Safeguarding Adult Review

Overview Report

Subject	**JACK**
Died	**2023**
Age	**79 years**

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CONTENTS

1. CIRCUMSTANCES LEADING TO THE REVIEW BEING ESTABLISHED

1.1 In January 2023, Jack was admitted to an acute hospital after the West Midlands Ambulance Service (WMAS) responded to a 999 call reporting that Jack had had 4 falls within 24 hours. On admission, Jack was described as displaying confusion and subsequently found to have pneumonia and a urinary tract infection.

1.2 A safeguarding referral was submitted by WMAS as Jack had presented as unkempt and the house was described as uninhabitable. 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.

1.3 After his 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.

1.4 After being transferred to a community hospital for rehabilitation, Jack was then returned home to live with Kyle on 14th February with a plan for support to be provided by community nursing services and the local authority rehabilitation team. However, the latter's involvement ended after 4 days at Jack's and Kyle's request.

1.5 On 10th March, Jack was readmitted to hospital when WMAS responded to a 999 call from a passer by who had heard Jack screaming for help. The paramedics found Jack in an unkempt state, covered in urine and faeces having allegedly been left on his own for 3 days by Kyle. WMAS again raised safeguarding concerns about the circumstances they had found Jack in.

1.6 The following day, Jack's other daughter informed the police that Kyle had stolen Jack's money and was publicly bragging about the fact he was not caring for Jack. The daughter also alleged that her father was extremely afraid of Kyle who was said to be aggressive and making threats. Jack confiirmed this when spoken to by police officers in hospital and he also alleged that Kyle had been misuing Jack's bank cards.

1.7 Kyle was arrested on 13th March but after giving a 'no comment' interview, he was released on bail with conditions not to contact Jack, directly or indirectly, or visit Jack's home address.

1.8 At the time of this latest admission, although it had been agreed in January that the original safeguarding concerns met the criteria for Section 42 safeguarding enquiries, these had not been progressed and Jack's case was still awaiting allocation.

1.9 After his admission to hospital, Jack was subsequently classed as 'recovery uncertain' at the start of May and was 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.

2. PARALLEL PROCESSES

2.1 The post mortem carried out in June 2023 concluded that the cause of death was a combination of the effects of ischaemic heart disease and high-grade malignant B cell lymphoma.

2.2 The outcome of the lengthy and complex police investigation was the conclusion that the threshold for bringing charges had not been met and the investigation was filed in April 2024. More details about the reasons for this outcome are included later in the report.

2.3 Herefordshire and Worcestershire Health and Care NHS Trust (HWHCT) applied its serious incident process with a root cause analysis investigation being carried out which included a 'Round Table Event' with relevant staff. [1] The report setting out the learning and action plan was approved in June 2023.

3. REASONS FOR ESTABLISHING THE SAFEGUARDING ADULTS REVIEW

3.1 Under Section 44 of the Care Act 2014, the Local Safeguarding Adult Board (SAB) must carry out a Safeguarding Adult Review (SAR) where an adult with care and support needs (whether or not those needs are met by the local authority) in the Safeguarding Adult Board's area:-

(i) has either died as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked together more effectively to protect the adult"

(ii) the adult has not died but the SAB knows or suspects that the adult has experienced serious abuse or neglect.

3.2 The decision to establish an 'extended' SAR was made by the Independent Chair of the Worcestershire Safeguarding Adults Board (WSAB) on 25th May 2023 who endorsed the findings of a 'Rapid Review' held that day which concluded that the Care Act criteria were met.

Purpose of the Safeguarding Adult Review

3.3 The approach taken in carrying out this SAR reflected the safeguarding principles set out in the Statutory Guidance to the Care Act 2014:-

- to establish whether there are lessons to be learnt from the circumstances of the case about the way in which local professionals and agencies work together to safeguard adults at risk;

- to determine what agencies and individuals involved might have done differently to prevent the harm or death;

- to review the effectiveness of multi-agency safeguarding arrangements and procedures (both multi-agency and those of individual organisations);

[1] *Community Hospital, Neighbourhood team, HWHCT Patient Safety Team and WCC Social Worker (Onward Care) and Reablement Team.*

- to identify the learning, including examples of good practice, and apply these to improve practice and partnership working to prevent similar harm occurring again in future cases.

4. TERMS OF REFERENCE

4.1 The Rapid Review, and the subsequent handover meeting involving the Rapid Review Chair and the SAR Lead Reviewer, identified the following key lines of enquiry where there was the potential for learning:-

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- How the safeguarding concerns raised by both professionals and family members were progressed;

- The effectiveness of hospital discharge planning;

- What information was shared about the previous safeguarding concerns when Jack was discharged from the 2 hospitals;

- Were there occasions when further safeguarding concerns could have been raised;

- The rationale for the decision of the ASC reablement team to end support;

- The approach taken to multi-agency working and information sharing;

- To what extent was Jack's 'voice' heard in decisions being made about his care and support, and how the Mental Capacity Act was applied.

- What steps were taken by agencies to establish the nature of the relationship between Jack and Kyle, and how that affected decisions made about the provision of support;

- The approach taken by professionals in assessing Kyle's willingness and competence in providing support to Jack;

- How Kyle's own needs were considered and whether he was offered a carer's assessment;

- Whether professionals considered the possibility that Jack was a victim of coercion and control from Kyle.

Time period to be reviewed

4.2 In order to explore the key lines of enquiry, and ensure that the review was proportionate, the review covered the period from 1st January 2023 up to Jack's death in June 2023. This start date was chosen in order to enable exploration of multi-agency planning as to how Jack's health and care needs would be met following his admission to hospital in January 2023 and the response to the safeguarding concerns raised at the time. It was also agreed that the review would take into account any significant events outside of this timescale.

5. REVIEW PROCESS

Timescales

5.1 The SAR commenced in October 2023. The terms of reference were approved by the WSAB SAR Group in January 2024 following an extended consultation process, and agencies then submitted their reports in March 2024. Two meetings of the SAR Panel comprising the agency report authors were held during May and June which resulted in agreement on the findings and recommendations presented in an interim report. This overview report was finalised after being circulated for comment to the SAR Panel in June and the SAR Review Group in July 2024.

Organisations contributing to the SAR

5.2 The following agencies contributed to this review through submission of chronologies and agency reports covering their involvement with the agency authors forming the SAR Panel:-

Worcestershire County Council Adult Social Care (ASC)
Worcestershire Acute NHS Trust (WAHT)
Herefordshire & Worcestershire Health & Care NHS Trust (HWHCT)
West Mercia Police (WMP)
Herefordshire & Worcestershire Integrated Care Board (HWICB) on behalf of Primary Care

An information report was also provided by West Midland Ambulance Service (WMAS).

Family involvement

5.3 Letters were sent to Jack's 2 daughters, Susan and Helen, in February 2024 who quickly indicated their willingness to contribute to the review. A first meeting took place using the 'Teams' platform later in February when Susan and Helen shared helpful insights about Jack, their perspectives of Jack's relationship with Kyle, and their experiences of contact with agencies involved in Jack's care. These perspectives are included later in the report. Further meetings were held in May and early August to provide feedback on the review findings.

Practitioner Reflection and Learning Events

5.4 Careful consideration was given to the most appropriate way of engaging with practitioners and managers who were involved in the case given that many had previously been involved in learning and feedback events within their own agencies, which had proved a difficult experience for some staff. It was agreed therefore that carefully managed multi-agency learning events would best be held following WSAB's consideration of the report.

6. AGENCY INVOLVEMENT PRIOR TO THE SAR REVIEW PERIOD

6.1 There had been no involvement of Adult Social Care and community nursing services prior to the SAR review period. There had been little contact with GP services other than in relation to routine screening and oversight of Jack's diabetes – the last review being in September 2021. There had been several hospital attendances and admissions in the past but none that were significant in terms of the SAR key lines of enquiry.

6.2 The police had been involved on the following 3 occasions in relation to Kyle - one of these related directly to safeguarding concerns regarding Kyle's behaviour towards Jack. Reference to the outcome of these is important because of the implications these had for the later police involvement during the review period.

Theft / domestic abuse investigation 12 May 2018

6.3 In May 2018, Kyle's parents alleged financial abuse by Kyle who had been allowed to have control of their finances and had used their bank cards to take money for his own use. However when visited by officers the couple did not wish any further action to be taken as they had retaken control of their finances and the relationship with Kyle was said to be improved.

Adult Protection Investigation 23 November 2018

6.4 Susan, Jack's younger daughter, reported that Jack was afraid of Kyle, his lodger for the past 10 years, and Kyle had been taking money from him. Jack wanted Kyle to leave but he had refused saying he would kill Jack first. Susan described how her father was vulnerable because of physical and mental health issues. However, when Jack told the officers that he was happy for Kyle to remain living with him it was concluded that the situation was a general fallout between landlord and tenant and that no crime had been committed. The police Harm Assessment Unit (HAU) determined that the threshold had not been made for any referrals to be made.

