OLDHAM SAFEGUARDING ADULTS BOARD

THEMATIC SAFEGUARDING ADULT REVIEW
EXECUTIVE SUMMARY

SELF-NEGLECT with SUBSTANCE MISUSE and MULTIPLE EXCLUSION HOMELESSNESS

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1. Introduction

1.1. Oldham Safeguarding Adults Board (OSAB) received four referrals for consideration as Safeguarding Adult Reviews (SARs) between November 2018 and April 2019.

1.2. The case of Desmond[1] was referred by Oldham Adult MASH on 14th November 2018. He died in the waiting area of an Integrated Care Centre aged 43. Cause of death was respiratory depression, with alcohol, cocaine and benzodiazepines as associated factors. He had been homeless, with a history of self-neglect and substance misuse.

1.3. The case of Kasia was referred by Greater Manchester Police (GMP) on 30th November 2018. She died at home, aged 34, at which time she had been at risk of homelessness. She had a history of substance misuse and self-neglect. An inquest into her death is scheduled for February 2020.

1.4. The SAR sub-group of OSAB decided to commission a SAR with respect to these two cases on 8th January 2019 on the basis that the mandatory criteria in section 44 Care Act 2014 had been met. Both adults had care and support needs, had died as a result of abuse and/or neglect, which includes self-neglect, and there was concern that the agencies involved could have worked together more effectively to protect them.

1.5. On 2nd April 2019 GMP referred the case of Joshua who died at home, aged 62. Cause of death was carcinomatosis, carcinoma lung and ischaemic heart disease. There was a history of self-neglect and he had regularly used alcohol and cannabis. His housing situation was insecure at the time of his death. The SAR referral observed that he slept on a mattress on the floor, with urine and faeces within the property. A decision to commission a mandatory SAR was made by the OSAB sub-group on 25th April 2019.

1.6. On 24th April 2019 Pennine Care Foundation Trust (PCFT) referred the case of Aubrey who died in a fire at home, aged 76. The Coroner returned a verdict of misadventure, cause of death being carbon monoxide poisoning. The OSAB sub-group decided that the mandatory criteria for a SAR were met on 9th May 2019. There were evidence of self-neglect, including a history of alcohol abuse.

1.7. All are recorded as having been White British.

1.8. Owing to the theme of self-neglect permeating the referrals, OSAB decided to commission a thematic review for learning from recurring themes that would indicate systemic issues to be addressed. From the SAR referrals and initial chronologies, the following themes were identified as the initial terms of reference:

- Responses to self-neglect;
- Pathways into mental health services;
- Responses to non-engagement;
- Responses when adults are homeless or threatened with homelessness;
- Responses when adults are engaged in long-term substance misuse;

[1] All names have been changed for the purposes of anonymity and confidentiality.

- Responses to repeating patterns;
- Partnership and collaborative working;
- Notifications of concerns and safeguarding pathways;
- Risk assessment and mitigation planning;
- Mental capacity assessments;
- Responses to concerns about care providers.

1.8.1. It was agreed that the information made available by the agencies involved would be compared and contrasted with the evidence-base that is available for working with adults who self-neglect[2]. This evidence-base has been extended to incorporate what is known about best practice with adults who misuse substances and/or are homeless. The aim of the thematic review is to present an analysis of the degree to which practice and policy in these four cases corresponded with "what good looks like".

1.8.2. The review adopted a whole system focus. What enables and what obstructs best practice may reside in one or more of several domains. Individual agency chronologies, incorporating analysis and reflections regarding their involvement, were submitted by partner agencies. It was agreed that the chronologies would report in detail contact with the individuals whose cases were being reviewed from January 2016 (Kasia and Joshua) and March 2017 (Desmond and Aubrey), whilst also highlighting significant events prior to that date. The chronologies were combined by the reviewer and discussed by the review panel. This process generated further questions and generated requests for additional information from the agencies involved, responses to which were also discussed by the review panel. Themes emerged from this volume of information, which were explored at a well-attended learning event.

1.8.3. As advised by the statutory guidance[3], family members were approached to invite their participation in the review. Family members of Joshua and Aubrey declined the opportunity to participate in the thematic review.

1.8.4. The independent reviewer and the chairperson of the review team met with Desmond's father and also with Kasia's mother and step-father. The independent reviewer is very grateful for the reflective insights that they were able to offer about the involvement of services.

[2] Braye, S., Orr, D. and Preston-Shoot, M. (2014) *Self-Neglect Policy and Practice: Building an Evidence Base for Adult Social Care*. London: Social Care Institute for Excellence. Preston-Shoot, M. (2019) 'Self-neglect and safeguarding adult reviews: towards a model of understanding facilitators and barriers to best practice.' *Journal of Adult Protection*, 21 (4), 219-234.

[3] Paragraph 14.165 DHSC (2018) Care and Support Statutory Guidance: Issued under the Care Act 2014. London: The Stationery Office.

2. Four Cases

2.1. Desmond was homeless at the time of his death. He had had multiple contacts with police, A&E services and a walk in centre, and considerable involvement with Adult Social Care, housing services, mental health and substance misuse services. He had been a frequent flyer. Desmond had a history of violence and was registered with his GP under the violent patient scheme. He had previously been de-registered by a GP because of violent behaviour. His interactions with services could be abusive and aggressive. The majority of agencies who had been involved with Desmond had discharged him due to a lack of engagement. There is no evidence of any agency taking on a co-ordinating role.

