WOLVERHAMPTON
SAFEGUARDING
TOGETHER

Safeguarding Adult Review

“Patrick”

Lead reviewer and report author: Jenny Butlin.

Contents.

1. Background.

1.1. The purpose and underpinning principles for undertaking reviews of an adult's circumstances are set out in the Care Act 2014 and underpinned by statutory guidance. This review takes a systemic approach in its examination of the key lines of enquiry including highlighting good practice, using Patrick's circumstances as a lens through which to consider wider adult safeguarding practice undertaken in Wolverhampton.

1.2. The responsibility for reviewing the serious incidents of adult's rests with the Local Authority, the Integrated Care Board in the area and the Police in accordance with the Care Act 2014. This particular review will use Patrick's circumstances to review the multi-agency response to adults at risk of neglect, self-neglect and hoarding and identify improvements to the safeguarding system accordingly.

1.3. This review is concerned with "Patrick" who was a man in his 50s of white British origin who lived with his wife and brother-in-law. He had a diagnosis of schizophrenia, a learning disability and a hearing impairment. He was sadly found deceased at home by his wife. Prior to his death, Patrick received support from the Community Psychiatric Nursing Service, the District Nursing Service, the Phlebotomy Service, Primary Care Home Visiting Service and Adult Social Services. For reasons of confidentiality, no further identifying details will be provided and he will be known as Patrick throughout the report. Patrick's wife and brother-in-law will be referred to by their relationship to Patrick

2. Methodology

2.1. An Independent lead reviewer was appointed to lead the review.[1] The methodology adopted for this Safeguarding Adult Review (SAR) was a hybrid system approach with a focus on evaluating the practice response to the individual, identifying strengths of practice and areas for improvement in order to improve the multi-agency response to safeguarding adults in Wolverhampton.

2.2. The panel[2] had access to the key single and multi-agency documents and met with practitioners involved with Patrick in reflective sessions where Patrick's circumstances and the practice response were discussed. This approach is consistent with the purpose of SARs as outlined in the statutory guidance.

2.3. Patrick's wife was offered the opportunity to contribute to the review, but she chose not to.

2.4. Drafts of this report were shared with those involved as well as with One Panel and the Scrutiny and Assurance Group to ensure collaboration and ownership and provide scrutiny and challenge. The recommendations were written by the Lead Reviewer and the panel. The Executive Group formally approves the report.

[1] Jenny Butlin is an experienced independent social work consultant who is independent of the partnership.

[2] The panel was comprised of senior leaders from the agencies who supported Patrick and his family

2.5. This report has been written in the anticipation that it will be disseminated for learning to the members of Wolverhampton Safeguarding Together and contains only the information that is relevant to the learning established during this review.

3. Narrative chronology of professional involvement and family background

3.1. In early October 2023, Patrick attended a combined learning disability and mental health review appointment with the healthcare assistant and then the GP which included a broad checkup and full blood testing. Patrick was last seen at the GP surgery a few weeks later.

3.2. In early November 2023, the community mental health team was advised that Patrick was unable to come to the clinic for his depot injection[3] due to physical problems with his legs. The injections were subsequently administered at home.

3.3. From the end of November until the end of December 2023, the Community Psychiatric Nurse (CPN) visited Patrick at home to administer the depot injection. The CPN reported that Patrick appeared to be “unkempt” with “poor personal hygiene”. It was noted that it was hard to communicate with Patrick because he was deaf.

3.4. In late December and early January 2024, the CPN again visited Patrick at home to administer the depot injection and the CPN noticed that the lounge was cold, and the furniture and carpet appeared mouldy. Patrick again presented as unkempt and there was an offensive odour of urine present. Patrick also had a rash all over the thigh, groin, back and abdomen area. The CPN advised Patrick’s wife to “seek support from social services”. It was again noted that it was hard to communicate with Patrick as a result of his deafness.

3.5. Several days later the concerns regarding the home conditions and poor hygiene in the home were considered in a multi-disciplinary meeting attended by the CPN who was advised to make a referral to Adult Social Services and Occupational Therapy.

3.6. In late January 2024, a GP visited Patrick at home and later advised the CPN that Patrick was awaiting an Occupational Therapy assessment. The GP also made a referral to the District Nursing Service for assessment of Patrick’s bilateral leg ulcers.

