessment tools, for assessing self-neglect, being used. *Professionals should be aware of risk assessment indicator tools available within agency practice and when to use them to support their assessments*.

Within assessments 'mental health' should be considered as well as 'physical health'. There were no assessments of Arthur's mental health despite one reference to "significant mental health problems" by one professional and another noting a history of low mood and depression.

Assessments are most effective when completed face to face and in the individual's home environment so that a full picture can be seen of where and how they are living, what care and support needs they may have and what their reactions and expressed feelings are (non- verbal communication).

Assessments should be timely, in Arthur's case some assessments took a significant time to start and be completed which lead to delays of care and support with Arthur having to chase his own referrals.

Recording

Professionals should keep clear and accurate records of the individual concerned including visits, telephone calls, meetings, assessments and referrals. Records need to be: clear, concise, void of agency jargon, up to date and have management oversight.

In Arthur's case some agency records were incomplete or unclear. Records of referrals were missing and no indication of when and if visits took place. Multi-agency meetings were not recorded and case files did not contain senior management oversight. On some files, the incorrect details for Arthur had been recorded which lead him missing out on health provision and it was not clear, from the records, what advice had been given to Arthur by various professionals.

Making Safeguarding Personal – The Lived Experience of the Adult at Risk

Building relationships. There was little evidence that anyone sought to understand Arthur's life history or the rationale behind any of Arthur's decisions, for example no one asked why, at times he refused help, failed to respond to telephone calls or letters and missed medical appointments. The intention, by practitioners, may have been to respect Arthur's choices and to promote his independence but this approach underplayed the apparent health risks.

Professionals should consider how to mitigate the risks arising from an individual declining services and failing to keep appointments. Agencies must consider why someone may not be responding, and consider using a different approach to engage with the service user. In Arthur's case it was suggested that 'a more assertive outreach approach, coupled with an exploration of his choices and the history behind them, may have proved more effective'.

It was identified from the learning event that Making Safeguarding Personal (MSP) was misunderstood by some practitioners. Yet in some instances his case to services was closed due to his wishes, which showed a strong adherence to MSP. However, by practitioners taking his wishes at face value they did not balance those wishes against the levels of risk to his health and wellbeing.

Practitioners should always communicate with the adult at risk and ascertain their thoughts, feelings and wishes; though at the same time professionals should find out the reasons why services are being declined and weigh up what the risks of significant harm are for that individual if services are not implemented or are withdrawn.

Friends and Family. In Arthur's case his neighbour played a big part, calling the ambulance for him, tidying and decluttering his flat and speaking to professionals. However, the neighbour was not recognised as a carer nor asked about Arthur's past life nor his current life experiences.

In order to ascertain the lived experience of the adult at risk professionals need to communicate with friends, family and carers to find out the wider history and life of the individual. Working alongside significant others helps to safeguard the adult at risk.

Further Information

Adult Safeguarding Partnership Board Website
http://www.safeguardingcambspeterborough.org.uk/adults-board/

Multi-Agency Safeguarding Training
http://www.safeguardingcambspeterborough.org.uk/availabletraining/

Safeguarding Adult Reviews
http://www.safeguardingcambspeterborough.org.uk/adults-board/about-the-adults-board/sars/

Multi-Agency Risk Management Guidance (MARM)
http://safeguardingcambspeterborough.org.uk/adults-board/information-for-professionals/cpsabprocedures/multi-agency-risk-management-guidance/

Leaflets, Resource Pack and Information on Self Neglect
http://www.safeguardingcambspeterborough.org.uk/adults-board/about-the-adults-board/leaflets/

http://safeguardingcambspeterborough.org.uk/adults-board/information-for-professionals/neglect

Multi-Agency Policies and Procedures
http://www.safeguardingcambspeterborough.org.uk/adults-board/information-for-professionals/cpsabprocedures/hoarding/
http://safeguardingcambspeterborough.org.uk/adults-board/information-for-professionals/selfneglect/

Social Care Institute for Excellence
https://www.scie.org.uk/self-neglect/at-a-glance