2.2. Agencies do not appear to have considered Desmond's mental capacity for any decision. There is no evidence of recognition by services that, if Desmond did have mental capacity for his lifestyle decisions, that this could be viewed as self-neglect. There is limited evidence of multi-agency communication and multi-agency working. When referrals were made to an agency, they were often closed to one agency under the premise of being open to another.

2.3. There is limited evidence of any risk assessment and planning in response to assessed risks. There appears to have been limited engagement with his family network or consideration of pathways into mental health support. Before the period under review, in 2015, his mental health had been assessed by the Rapid Assessment, Interface and Discharge (RAID) service[4].

2.4. GTD Healthcare completed an incident report in July 2018 that focused primarily on events in the Integrated Care Centre (ICC) where he died, having accessed a walk-in centre in the same building earlier in the day. He was a frequent attender at the walk-in service (17 occasions in 2015, 16 in 2016, 33 in 2017 and 8 in the first three months of 2018). He attended with dental problems, skin complaints, low mood and social issues but sometimes, on his own admission, with no specific reason other than to use the building, especially in colder weather. His behaviour at the ICC had twice resulted in the police being called. He often fell asleep, could present as unkempt and was sometimes intoxicated. On the day he died no clinical issue or concerns were identified when he was examined. The report noted, however, that the walk-in service did not have access to an individual's full patient records, which resonates with information-sharing concerns that emerged in this thematic review. When reviewing contact with Desmond by the walk-in service, it was observed that no mental capacity assessment had been completed, often perhaps because he was intoxicated, that referrals had been sent to the GP when he was unkempt, and that the correct pathway for dental pain presentation had not always been followed.

2.5. The incident report concluded that the care provided on the day of his death had been appropriate. A safeguarding referral was made as a result of his death but staff had not been aware that this should happen. As will be apparent later, the issue of

[4] This service is now called the Mental Health Liaison Team.

pathways, including into adult safeguarding, is a theme in this thematic review. The incident report recommends clarification of the roles and responsibilities of walk-in service staff relating to adult safeguarding and the exploration of options for working with homeless people, including seeking support from other services. This resonates with a theme in this thematic review, namely working together. The incident report further recommends a review of building security and training for security staff on removal of people from a public building, and reminders to staff about information-sharing with the police to ensure compliance with data protection legislation. It advises a special note to flag on record systems a frequent flyer to assist with case management planning.

2.6. Kasia was at risk of being made homeless at the time of her death. There was no heating in her accommodation. She had had previous contact with GMP, A&E services, with Adult/Children's Social Care, First Choice Homes Oldham, mental health and substance misuse services. Kasia was a frequent flyer and shortly before her death had been admitted to hospital when found unconscious with hypothermia outside her house, whilst intoxicated.

2.7. Kasia had been a victim of domestic violence. She had 3 children, who were living with their father and other extended family members. When she did engage with services, she could be abusive and/or aggressive. There were concerns about Kasia's mental health and wellbeing. Elements of self-neglect were recognised. Kasia was living in a property with no food or heating. However, the concerns were not recorded as self-neglect. There is evidence that she sustained various physical injuries in the 12 months prior to her death. These were relatively minor injuries, such as bruising and grazes, and associated with falls.

2.8. There is no evidence that agencies considered Kasia's mental capacity for any decision. There is no evidence of recognition by services that, if she did have mental capacity for her lifestyle decisions, this could then be construed as self-neglect. There is no evidence of multi-agency communication or multi-agency working. Whilst risks may have been prominent, there is limited evidence of planning in an attempt to mitigate them. She had housing-related needs but the response to these appears again to have been limited.

2.9. Kasia's mother attempted to seek support for her daughter on a number of occasions and finally reported concerns to GMP after no one had seen her for approximately 2 weeks. When Police entered Kasia's property, she was deceased behind the front door. There were around 100 empty alcohol bottles littered throughout the downstairs of the property.

2.10. Joshua lived alone and frequently did not attend appointments with various services. He had housing-related needs. There is evidence of a breakdown in family relationships. Joshua had a history of mental illness and regularly used alcohol and cannabis. There does not appear to have been any assessment of mental capacity or risks. Joshua did have involvement with a number of agencies, including GMP, Adult Social Care, the GP and mental health services. There was a history of self-neglect. There were no multi-agency meetings before he died.

2.11. Joshua called the Police 4 days prior to his death because he was unable to get up from the floor to get himself a drink. He told the Police that he had been stuck there for two days. He refused further help. Joshua declined a referral to Adult Social Care and refused to go to hospital. He was found deceased on the floor by a neighbour and NWAS. The neighbour told the Police and NWAS that Joshua lived and slept on the floor, and did not eat well.

2.12. Aubrey was living alone with carers 4 times a day and a private cleaner. He has been described as a recovering alcoholic, with a long history of self-neglect. Aubrey had multiple health problems, including diagnoses of hypertension, COPD, a previous CVA resulting in right-sided weakness, prostate cancer, decline in mobility, history of falls, recurring UTIs, Spondylitis, Diabetes (insulin dependent), liver disease, previous throat and lung cancer, and renal impairment.

2.13. Aubrey had significant involvement with a number of agencies, particularly Adult Social Care, the GP and community health teams. There were joint visits but no multi-agency meetings. No mental capacity assessment appears to have been undertaken. Aubrey had been deemed a significant fire risk, as he had been known to throw lighted cigarettes on the floor. There is evidence of discussion of risks but no clear mitigation plan.