Sending letters with intent to cause distress – 15 September 2021

6.5 Kyle's sister reported that she had been told by her mother that Kyle had threatened to kill her. Attempts to interview the sister were unsuccessful but officers spoke to Kyle's mother who explained that Kyle was prone to saying 'stupid things' when he was angry due to his mental health issues. Whilst it was noted that Kyle was known to the police because of the previous incident, the investigation was filed for no further action as there was no supporting evidence or history of previous violence. A few weeks later, Kyle's sister made the same report to Derbyshire police as she had recently moved into their area. When this was then transferred to West Mercia Police it was established from Kyle's sister that she no longer wished to make a complaint as the harassment from Kyle had stopped.

6.6 A recurring gap in the approach taken by police officers identified in the police agency report was that contrary to what would have been expected, Kyle was never spoken to directly during these episodes to explore the safeguarding concerns reported. This was a significant oversight given subsequent events.

7. CHRONOLOGY FROM JANUARY 2023

7.1 On 15th January 2023, Jack was admitted to the Alexandra Hospital after paramedics responded to a 999 call reporting that he had had 4 falls within 24 hours and they identified possible indicators of a stroke.

7.2 The paramedics submitted a safeguarding referral which raised concerns about apparent neglect / self neglect because Jack had been found in an unkempt state with evidence of poorly managed diabetes and mobility issues. The referral highlighted the poor condition of the house which suffered from leaks and was very dirty. Jack had been living upstairs and sleeping on a mattress that was decomposing. He had been unable to access the toilet resulting in excrement on the floor. The paramedics' view was that the house was uninhabitable and Jack should not be discharged back to the property. They also raised questions about the situation of Kyle living with Jack given the state Jack was found in.

7.3 Soon after admission to hospital, the ward submitted a request for a Deprivation of Liberty Safeguards (DoLS) Urgent Authorisation to enable care and treatment to be provided. This was because Jack was presenting as confused and displaying aggression when objecting to treatment which included pulling out intravenous devices.

7.4. On 18th January, a hospital social worker (HSW1) also raised a safeguarding concern after speaking to Helen, Jack's older daughter, who had shared her view that her father was at high risk of self-neglect and it would be unsafe for him to return home. This was because of the poor condition of the home, his increasing difficulty in managing his own needs, and his cognition having shown signs of deterioration. Helen also shared her concerns that Jack had told her that he was frightened of Kyle who had been his lodger for several years, and he had been coercing Jack into giving him money which he then spent at the pub.

7.5. On 27th January, the safeguarding concerns raised by WMAS and HSW1 were triaged by the ASC Adult Safeguarding Team. This included a discussion with Helen who repeated her concerns and said that her father had agreed to move into a care home. The decision was made that the criteria for Section 42 enquiries were met and the case was placed on the waiting list for allocation given that the risks to Jack were temporarily being mitigated through his being in hospital.

7.8 After being deemed medically fit for transfer, Jack was moved to the Princess of Wales Community Hospital (POWCH) on 1st February for rehabilitation, and HSW1 sent notification of transfer of responsibility to the social work team there.

7.9. The following day, Jack told the physiotherapist that he was 'very keen' to return home and did not want to go into a care home. However, during the discussion with the ward sister when completing the patient contact form, Jack disclosed that he was not coping at home and felt intimidated by Kyle. The ward sister therefore, with Jack's consent, sent an internal SAP form raising a safeguarding concern in respect of this disclosure to the hospital social worker linked to the ward (HSW2).

7.10 On 3rd February, after speaking to Jack who was described as lucid, HSW2 recorded that there were no concerns about his mental capacity regarding his wish to return home. HSW2 then sent an email to the occupational therapist (OT) explaining that Jack was happy to have Kyle stay with him and had not wanted the safeguarding concerns raised by Helen to be taken further. In response to the question raised as whether a pre discharge home visit would be made as the house was 'in a bit of a state', the OT responded to explain that OT involvement would start the following week as the physio was still working with Jack.

7.11. On 5th February, Kyle attempted to visit Jack but was initially denied access because he was not on the agreed list of visitors. Jack told an agency nurse 'that he would feel like dying' if Kyle was not allowed to visit. Access was then allowed after Kyle had managed to obtain the password from a member of the family. Jack was pleased to see Kyle and told ward staff that he was like a grandson, Kyle was renovating the house including the installation of a bathroom / wet room, and was going to be his full time carer.

7.12 On 7th February, the pre-discharge assessments carried out by the OT and Physio identified that Jack needed assistance with dressing, and a 'mo lift' and a hospital bed were ordered as Jack would need to live downstairs. Jack gave consent for the OT to update the family and to ring Kyle who would need to make space for the equipment.

7.13 On 8th February, the Multi Disciplinary Meeting (MDT) identified no concerns about Jack being discharged home once the equipment was in place. HSW2 was informed by ward staff that Kyle was visiting Jack despite not being on the list of agreed visitors but that this was what Jack wanted and he had capacity to make that decision.

7.14 Referrals were made to the ASC Rehabilitation Team and also the HWHCT community team (district nurses) given Jack's continuing incontinence and his lack of self confidence in insulin administration. Both teams separately carried out assessments at home on the day Jack returned home on 14th February resulting in each service making a plan for multiple daily visits.

7.15 Although the district nurse documented that Jack was adamant that he would manage with Kyle's help, the reablement assessor was more cautious about Kyle's suitability to be Jack's carer given the previous safeguarding concerns, and was insistent with Kyle that 4 calls would be made each day by promoting independence assistants (PIAs) to ensure that Jack was safe. The following day after visiting and finding the home conditions to be unkempt, an OT from the reablement team emailed an OT colleague to say that the previous safeguarding concerns would need further investigation by the assessor / case manager. This was because the house was observed to be unkempt and it was not clear from talking to a nurse what support Kyle was able to offer with domestic tasks.

7.16 Over the first 3 days, the PIAs often found that apart from help with medication, their support was often declined by Jack as all other tasks were being carried out by Kyle. This led to the service assessor being informed by a PIA that Kyle wished things to return to how things had been previously, with Kyle providing all support which he considered was going well.

7.17 After telephoning Jack who confirmed this was what he wanted, the service assessor ended the support immediately. The recorded rationale for this decision was that there was no reason to doubt Jack's mental capacity to make this decision, Kyle was providing all support, and all outstanding health issues had been passed to the district nursing team. This included information being passed on after the final visit that the TED stocking were too long, his nails looked filthy and needed cutting, and that the PIA had discovered open wounds to Jack's ankle and right heel. The PIA had also recorded that these had been reported to the GP.

7.18 From the outset of the district nurses involvement, they had identified recurring problems in relation to Kyle carrying out checks of Jack's blood sugar levels and helping Jack to administer his insulin. This resulted in the nurses carrying out the task and providing further demonstrations on several of the visits. However, by 23rd February, after establishing that Kyle was now able to administer the insulin, the contact to check that things were going well was switched to telephone calls and the insulin support was ended after a final visit on 28th February.

7.19. On 25th February, the police attended immediately after a member of public had heard a heated argument from Jack's address. They established that Kyle had been arguing over the phone with his sister and Jack had not been sure if Kyle was shouting at him or down the phone because he was hard of hearing. Jack informed the officers that he felt safe at home but was having a meeting with Adult Social Care (ASC) as he was hoping for more support. The officers recorded that Kyle was Jack's grandson and had been acting as his carer for 17 years. A DASH risk assessment resulted in a conclusion of medium risk. Following a review by the police Harm Assessment Unit (HAU), the decision was made that no further action would be taken and no referrals were required given the information that Jack and Kyle were related, and that ASC were already aware of them.

7.20 On 28th February, a physiotherapist carried out an assessment and found Jack sitting on a pad with no clothes on with food on his chest and in his lap. The house was noted to be in an unkempt state which Kyle apologised for. Jack was able to pull himself up with the molift but he had reduced power in his right leg. The physio recorded a plan to review this with the GP.

7.21 On 6th March, a referral from Kyle asking for support with Jack's care was passed to the area social work team by the Targeted Adult Support Team (TAST). The referral included reference to there being safeguarding concerns in respect of Jack living with Kyle who was recorded as being Jack's grandson. The area team duty worker (ADW1) rang Helen as there were no contact numbers for Kyle on the local authority record system (LAS). Helen provided the telephone numbers for Jack and Kyle explaining that Kyle was not Jack's grandson and she had previously raised safeguarding concerns.

7.22 2 days later, on 8th March, 2 further unsuccessful attempts were made by ADW1 to ring Jack and voicemails were left asking for him to ring the duty team if the situation was urgent as ADW1 would be on leave until Monday 13th March, and to let the duty team know the best time and number for ADW1 to ring on her return. An attempt to leave a message on Kyle's phone was not possible because the voicemail was full.

7.23 ADW1 then sent a message to the area social work duty team via LAS on Thursday 9th March to explain that the case was open to adult safeguarding and to request the duty officer (ADW2) to make further efforts to contact Jack to ascertain if support was needed. ADW2 spoke to Helen and recorded that she did not raise any concerns and would be visiting that day. Further voicemail messages were then left for Jack and Kyle to either contact the allocated worker on Monday 13th March or the duty team in the meantime.

