Adult W Learning Briefing

The Background

Adult W had a history of self-neglect and non engagement with key agencies involved with him. He had multiple mental health diagnoses, heart problems, dementia and substance misuse issues. He was last seen by the Community Mental Health Team in 2016 with poor short-term memory and cognitive decline, self-neglect and concerns about his hygiene. Adult W had been offered input from services and rehousing but records state he declined these interventions.

Safeguarding Concerns

In early June 2019 Adult W was seen by his GP and referred to Adult Social Care urgently with safeguarding concerns in relation to self-neglect and vulnerability. The GP report that Adult W may have had a better outcome had services considered the concerns about the severity of self neglect he was experiencing, assessment of his capacity and his disengagement from agencies.

Prior to Adult W's death, a safeguarding referral from the supported housing provider to adult social care noted that…*'He is not eating properly, he drinks heavily every day. His property is in a very bad state, He has not changed his clothes for months. His shoes have no soles. He has been found wondering around the block where he lives and in a very confused state'*

Adult W had a history of falls and the most recently fall before his death he was seen by the GP practice and subsequently admitted to hospital. A safeguarding referral was made by the Ambulance Service to Adult Social Care at this point which reported self neglect of Adult W's home and of himself.

Adult W was assessed and offered social support but he declined and was discharged back home.

The Incident

Adult W was found deceased in his armchair in June 2019 and the case was referred to the Coroner as an unexpected death in the context of neglect. The cause of death was heart disease. The Southampton Safeguarding Adults Board received a referral for Case Review Group for Adult W for consideration from his GP Surgery. The Safeguarding Adult Board (SAB) Case Review Group recommended that, although the case did not meet criteria for statutory or discretionary review, it would like to produce a review briefing to explore the concerns, multi-agency response and multiagency learning from Adult W's case.

Learning

There had been a number of concerns about Adult W's wellbeing and ability to make decisions about his ongoing care and support. Adult W was clear that he wished to remain independent whilst he was still mobile in spite of concerns about his ability to care for himself. Capacity assessments completed supported his decision making.

The following learning points were identified by agencies involved with Adult W:

1. **Understanding and implementation of the law**
   The Care Act 2014 – a Safeguarding Referral should have been submitted to Adult Social Care which detailed the severity of Adult W's self neglect. Adult W was a very independent gentleman, but acknowledgement and risk assessment of his self neglect appeared lacking.

2. **Mental Capacity Act**
   A robust, decision specific assessment was required of Adult W's mental capacity in view of his continued fluctuating capacity in the context of mental illness and alcohol abuse, disengagement with services and alcoholic dementia.

3. **Making Safeguarding Personal (MSP)**
   There was poor engagement between Adult W and health and social care professionals who needed to complete a holistic assessment to consider why Adult W did not want support and what the history behind those decisions was. Engagement with an independent Advocate should have been explored with Adult W.

4. **Professional curiosity and challenge**
   There was lack of professional curiosity and challenge in acknowledgement and risk assessment of Adult W's self neglect, and assessment of Adult W's capacity. There were missed opportunities to make a difference to Adult W due to a lack of professional understanding of the complexity of Adult W and his history.

Good Practice

- Adult W was offered many opportunities to accept support and services.
- The challenges associated with his strong views to remain independent were considered, however, this may have led to Adult W's needs not being met and may prevented the professional curiosity needed to complete holistic risk assessment of Adult W's self neglect.
- Supported Housing staff were mindful of the need to monitor Adult W and recorded and acted on his wishes. Safeguarding concerns about Adult W were identified and acted upon by Housing staff.
- Liaison with GP by Supported Housing Provider was timely and responsive to his changing need for their observation not to be intrusive.

Recommendations and actions

1. Use of the 4LSAB Multiagency Risk Assessment Framework to coordinate a multi-agency response network and planning when safeguarding criteria has not been met.
2. Professionals to utilise supervision and training opportunities to facilitate reflective practice for complex case work.
3. Professionals and agencies to seek specialist support from their MCA leads for complex assessment.
4. To ensure that decisions to self discharge from health settings are supported by Mental Capacity assessments where there is concern that the person has an impairment to their cognitive functioning or lack of capacity has been indicated
5. If a safeguarding concern is noted then professionals involved with an individual should maintain contact with them to be able to respond to changes in their wellbeing.
6. The role and responsibilities of Housing Services and commissioned providers to be clear in identifying and responding to adults at risk.
7. Professionals need to consider referral to specialist services such as substance misuse for

Useful links for good practice

- Southampton SAB Website
- 4LSAB MARM and appendices
- 4LSAB working with self neglect guidance
- 4LSAB Escalation Policy
- Fluctuating Capacity and the Law – Community Care Briefing (Tim Spencer Lane)
- Blue Light Toolkit – Working with change resistant drinkers
- One Minute guide to self neglect
- One Minute guide to advocacy