2.14. Aubrey was living in squalid conditions with urine and faeces all around. He had housing-related needs, with no heating or hot water in his accommodation being reported on two separate occasions. In the last 3 months of life, his physical health deteriorated. He was unable to get out to get any money, therefore was unable to pay the cleaner (so she wouldn't visit) or buy any food. It is thought that Aubrey was having a cigarette when seated on a chair and dropped it; the chair set on fire and it is suspected that his clothes must have been on fire as he walked over to the bed where he was found.

2.15. Oldham Council submitted a report to the Coroner, dated August 2019. This covers in particular the period from May 2018 to his death. It comments that Aubrey frequently declined support including equipment that would mitigate the risk of fire. The report contains several embedded documents. The first relates to an adult safeguarding concern in May 2018 because of self-neglect that concluded with a proposed multi-disciplinary approach, referral for fire safety services and an increase in the care package. Another adult safeguarding concern from March 2019 is included. This resulted in an enquiry that substantiated self-neglect. It found that services were working in silos and that there was no joint risk management. It concluded that care agency staff could have done more in response to Aubrey's self-neglect, including his squalid living conditions. The enquiry recommended in respect of his case that a mental capacity assessment be completed regarding care needs and finance, a referral be made to RAID for mental health assessment, an urgent review be completed of the care plan with the care provider, the GP be asked to confirm medical diagnosis, GMP be asked if his private cleaner was known, and the housing provider be invited to the next safeguarding strategy meeting. Aubrey died before these recommendations could be followed through. An adult safeguarding concern was

submitted after his death. The report to the Coroner records that a SAR had been commissioned.

2.16. There are clear resonances between the findings of this thematic review and the recommendations that the March 2019 investigation made on the basis of a review of Aubrey's case. It recommended the establishment of a complex case forum (the thematic review focuses on multi-agency risk management meetings and also panels where challenging cases can be discussed, with advice from safeguarding, legal, mental health and mental capacity specialists); the sharing of risk assessments (multi-agency collaboration and information-sharing); the involvement of advocates; support planning between ASC and care providers to address a person's needs (commissioning); robust recording to enable staff new to cases to appreciate the historical background; completion and full recording of mental capacity assessments, and fast tracking of funding approval in self-neglect cases (twice deep cleans had been arranged but each time Aubrey withdrew consent).

2.17. Those attending the learning event did not believe that these cases were unique but instead typical of the needs encountered routinely by practitioners, especially the challenges of self-neglect. That feature of practice accentuates the risk of desensitisation.

2.18. To varying degrees these cases exemplify characteristics that combine in multiple exclusion homelessness. This comprises extreme marginalisation that includes childhood trauma, physical and mental ill-health, substance misuse and experiences of institutional care[5]. Adverse experiences in childhood can include abuse and neglect, domestic violence, poverty and parental mental illness or substance misuse[6]. These cases demonstrate again that, for many, homelessness or being threatened with loss of accommodation is a long-term experience and associated with tri-morbidity (impairments arising from a combination of mental ill-health, physical ill-health and drug and/or alcohol misuse) and premature mortality[7].

2.19. This thematic review also presents an opportunity to compare and contrast the experiences of women and men who experience multiple exclusion homelessness (including insecure accommodation). The majority of reviews have concerned men[8].

[5] Mason, K., Cornes, M., Dobson, R., Meakin, A., Ornelas, B. and Whiteford, M. (2017/18) 'Multiple exclusion homelessness and adult social care in England: exploring the challenges through a researcher-practitioner partnership.' *Research, Policy and Planning*, 33 (1), 3-14.
[6] Public Health England (2018) *Evidence Review: Adults with Complex Needs (with a particular focus on street begging and street sleeping)*. London: Public Health England.
[7] Mason, K., Cornes, M., Dobson, R., Meakin, A., Ornelas, B. and Whiteford, M. (2017/18) 'Multiple exclusion homelessness and adult social care in England: exploring the challenges through a researcher-practitioner partnership.' *Research, Policy and Planning*, 33 (1), 3-14.
[8] Martineau, S., Cornes, M., Manthorpe, J., Ornelas, B. and Fuller, J. (2019) *Safeguarding, Homelessness and Rough Sleeping: An Analysis of Safeguarding Adult Reviews*. London: Kings College London.

Research[9] has found that the causes of homelessness are multi-faceted and impact differently on men and women. Routes into homelessness can have a gendered dimension, founded in abuse and violence in close relationships, just as the case of Kasia demonstrates here. Support is often fragmented, available across separate agencies, with budget cuts intensifying this picture. The research has found positive appreciation of keyworker and women only provision but frustration at having to engage with multiple services at the same time and with provision that was not personalised to their needs. Adverse childhood experiences have resulted in homeless women experiencing a complex range of social and health needs and their situation exposes them to risk of further abuse.

2.20. Those attending the learning event suggested that historically, in Oldham, services for men had been better than that for women, including hostel provision. It was also suggested that stereotypes, or what might be termed unconscious bias, affected how services responded to gender and also age.

2.21. Those attending the learning event were asked to review the information about the four cases against their perspectives of the strengths of agency provision and multi-agency partnership, the challenges that such cases present, and what changes to policy and practice would be helpful.