3.7. A few days later, an unannounced home visit took place for an assessment of Patrick’s needs by the district nursing service. Patrick declined to have his legs washed which were dry and he declined any further assessment, support or further referrals. Consequently, the nurses were unable to access his leg wounds. The living circumstances were observed to be untidy and unkempt with a strong smell of ammonia present. The District Nurse notified the GP that both of Patrick’s legs were abnormally swollen with fluid and that Patrick may require medication to reduce this. It was noted that Patrick appeared to have full mental capacity during the visit and was therefore discharged from the caseload as there was no presenting nursing need. It was noted that Patrick had a past medical history of mental health issues.

[3] A depot injection is a slow-release form of medication. Mind website.

3.8. Between late February and early April 2024, five home visits to Patrick were undertaken by the CPN to administer the depot injections. Concerns in relation to the poor home conditions were noted on each visit. On the last visit, Patrick's bottom appeared wet, tender and covered in faeces and urine and his legs also appeared swollen with leg sores. His wife expressed concerns about providing Patrick's personal care as he was not able to walk to the bathroom.

3.9. At the beginning of April, the CPN made a referral to Adult Social Care services.

3.10. The following week, the duty social worker from adult social care visited Patrick at home and was concerned about the home conditions. The social worker intended to make a further visit two working days later. The duty manager made a referral to the Community Mental Health Team and requested an urgent visit by a psychiatrist or GP

3.11. Two days later, an ambulance was called as Patrick was in cardiac arrest. The crew found Patrick lying on a sofa, wearing only a t-shirt. He was covered with a duvet with only his head showing. The sofa was covered in faecal matter and bodily fluids. The crew assessed Patrick and Recognition of Life Extinct was confirmed by the crew. Due to concerns with how long Patrick may have been deceased the crew requested that the Police attend the scene. The police arrived and it is documented that the police didn't think it was suspicious and left the scene. A member of the crew completed a safeguarding referral in relation to the concerns.

4. Detailed analysis.

4.1.1 The main feature of this SAR was the identification of neglect, self-neglect and hoarding behaviours and the detailed analysis explores the effectiveness of the safeguarding system in enabling this.

4.1.2. Self-neglect is a significant factor in adult safeguarding. The Annual Safeguarding Adults publication for England[4] shows that in England, self-neglect is the fifth highest risk for s.42 enquiries[5] and sixth highest in Wolverhampton. Therefore, Wolverhampton is largely in line with the national trend for 2023-2024. The Second National Analysis of Safeguarding Adult Reviews 2019-2023[6] found that the most commonly experienced type of abuse/neglect overall was 'self-neglect' which was a feature for 50% of the individuals who were the subject of a SAR and neglect/omission was a feature for 38%.

4.1.3. Patrick was seen at home by the Primary Care Home Visiting Service and the CPN on several occasions and the District Nurses, the Phlebotomist and the Social Worker from Adult Social Care on one occasion. All the professionals who saw Patrick at home noted that he was "unkempt" and that the lounge where he was seen was cold and the furniture and carpets were mouldy. There were also a number of bags of items stored in the room. Patrick's lower body was seen by the CPN who

[4] NHS England. Annual Safeguarding Adults publication 2023-24.https://app.powerbi.com/view?r=ey

[5] A section 42 enquiry relates to the duty of the Local Authority to make enquiries, or have others do so, if an adult may be at risk of abuse or neglect. This happens whether or not the authority is providing any care and support services to that adult.

[6] Second National Analysis of Safeguarding Adult Reviews 2019-2023 LGA & ADASS as Partners in Care and Health April 2024. Final report stage 1 analysis

administered the depot injections for his mental health condition, and he later noted that Patrick had a significant rash on his body and sores on his bottom and the duvet was noted to be stained with faeces. The district nurses saw Patrick's legs with the intention of treating his bi-lateral ulcers as referred by the GP, but Patrick refused permission for them to do so. Consequently, only part of his legs were seen which had extremely dry skin.

4.1.4. Given this description, it seems evident that Patrick either did not have the capacity to manage his own personal care and the property or he was unwilling to and similarly, his wife. However, none of the professionals explored this further and sought to understand the reasons why Patrick was living in such poor physical and environmental conditions. In light of this, the review explored the barriers to identifying neglect, self-neglect and hoarding behaviours.

4.1.5. In their work on self-neglect[7] Research in Practice identified that self-neglect may be challenging for practitioners due to "its varied presentation, complex mix of personal, mental, physical, social and environmental factors" and this is explored in this review. Further work is required by the partnership to understand how widespread this is in Wolverhampton. **(Recommendation 1)**

4.2. What tools are provided by the safeguarding system to support practitioners to identify the indicators of neglect, self-neglect and hoarding behaviours?

