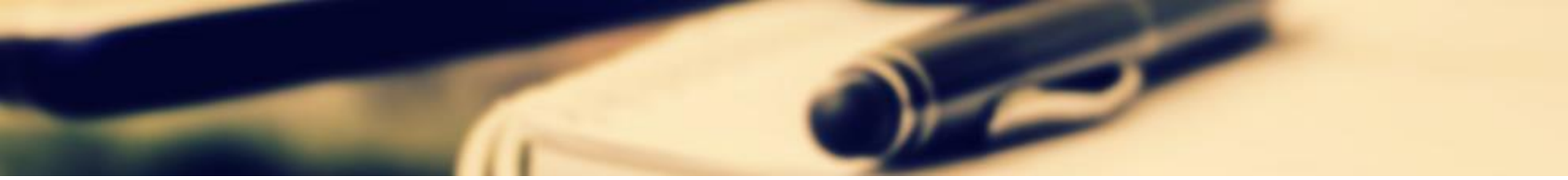


Learning Briefing

Regarding the learning from the death of BS

Produced by Karen Rees, Independent Reviewer

What were the circumstances that led to this Learning Briefing?

BS was a lady who had very little involvement with statutory services throughout her life. BS was found deceased at her home address at the end of 2019 having likely died a few weeks earlier. The exact date of BS's death is not known as she lived alone and is not believed to have had any contact with anyone for some time.

The information known to the author at the start of the review was that BS had agoraphobia, and suspected mental health needs; she was thought to be suffering with depression and was neglecting her self-care. BS's property was unkempt, with gardens very overgrown front and back. BS was believed to have had no running water or working toilet at her address. The referral for the review indicated that BS may also have suffered with alcohol dependency. The review found that BS did not drink alcohol.

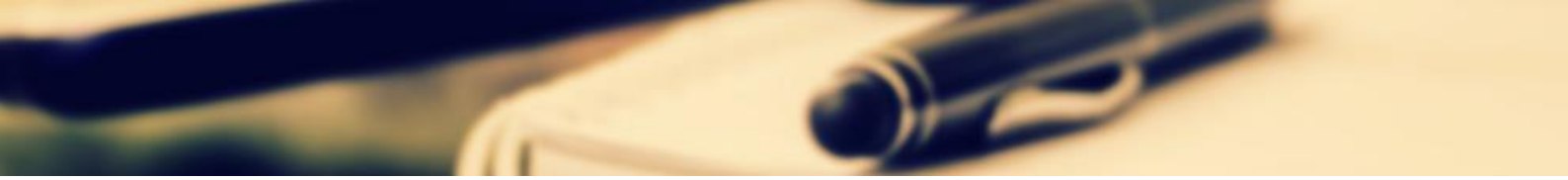
There were two occurrences during 2018 where a neighbour had reported a concern for BS's welfare to the police and once to adult social care by the same neighbour. The water company and the Mental Health Crisis team were contacted on the first occasion. Police visited on both occasions but were refused access by BS. BS spoke from an upstairs window telling the officers that all was well, and she did not need help and that their presence was not welcome. On both occasions vulnerable adults' referrals were sent to the police harm assessment unit but were not forwarded as there was no consent from BS to do so. The neighbour also contacted the Access Service for Adult Social Care where they signposted the neighbour to other services that may have been able to help.

BS's ex-partner made a call in the spring the following year to Adult Social Care. A social worker visited due to the concerns raised, again access to the house was refused by BS. The social worker managed to speak to BS on the phone from outside the property who assured the social worker that all was well, that she chose to live that way and that she was sorting out some house maintenance problems. No further action was taken. The ex-partner called back a few weeks later and was updated that BS was happy with her living conditions.

During this time BS had annual reviews for her medication from the GP practice over the phone and her medication was requested by her as expected and delivered by the pharmacy. BS had not attended any long-term conditions reviews at the GP practice, but as there were no conditions of significant concern, this was not followed up.

How was information and learning gathered for the review?

Initial chronologies were collated from Police and Adult Social Care, being the two agencies that had received notifications of concern and had visited with BS in the year prior to death. Contact was made



with BS's GP for information as well as local hospitals. The Terms of Reference were set to try and engage with local businesses and organisations that visited the house, as follows:

- Water Company- Had been notified of water leak and damage to neighbouring properties
- Local supermarket- Delivered groceries weekly
- Postal Service- Delivering letters and parcels
- Pharmacy- Delivering medications
- Local council refuse collections
- Gas and Electricity Providers

Despite several concerted attempts to engage with the above services it was only possible to engage with the Pharmacy and the supermarket and leads to learning about non health and care services engagement with safeguarding.

The Pharmacy were then engaged within the review process and the supermarket requested feedback on what they might offer drivers in their briefings.

Family Story

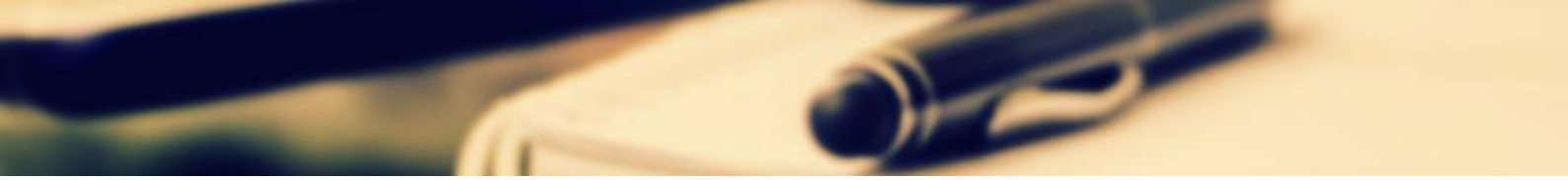
The author spoke at some length to the son of BS. He stated that BS was a single parent who had been a proud good looking well-dressed woman who worked as a secretary. Issues for his mother started when he moved away to university. Over the years he noticed a gradual decline in her appearance and self-care but as he lived abroad his visual contact with her was limited. In the last 2-3 years he had moved nearer to try and help. His mother convinced him that she was fine and that she was getting herself 'sorted' and did not need any help. BS told her son that if he involved any authorities that she would never speak to him again. It came to light that BS was a significant hoarder, buying things to make herself feel better and purchasing online, expensive clothes that she planned to wear when she had got herself straight again. The property was rat infested with significant water damage and in a neglected state. To resolve the water leak issue, she had turned the water off. There were also numerous unopened letters including those from the NHS.

The roundtable meeting and emerging learning

The round table meeting included key agencies that had been involved in the contacts with BS as well as members of the WSAB Case Review Group. The contacts and issues raised were discussed, some agencies identified single agency actions. The review recognises that attempting to work with a person who does not want help is an extremely complex area of work.

Learning emerged as follows:

- Policies are in place to guide practice regarding self-neglect and hoarding but are not always referred to.
- Agencies must listen to concerns that are raised by families and members of the public especially where they are genuinely showing concern and are not just wanting to complain. Further contacts may glean more information about the concerns to help inform decision making.



- Being able to be professionally curious about a situation and attempt to build a relationship with a person who does not want help, but observation might suggest otherwise, is a complex area of work. Supervision and multi-agency discussion can aid this.
- Information sharing may lead to alerting other services of the issues being raised and complete a more holistic picture.
- Consent still poses an issue where the person has not given specific consent to share. Consideration of use of cumulative risk from ongoing concerns being presented may mean the threshold to share is surpassed based on possible harm.
- Organisations need to assure themselves that there are checks and balances in place to identify where practice falls short of requirements.
- Environmental health teams can be a source of support and help where there are issues of self-neglect that may cause a public health issue.

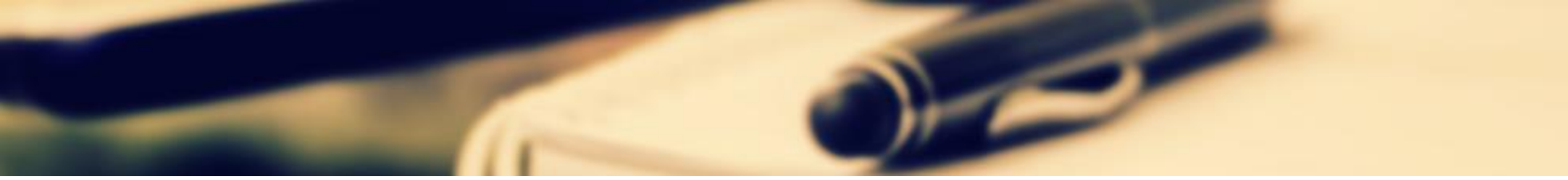
The review group thought that it was important that it is recognised that the son and the neighbour did not give up on BS. The neighbour continued to raise concerns and the son continued to try and encourage his mother to improve her situation.