2.22. Amongst the strengths of individual agency provision and multi-agency partnership working, the following drew comment, namely:

2.22.1. The operation of MARAC and MAPPA.
2.22.2. IDVA provision.
2.22.3. Section 42 safeguarding adult enquiries.
2.22.4. The commitment of some staff and services.
2.22.5. The existence of clusters of integrated services, which promoted risk assessment and management. Some clusters had produced directories of services. However, it was noted that Children's Social Care and Mental Health (Approved Mental Health Professionals) were not included.

2.23. The following challenges were noted, namely:

2.23.1. Lack of support for people being released from prison.
2.23.2. Lack of understanding across agencies of roles and responsibilities and/or lack of awareness of services.
2.23.3. Services closing cases, or stepping back and transferring responsibility, or operating fixed and rigid referral criteria and thresholds when a more flexible and proactive approach was required to attempt engagement and to meet a person's needs, for example in cases of dual diagnosis. The availability of Early Help for twelve weeks was cited as one example.

[9] Cameron, A., Abrahams, H., Morgan, K., Williamson, E. and Henry, L. (2016) 'From pillar to post: homeless women's experiences of social care.' *Health and Social Care in the Community*, 24 93), 345-352.

2.23.4. Lack of multi-agency working and also a failure to escalate concerns, although services may work well individually.
2.23.5. Lack of clarity about referral routes and what could be referred, with a corresponding need to be clear whether what is being referred and requested is a section 9 assessment for care and support or a section 42 enquiry (Care Act 2014).
2.23.6. Sharing of historical and current information.
2.23.7. Relying on assumptions of lifestyle choice to justify non-intervention.
2.23.8. Lack of assertive outreach provision and practitioners who specialise in working with people who self-neglect.
2.23.9. Difficulty in bringing agencies together.
2.23.10. Understanding and application of the Mental Capacity Act 2005 within and across services.

2.24. Amongst changes to policy and practice that were felt to be needed, participants strongly emphasised the importance of a multi-agency approach that included the appointment of a lead agency and key worker, a recognised pathway to request or convene a multi-disciplinary or multi-agency meeting, and panels at which complex and challenging, or stalled and stuck cases could be discussed and expertise shared. It was suggested that closer cooperation between Children's Social Care and Adult Social Care would be beneficial, when young people are approaching transition and/or when, as in the Kasia case, there are children in need or children requiring protection in a context of domestic violence and adults who self-neglect. To reinforce this importance, provision of multi-agency training was emphasised, covering such topics as self-neglect, mental capacity and safeguarding.

2.25. Individual agencies also needed to build in flexibility so that practitioners had the time to devote to complex cases of self-neglect when there are no quick fixes. All services needed to question whether patients/service users were not engaging because, in fact, services were not engaging with them. Seen in this light, a person's previous experiences of provision could affect their willingness to engage again. Services may be creating barriers to access, especially for those whose lives are chaotic and challenging.

2.26. Those attending the learning event, when reflecting on the four cases, felt that information-sharing could be improved, with a suggestion that an information-sharing protocol would be helpful alongside IT systems that enabled an integrated, whole system approach. The importance of supervision was also highlighted, alongside management oversight of the impact of workloads and staff churn on long-running challenging cases where risks were significant. In this context a risk register was recommended as potentially helpful to keep track of cases such as Aubrey or Desmond. A view was also expressed that the availability of supervision and staff support is inconsistent across and within agencies in Oldham. Also strongly recommended was the development of policies or procedures for escalation and for working with people who self-neglect.

2.27. Those attending the learning event were invited to comment on where, in an Oldham context, there were enablers and barriers with respect to modelling practice in line

with the evidence-base. They were asked also to highlight any changes that had occurred to policy or practice since the cases that had been included in the thematic review and also further changes that were felt to be necessary. Finally those present were asked to note any recommendations that the thematic review could consider.

2.28. Among the enablers the following were observed, namely:

2.28.1. Understanding different legal frameworks.
2.28.2. The development of a re-engagement policy[10] that promoted different ways of attempting to engage.
2.28.3. Partnership meetings.
2.28.4. Supportive staff teams.
2.28.5. Opportunities for reflection, including that provided by the learning event itself.

2.29. Among the barriers the following were observed, namely:

2.29.1. Requiring people to fit into services rather than services thinking creatively about how to respond to people's experiences and needs.
2.29.2. An over-professionalised rather than a human and humane response to people's needs, for example as shown in the four cases when services dis-engaged because the person was regarded as having dis-engaged.
2.29.3. Lack of time for person-centred approaches, for exploring repeating patterns or incidents more deeply and for multi-agency case discussions.
2.29.4. Lack of awareness of the impact of adverse childhood experiences and trauma, for example on mental capacity.
2.29.5. Lack of advocacy provision, it being observed that advocates were not used in any of the four cases to assist with their engagement in safeguarding and in care and support assessments and interventions.
2.29.6. Variable commitment to a multi-agency, multi-disciplinary or whole system integrated approach, with nominated leads to coordinate the work.
2.29.7. Lack of flexibility in agency procedures, for example in response to non-attendance at appointments or non-engagement with service offers; case closure due to thresholds; restrictions on the time available to build relationships and trust.
2.29.8. Lack of access to recorded information.
2.29.9. Lack of awareness of available provision.
2.29.10. Inconsistent management support and supervision.