7.24 The same day, a district nurse visited to provide planned wound care and found Jack sat naked on the commode covered head to toe in faeces saying he was cold. The house was described as very unkempt with puddles of water at the back of the property and soiled incontinence pads on the floor. Kyle said that he was just trying to clean Jack up.

7.25 Additional nurses attended to assist in providing personal care to Jack who screamed when they were cleaning his sacral area because it was so sore. The nurse spoke to Kyle regarding the situation who said he had telephoned Adult Social Care (ASC) for help the previous Friday. After seeking telephone advice from a band 7 colleague, the band 6 nurse rang the ASC area social work team to seek an emergency respite bed and raise concerns about Kyle's ability to cope. The nurse recorded that the response received from ASC was that they did not provide this but that the allocated worker would be visiting on Monday.

7.26 At around 5pm the following day. Friday 10th March, a member of the public rang the GP surgery after hearing Jack screaming for help and then rang 999 on the advice of a senior receptionist. Paramedics attended and found Jack in an unkempt state with heavily soiled clothing and bed linen soaked with urine and faeces. There was also no food or drink to hand and Jack's blood glucose (BG) was found to be elevated at 22.0 mmol/l. Jack was taken to hospital where it was noted that the wounds to his sacral area had the appearance of cigarette burns. The paramedics submitted a safeguarding concern.

7.27 Later that evening at 19.40 hours the police received a non-emergency call from the same member of the public who had been in the local pub when Kyle had been bragging about how much money he had and was buying everyone drinks. Kyle was saying he had taken full responsibility for Jack who was in bed and could not get out. The caller had then gone to check on Jack and could hear him screaming but could not get into his house. Police attendance was not requested as the ambulance had already attended and the call had only been made to raise concerns for Jack's welfare.

7.28 Initially the police call taker prompted the neighbour to call ASC because it was no longer an urgent safety issue as WMAS were already aware of the situation. When the caller declined to do this the call taker contacted the Adult Social Care out of hours duty team who stated Jack was open to them but Jack did not have a package of care in place but was receiving daily visits from the district nurses.

7.29 The call taker was also informed that there was an open safeguarding report due to concerns raised by Jack's daughter about Kyle. In addition, Jack was believed to have capacity because it was known to them that he liked Kyle. The out of hours service confirmed it would pass on details of the call to the area team on Monday 13th March. The police log was closed and graded as not for police attendance due to Adult Social Care having been contacted and made aware of the situation.

7.30 The next day, Saturday 11th March, Susan rang the police and provided the same information reported by the member of the public the previous day. Susan alleged that Jack was scared of Kyle who was aggressive, had made threats towards him and had been hitting him. Officers made contact with the hospital that evening and it was agreed they would visit Jack the following day. The nurse said the hospital was concerned about Jack returning home and that a professionals meeting would take place on the Monday morning.

7.31 The following day, a vulnerable witness statement was taken from Jack who said he met Kyle in the pub where Kyle offered to be his full time carer. However, after a few weeks Kyle had stopped caring for him and left him in bed for 3 days. Jack also stated that he had given Kyle his bank cards to pay for shopping and he had authorised this with his bank but Kyle had left and did not return. Jack recalled that Kyle had 'thumped' him but did not offer any further details but kept saying how scared he was. In exploring the possible cigarette burns, Jack denied that Kyle had ever burnt him.

7.32 An Adult Risk Assessment was completed with the finding of medium risk. The officer spoke with HSW1 who believed Jack would remain in hospital until the next day and would most likely be released back home with a full care package. Kyle was arrested and answered no comment to all questions in the subsequent interview. He was released on bail with conditions not to contact Jack directly or indirectly or to visit Jack's address.

7.33 On Monday morning, 13th March, Susan rang the area social work team to speak to the allocated worker but was told the latter was busy. Although Susan was told the allocated worker would ring her back, there is no record of that taking place. The same morning, HSW1 forwarded the safeguarding concern submitted by WMAS to the ASC Safeguarding Team and included the concerns previously raised by Helen in January.

7.34 Later that day, officers visited Jack's home which was described as being in a 'terrible state' because it was extremely dirty, untidy and in places unsafe for habitation. A Crime Scene Investigator took photographs of the conditions.

7.35 This led to the police supervisor having concerns given the information previously provided by the hospital that Jack was likely to be discharged home, as it did not appear that Jack would be able to care for himself and he would be at further risk of exploitation. A police CID officer then sought more information from first the safeguarding team, and then the allocated worker, regarding the plan for Jack explaining the allegations that had been made against Kyle and the bail arrangements.

7.36 On 16th March, the police HAU submitted a safeguarding concern to the ASC adult safeguarding team regarding possible offences of common assault and theft by Kyle. This was added to the case record that indicated that the safeguarding enquiries were still awaiting allocation to an Advanced Social Work Practitioner (ASWP).

7.37 On 18th March, a social work student in the hospital team requested the area social work team to find out from the police if the home was suitable for Jack to return to. Although agreeing to do this, the area team social worker confirmed that a home visit would be needed to assess its suitability.

7.38 The following day, the ASC safeguarding team was contacted by the Hospital Onward Care Team (OCT) asking if there is an update from the police about the home conditions as the OCT do not complete home visits and were hoping to use the judgment of the police to inform its decision making.

Treatment provided following readmission

7.39 Soon after admission, Jack was referred to the internal mental health team whose assessment found Jack to be extremely anxious and distressed as a result of the recent trauma. Jack expressed his wish to return home but with the 'right carers'. It was recorded that there was no evidence that Jack lacked mental capacity to make this decision.

7.40 The main medical issue that was investigated centred on whether Jack had a brain tumour or hemorrhagic metastasis. An MRI scan identified a non-specific hemorrhagic lesion in the left frontal lobe superiorly with surrounding oedema and ill-defined contrast enhancement. A recommendation for conservative management, and not for intervention was the outcome of the discussions at the Neuro-oncology MDT meeting.

7.41 At the start of May, Jack was classed as ‘recovery uncertain’ and he w as later fast tracked for ‘end of life’ care resulting in his transfer to a nursing home in early June where Jack subsequently died a few days later.

8. OUTCOME OF THE POLICE INVESTIGATION

8.1 The financial checks revealed there were some transactions where Kyle had used Jack’s card but there was no evidence that these had been made without Jack’s authority. Checks with the Department of Work and Pensions (DWP) also established that Kyle had never claimed a carers allowance. Therefore it was concluded that pursuing the financial abuse, and a possible charge of theft, was not viable given the above findings and because of the absence of a formal account from Jack. In addition, the charge of common assault was no longer being considered because the time permitted to bring this forward had passed.

8.2 Therefore the investigation focused on a possible offence under Section 5 of the Domestic Violence, Crime and Victims Act 2004 of causing or allowing the death of a vulnerable adult. This stemmed from the findings and recommendation made by the Forensic Pathologist that a Geriatrician should review Jack's care records covering the period prior to his admission to hospital to help establish if the cause of death, and the decline in Jack's health, had any links to the neglect / self neglect. However, after careful consideration, the huge amount of work involved in such enquiries was not considered to be proportionate, and as outlined previously, the investigation was filed for no further action.

PART 2 REVIEW FINDINGS

9. INTRODUCTION

9.1 The presentation of the review findings and learning is organised within the following 7 themes:-

- Assessments;
- Application of the Mental Capacity Act;
- Response to safeguarding concerns that were raised;
- Hospital discharge planning;
- Missed opportunities to raise further safeguarding concerns;
- Recognition and response to self neglect;
- Multi-agency and internal agency working.

9.2 Most of the learning is not new and reflects a number of common themes that have featured in previous reviews carried out by WSAB, particularly in respect of issues around mental capacity, professional curiosity, self neglect and multi-agency working.

9.3 Since this case a number of initiatives have been implemented which address some of the findings of this review and these will be described briefly at relevant points.

9.4 In addition, agencies have identified their own single agency learning and recommendations which are attached at Appendix 1. Most of those identified by HWHCT, HAWT and Primary Care have already been implemented which is shown by the description 'completed' in yellow highlighter.

9.5 First however, the report will summarise the information and perspectives provided by Jack's family.

10. PERPSECTIVES SHARED BY JACK'S FAMILY

10.1 After working for a car manufacturer, Jack ran his own garage repair business but sold this after he lost an eye in the early 1990s when a car battery blew up in his face. After the accident, as well as the physical side of the injury, Jack became more vulnerable and received counselling as he found it hard emotionally to deal with things. Jack never drank or smoked but enjoyed food with shopping being one of his favourite pastimes along with gardening.

10.2 About 20 years ago Jack suffered a series of mini strokes and then a heart attack which resulted in a stent being fitted. He then developed type 2 diabetes but found it difficult to control this through diet. Jack recovered from the strokes and remained active until 5 years ago when the onset of Parkinson's disease led to his mobility deteriorating resulting him buying a mobility scooter. Jack had also started to become more forgetful and kept repeating himself.

