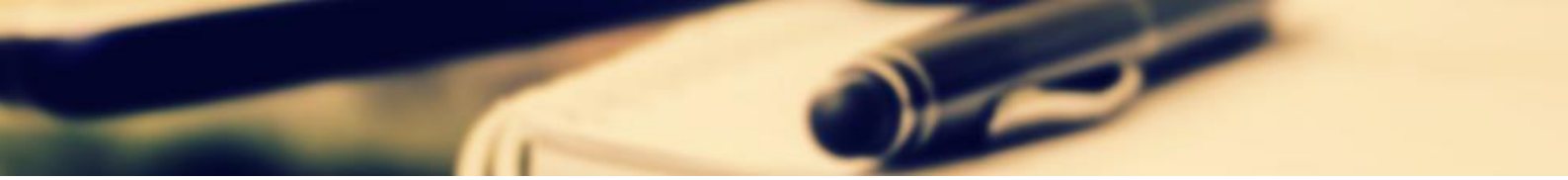


Learning Report – 'Jack' SAR

What were the circumstances that led to this SAR?

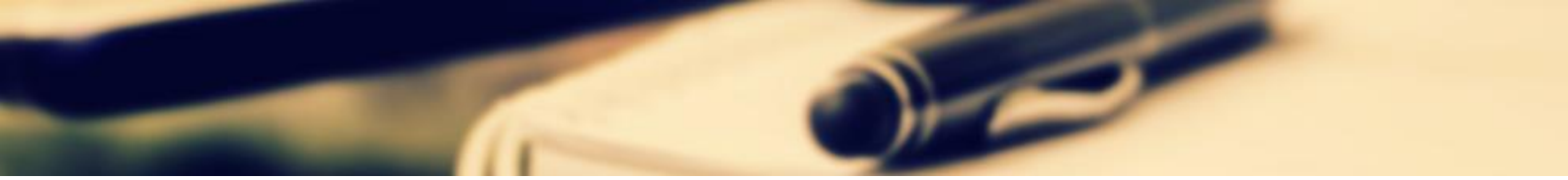
1. In January 2023, Jack was admitted to an acute hospital after having 4 falls within 24 hours. Paramedics submitted a safeguarding referral as Jack had appeared unkempt, the house was uninhabitable, and Jack had been sleeping on a mattress that was decomposing and he had been unable to access the toilet resulting in excrement on the floor. The paramedics' view was that Jack should not be discharged back to the property.

2. After admission, one of Jack's daughters told the social worker that Jack was frightened of his lodger Kyle who was allegedly coercing Jack into giving him money, and in her view, Jack was at very high risk of self-neglect because of the home conditions and also, he was no longer able to look after himself.

3. After being transferred to a community hospital for rehabilitation, Jack was then returned home to live with Kyle in mid-February with a plan for support to be provided by community nursing services and the adult social care rehabilitation team. However, the latter's involvement ended after 4 days at Jack's and Kyle's request. During the community nurses' visits, there were recurring concerns that Kyle had difficulty in helping administer the insulin for Jack's diabetes or take accurate blood sugar readings.

4. In early March, Jack was readmitted to hospital after a passer-by heard Jack screaming for help. Paramedics again raised a safeguarding concern having found Jack in an unkempt state, covered in urine and faeces having allegedly been left on his own for 3 days by Kyle. Jack's other daughter also raised a safeguarding concern that Kyle had stolen Jack's money and had been bragging in the pub that he was not caring for Jack. She also repeated that Jack was extremely afraid of Kyle who had allegedly been aggressive towards him. Jack confirmed these allegations when spoken to by police officers.

5. During Jack's extended stay in hospital, he was classed as 'recovery uncertain' in May and then fast tracked for 'end of life' care resulting in his transfer to a nursing home in early June where sadly he died a few days later.



Review Findings

Assessments

6. Assessments did not apply the required professional curiosity to establish the origin and nature of Jack & Kyle's relationship resulting in continuing misinformation about Kyle's status who was variously described as a lodger, friend, grandson and carer.

7. Jack's wish to return home became the sole driver of the hospital discharge planning and little weight was given to the risks of Jack returning to exactly the same home situation that led to his admission and his assurance that that there were no problems in his relationship with Kyle were taken at face value. There was no further exploration with Jack's daughters about the safeguarding concerns they had raised, nor were the details of these included in the hospital transfer summary.

8. No home visit was made prior to discharge to assess the home conditions which had been described as uninhabitable. Nor was there any exploration with Kyle to check out directly his willingness and ability to provide support to Jack or a carer's assessment being offered.

Mental Capacity

9. Jack was continually assumed to have capacity but there was insufficient consideration of Jack's executive functioning to weigh and use information about the risks around returning home, and whether coercion and control could be impacting on his decisions.