2.30. It was recognised that a self-neglect policy was close to being finalised by OSAB and that a multi-agency risk management panel approach had been instituted. It was felt that joint working had increased as had the use of professionals' meetings and nominated lead agencies, although it was also stressed that the use of safeguarding meetings, of panels when cases were stalled or stuck, and of lead agencies and professionals could be further developed.

2.31. Amongst the changes that were felt to be necessary were:

2.31.1. Training and awareness-raising (the use of newsletters and briefings), for example about the law, mental health, use of strengths-based interventions and

[10] Available from Turning Point.

motivational interviewing, referral criteria, and mental capacity, including the impact of coercive control and domestic violence on women's decision-making.

2.31.2. A focus on discharge planning when people are homeless, or threatened with homeless, and/or when they self-discharge or admissions demonstrate a pattern of recurring issues.

2.31.3. Clearer pathways, for example for care leavers and/or for those experiencing different levels and types of mental distress.

2.31.4. Availability of legal advice.

2.31.5. The development and dissemination of risk assessment, mental capacity and other assessment tools that could be used across services.

2.31.6. Reviewing the approach to dual diagnosis to model an integrated rather than revolving door approach.

2.31.7. Review of gaps in service provision, such as outreach.

2.31.8. Review of workloads but also of currently available resources to explore how these might work more effectively. For example, the positive benefits of colocation and of a one-stop service to meets people's health, housing and social care needs were highlighted.

2.31.9. The development and dissemination of policies and procedures for working with people who self-neglect and who experience multiple exclusion homelessness, or elements of it, that reflect the evidence-base.

3. Themed Analysis

3.1. From the domain of direct practice with individuals, seven themes were identified and these are explored in turn.

3.1.1. *Professional curiosity and service refusal*. From the information supplied it did not appear that Making Safeguarding Personal was embedded across the agencies and services involved – finding out about the person, their life experiences, their hopes and fears, history. Little information emerges from all the documentation about individuals' hopes and desired outcomes. The responses to non-engagement and to missed appointments, reflected in case closures rather than outreach and exploration for example, appeared to suggest reliance on untested notions of lifestyle choice rather than a deep understanding of addiction and of the impact of chaos, disability, substance misuse, mental distress and trauma. There is evidence, for example in the cases of Joshua and Aubrey that responses to the offers of assessment and support were taken at face value rather than respectfully challenged and explored. Repeated dis-engagement did not prompt a more integrated multi-agency response or review of the approach being taken to case management.

3.1.1.1. At the learning event and in documentation supplied in response to review panel questions, views were expressed that agencies tended to focus on the needs or requirements of the service rather than a person's individual needs, and that time constraints impacted on the ability to respond more proactively to non-engagement. Hence, cases might be closed after three attempts to engage rather than further efforts to "reach out." Assumptions might be made that individuals were making conscious, albeit unwise decisions, when their responses might in fact represent the impact of co-morbidities. In each of the cases here, non-engagement or dis-engagement in the context of significant risk might have been expected to prompt feedback to referrers and other services involved and/or a multi-agency risk management meeting.

3.1.1.2. Participants at the learning event also felt that training on labelling, or unconscious bias, would be helpful, alongside the sharing of information between services on how best to engage with particular individuals.

3.1.1.3. Not all services appear to have a policy on how to respond to people who "do not attend". OSAB might consider whether it would be beneficial to have multi-agency guidance on best practice with respect to engagement concerns.

3.1.1.4. Some staff who attended the learning event felt that the training offer should include how to ask difficult questions.

3.1.1.5. At the learning event it was also acknowledged that an event for people with lived experience had recently taken place and that a cohort of

patients/service users had been identified that could help to inform OSAB's work. Such developments may help to strengthen the implementation of Making Safeguarding Personal.

3.1.2. *Recognising, assessing and responding to needs and risks*. From the information supplied by services involved with the four cases under review, it was clear that incidents were seen in isolation rather than as a pattern. As a result, repeating patterns remained and did not prompt a change in approach, contingency planning or follow-up. It is also clear from the reflective agency contributions that there was some frustration about the lack of clarity about to whom one could turn and the process for responding to cases where practitioners felt stuck. Equally, some agencies clearly felt that their concerns were not taken seriously.

3.1.2.1. Thus, several questions arise. The first focuses on how and when practitioners might escalate concerns about continuing and increasing risks, and whether an accessible formal escalation protocol would be beneficial. The second asks when continuing unmitigated risks, as in the cases of Desmond or Aubrey, should trigger safeguarding enquiries and/or referral to a high risk panel or similar forum for stalled and stuck cases where all agencies need to combine their resources to attempt problem resolution. A high risk panel was in place at the time of these cases.

3.1.2.2. The third question concerns whether risk assessment templates or tools would be helpful. Practice of risk assessment appeared uneven within and across the four cases under review. Thorough assessments, discussed in a multi-agency forum, would have enabled stronger coordination of holistic and person-centred responses to needs for care and support, housing, mental health and substance misuse intervention. The fourth invites exploration about how cases might move between Early Help and other ASC intervention, depending on the needs being presented. For example, when Early Help did not feel they could offer anything further to Desmond, but needs and risks remained, what other ASC intervention might have been appropriate?