4.2.1. Whilst the practitioners were able to describe Patrick's physical well-being and the home conditions, they struggled to accurately record their observations without seeming judgemental and used words such as "unkempt" and "poor home conditions." This meant that the records did not accurately convey to their service and those who may be able to access the records, the serious nature of Patrick's physical appearance and the poor standards within the home.

4.2.2. Wolverhampton's Safeguarding Partnership, Wolverhampton Safeguarding Together adheres to the West Midlands regional policies and procedures for adult safeguarding which include the identification and response to self-neglect and hoarding through a use of supportive professional tools. These aim to provide an understanding of the severity of the concerns and a shared, objective language for professionals to describe the neglect observed.

4.2.3. The practitioners felt that the understanding of neglect was subjective. The practitioners had not considered using the tools and neither had their managers or the professionals who attended the multi-disciplinary meeting convened by the Community Mental Health Team. The review learned that practitioners and managers had not received training in using the tools and this was likely to have impacted on their ability to know about them and to be confident to use them appropriately. This indicates that the self-neglect and hoarding tools are not sufficiently embedded across the safeguarding system. **(Recommendation 2)**

[7] "Working with people who self-neglect" Research in Practice December 2020.

4.2.4.

Learning points:

- Recording of the observations of an individual should be factually descriptive to support a clear understanding of the individual's well-being and circumstances.
- The use of the neglect tools may have enabled the identification of self-neglect and possibly hoarding behaviours.

4.3. How well did the safeguarding system support practitioners to seek and obtain consent?

4.3.1. The review found that the professionals struggled to identify the indicators of self-neglect and hoarding behaviours because they understood that they would need the person's informed and valid consent to undertake further explorations, and they often found this challenging. Research in Practice's work identified that the "ethical dilemmas between respecting autonomy and fulfilling a duty of care" pose a challenge for professionals in working with self-neglect and this was a feature of this review.

4.3.2. The management of an individual's own physical care and that of their home is personal and the practitioners told the review that in such circumstances, they did not want to offend people, and this acted as a barrier to seeking consent, particularly when someone is hostile. The review found that the safeguarding system had not enabled practitioners to feel sufficiently skilled to implement strategies to engage Patrick and to create an environment in which a relationship could be built with him and his wife where their consent could be sought to discuss things further.

4.3.3. Research in Practice's work also identified that practitioners may work within "workflow systems that prioritise short-term, task-focused involvement" which was a factor found in this review. The CPN saw Patrick regularly at planned home visits and Patrick was compliant with receiving his depot injections. However, the CPN's high workload meant that his visits were swift and focused on administering the injection. As a result, he had not established a trusting relationship with Patrick in which explorations could be made about how Patrick's physical and environmental needs were being met.

4.3.4. When the District Nurses visited Patrick on an unplanned home visit, he would not allow them to see all of his legs and refused to consent to any further support. His legs were noted to have very dry skin however, he would not allow his leg ulcers to be seen and therefore they could not be treated. The home conditions referred to throughout this report were evident. The District Nurses told the review that the patient notes included that he had been verbally aggressive to another District Nurse previously and this had impacted upon their ability to explore the need to see his legs and treat him. Patrick's wife told the District Nurse that she had been washing his legs and putting cream on them; although the condition of his legs did not support this, it was not explored with her because Patrick wanted the District Nurses to leave the house, and he was becoming agitated.

Consequently, the District Nurses did not have a good understanding of the physical condition of Patrick's legs, and they were left untreated.

4.3.5. When the phlebotomist undertook a home visit to Patrick, he refused to have his blood taken and as a result no further action was taken that day, but it was intended that they would continue to attempt to take his bloods at future home visits. This was not explored further with him.

4.3.6. The duty social worker was able to gain the consent of Patrick's wife to undertake a home visit and this provided the opportunity to build a relationship with her. The social worker planned to undertake a further visit within two working days, however Patrick sadly died before this could take place.

4.3.7. There was no consideration by the practitioners of the Think Family approach[8] in consideration of the wider family and the capacity of Patrick's wife to care for him. Although she was understood to be his carer, she was not offered a Carer's Assessment[9] and therefore any challenges that she may have been experiencing were not explored. Given Patrick's poor physical health and the condition of the property it was evident that she was not coping. The CPN made a referral to Adult Social Care, but this was delayed. This is explored further in 4.5. **(Recommendation 3)**

4.3.8. The review found that there was a lack of professional curiosity applied when considering Patrick's circumstances and this was likely to be attributable to the high workloads experienced by the professionals and a lack of confidence to query and challenge Patrick and his wife. When Patrick told the community mental health team and the GP practice that he was unable to attend the clinics, he was appropriately provided with home visiting services, but no-one sought to understand why his physical health had deteriorated. Patrick's wife told the CPN that she was struggling to take Patrick to the toilet, but she was not asked how his toileting needs were being met in light of this. None of the professionals were aware that Patrick's brother-in-law was a member of the household and also experienced mental ill-health. The lounge was seen by professionals to be in a poor state, but no-one asked to see the rest of the house. This was not identified by managers or the MDT meeting held by the community mental health team which indicates that the safeguarding system did not promote professional curiosity. **(Recommendation 4)**

4.3.9.

Learning points:

- Practice with people who self-neglect is more effective where practitioners build rapport and trust - showing respect, empathy, persistence and continuity.

[8] "A Think Family approach refers to the steps taken by children's, young peoples and adult practitioners to identify wider family needs which extend beyond the individual they are supporting." Wolverhampton Safeguarding Together Website.

[9] Care Act 2014 section 10 (1) and (4)"a carer's assessment must be undertaken when there is an appearance of need, whether currently or in the future, and regardless of the level of need or the carer's financial resources." NRPF Network website.

- The Think Family approach should be considered when working with an individual to identify wider family needs.
- Professional curiosity supports a deeper exploration of issues of concern and should be promoted and supported across the safeguarding agencies.

4.4. How well did the safeguarding system support practitioners to understand Patrick's capacity to make decisions?

4.4.1. Linked to the issue of consent was the understanding of Patrick's mental capacity. Did Patrick have the capacity to make the decision to refuse his legs to be treated and to refuse having his blood taken and to live with poor physical health and poor environmental conditions? Did he truly understand the implications for his physical health when he refused interventions? "The challenges of assessing mental capacity" were also identified by Research in Practice's work.

4.4.2. The Mental Capacity Act 2005 states that one should assume a person has the capacity to make a decision themselves, unless it's proved otherwise. Examples of when a person may lack capacity include those with severe learning disabilities and mental health conditions.

4.4.3. Whilst an adult can choose to make unwise decisions, self-neglect should be considered in the following circumstances: A lack of self-care to an extent that it threatens personal health and safety, neglecting to care for one's personal hygiene, health or surroundings, an inability to avoid harm as a result of self-neglect, a failure to seek help or access services to meet health and social care needs and an inability or unwillingness to manage one's personal affairs.[10] In view of these factors, Patrick's mental capacity to make decisions that related to refusal for interventions to support his physical and health needs should have been considered.

4.4.4. The review found that the practitioners did not have a clear understanding of the Mental Capacity Act 2005 and the action they could have taken to explore whether Patrick had capacity to make decisions to refuse treatment for his legs and to have his bloods taken. Unfortunately, none of the professional agencies considered this at the time which indicates that this is a widespread issue. **(Recommendation 3)**

4.4.5. Patrick was deaf and none of the practitioners considered whether he required alternative provision to ensure that he understood what the professionals were saying and could therefore make informed decisions about his care. The phlebotomy service and the Adult Mental Health service who supported Patrick were not aware that he had a diagnosis of a learning disability and therefore did not consider any adjustments in communicating and supporting him. However, the review learned that even if this information had been known, Adult Mental Health Services would not have been able to access services from the Learning Disability Team because Patrick was receiving a mental health service. The rigidity of the arrangements for accessing specialist learning disability services means that adults may not have their complex needs met.

[10] Definition of self-neglect by the Social Care Institute for Excellence.

4.4.5.

Learning points:

- Greater consideration of Patrick's mental capacity, learning disability and hearing impairment may have enabled an improved understanding of Patrick's ability to make decisions about refusing interventions.

4.5. How effective was the communication by agencies and between agencies to support Patrick?

4.5.1. The review considered the communications within agencies and between agencies and found that they had not been effective in safeguarding Patrick. The review found that the professionals supporting Patrick mainly worked in isolation to each other and did not communicate beyond referral processes.

4.5.2. The CPN remained concerned about Patrick and in mid-January 2024, appropriately discussed his circumstances at a multi-disciplinary meeting within the community mental health service where he was advised to make a referral to Adult Social Care and Occupational therapy. This was a missed opportunity to consider what action the service could take directly to support Patrick such as convening a multi-disciplinary team meeting (MDT) and involving the other professionals that were supporting Patrick to share information and consider a coordinated plan of support. As a result, the different professionals worked in isolation and there was no clear plan of support. This was also highlighted in Research in Practice's work where they found that "the need for coordinated interventions from a range of agencies" can be challenging for practitioners when working in self-neglect. An MDT would have enabled the practitioners to share the information they held about Patrick and the other members of the household and consider any action that could be taken collaboratively to improve Patrick's health and his home environment. The practitioners told the review that they were not confident about convening an MDT. This requires further consideration by the partnership. **(Recommendation 1)**

4.5.3. Following the MDT meeting, the CPN did not immediately make a referral to Adult Social Care as recommended by the meeting because they had mistakenly understood that the Occupational Therapy Service would need to see Patrick first and there was a shortage of staff which delayed this. Consequently, the referral was not made for a further four months. The service has identified that this was an individual error, and the learning has been shared as part of this review.

4.5.4. Following Patrick's refusal to allow the District Nurses to see his leg ulcers, the district nursing service withdrew, and the GP was notified. However, in error, the District Nurses' notes did not include that his leg wounds had not been seen and therefore the GP was not aware of this. This was a missed opportunity for the GP to be able to consider the further action to be taken.

4.5.5. There was no formal communication system in place to enable the different professionals

from different parts of the safeguarding system to communicate. Therefore, the CPN was not aware the district nursing service was no longer involved with supporting Patrick and could not consider the impact of his untreated leg wounds upon his physical and mental health.

4.5.6. The review learned that when a patient receives support from the Primary Care Home Visiting Team, the GP ceases to hold responsibility for the management of the patient's health needs. The composition of the team means that they do not come into frequent contact with the GP practice, and this reduces the opportunity for informal discussions about patients and therefore the GP's knowledge about the patient's progress. In light of this learning, the Integrated Care Board should consider how to address this.

4.5.7. The review found that the electronic recording system operated by the community mental health team did not promote intra-agency communication and consideration of the Think Family approach because the system was not joined up across the different services. Patrick's wife was assessed by the psychology service which was part of the community mental health team however, neither the psychologist nor the CPN were aware of each other's involvement because the electronic record system does not link different members of the same household. This was a missed opportunity for the services to consider the impact upon Patrick and his wife of each other's conditions and the capacity of Patrick's wife to care for Patrick. This learning is to be shared amongst the team to support improved practice.

4.5.8. Referrals by one agency to another are a form of communication about the needs of the individual and how the agency referred to is being asked to meet them. When the GP made the referral to the phlebotomy service, the referral did not include fuller information about Patrick's needs. The phlebotomy service was unable to access Patrick's patient records held by the GP practice and therefore they did not have a full understanding of Patrick's needs. This was likely to have impacted upon their ability to engage Patrick and obtain his consent. The review learned that the service would continue to try to take Patrick's bloods, but they were unsure if the GP would be informed of his refusal. This was learning for the GP practice and requires further consideration. Similarly, when the referral was made to Adult Social Care, the service was not aware of the extent of Patrick's needs as they were not included in the referral. This meant that when the home visit was undertaken, the Social Worker had not taken into account Patrick's hearing impairment, and this impacted upon their ability to communicate with him and understand his needs effectively.

4.5.9.

Learning points:

- MDT meetings provide a valuable opportunity for professionals to share information and consider any further collaborative action to be undertaken.
- Referrals should provide relevant full information about the individual's needs so that the agency being referred to can provide support appropriately.

5. Recommendations.

In light of the learning, the following recommendations are made to Wolverhampton Safeguarding Together Partnership:

Recommendation 1.

The partnership should undertake a piece of work to understand the barriers and enablers to identifying self-neglect and hoarding and the challenges for professionals in convening MDTs, across the partnership.

Recommendation 2.

The partnership should review the training provided about the tools for self-neglect and hoarding and consider whether this requires further action to embed the use of the tools across the partnership.

Recommendation 3.

The partnership should seek assurance that professional curiosity and the Think Family approach are promoted, encouraged and supported by its member agencies.

Recommendation 4.

The partnership should review the training provided about the Mental Capacity Act 2005 and consider whether any further action is needed to support an improved understanding across the partnership.