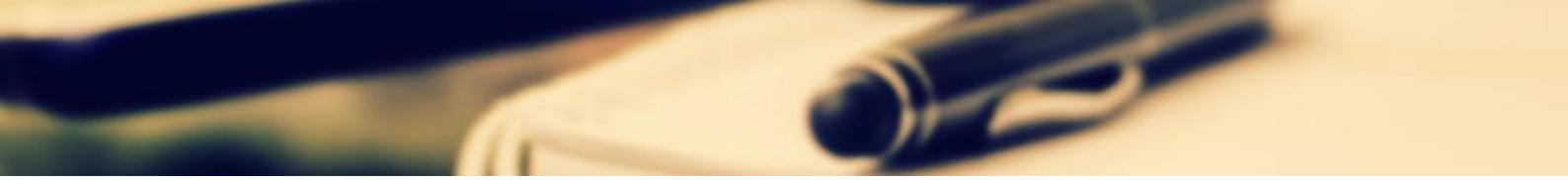
Response to safeguarding concerns

10. No referral was made to the MASH in January 2023 regarding the safeguarding concerns raised and the planned Section 42 enquiries remained unallocated until May 2023 because of backlog of cases. While there was a justifiable rationale for Jack's case being classed as low priority while safe in hospital, this needed to be kept under review. However, the adult safeguarding team was not informed of Jack's return home, nor later, the ending of the rehabilitation team involvement that meant there was no oversight of Jack's situation.

11. There were missed opportunities to raise further formal safeguarding concerns, first when Jack was found naked on the commode with food on his lap, and later when he was found naked covered in faeces the day before his readmission to hospital.

Recognition of neglect / self-neglect

12. There was no evidence that practitioners drew on the WSAB guidance on self-neglect to inform their assessment of Jack's situation, and there was a marked difference in the benchmarks applied by practitioners in considering whether the home conditions, and / or Jack's presentation amounted to neglect or self-neglect. While the paramedics' view in January and March that the house was uninhabitable, a view also reached by the police, other professionals had been visiting the home and not identified any issues.



Multi-agency working

13. Multi-agency working became almost non-existent after Jack returned home with no liaison between the community nurses and the reablement team to share perceptions about Jack's situation or the response from Jack and Kyle to the support being offered. The community nurses and family were unaware that support from the rehabilitation team had been withdrawn and no information was shared with the GP.

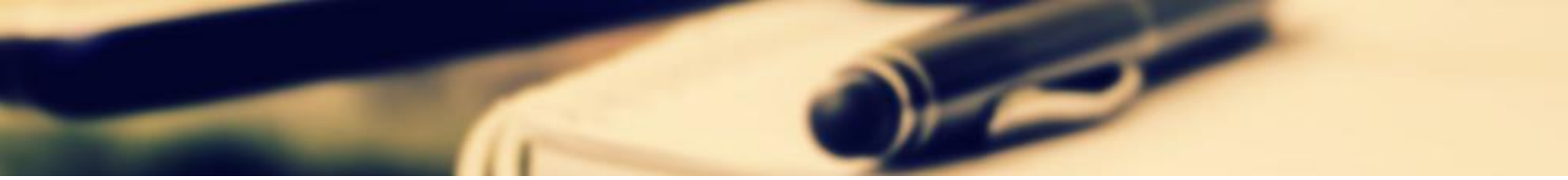
Referrals and Information Sharing

14. There were missed opportunities by the police to make referrals in April 2018 when previous safeguarding concerns had been raised about Kyle, and in February 2023, due to the lack of research on police systems, no direct contact being made with Kyle but instead decisions not to refer being based on information provided by family members.

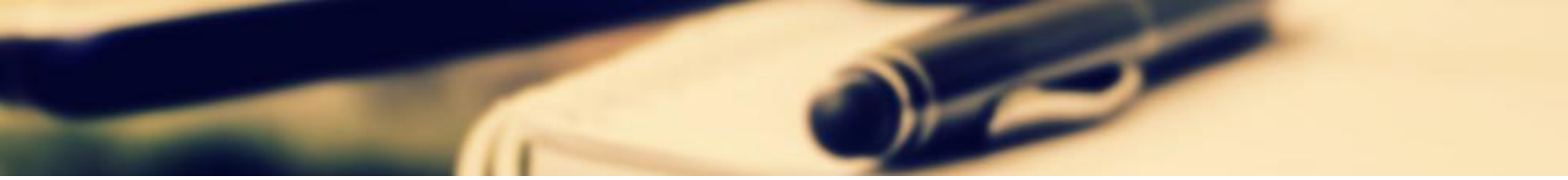
15. Police officers did not consider a referral was necessary following a visit in February 2023 because they accepted at face value the assurance provided by Jack that he was about to be visited by adult social care - information that was incorrect as no referral had been made to ASC at that point.