3.1.2.3. One risk that not uncommonly arises in self-neglect cases is where individuals are willing to accept care and support but decline to pay for it. The Aubrey case illustrates this phenomenon. Care and support in a person's home may attract a financial charge but local authorities have discretion about whether or not to impose it. Accordingly, such a decision should be clearly informed by a risk assessment that focuses on the possible consequences of a decision not to provide a service because the individual will not pay. There is a clear link here to the theme of recording of decision-making.

3.1.2.4. There were occasions when GMP and/or NWAS saw the hospital as a place of safety and therefore did not notify ASC of their safeguarding and wellbeing concerns. This could create a misleading impression of a case.

3.1.2.5. Those present at the learning event agreed that access to risk assessment templates would be helpful, alongside clarification of pathways into multi-agency risk management meetings.

3.1.2.6. It was acknowledged at the learning event that some healthcare services have introduced procedures regarding frequent flyers. However, the concerns generated by cases of frequent flyers was one example where those attending the learning event felt that an integrated records system would assist with information-sharing.

3.1.3. *Mental capacity*. One service in their contribution to the thematic review described mental capacity assessment and practice as a "massive learning need." Both in agency responses to review panel questions and in the learning event, what emerged was a lack of confidence felt by many practitioners in assessing mental capacity and the need for increased staff support. This was especially evident in cases of fluctuating capacity. From agency reflections it is clear that not all agencies provide training and supervision on mental capacity assessments and, even when they do, a question remains of how supported staff feel to apply the learning in practice.

3.1.3.1. There also appeared to be uncertainty about the assessment of executive capacity and how trauma and adverse life experiences can affect a person's decision-making. Repeating patterns, for example when individuals are in the grip of addiction, are often a clue about the importance of assessing executive capacity and the impact of trauma, and challenging assumptions about lifestyle choices. Thus assessments should distinguish between unwillingness and inability.

3.1.3.2. Guidance has commented that it can be difficult to assess capacity in people with executive dysfunction. It recommends that assessment should include real world observation of a person's functioning and decision-making ability[11], with subsequent discussion to assess whether someone can use and weigh information.

3.1.3.3. Overall, agencies responding to the questions raised by the review panel felt that mental capacity should always be considered, and was not in these four cases, and that an alert system should be considered to flag those individuals whose unwise decision-making could be indicative of impairment of mind or brain.

3.1.4. *Family involvement*. In all four cases there were "back stories" about family relationships that, if explored, might have shed light on each individual's history and journey into the situation where Oldham practitioners and services found them. Engagement with the individual in the context of their relationships might

[11] NICE (2018) *Decision Making and Mental Capacity*. London: National Institute for Health and Clinical Excellence.

also have opened up exploration of the degree to which potential circles of support existed. Family Group Conferences is one approach that might have been considered. Much of this history, however, appeared unexplored, raising the question of whether there is confidence to request information and explore the family story. Similarly, mindful of the importance of legal literacy to best practice and defensible decision-making, is there confidence about when information can be lawfully shared?

3.1.4.1. The Kasia case invites exploration of the support available for parents when their children are removed from their care because of abuse and/or neglect, and of the collaboration between Children's Social Care and Adult Social Care when safeguarding and promoting the wellbeing of children and working with a parent with care and support needs, and mental health and substance misuse challenges. In a candid reflection, the contribution of Children's Social Care recognised that the importance of "think family" was "an absolute omission" in this case. Children's Social Care and ASC could have combined, for example, in a risk assessment of the arrangements for contact between Kasia and her children, and in thinking through her support needs after the removal of her children and during and after contact.

3.1.4.2. Other SARs have highlighted the importance of engaging with family members, especially when they are requesting help or withdrawing, both of which occurred in the cases in this sample, and of children's services and adult services liaising closely when appropriate[12]. It has been recognised that Children's Social Care must not become so adult focused that line of sight of the needs of children and young people is lost. However, Children's Social Care has acknowledged the importance of understanding what ASC can offer, for example through Early Help.

3.1.4.3. The documentation supplied by Housing has identified one change since implementation of the Homelessness Reduction Act 2017, namely the inclusion in personal housing plans of family details. However, ASC referral forms do not routinely record family network details.

3.1.5. *Hospital discharge*. Several of the cases in this thematic review invite a question about how secondary healthcare settings respond when patients self-discharge, especially when risks significant and repeating. There is also a question about an appropriate response to frequent flyers by services such as GMP, NWAS and secondary healthcare settings. When notifications of concern were sent to Adult Social Care as one response, was it clear whether what was being requested was a care and support assessment and/or a safeguarding enquiry? Such clarity would help ASC MASH to triage referrals.

[12] Preston-Shoot, M. (2019) 'Self-neglect and safeguarding adult reviews: towards a model of understanding facilitators and barriers to best practice.' *Journal of Adult Protection*, 21 (4), 219-234.

3.1.5.1. There is a duty on hospitals to refer under the Homelessness Reduction Act 2017 in order to prevent homelessness or to ensure that advice and help is offered to individuals already homeless. Referral is designed to ensure that services are available to support individuals post-discharge, including suitable temporary accommodation and wrap-around support through Housing Options. That approach did not succeed in finding Desmond accommodation, raising a question about the difference that the 2017 Act has made.

3.1.5.2. Hospital discharge represents one significant transition that individuals may experience. Whilst not directly represented in the sample of cases for this thematic, attention was drawn at the learning event to another significant transition, namely young people leaving care. This point was made with reference to the importance to be attached of strengthening collaboration between ASC and Children's Social Care.

3.1.6. *Assessing and responding to housing need*. In addition to a focus on the impact of the Homelessness Reduction Act 2017, in the context of Desmond's ongoing homelessness, there were also delays in housing repairs in Aubrey's case. Kasia, Joshua and Aubrey, adults at risk of self-neglect, lived for periods of time in accommodation without heating and/or hot water. The case of Desmond was closed when he was homeless and had care and support needs. Two questions then arise, namely how housing services respond to such situations and how Adult Social Care and Housing staff collaborate when there are housing, safeguarding and wellbeing concerns, and care and support needs.

3.1.6.1. The Desmond case invites agencies to consider other questions, for instance about the response when people do not engage with housing support services, including cold weather provision. The response should be influenced by risk and mental capacity assessments but a sense permeates the documentation that there is "no solution."

3.1.7. *Assessing and responding to mental health concerns*. It is evident from the contributions of different services that, at the time when there were active concerns about the individuals in these cases, pathways into mental health services appeared either unclear or difficult for access, for example for staff in housing services, GMP and ASC. As a result, here and also with respect to other concerns about individual needs, Adult MASH was seen as the default referral option. More positively, there were positive expressions of support for colocation, for example of a mental health worker within GMP.

3.1.7.1. For individuals like Kasia and Desmond, in agency responses to review panel questions and at the learning event, a revolving door approach seemed characteristic rather than an integrated approach to issues of dual diagnosis and co-morbidities (mental distress and substance misuse). Similarly, in review panel discussions and at the learning event, a tendency was recognized whereby services referred mental health to specialist providers rather than explored what contribution they could

make to enhancing an individual's mental health wellbeing. Both Desmond's father and Kasia's mother and step-father were highly critical of what they perceived to be "buck passing" between mental health and substance misuse services, and the lack of sustained support, especially from mental health.

3.1.7.2. The lack of outreach provision for people with suicidal ideation, depression and anxiety was recognised by the review panel and at the learning event. Such provision would also assist with more effective follow-up of patients after discharge from Mental Health Act 1983 admissions. The available of assertive outreach provision might also assist with meeting the challenge presented by individuals who are more difficult to engage.

3.1.7.3. Review panel members commented on the challenges and barriers when seeking to use pathways into mental health, and felt that a multi-agency perspective was necessary rather than just looking at cases through the lens of an individual service. Review panel members observed that strategic work would be beneficial on pathways relating to mental health, and also dual diagnosis (mental health and substance misuse, and mental health and learning disability).

3.2. From the domain of the team around the person, four themes emerged.

3.2.1. *Multi-agency coordination*. Within this theme several lessons are highlighted by the four cases. Pathways for identifying and then responding to individuals experiencing multiple exclusion homelessness (homeless/insecure accommodation + substance misuse + offending + mental and physical ill-health) could be clearer in order to promote whole system/integrated working. For example, at the learning event there was some confusion about whether mental health services would accept GP referrals or required self-referral.

3.2.1.1. Use could be strengthened of multi-agency risk management meetings, high risk panels, multi-disciplinary meetings and/or section 42 enquiries for complex cases with ongoing, repeated concerns. This approach would enhance coordination between services, information-sharing, and the agreement and then monitoring and review of risk management and contingency plans. Good practice here would also indicate the appointment of a lead agency and key worker, as in the early days of the Desmond case. The use of panels and risk management meetings would also meet a recommendation from the learning event, namely a risk register to which all services could have access for information purposes.

3.2.1.2. A protocol to promote shared understanding regarding information-sharing would appear helpful, including when consent is not necessary in law to refer and/or to share information.

3.2.1.3. A view was expressed at the learning event that health care provision was fragmented and that consideration could be given to how to promote integrated working across this sector.

3.2.1.4. A view was also expressed that working together would be promoted if agencies knew what other services were available, for example through a directory that was regularly updated. Such a directory could include contact details of each service's safeguarding lead.

3.2.2. *Referrals*. Clarity about when referrals can be made without consent and about what referrers are requesting when sending notifications of concern has already been referred to. Similarly reference has already been made to a lack of clarity about how to escalate concerns and navigate complex systems. Referral pathways did not seem clear to some participants at the learning event or to the independent reviewer when thinking about how to secure the involvement of adult safeguarding, mental health provision or care and support assessors. Joshua, for example, had physical disabilities that should have triggered a section 9 Care Act 2014 assessment of care and support needs. It is not clear that such an assessment was completed, with section 11 empowering such an assessment where the circumstances indicate it is necessary despite the person declining to engage.

3.2.2.1. Judging by agency responses to questions asked by the review panel in response to initial documentation, there is some uncertainty about the roles and responsibilities of different services and some lack of confidence in referral processes. This might help to explain missed referral and assessment opportunities in the four cases.

3.2.2.2. At the learning event it was suggested that referral forms should be updated in line with the Care Act 2014 and that OSAB partners might explore whether a common referral form across services could be developed. As is not uncommon, there were also suggestions that feedback was not always provided about the appropriateness and outcome of referrals, for example in the Aubrey case.

3.2.3. *Safeguarding and self-neglect*. Reflections provided by the services involved and contributions at the learning event indicate that more awareness of self-neglect is required to ensure that it is seen as a safeguarding concern and to challenge assumptions that individuals are making lifestyle choices. It was also acknowledged that practitioners can become inured to repetitive and longstanding situations, which links to the importance of supervision, staff support and the use of panels and multi-agency meetings to explore and challenge the approach to case management that is being adopted.