Jack's relationship with Kyle

10.3 Shortly after Jack divorced in the mid 2000s, he offered Kyle a home to avoid the latter becoming homeless after he was forced to leave home by his parents because of his behaviour. Kyle was 16 years old and Jack knew his parents well. Although the daughters' perception was that Jack was afraid of Kyle from quite early on, Jack would always say that he did not want to live on his own and Kyle would be there to help if anything happened to him. Over time, Jack would tell people how Kyle had become like a grandson.

10.4 For a number of reasons the daughters did not visit Jack as much as they felt they should have, or wanted to, and instead telephoned him regularly. Both were in full time work and Helen was also caring for their mother who had a serious health issue. The main reason however was that Kyle made it very clear he did not want them to visit, and they felt intimidated by the aggressive way he spoke and because he was always drinking alcohol. They described Kyle as an alcoholic who never worked apart from occasionally helping out in the pub to fund his habit, which he was also alleged to have done by taking money out of Jack's bank account every other day. Kyle also had a Staffordshire bull terrier which Susan did not trust and wanted to protect her 2 young children whom she would need to take with her as she was a lone parent.

10.5 Although Jack often told them about Kyle's aggression and violence towards him, he would then always say he was fine if they then visited to check on him and there was not much they could do. This was the background to the call that Susan made to the police in 2018. Susan understood why the police concluded that they could not do anything as Jack told the officers that everything was fine but she did think they could have pressed her father a little more to establish what was going on.

Decision to return Jack home in February 2023

10.6 After Jack had agreed to move into a care home after being reassured that this would not mean losing his independence, they felt frustrated that their concerns were not listened to about the risks if Jack was to return home given the unfit state of the house, and the practical problems of living in an old small 2 up / 2 down cottage that had very steep stairs with the toilet and bathroom being outside. They pointed out that the proposed solution of putting a hospital bed and commode in the sitting room would not resolve the problem that Jack would not be able to get out of bed during the night to use it as he was unable to do much for himself. They also could not see how the provision of daytime carers would address that problem.

10.7 They were unhappy that Kyle was allowed to visit Jack in hospital despite their attempts to protect Jack by preventing these, and that hospital staff then took Kyle's assurances as 'gospel' that he could take care of Jack despite the previous safeguarding concerns that had been raised. In addition, they noted that Kyle's visits coincided with Jack's insistence that he wanted to return home and felt that this was in part due to pressure from Kyle who wanted Jack to eventually sign the house over to him. [2]

[2] *This would not have been possible because the house was jointly owned by Jack and his brother who had been joint inheritors following their parents' death.*

10.8 Their perception was that Jack did not comprehend what they, or hospital staff, were saying during the discussions about the discharge plans. While they could understand why Jack kept saying he wanted to return home and see the dog, his views about improving the home conditions were unrealistic - for example Jack seemed to think that hoovering the carpet was all that was needed. Their perception was that Jack had forgotten how difficult things had been at home for him prior to his admission, and he was just harking back to the good times in the past.

Care provided after Jack's return home

10.9 Although the daughters were pleased that carers started to visit daily they did not think it was right that they suddenly stopped going when Kyle said he could provide all the care. They were also unhappy that they were not informed that the visits had ended.

10.10 Their view was that Kyle should have not been allowed to just take over the tasks and there should have been a process for his ability to do these to be assessed. Given the state of the house that the paramedics found Jack in on both occasions they took him to hospital, the carers should have seen that Jack and Kyle were not coping. They also commented that when they visited the house after Jack's readmission to hospital to clean the equipment for collection, both the bed and the commode were in a filthy condition and the smell was overwhelming.

Reaction to the outcome of the police investigation

10.11 The daughters expressed their disappointment with the outcome of the police investigation and that in their view 'Kyle had got away with it all'

11. ASSESSMENTS

11.1 Despite being a key foundation for achieving accurate assessments, those carried out in this case did not gather basic information about Jack and Kyle nor display the required professional curiosity in exploring the origin and nature of their relationship. This resulted in continuing misinformation about Kyle's status who was variously described as a lodger, friend, grandson and carer. This was despite the clarification previously provided by Jack's daughters that Kyle was a lodger and not related to Jack.

11.2 It was good practice that applying the 'making safeguarding personal' approach resulted in Jack being seen alone and his views sought on several occasions during the discharge planning. However, Jack's wishes appear to have become the sole driver of the plan for him to return home, and the assessment completed by HSW2 did not include any reference to the safeguarding concerns raised by WMAS and Helen. This meant little weight was given to the possible risks of Jack returning to exactly the same home situation that existed prior to his admission.

11.3 A significant gap was that Helen was not approached to seek more detail about the perspectives she had previously shared with HSW1 about Jack's situation, the nature of the relationship with Kyle, and the allegations of abuse perpetrated by the latter. Instead Jack's self reporting of his relationship with Kyle, who presented well when he visited the ward, seemed to be accepted at face value by HSW2.

11.4 In addition, there was no exploration with Kyle to check out directly his willingness and ability to provide support to Jack, nor was any consideration given to offering Kyle a carer's assessment - both prior to discharge, or after Jack's return home. Again, the reliance on Jack's self reporting, without seeking any corroboration, led to a false picture being gained about the extent to which Jack was reliant on Kyle's support. The conclusion reached by HSW2 that Kyle was not undertaking any substantial care tasks resulted in Jack being assessed as semi-independent.

11.5 After Jack returned home, the conclusion of the HWHCT report was that Kyle's competence to check the blood sugar readings and assist with the insulin administration was not robustly assessed, and increasingly nurses took his word for it that the tasks had been carried out satisfactorily. Concerns regarding Insulin storage and documentation in the home were also not dealt with appropriately.

Working with adults who have a hearing impairment

11.6 In seeking to gain Jack's views, his hearing impairment was not taken into account sufficiently by practitioners. On admission to POWCH it does not appear that checks were made initially that Jack was using his hearing aid after it was observed that he appeared very deaf. After Jack's return home, crucial discussions about the provision of support were too often carried out inappropriately through phone calls – a method of communication fraught with the potential for mishearing and misunderstandings for someone with severe hearing difficulties. Both the ASC and HWHCT reports identified that home visits should have been made to hold these discussions.

Recommendation 1

WSAB should seek assurance that agencies have taken the necessary steps to check that when practitioners carry out assessments, they are:-

- *establishing accurate baseline information about the service user, others living in the household or involved in providing support, and the nature of those relationships;*

- *assessing the willingness and capacity of informal carers to provide support and always considering whether a carer's assessment needs to be offered;*

- *engaging with family members to gain their perspectives about the service user's situation, including any safeguarding risks and support needed.*

- *checking with adults with hearing impairments that they are able to hear and understand what is being explained to them, and holding face to face meetings wherever practicable.*

12. APPLICATION OF THE MENTAL CAPACITY ACT

12.1 After the DoLs application made by the ward at the Alexandra Hospital, Jack was assumed to have capacity throughout the subsequent agency involvement having recovered from his earlier delirium and confusion.

12.2 However, within the assessments to inform the discharge planning, there was insufficient consideration of Jack's executive functioning as to whether he could make use of salient information to weigh up the risks that he might face in returning to what was previously an unsafe home environment. Exploration of this in greater depth, in the context of the known indicators of self neglect, would have been expected given that Jack's own reporting of his ability to live safely in the community was at odds with the concerns previously reported by WMAS and Helen.

12.3 If appropriate consideration had been given to the indicators of self-neglect, cognitive decline and potential coercion of Jack by Kyle, there would have been a greater chance that a reason to call into question Jack's capacity would have been triggered resulting in appropriate assessments being carried out. As it was, it was never established if Jack understood the inherent risks associated with his home conditions, nor the reasons why his property and his physical health had deteriorated so significantly, as the historic context was never explored.

12.4 In considering the professional difference of opinion between the ward sister and HSW2 when the former raised the internal safeguarding concern, the panel agreed it would have been beneficial for an assessment to have been carried out jointly – an approach that should be considered in similar situations in the future.

12.5 Given that the lack of consideration of an adult's executive functioning has been a finding in previous reviews, resulting in signposting on the WSAB website to relevant case studies from these, it would appear that there is still a need for further steps to be taken to address this issue.

12.6 In reaching that finding, the review noted the observation made by the police that although officers do carry out informal assessments, it is not part of its statutory role to undertake formal capacity assessments. Instead officers would look to make referrals to other agencies for assessments to be carried out where a possible issue around executive functioning is identified.

12.7 The ASC report also picked up an issue around the incorrect use of terminology. The frequent references in the records that Jack had capacity implied that an assessment had been carried out which was not the case. Having regard to the underpinning principles of the MCA, practitioners should have used the phrase "there is no reason to doubt Jack's capacity", which would then explain why no formal decision specific assessments had been considered necessary.

Recognition of possible coercion and control

12.8 Linked to the above findings are those relating to the lack of consideration by practitioners, other than the ward sister at POWCH, as to whether Jack was a victim of coercion and control from Kyle and whether this may be impacting on his mental capacity to make decisions about his care arrangements. This was despite the 3 possible indicators reported by Jack's daughters:-

(i) Jack's alleged fear of Kyle;

(ii) the allegations that Jack was being coerced into giving Kyle money;

(iii) Kyle seeking to pressure Jack not to sell the house and move into residential care.

12.9 In respect of the latter, there was no follow up by HSW2 or the ASC adult safeguarding team of the information provided by Helen that she had spoken to the ward to prevent Kyle visiting. Had more input been sought from Jack's daughters during HSW2's assessment, a more complete picture of Kyle and his behaviours may have been gained as were shared with the author during the SAR process.

12.10 It remains unclear whether Jack was spoken to on his own face to face by professionals after his return home. It was significant that the request for things to return to how they were, without support from the reablement team, was instigated by Kyle. The decision to seek Jack's wishes regarding this request via a telephone call meant that the assessor would not have known if Jack was being placed under any actual duress, or was fearful of duress, if Kyle was present during that call.

12.11 The review findings would suggest that there is a need for further work to raise awareness around how to recognise and respond to indicators of possible coercion and control, and how this needs to taken into account when considering mental capacity.

Action already taken

12.12 The review panel noted that there is already some quality assurance activity taking place. Information was provided by ASC regarding the rolling programme of single agency monthly audits [3] carried out by a Senior Best Interests Assessor (BIA) in the DoLS Team. These audits, that form part of ASC's arrangements for assessing practitioner competencies, examine the quality of MCA assessments and best interest decisions thus providing an opportunity for learning from good practice, as well as identifying any areas for improvement. [4]

12.13 In addition to individual feedback to practitioners and their line manager, the themes emerging from the audits are collated by the DoLS team manager. These are then cascaded through the organization via the BIA link workers who attend team meetings and reflective practice sessions.

12.14 Within the panel discussions it became evident that not all agencies were aware of the ASC audit programme, and it was agreed there would be value in this being built on to develop a multi-agency approach.

12.15 In addition, it was agreed that the findings from this SAR should be used to further promote the podcast on executive function produced by the WSAB Independent Chair in partnership with New Possibilities. [5]

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3 *Five cases are selected at random each month along with the corresponding best interest decision record. The findings result in one of 4 gradings - inadequate; requires improvement; good; outstanding.*

4 *The introduction of the audits in part stemmed from questions being raised as to how much time was being allocated by area and hospital team managers to this area of work and how robustly the evidence was being tested.*

5 *This podcast can be found on the WSAB website using the following link. https://www.safeguardingworcestershire.org.uk/learning-development/training-a/network-group/*

Recommendation 2

WSAB should update the MCA competency framework to include competencies relating to executive functioning, including awareness of how capacity may be impaired where the adult is a victim of coercion and control, then disseminate the revised framework across the safeguarding partnership and seek assurance regarding how the changes are being applied.

Recommendation 3

WSAB should request its Learning development, practice and communications sub group to consider what further steps can be taken to promote the WSAB Chair's podcast on assessing executive functioning.

13. RESPONSE TO THE SAFEGUARDING CONCERNS THAT WERE RAISED

13.1 Given the information provided in the original safeguarding concerns raised by WMAS and Helen, which suggested that criminal offences might have been committed, a referral should have been made to the MASH. This oversight meant that in respect of both its February and March involvement, the police were unaware of this information which would have been crucial in shaping their investigations. Had an investigation been mounted in January, it might have avoided Jack being discharged back into an unsafe environment and being cared for by Kyle.

13.2 Throughout the SAR review period, the section 42 enquiries that had been agreed through the triage process remained unallocated because of a backlog of cases at that time. The potential implications arising from this resulted in the backlog being added to the local authority's risk register and also being monitored by WSAB.

13.3 While there was an understandable rationale for deeming the enquiries as low priority while Jack was protected in hospital, possible changes in his situation needed to be kept under regular review. A serious omission therefore was the absence of information being shared with the safeguarding team who remained unaware that Jack had returned home to exactly the same situation which had led to the concerns being raised, or that later the reablement team had ended support and there was no longer any ASC oversight of his situation. Had these developments been shared, it may have resulted in a review of the priority level for allocation.

13.4 Equally, due to the backlog, the safeguarding team was not proactive in checking with the hospital whether there had been any developments regarding Jack's future. The absence of any updates being provided by the safeguarding team to other professionals / agencies involved regarding the latest position on allocation appears to have led other ASC practitioners to assume that the enquiries were being actively pursued.

Response after Jack's readmission to hospital

13.5 The discovery of the poor home conditions resulted in further safeguarding concerns being raised by WMAS and the police. However, receipt of these referrals did not result in the priority level being raised by the safeguarding team for more urgent allocation – the case not being allocated until 18th May, some 4 months since the first safeguarding concerns raised in January.

Developments since this case

13.6 From October 2023, fundamental changes have started to be implemented to the organisational arrangements for adult safeguarding. These changes include the establishment of the Safeguarding Early Response and Triage Team (SERTT) and the Safeguarding Enquiry Team (SET).

13.7 The SERTT provides advice, undertakes safety planning, makes decisions on whether the criteria for section 42 enquiries are met, identifies alternative actions where these are not met, and undertakes low risk safeguarding enquiries. The role of the SET is to focus on moderate, high and extreme risk section 42 enquiries, safety planning, quality assurance, development of safeguarding plans, and recording of agreed outcomes.

13.8 In addition, the formalised Enquiry Officer role has been established within all social work teams and partner agencies, with the online form for reporting safeguarding concerns being moved to the LAS portal.

13.9 These changes have already led to the following improvements being identified that address the issues that featured in this case:-

- closer partner working has seen an increased use of the MASH process; [6]
- development of a process for prioritisation;
- robust recording of S42(1) decisions;
- ensuring timely, proportionate enquiry with the aim of developing a safeguarding plan and reducing enquiry 'drift'.

In addition, significant progress continues to be made on eliminating the previous backlogs.

13.10 Given that the changes are subject to ongoing evaluation, the panel agreed that the only recommendation that should be made was to reinforce the learning that it is essential that regular updates are exchanged between the safeguarding team and other agencies involved so that these can be taken into account to inform their respective work.

Recommendation 4

WSAB should seek assurance from agencies 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 for example discharge home or the withdrawal of agency support;*

- *agencies are aware that contact can be made with the adult safeguarding team to check the current position regarding any safeguarding concern that has been raised;*

- *the adult safeguarding team is informing agencies known to be currently involved with the service user of the outcome of any Section 42 enquiries.*

[6] *HWHCT reported that MASH checks being received had increased from approximately 10 to 100 per month,*

14. HOSPITAL DISCHARGE PLANNING

14.1 Although all the appropriate professional disciplines were involved in the discharge planning at both the Alexandra Hospital and POWCH, the review has identified a number of gaps that were to prove significant in terms of the outcomes for Jack.

14.2 A significant omission in the transfer summary sent by the Alexandra Hospital to POWCH was that there was no reference to the original safeguarding concerns. However, HSW1 had sent a 'workflow' to the duty tray of the social work team at POWCH which would have prompted HSW2 to view on LAS [7] the history of social work involvement during Jack's stay at the Alexandra Hospital and details of the safeguarding concerns that remained open to the adult safeguarding team.

14.3 In addition, the discharge summary was not sent to the GP which HWHCT identified was an oversight that was linked to the ward not having its own clerk at that time and its reliance on whatever support could be obtained from clerks or bank staff on other wards.

14.4 In respect of the decision to involve the reablement team, the ASC agency report made the observation that at the point of discharge consideration should have been given to referring Jack's case to the area social work team for allocation to a qualified social worker given the many complex issues arising from the safeguarding issues that still needed to be addressed.

14.5 Although the discharge summary sent to the Community Team and the reablement team referred to the safeguarding concerns about the poor home conditions, it made no mention of those raised by Helen in respect of Jack allegedly being frightened of Kyle. This meant that a potential abuser remained in plain sight without practitioners being aware of the historic concerns.

14.6 These findings mirrored those in other SARs completed by the author in that very often discharge summaries either fail to include any reference to previous safeguarding concerns raised at the point of admission, or the summary does not include the necessary detail.

Recommendation 5

WSAB should ensure that the planned joint audit with Herefordshire Safeguarding Adult Board of the hospital discharge pathway, following a recommendation made in the 'Dorothy' SAR, includes 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.

Lack of a pre-discharge assessment of the home conditions

14.7 A significant oversight prior to Jack's discharge home from POWCH was that no home visit was made to assess its suitability and condition which would have been essential given the graphic description reported by WMAS as to how poor these were. Helen had also flagged this up as an issue with HSW2.

[7] *On the LAS system, 'lozenges' show up on the case record when a case is currently open to the adult safeguarding team*

14.8 The reason cited for no home visit being made was that no concerns had been raised about the home conditions. This was evidently not true given that these were ultimately described fully in the discharge summary sent to the reablement and community teams. In addition, the home conditions had been referred to in the email sent by HSW2 to the OT to enquire if the latter would be making a home visit.

14.9 A possible contributory factor for no visit being made after this enquiry stemmed from the language used by HSW2 to describe the home conditions which downplayed their seriousness by describing the home as being 'in a bit of a state' rather than using the original WMAS description.

14.10 In exploring the general issue of when assessments of home conditions are carried out, the explanations provided by the managers of both the ASC urgent care team and the reablement team is that the usual practice is for these to be carried out post discharge as part of the Pathway 1 (PW1) transfer to the reablement team and completed alongside the level 1 risk assessment. Pre discharge visits are only carried out either when significant alterations are needed to the home environment to facilitate the return home, or concerns have been raised about the home conditions,

14.11 In the case of the latter, the manager of the reablement team explained that more information would be requested, and that the team would need a way of escalating these concerns through social work colleagues within and outside of the service. The manager's view was that responsibility would rest with a different team initially but should then be worked on jointly with the onward care or urgent care team.

14.12 However the findings in respect of this case indicate that this was not a view that was shared by the hospital based teams at that time. This is evident from the inappropriate request being made to the police for its assessment of the current home conditions to inform discharge planning following Jack's readmission to hospital in March. It would appear therefore that at present there is no shared understanding or agreement as to who would be responsible for carrying out pre discharge home visits when these are deemed necessary because of issues about the home conditions.

14.13 The panel discussed whether the new safeguarding arrangements would avoid a similar situation occurring in the future as these should ensure a plan is drawn up, and tasks allocated as part of the Section 42 enquiries which could include addressing any concerns about home conditions.

14.14 However, it was noted that these arrangements are still being bedded in and there was not complete confidence that all agencies are clear about these at this stage. The fact that the role of the new safeguarding teams was not mentioned in the explanations about pre discharge home visits provided by the managers of the urgent care team and reablement team would lend support to this question mark. In addition, the panel raised the question of whether safeguarding plans will be shared with all partner agencies so everyone is clear on what action is being taken and by whom.

Recommendation 6

WSAB should ensure that ASC, HWHCT, and WAHT produce joint guidance which sets out where responsibility sits for carrying out pre- hospital discharge home visits to assess the home conditions where these have been previously raised as a concern immediately prior to, or during, the hospital admission and who will act as the lead professional to coordinate agency input.

15. MISSED OPPORTUNITIES TO RAISE FURTHER SAFEGUARDING CONCERNS

15.1 There were 3 occasions when there were missed opportunities to raise safeguarding concerns. The first was the OT in the reablement team not using the correct communication channels to report her view that there were safeguarding issues that needed to be explored further. This view was only shared with a colleague OT and not brought directly to the attention of a service assessor. The review heard that had the assessor been informed, it would have resulted in further investigation.

15.2 The second was when Jack was found sitting on a pad naked with food on his chest and lap. It appears that the physio did not consider the need for further action as the mitigation from Kyle was accepted that he was just about to clean up. Had greater professional curiosity been applied to explore the reasons for Jack's presentation, and how care was being provided by Kyle, this may have resulted in appropriate referrals being made for further assessments to be carried out. However, the possibility of neglect / self neglect was not recorded which suggests this was not considered.

15.3 The third occasion was the district nurse visit on 9th March when Jack was found naked on the commode covered in faeces. Although the nurses provided the necessary personal care, it is unclear whether checks were made of his BG level and hydration – issues that were picked up by the paramedics and Alexandra Hospital the following day when Jack was found to be dehydrated and his blood sugar extremely high.

15.4 Although the nurses acted promptly in seeking to remove Jack from the situation by contacting the ASC area social work team to request urgent respite care, a formal safeguarding concern should also have been raised. In addition, a finding of the HWHCT review was that when the respite care request was unsuccessful, the care plan was not updated to ensure urgent follow up visits were made to check on Jack's welfare pending securing ASC or other health professionals' input. The HWHCT review established that this was the nurse's intention although it was not recorded at the time.

15.5 Within the SAR panel discussions, HWHCT explained that a contributory factor to these omissions was that at that time, the team was carrying 10 Registered Nurse vacancies and many staff were inexperienced. That situation has since been resolved and the team is now fully staffed.

15.6 In addition, since this case there has been a remapping project for safeguarding adult training at levels 2 and 3. [8] The number of staff mapped to level 3 has increased from 260 to 1953 with current compliance standing at 55% against the target of 90%. Progress on meeting this target is monitored monthly at the Integrated Safeguarding Committee.

16. RECOGNITION AND RESPONSE TO SELF NEGLECT

16.1 A key finding linked to the missed opportunities to raise further safeguarding concerns is that none of the agency reports found evidence that practitioners drew on the WSAB guidance on self-neglect to inform their assessment of Jack's situation.

[8] *The level 3 training package, rewritten in March 2024, is aligned with Intercollegiate guidance and Health Education England's Core Skills Training Framework.*

16.2 It is evident from the various descriptions provided at the time, and the actions taken or not taken, that the various practitioners involved were applying very different benchmarks in considering whether the home conditions, and / or Jack's physical presentation, amounted to possible neglect or self neglect as described in the guidance.

16.3 In respect of the home conditions, the observations made by the paramedics that the house was uninhabitable, do not appear to have been shared by the community nurses, the reablement team, and the police officers who attended in February. None recorded having any concerns about the home conditions other than the comment made by the police officers that the home was a bit cluttered.

16.4 This gap in perception was reinforced by the later observations of the poor home conditions by the paramedics who readmitted Jack to hospital in March, and those of the police officers who visited the house later – observations that were substantiated by the photographs subsequently taken. While it remains possible that there had been a sudden deterioration in the home conditions over the 2 week period since the police visit in February, the fact remains that the description of some of the conditions in March echoed those made in January by the paramedics.

16.5 The findings from this SAR are a concern given the steps previously approved by WSAB to equip practitioners with the knowledge and tools to improve the recognition and response to self neglect. This initiative stemmed from the fact that nationally and locally self-neglect is the most frequent reason for a case to be referred for a SAR with review findings repeatedly identifying recognition, assessment of needs and risk assessments as the practice areas requiring improvement.

16.6 During 2022, the WSAB undertook an extensive review of the self-neglect policy, which resulted in updated guidance being issued in March 2023 – now titled the self neglect and hoarding policy. This included clarification of the multi-agency pathway to provide support, circumstances that require Section 42 enquiries, and an approach of 'No Wrong Door'. The WSAB website also has a page dedicated to self neglect with links to additional supporting material. The review acknowledged that this case occurred around the time the existing 2023 guidance was issued and was therefore still being rolled out.

16.7 The review was also informed that a further review of the policy has recently taken place and an updated version has been approved by WSAB that incorporates the changes made to the safeguarding arrangements described earlier. This will be launched during the summer of 2024.

16.8 In the light of this latest development, and that this case has again identified gaps in the approach taken by practitioners, it is recommended that a multi-agency audit of cases involving self neglect and / or neglect should be considered as a high priority after the updated guidance has been issued to establish how effectively this is being applied.

16.9 In addition, on the issue of providing benchmarks to assist practitioners in assessing home conditions, it is recommended that the police photographs that were taken of Jack's home should be used by agencies within the training on self neglect, and learning events in respect of this SAR - subject to the permission being obtained from the family to their use for this purpose.

Recommendation 7

WSAB should ensure that an audit questionnaire Is produced based on the learning from this review in relation to neglect and self-neglect in order to establish a clearer baseline picture as to the extent professionals are drawing on the updated 2024 WSAB guidance on self neglect to inform their practice, and where this is not happening to explore with practitioners the reasons for this.

Recommendation 8

WSAB should recommend, subject to the agreement of the family, that the photographs of the home conditions taken by the police are included within learning material in respect of the findings from this SAR

17. MULTI-AGENCY AND INTERNAL AGENCY WORKING

17.1 Although appropriate multi-disciplinary input was evident during the hospital stays, multi-agency working appears to have become almost non existent after Jack returned home with the two services involved working in isolation.

17.2 There was no dialogue and exchange of information between the reablement team and the district nursing team to compare notes about Jack's situation, and the response from Jack and Kyle to the support being offered. This would have been important to inform each service's subsequent decisions about their input.

17.3 Despite WSAB guidance, and the learning from previous reviews, there was no discussion either prior to, or post discharge, to agree who would take on the lead professional role to co-ordinate and provide an oversight of the input. This gap, and the subsequent lack of liaison, resulted in decisions being made to end support without consulting or informing other services of this intention.

17.4 The decisions made by both the reablement team and the district nurses to end support were premature and gave too much weight to the assurances received that Kyle had completed the tasks that had been assigned to the two services to carry out.

17.5 The reablement team should have carried out a reassessment before making the decision to withdraw to gauge how well Jack's rehabilitation was progressing if support was to be withdrawn. That reassessment should have included contact with the district nursing team to gain their perspectives. Had that taken place, the concerns identified by the nurses regarding the insulin administration and glucose monitoring might have led to the reablement team not ending its involvement at that stage. As it was, the district nursing team was not aware that the reablement team had stopped visiting.

17.6 The decision made by the district nursing team to end the support for insulin administration was made despite the recurring pattern of Kyle lacking the confidence and ability to carry out the BG monitoring accurately or prepare the insulin pen. This needed to be monitored over a longer time period by direct observation rather than relying on Kyle's self reporting through telephone calls.

17.7 An oversight by both services was that Jack's daughters were not informed that the support had ended. As they observed during the discussion with the report author, it would have been important for them to know this so that they could consider what steps to take to support their father and / or raise their concerns about the ending of support.

Lack of information sharing with the GP Practice

17.8 Given the importance of keeping GPs in the information loop, a major gap in multi-agency working was the absence of any communication with the GP Practice. The practice was not sent a discharge summary by POWCH which meant it was not aware of Jack's return home or the safeguarding risks that had been raised. The practice only became aware of these after Jack was readmitted to hospital in March 2023. In addition, the practice was not informed of the clinical issues identified by both the reablement and community teams, for example the wounds found on Jack's heel and calf.

17.9 The finding that the GP Practice was unaware that Kyle was living with Jack, despite both being registered with the same practice, raised the question as to why the GP Practice had not picked this up and whether there are any arrangements in place to ensure GP records hold up to date information on patients' registration details - address, contact telephone numbers, next of kin / emergency contacts, and any other persons providing care.

17.10 The SAR Panel was informed that responsibility to update this information rests with patients because with an average patient list size of between 11,000 and 14,000 patients it is too much of a logistical challenge for GP Practices to have in place systems for proactively checking with patients as to whether their registration details have changed. Unfortunately, the experience of the GP Practice is that patients often do not inform the practice of any changes, and ensuring that up to date information is held is particularly a challenge when the patient is not in regular contact with the GP Practice.

17.11 The review noted the perspectives from the ICB and HWHCT that the continuing development of IT systems, including refinement of the 'shared care' record system , should eventually provide a sustainable solution to checking the demographic information held by health and social care organisations.

Action taken to promote effective joint working

17.12 The review was informed that steps have been taken to promote effective joint working between the ASC reablement and HWHCT community teams through yearly joint learning events. In addition, since September 2023, the daily referral handovers have been changed from telephone phone calls to 'teams' meetings which has helped to embed shared learning and improved communication.

17.13 To address the issues identified in this case and build on the steps already taken to achieve more effective collaboration, it is recommended that the findings from this SAR are shared at a future joint learning event which should also involve GP representation.

17.14 This would also enable discussion of the anecdotal observation made by staff in the community team that it is often difficult to know which ASC staff are involved and who to contact. In addition it would provide the opportunity to address the perspective shared during the review discussions that agencies are often still making assumptions as to who is, or should be, the lead professional despite this needing to be the subject of discussion and agreement.

Recommendation 9

WSAB should request ASC and HWHCT to utilise its existing arrangements for periodic joint learning events involving their community-based staff, 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.

17.15 It should be noted that given the gaps in multi-agency working, the panel considered whether this was a case that might have benefited from use of the Complex Adult Risk Management (CARM) process which was implemented from 2022. This provides a framework to facilitate effective working with adults where there is a risk of harm due to their complex needs, there have been difficulties in engaging with the adult, and the standard agency procedures have not been able to resolve the problem.

17.16 However, it was concluded that this case did not meet the CARM criteria because neither the care and support assessment process, nor the safeguarding enquiry process, had been exhausted. In this case, the adverse outcomes for Jack stemmed from those processes not being applied as would be expected having regard to WSAB and individual agency guidance.

Lack of information sharing by the police

17.17 There were 2 episodes of police involvement where referrals should have been made – one of these being after the allegations made by Susan in 2018 that Jack was afraid of Kyle and being exploited financially. The second was the attendance in February 2023 when a caller had overheard shouting from within Jack's house. On both occasions, the decision that referrals were not required stemmed from the reassurances provided by Jack.

17.18 In 2018 Jack's reassurance that everything was fine led to the conclusion that the incident had been a general fallout between landlord and tenant. The police agency report made the observation that the way the investigation was recorded implied that the referral from Susan had stemmed from her protectiveness for her father rather than a genuine concern being raised by Jack himself. There is no evidence that Susan was informed that referrals had not been made as had initially been promised by the attending officers. This would have been important to avoid her being under the false assumption that actions were being taken by agencies to safeguard Jack.

17.19 As regards the February 2023 attendance, it was Jack's assurance that Adult Social Care were due to visit within the following 2 days and were therefore aware of the situation. That was a misplaced assumption as Adult Social Care had not been approached for support at that stage.

17.20 The outcome of the February 2023 attendance highlights the gaps that can arise in investigations where officers do not complete proper research to gain a full understanding of previous incidents. This can then result in incidents being viewed in isolation and not being considered holistically in the context of the wider picture. A check of police systems would have shown that previous involvement had established that Kyle was a lodger and not a grandson as officers were led to believe.

17.21 This knowledge would have avoided officers arriving at the misplaced assumption that Jack and Kyle were related – an assumption which appears to have influenced officers' perceptions about Jack's situation because they believed he was receiving support from a family member. If full research had been carried out and revealed that Kyle was a lodger, this may then have raised questions as to whether Kyle was an appropriate person to be caring for Jack and may have opened up more pathways of support.

17.22 This finding provides a reminder for all agencies of the danger in accepting at face value assurances provided by service users about alleged existing agency involvement, and the importance of making the necessary enquiries with the agency, when the need for possible health and care support is identified, to check that the information provided is correct. Although the issue in this case related to police involvement, this observation applies to all agencies.

17.23 A further benefit of such contact is that where there is existing agency involvement, awareness of the circumstances found during another agency's attendance would be important information to add to what is already known in order to decide what further action is required.

17.24 Although no specific learning or recommendations were identified for the Police, it was explained that the investigative issues in this case have been addressed by the training delivered through 'Operation Reset' introduced in 2022. This aims to improve the quality of investigations, applying an evidence-based approach, and includes new supervision processes. In addition, recent training delivered on elder abuse included a focus on how crucial information can be missed in cases such as this.

Recommendation 10

WSAB should seek assurance that any learning from this SAR taken forward through existing 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.

Use of escalation procedures

17.25 The review has identified that there is a continuing need to encourage professionals to use the internal arrangements and / or WSAB escalation procedures to escalate their concerns and challenge decisions made by other agencies.

17.26 There were 2 instances where this could have been considered. The first was after the POWCH ward sister had raised safeguarding concerns with HSW2 and disagreed with the decision that despite these concerns Jack's wish to return home was being progressed. [9] The second was when the request for respite care made by the district nurses was rejected by ASC.

[9] *All staff working with adults have access to Safeguarding Supervision by their line manager and a Named Nurse on duty Monday to Friday 8.30 – 4.30. Outside of these hours a duty manager is available.*

Recommendation 11

WSAB should disseminate the updated escalation policy across the safeguarding partnership and seek assurance 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.

Internal agency working

17.27 The review identified some significant gaps in internal agency information sharing. The HWHCT report identified that the gaps in communication between POWCH, the NT Team, and the therapy team were in part attributable to each using a different electronic recording system. While these are all available for other services to view, this would require staff to remember to check the record systems being used by other services for any updates regarding their patients, or for those services to provide signposting on the need for certain records to be viewed to access full information.

17.28 In respect of the ASC response to the referral received from Kyle on 6th March, there was no discernible rationale for the decision made by the duty worker, ADW2, on 9th March to delay follow-up action until ADW1's return on Monday 13th March. This stemmed from a misunderstanding that ADW1 had been allocated the case and therefore was the appropriate person to make further attempts at contact. This decision was made without seeking advice from their line manager who told the ASC report author that instructions would have been given for an immediate visit to be made given the information provided by the district nurse that day that Kyle was having difficulty caring for Jack.

17.29 With regard to the conversation between the district nurse and the area team on 9th March, the SAR was unable to resolve the differing accounts provided by ASC and HWHCT as to which service initiated the call. According to ASC this call was made by the area team to inform the follow up work on the referral received from Kyle. However, according to HWHCT it was initiated by the nurses to request urgent respite care although ASC have no record of such a request being made. ASC informed the SAR panel that it would have been unlikely that a duty officer would have said that respite care could not be offered as that would be incompatible with the requirements of the Care Act 2014.

Case recording

17.30 A general finding by ASC and HWHCT was that recording often lacked sufficient detail, particularly in respect of discussions between different professionals, which contributed to misunderstandings and miscommunications.

18 FULL LIST OF RECOMMENDATIONS

1. WSAB should seek assurance that agencies have taken the necessary steps to check that when practitioners carry out assessments, they are:-

   - establishing accurate baseline information about the service user, others living in the household or involved in providing support, and the nature of those relationships;

   - assessing the willingness and capacity of informal carers to provide support and always considering whether a carer's assessment needs to be offered;

   - engaging with family members to gain their perspectives about the service user's situation including any safeguarding risks, and the support needed.

   - checking with adults with hearing impairments that they are able to hear and understand what is being explained to them, and holding face to face meetings wherever practicable.

   (Direct work with the person – professional curiosity; carer assessments)

2. WSAB should update the MCA competency framework to include competencies relating to executive functioning, including awareness of how capacity may be impaired where the adult is a victim of coercion and control, then disseminate the revised framework across the safeguarding partnership and seek assurance regarding how the changes are being applied.

   (Direct work with the adult – balancing consent with risk; MCA assessments)

3. WSAB should request its Learning development, practice and communications sub group to consider what further steps can be taken to promote the WSAB Chair's podcast on assessing executive functioning.

   (SAB Governance – Training)

4. WSAB should seek assurance 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 for example discharge home or the withdrawal of agency support;

   - agencies are aware that contact can be made with the adult safeguarding team to check the current position regarding any safeguarding concern that has been raised;

   - the adult safeguarding team is informing agencies known to be currently involved with the service user of the outcome of any Section 42 enquiries.

   (Direct Practice – communication / information sharing)

5. WSAB should ensure that the planned joint audit with Herefordshire Safeguarding Adult Board of the hospital discharge pathway, following a recommendation made in the 'Dorothy' SAR, includes 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.

(SAB governance – quality assurance)
(Organisational features – agency policies)

6. WSAB should ensure that ASC, HWHCT, and WAHT produce joint guidance which sets out where responsibility sits for carrying out pre- hospital discharge home visits to assess the home conditions where these have been previously raised as a concern immediately prior to, or during, the hospital admission and who will act as the lead professional to coordinate agency input.

(Organisational features – agency policies)

7. WSAB should ensure that an audit questionnaire Is produced based on the learning from this review in relation to neglect and self-neglect in order to establish a clearer baseline picture as to the extent professionals are drawing on the updated 2024 WSAB guidance on self neglect to inform their practice, and where this is not happening to explore with practitioners the reasons for this.

(SAB governance – quality assurance)

8. WSAB should recommend, subject to the agreement of the family, that the photographs of the home conditions taken by the police are included within learning material in respect of the findings from this SAR

(Interagency working– training)

9. WSAB should request ASC and HWHCT to utilise its existing arrangements for periodic joint learning events involving their community-based staff, 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.

(Direct practice – multi-agency working & lead professional)

10. WSAB should seek assurance that any learning from this SAR taken forward through existing 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.

(Direct Practice – communication/information sharing)

11. WSAB should disseminate the updated escalation policy across the safeguarding partnership and seek assurance 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.

(Organisational features – agency policies)
(Direct practice – professional challenge)

APPENDIX 1 SINGLE AGENCY LEARNING AND RECOMMENDATIONS

WAHT

1. The finding that the Practitioner did not include safeguarding concerns in the discharge summary will be taken back to the practitioners involved via individual case supervision. **COMPLETED**

GP Practice

1. Receptionists are now trained to raise safeguarding concerns with clinical staff and this is now included in their induction and revisited at appraisals. **COMPLETED**

ASC

1. The Adult Safeguarding Team to ensure MASH referrals are initiated at the earliest opportunity; **COMPLETED**

2. Steps to be taken to reduce the backlog of cases, waiting times and timely delivery of safeguarding services; **IN PROGRESS**

3. Re-ablement Service – improvements required in the sharing of information within the MDT forum. Further support is needed to enhance MCA understanding and practice; **IN PROGRESS**

4. The Area Social Work Team to offer reflection to practitioners to explore when the duty worker should escalate safeguarding concerns, when advice should be sought from their line manager, and when consideration should be given to carrying out a home visit; **IN PROGRESS**

5. Continued improvements required in the practical application of the MCA across ASC. **COMPLETED**

HWHCT (Action Plan updated 18.10.2024)

Recommendation	Actions (SMART)
The existing holistic assessment that is currently in use across the SDU is not routinely being completed by all clinicians. Patients with complex needs require a holistic assessment on admission to the caseload and reviewed at regular intervals. Consideration must be given to any carer support required and whether it meets the patient's needs. It is important to record the patient's mental capacity status. (Action 7412 on Ulysses)	The Service Delivery Unit (SDU) to review the current holistic assessment process and to implement an alternative that meets the needs of the practitioners using it and fully identifies the patient's' needs to support appropriate care planning. In the interim the SDU to ensure all staff are aware of their responsibility to document fully the patient's' needs on assessment and the care provided. Evidence required to close action: Documentation group action points to be uploaded to the incident **COMPLETED**

The Neighbourhood Team (NT) have a duty of care to raise concerns with the local authority regarding abuse, neglect & self-neglect concerns for a vulnerable housebound patient. Staff should proactively seek advice from the integrated safeguarding team and discuss identified concerns with safeguarding teams. (Action 7415)	SDU to consider monthly safeguarding meetings where cases can be presented by NT's Mandatory safeguarding compliance to be reviewed by the SDU service leads All staff to utilise and reflect on this patient's story and the importance of handover when safeguarding concerns are in place **COMPLETED**
The NT have a duty of care to raise concerns with the local authority regarding abuse, neglect & self-neglect concerns for a vulnerable housebound patient. Staff should proactively seek advice from the integrated safeguarding team and discuss identified concerns with safeguarding teams. Action 7413	NT to discuss the self-neglect and safeguarding pathway as a team and reflect on this patient's story and the identification of the friend / Lodger as the patient's grandson Self-neglect policy/CARM framework to be shared and discussed during supervision with the focus on professional curiosity. Evidence required to close action: MDT Supervision- team meeting. **COMPLETED**
Improved multi-agency handover of safeguarding information with documentation across all agencies. To share and emphasise specific relevant detail regarding housing environment and views of relatives in the discharge planning. Action 7408	All staff to utilise and reflect on this patient's story and the importance of handover when safeguarding concerns are in place, especially when planning a discharge. Evidence required to close action: Ongoing MDT discussions Liaison with social services Clear detailed documentation in Carenotes Ongoing effective review and handover of raised social services concerns. **COMPLETED**
Improved multi-agency handover of safeguarding information with documentation across all agencies. To share and emphasise specific relevant detail regarding housing environment and views of relatives in the discharge planning. Action 7407	Ward staff - to ensure that any detail of information shared on discharge to supporting care providers. All staff to utilise and reflect on this patient's story and the importance of handover when safeguarding concerns are in place, especially when planning a discharge. Evidence required to close action: Ongoing MDT discussions Liaison with social services Clear detailed documentation in Carenotes Ongoing effective review and handover of raised social services concerns. **COMPLETED**

For the NT to have a plan of care demonstrating when a level of competency has been reached by the person supporting with administration of insulin. Action 7410	NT - Evidence of competence in teaching / supervising insulin administration and supporting care including consent of the patient to be documented in the patient's electronic records. Documenting and establishing competence at first assessment and then ongoing until an appropriate level of competence is identified. Evidence required to close action: Minutes of team meeting/clinical supervision to be uploaded to incident **COMPLETED**
Improved multi-agency handover of safeguarding information with documentation across all agencies. To share and emphasise specific relevant detail regarding housing environment and views of relatives in the discharge planning. Action 7406	Ward Staff - To provide detail in documentation regarding safeguarding / handover of social worker discussions and details of conversations with family. Evidence required to close action: Ongoing MDT discussions Liaison with social services Clear detailed documentation in Carenotes Ongoing effective review and handover of raised social services concerns. **COMPLETED**
Improved multi-agency handover of safeguarding information with documentation across all agencies. To share and emphasise specific relevant detail regarding housing environment and views of relatives in the discharge planning. Action 7405	Ward Staff- To identify through multi-disciplinary liaison how to monitor, share and discuss any open safeguarding concerns for patients on admission. Evidence required to close action: Ongoing MDT discussions Liaison with social services Clear detailed documentation in Carenotes Ongoing effective review and handover of raised social services concerns. **COMPLETED**
All patients should be involved in decision making regarding their health care. Opportunities to explore safety and carer's ability to meet the patient's' needs should be discussed. Action 7409	NT Clinical leads to undertake clinical supervision with all team members using 'no decision without me' as a focus and to revisit the true meaning of gaining patient consent. Evidence required to close action: Clinical Leads to email comm care when this has been completed. **COMPLETED**

For the NT to have a plan of care demonstrating when a level of competency has been reached by the person supporting with administration of insulin. Action 7411	The patient's electronic record should clearly demonstrate that a plan of care is in place to support handover of insulin administration to a delegated carer/relative. Including patient's consent and competence of administration. Evidence required to close action: RCA report to be shared at the ICS quality meeting and uploaded to incident. **COMPLETED**
The NT have a duty of care to raise concerns with the local authority regarding abuse, neglect & self-neglect concerns for a vulnerable housebound patient. Staff should proactively seek advice from the integrated safeguarding team and discuss identified concerns with safeguarding teams. Action 7414	Named Nurse for Safeguarding Adults to attend a Quality meeting to disseminate a summary of the related safeguarding policies to encourage a culture where NTs discuss safeguarding concerns with integrated safeguarding team. Evidence required to close action: Quality Meeting Minutes uploaded to Ulysses **COMPLETED**