REMEMBER:

THINK THE UNTHINKABLE - COMMUNICATE and COLLABORATE

What should the Board do?

Learning identified	What will help?
Policies and guidance	WSAB should refresh and relaunch the Multi Agency Self Neglect Guidance with a focus on: • Readability for all practitioners. • Highlight Hoarding as a separate section with specific features. • Section on how to work with people who you are not able to engage with. • Include need to be professionally curious
Encouraging a professionally curious workforce in safeguarding Adults	WSAB should consider work recently undertaken through Research in Practice "**Professional curiosity in safeguarding adults"** and identify elements that may provide for brief guidance for professionals and other work that may promote a professionally curious workforce.
Hearing members of the public with genuine concern.	WSAB should ask the relevant subgroups to undertake communications work; • For the public regarding what to do if it is felt that genuine and ongoing concerns for a person have not been heard • For professionals regarding listening and involving the reporter in gleaning information regarding the concern they have.

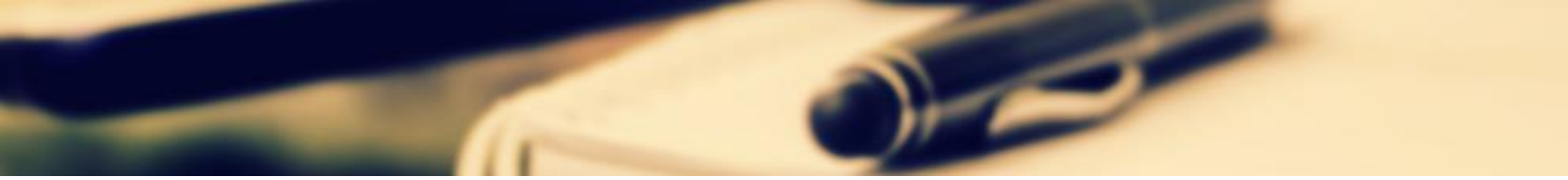


What should organisations do?

Learning identified	What will help?
Relationship work	It is known that in complex cases with those who are difficult to engage with and especially in self neglect and hoarding cases, that the key to improving outcomes is the ability to build positive relationships; this can take considerable time. • Ensuring that your organisation recognises this and supports the longer-term engagement of practitioners to give time for this to happen? • Ensuring that there are mechanisms in place to measure the quality and outcomes of this longer-term work to evidence its requirement.
Supervision for staff	• Ensure that you have appropriate supervision in place that supports practice especially in safeguarding.
Professional curiosity	• Ensuring that the organisation provides a culture where curiosity to see beyond what is observed is encouraged? • Demonstrating how recording and assessment documentation allows for analysis and reflection and encouragement of professional curiosity e.g. 'three conversations', 'careful questions'
Information sharing	• Provide clarity on where to seek support where consent has not been given but concerns remain and are still being reported.
Professional practice	• Assurance that there are checks and balances to ensure that practice that falls below that which would be expected can be identified and improved.

What should professionals do?

Learning identified	What will help?
Polices and guidance	Ensure that you are aware of the policies in place to provide guidance and where to find them. Most safeguarding policies are accessed here https://www.safeguardingworcestershire.org.uk/ The Self Neglect Guidance is accessed here: Multi Agency Self Neglect Guidance
Concerns raised by members of the public	Reflect individually and in teams on how you respond to these. Is the motivation genuine concern? What are their concerns? What do they want to happen as a result of reporting the concern?



Professional curiosity	In your next team meeting or supervision, reflect and highlight when you have exercised professional curiosity. What difference did it make to you and the person?
Information sharing and consent	Discuss in teams or reflect individually when it is OK to share information? If you are not sure what to do if there is no consent but concerns of possible harm remain, what action can you take? Is there evidence of cumulative risk or ongoing concerns? https://www.scie.org.uk/safeguarding/adults/practice/sharing-information#does-not-want-you-to-share
Practice Standards	Think about how you do cross check your decision making especially if working virtually and not in an office where peer discussions can take place? How often do you take time to reflect on practice, do you ensure that you prioritise your time for supervision?
Who can help?	Consider the circumstances of a case, how can you find out other organisations that may help? Do you have access to a service directory? Have you checked the relevant policy for contacts and support?