3.2.3.1. Reflections also indicate variable understanding and therefore use of pathways into adult safeguarding and concern about the thresholds being used for care and support assessment and safeguarding enquiries.

3.2.4. *Recording*. Reading all the documentation provided by the agencies involved in the four cases leads to a conclusion that records do not always indicate the outcome of mental capacity assessments, referrals and multi-agency meetings. It is not always clear how, why and by whom decisions were reached. Assessments of risk and of need should be clearly recorded and follow-through intervention clearly appraised. For example, in Desmond's case, it remains unclear what ASC's response was to Positive Steps when a request was made for a multi-agency meeting around October 2016. Equally, how information received from the Emergency Duty Team is recorded by 9-5 weekday services could be clarified.

3.3. In the domain of organisations around the team, two themes emerged.

3.3.1. *Workforce and workplace concerns*. At the learning event and permeating the documentation provided by the services involved, for example in the Joshua and Kasia cases, it emerged that supervision of complex, high risk cases is variable, as is access to specialist legal, safeguarding and mental capacity advice, for example for GPs. Concerns were expressed about the impact of workloads when holding cases that required significant investment of time to assess risk and meet people's complex needs and, for instance in the Kasia case, about the risk of staff burnout. It was also observed that staff leaving had disrupted continuity in some of the cases being reviewed and that a clearer focus should be given to managing the transition of complex cases between staff.

3.3.1.1. Request for training also emerged at the learning event and through the documentation supplied by agencies. This focused on mental capacity, risk and mental health assessments, and also on self-neglect. It might usefully also focus on unconscious bias, on how practitioners and managers respond to those whose behaviour is challenging, whether characterised by offending, aggression, self-neglect and/or substance misuse. It appears that not all agencies have a safeguarding training offer to staff and that there is a reliance on e-learning, the use of which is not routinely audited.

3.3.1.2. Responding to requests for training about self-neglect and about risk assessment and management could usefully be provided once OSAB has disseminated procedures for responding to cases of self-neglect and a protocol on responding to risk. However, partner agencies also need to reflect on what changes in the workplace are required to enable their staff to implement learning about best practice from training[13].

3.3.2. *Commissioning and contract management*. The Aubrey case involved concerns about whether a care provider was delivering the care package that had been delivered. The chronology does indicate how Adult Social Care attempted to resolve these concerns but the ongoing risks in the case might have indicated the appropriateness of commissioner, provider and social work staff meeting

[13] Braye, S., Orr, D. and Preston-Shoot, M. (2013) *A Scoping Study of Workforce Development for Self-Neglect Work*. Leeds: Skills for Care.

together to agree and follow-through on an approach to delivery of the care package in this complex and challenging case. Equally, at the time of this case, greater clarity might have been helpful about when doubts about how a care package was being delivered were responded to through a safeguarding and/or provider concerns pathway.

3.3.2.1. At the learning event two other commissioning issues were voiced. The first focused on advocacy and a perceived shortage of provision with respect to Care Act 2014, Mental Capacity Act 2005 and Mental Health Act 2007 advocates. The second focused on the need to ensure that when one service is decommissioned and a new service is commissioned, records of contact with patients/service users are transferred.

4. Recommendations to Oldham Safeguarding Adults Board

4.1. Produce and disseminate multi-agency procedures for working with people who self-neglect, such procedures to include clear pathways for convening multi-agency panel meetings and for escalation of concerns, and arrangements for agreeing on lead agency and key worker to coordinate practice; SAB partners should nominate a strategic manager to lead on this aspect of system development;

4.2. Produce and disseminate procedures for responding to frequent flyers and to patients/service users who do not engage or attend appointments in situations where risks are significant;

4.3. Produce guidance and tools for assessing risk in respect of adults who self-neglect;

4.4. Commission multi-agency training on self-neglect, legal literacy (including information-sharing), unconscious bias, mental health and mental capacity assessments, and risk assessment;

4.5. Distribute seven minute briefings as a means of disseminating learning from SARs and raising awareness of OSAB policies and procedures, and consider other methods of seeking to embed review outcomes in service development and practice;

4.6. Convene a summit to review commissioning of mental health provision, and to strengthen strategic relationships and operational practice between Adult Social Care and mental health providers;

4.7. Audit decision-making regarding section 42 enquiries and practice standards within completed investigations;

4.8. Conduct a multi-agency audit to establish the extent to which Making Safeguarding Personal is embedded in practice;

4.9. Review the need for a multi-agency information-sharing protocol with respect to adults at risk of significant harm, to include guidance on when information-sharing is lawful;

4.10. Audit standards of recording, including of supervision, to ensure that it is clear how decisions have been reached, when, in consultation with whom and why after review of all relevant considerations;

4.11. Map service developments and current single and multi-agency provision with respect to adults who self-neglect and/or misuse substances and/or are homeless or threatened with homelessness and, at a summit, consider what refinements and further developments are advisable in light of learning from this SAR;

4.12. Request that senior managers in Children's Social Care and Adult Social Care review the offer of family support when children are removed from parental care and disseminate guidance about best practice;

4.13. With partner agencies review how staff are supervised and supported to work with adults who self-neglect in line with the evidence-base used in this thematic review, making any adjustments necessary to remove barriers to best practice;

4.14. Audit progress on learning from this SAR after one year from publication.