Escalating concerns

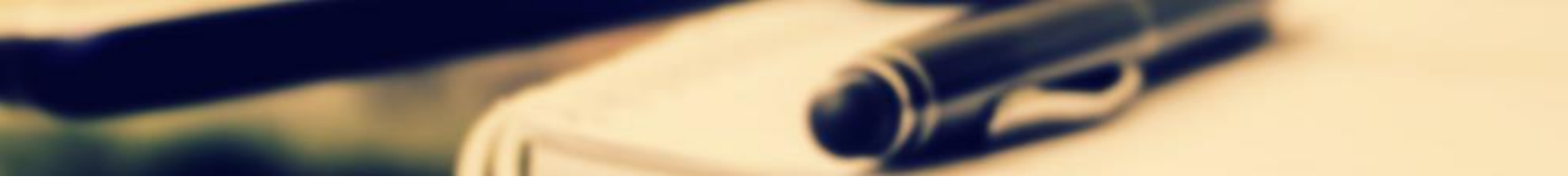
16. There were 2 occasions when professionals could have escalated their concerns, and challenge decisions made by other agencies. The first being the ward sister's disagreement with the social worker's decision to still progress Jack's wish to return home despite Jack having disclosed his fear of Kyle. The second when the request for urgent respite care made by the community nurses the day before Jack's readmission to hospital was allegedly rejected by adult social care



Learning identified	What will help?
Assessments Importance of applying professional curiosity to gather basic factual information about a service user and relationship to other household members / informal carers Importance of assessing a person's willingness and capacity of people to provide support and offer a carer's assessment.	Check agency record systems and contact other agencies to check accuracy of information; Seek the family's perspectives about the person's situation and any safeguarding concerns that have been raised. Carry out face to face visits wherever possible where the person has a hearing impairment, particularly where important decisions have to be discussed about care and support arrangements as the person may find telephone calls difficult to hear what is being said.
Considering Mental Capacity Importance of considering a person's executive functioning in being able to weigh up and use information.	Updating the MCA competency framework around executive functioning and how capacity may be impaired where the adult is a victim of coercion and control and then check how the competencies are being applied. Promote greater use of the WSAB Chair's podcast on assessing executive functioning.
Safeguarding The importance of the safeguarding adults' team being provided with information about any changes in the person's situation that could affect the conduct of planned Section 42 enquiries. The outcome of Section 42 enquiries to be shared with agencies that remain involved with the person to inform their future work.	Agencies reminding practitioners that where agencies are aware that the case remains open to the adult safeguarding team, the latter is being informed of any significant development or change in the service user's situation – e.g discharge home or withdrawal of support.



Learning identified	What will help?
Hospital discharge planning The importance of hospital transfer summaries including full details of any safeguarding concerns so that these can be taken into account in future agency involvement. Home visits need to be made prior to discharge to assess the home conditions where safeguarding concerns have been raised about these.	The planned joint audit of the hospital discharge pathway should include examination of whether hospital transfer summaries are including full details of any safeguarding concerns raised either at the point of admission and / or during the patient's stay in hospital. Joint guidance should be developed which sets out where responsibility sits for carrying out pre- hospital discharge home visits where concerns have been raised about the home conditions.
Neglect & Self Neglect Importance of practitioners drawing on the WSAB guidance on neglect and self-neglect.	Develop an audit questionnaire to establish a baseline picture as to the extent professionals are drawing on the updated 2024 WSAB guidance, and where this is not happening to explore with practitioners the reasons for this. Subject to the agreement of the family, the photographs of the home conditions taken by the police are included within learning material in respect of the findings from this SAR.
Multi-agency working The need for closer working and information sharing between practitioners working in the community	ASC and HWHCT to use its existing arrangements for periodic joint learning events to share the findings from this SAR in order to agree how joint working can be improved, including arrangements for agreeing a lead professional where multi-agency support is being provided, and ensure that practitioners are aware of the importance of including the service user's GP in the information sharing loop.



Learning identified	What will help?
Referrals & Information Sharing Where practitioners identify the need for care and support, the importance of checking out with relevant agencies that information about their involvement provided by the person is accurate, and where this is not the case, taking steps to make the necessary referrals.	Existing WSAB work programs, including those covering professional curiosity, should include the need for agencies to reinforce with their staff that, subject to obtaining the consent of the person, or considering whether there are grounds to override the person's wishes, referrals should always be made to the relevant organisations where possible unmet care and health needs have been identified, regardless of any assurances provided by the person about existing agency involvement.
Challenge and Escalation The importance of practitioners knowing how to escalate concerns and having the confidence to challenge decisions made by other professionals.	Disseminating the updated escalation policy across the safeguarding partnership and agencies checking that practitioners are clear about processes for seeking advice and / or escalating concerns both through their own agency internal arrangements and the WSAB escalation procedure.

Single Agency Learning Section: