Worcestershire Safeguarding Adults Board

ROBERT

A Safeguarding Adults Review

V6.1

Author: Karen Rees

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1. INTRODUCTION

1.1. Robert was a 68-year-old white British man who identified as homosexual. Robert's life up until the point of the scoping period for this review will be discussed in detail in section 4 of this report.

1.2. Robert had a history of mental health illness and physical health conditions of chronic obstructive pulmonary disease (COPD)[1], hepatitis B and was diagnosed as HIV positive when he was 47 years old after testing that followed his partner's death.

1.3. In recent years Robert's wellbeing had deteriorated through self-neglect and alcohol use. Robert became increasingly frail, and his mobility became poor. His property, which he owned, was severely neglected. Despite the offer of several services and deep cleans by family and a professional cleaning company, improvements were not maintained and the situation deteriorated further. Services found it hard to have any meaningful engagement with Robert, with him often refusing help. Despite involvement from the fire service to install smoke and heat alarms and carbon monoxide detectors, in the summer of 2024, Robert died four days after his 68th birthday as a result of a house fire, started by a faulty electrical appliance.

1.4. A Safeguarding Adult Review (SAR) referral was made by the fire service. The Coroner's inquest will be a document only inquest and will take place in May 2025.

2. PROCESS AND SCOPE

2.1. The SAR referral was triaged, and scoping information was requested from the involved agencies. A Rapid Review meeting evaluated the available information, concluding that the criteria for a mandatory SAR were met. The insights gained and discussed during the Rapid Review indicated that the provided information and chronology were sufficient for extracting learning. However, it was also suggested that a learning and reflection workshop with the involved practitioners would offer valuable perspectives. It was agreed that the time period for the review would be 18 months prior to Robert's death as, although not the start of the increasing concerns from family and friends regarding his wellbeing, it was the start of the point of significant escalation in his self-neglect. The main methodology and decision making regarding this SAR Rapid Review is available in Appendix 1 (Terms of Reference).

3. FAMILY INVOLVEMENT IN THE REVIEW

3.1. A key part of undertaking a SAR is to gather the views of the family and share findings with them. The Rapid Review Chair notified the family about the review. Contact was made with Robert's only close family member. Discussions with the family member were extremely helpful to the review

[1] **Chronic obstructive pulmonary disease (COPD) is the name for a group of lung conditions that cause breathing difficulties.**
It includes:

- emphysema – damage to the air sacs in the lungs
- chronic bronchitis – long-term inflammation of the airways

COPD is a common condition that mainly affects middle-aged or older adults who smoke. Many people do not realise they have it. The breathing problems tend to get gradually worse over time and can limit your normal activities, although treatment can help keep the condition under control. https://www.nhs.uk/conditions/chronic-obstructive-pulmonary-disease-copd/

process and outlined the history of Robert's life and the deterioration that became apparent, more noticeably post the Covid 19 pandemic. Discussions highlighted how the family member had found it very difficult to be as supportive as they would have liked, living some 400 miles away from Robert. The family member provided the author with file notes documenting contacts with services, letters to the GP, and photographs of Robert and his garden prior to his significant decline. The family member's views and the information they shared are incorporated throughout this report as pertinent to the learning.

4. BACKGROUND & ROBERT'S STORY (KEY EVENTS ONLY)

4.1. Robert was the middle child of three siblings born to what the family member describes as an ordinary middle-class family raised attending the Church of Scotland.

4.2. Robert's father was violent to his mother and all three children witnessed this domestic violence. Robert's schooling provided him with a good education. Information supplied by the family member indicated that he had attended college and achieved a diploma in horticulture and a certificate in bee keeping. Robert's career advanced as he worked in various DIY chains, holding roles that included senior management and project positions. He found the most satisfaction in his gardening-related roles, where he contributed to the introduction and expansion of the gardening section in one of the larger DIY organisations. Robert relocated across the UK for different positions. Eventually, he secured a role at a garden centre in Worcestershire, where he held various positions, including manager. Robert received numerous accolades, such as the Garden Centre of the Year award and an RHS Silver Gilt Medal for his garden at Gardeners' World Live at the National Exhibition Centre. His own garden was described as immaculate, with a family member noting it could have been showcased at the Chelsea Flower Show. Robert's home was also reported to be immaculate, adorned with various artifacts.

4.3. Robert was very close to his younger sibling. According to the family member, this bond was strengthened by their shared experience of being gay, which allowed them to empathise with each other deeply. Tragically, Robert's younger sibling passed away at the age of 46 due to a brain tumour, a sudden and unexpected event given their healthy lifestyle and lack of prior illnesses. Robert was devastated by this loss. On the first anniversary of his sibling's death, Robert decorated a bedroom in their honour and lit candles in memory. Unfortunately, this led to a fire, and Robert was hospitalised for smoke inhalation. He was heartbroken by the damage to his beautiful home. Fortunately, he recovered well, and the insurance covered the repairs. The family member noted that this event had a profound impact on Robert. Additionally, the death of Robert's partner from complications related to AIDS (Acquired Immunodeficiency Syndrome) further compounded the trauma he experienced in his life.

4.4. According to a family member, Robert was the life and soul of the party and an excellent host. His 60th birthday was celebrated with a lavish black-tie event. Robert was an active member of the local gay community, and many from this community attended both his 60th birthday party and his funeral. He was clearly a well-loved and respected member of his family and social circles.

4.5. Albeit the above paints a positive picture of Robert as the outgoing 'mien host', as described by his family member, there was also a part of Robert that struggled considerably with his mental health.

Information for this review indicated an overdose in 2008 and ongoing struggles with depression and low mood. Historically, Robert was seen by the local mental health team and treated with medication. Latterly, Robert had stated that his medication worked well and in the timeframe of this review, there were no admissions to hospital or the emergency department due to self-harm or suicidal ideation, although he still at times reported low mood.

4.6. Robert was concerned about the risk of developing Alzheimer's disease, particularly because his mother had died from complications associated with the condition. He expressed worries regarding his memory problems and was evaluated by the adult mental health team in 2017. The results of his mini mental state examination were satisfactory at that time. Following Robert's death, his family discovered notes suggesting that he had been documenting issues related to his memory loss. It is important to consider that Robert's alcohol consumption might have also contributed to his memory issues, as it is known that alcohol can impair memory function. This topic will be discussed in greater detail later in this report. Although Robert felt that his depression was managed with medication, he had begun to experience some anxiety. However, anxiety does not feature within the time period of the review.

4.7. Prior to the time frame of the review, Robert's self-care began to diminish. There were several occasions where Robert fell (five times recorded within chronology for the SAR) and was seen within the emergency department at the hospital. It appears from recordings that these falls were related to times when Robert had been drinking.

4.8. The onset of the COVID pandemic was a significant period for Robert, as he needed to shield due to his COPD. During this time, Robert made an attempt on his life while very intoxicated and was referred to the mental health crisis team. Upon recovering from his intoxication, Robert stated that he could not remember feeling that way. No further mental health intervention was required. Robert contacted Adult Social Care (ASC) for support with shopping during the pandemic. He also disclosed to ASC that he had a tendency to hoard, which was becoming unmanageable. He was directed to services that could assist with this issue. Neighbours and a local church supported Robert during this time. Due to Covid restrictions, face to face contact by adult social care was carried out following risk assessment; contact with Robert was via telephone at this time.

4.9. Once the lockdown was lifted enough to allow travel, Robert's family member visited. The family member told the author that they were shocked at what they had found. Robert looked very unkempt, and the house was 'filthy'. The family member contacted ASC and told them what they had found. The family member again travelled back to see Robert and spent a considerable amount of time cleaning the property. Following calls and visits to assess and advise Robert of the support services that he could contact, ASC ended their involvement. It is of note that Robert was over the capital limit for any funding of services and therefore would have to pay for any services that he engaged with which were not free to all.

4.10. Five months later, after another visit from the family member, the property was reported to be in worse condition again. A social worker visited, resulting in several referrals, including one to Age UK's befriending service. Following a 999 call, the ambulance service visited the property and referred Robert to ASC with concerns that he was struggling to care for himself and his home. Once again, Robert was directed to services that could assist him.

4.11. At the start of the SAR timeline there was again another call to ASC from the family member, who had been in contact with a neighbour of Robert's who kept an eye on things and supported Robert. This resulted in a visit to Robert by the social worker. On first call Robert was not answering the door. On return 45 minutes later, Robert was found outside of his house in a chair. Robert had fallen whilst trying to get into his house; a neighbour had manged to get Robert into a chair. Robert was extremely cold. There was no electricity at the property and the fridge was not working. Robert agreed to a safeguarding referral with the ambulance crew.

4.12. This time Robert was admitted to hospital. When he was ready for discharge, it was felt that his house was not safe for him to be discharged to. Robert had lost his key to his house, so ASC arranged for locks to be changed. Robert agreed to pay for a deep clean of his property. As this was going to take some time to arrange, Robert was discharged to a budget hotel in the centre of town.

4.13. Following this deep clean and Robert's move back to his home, the clean environment was not sustained and things quickly deteriorated again. The Age UK befriender was now supporting Robert and had built a good, trusting relationship with him. The safeguarding referrals that had been made by the GP following contact from Robert's family member and from the ambulance service were not progressed, as it was noted that ASC was already involved. Throughout the review period, Robert frequently sought help or was found needing it. He was assessed and referred to supporting services but, despite initially agreeing, then often refused to pay for them, resulting in continued self-neglect.

4.14. Despite the input of ASC, Age UK, police community support officers, health services and family, Robert was not able to change his lifestyle, and he died in a house fire. In order to prevent repetition, the details of the interventions within the timeframe of the review will be discussed in detail with analysis and learning within the next section of this report.

5. FINDINGS AND LEARNING

History – using professional curiosity

5.1. The history mentioned earlier was not familiar to all practitioners who interacted with Robert. While most were aware of his career, they did not realise the extent of his achievements. Practitioners did not recognise that the Robert they encountered during the review period was quite different from the Robert of eight years ago.

5.2. It is also clear that Robert was not the type of person who neglected all aspects of his health. The hospital reported that he attended all of his appointments with the Blood Borne Virus Team for his HIV, telling the author that he only missed a few.

5.3. All practitioners who interacted with Robert during the review period noted his excessive alcohol use and self-neglect. However, not all practitioners were aware of the trauma and bereavements he had experienced. While this history was not understood, it was knowable, and there was no evidence to suggest that Robert would not have shared it if he had been asked.

5.4. Had practitioners known of his whole history it is more likely that they would have employed more professional curiosity in order to understand the dramatic change in his home and lifestyle and his isolation that became a feature in his later life; Robert was not a person who had always lived in the

way that he did in the last eight years of his life. Deep rooted psychological issues from bereavement and trauma are key triggers to self-neglect[2]. This leads to learning, some of which is highlighted below and some which is linked to later sections.

Effective/Good Practice:

- Several practitioners understood about some of Robert's life and career.

Learning:

- Where a person is significantly self-neglecting it is useful to consider triggers to the behaviour as there may be keys to supporting change – use of professional curiosity is helpful here

Alcohol use

5.5. The family member told the author that the drinking was not always the issue that it had become during the timeframe of the review. One of the issues that first brought Robert to the attention of adult social care was the pandemic lockdown. During this time Robert became isolated due to his need to shield. Albeit that his drinking had been problematic previously as evidenced with the falls he had, it is likely that this increased during the pandemic. Several practitioners who visited noted that there were numerous bottles of wine and whisky scattered around the floor. On any occasion that practitioners discussed his drinking with him, Robert always stated that he did not see it as a problem and had no intention of giving up drinking, declining referrals for support to reduce his intake.

5.6. It is not clear if practitioners discussed the likely impact on the body and brain that alcohol use would have. It is known that the Bladder and Bowel Service nurse concluded that Robert's incontinence and urgency that he had developed was likely to be due to Robert's alcohol use as no other issues were found.

5.7. Working with someone who has problematic alcohol use but where they do not want support to reduce drinking can be challenging. There are multiple sources to support someone who would like to change but less for practitioners who are not alcohol misuse specialists to support a person who is not ready/does not want to change. At the learning event for the SAR it was stated that Robert was in denial regarding his alcohol use. The view appeared to be that if Robert did not want to change then there was nothing that could be done; this was a feature with the self-neglect as well which will be discussed later. In the book of *Motivational Interviewing: Helping People Change and Grow*,[3] denial is addressed as a common reaction when individuals are confronted with the need to change. The book emphasises understanding denial not as a stubborn refusal to see reality, but as a form of ambivalence where the person is struggling with conflicting feelings and thoughts about change.

5.8. The Blue Light Project manual[4] for working with change-resistant drinkers emphasises the importance of persisting in efforts to motivate change in problem drinkers. It suggests that there are

[2] Social Care Institute for Excellence (2011) *SCIE Report 46: Self-neglect and adult safeguarding: findings from research*. London: SCIE.
[3] Miller, W.R. and Rollnick, S., 2023. *Motivational interviewing: Helping people change and grow*. 4th ed. New York: Guilford Press.
[4] Ward, M., & Holmes, M. (2014). *Alcohol Concern's Blue Light Project: Working with change resistant drinkers - The Project Manual*. Alcohol Concern. ©Alcohol Concern October 2014

many strategies to identify and manage risks and reduce harm while supporting individuals towards change. This need is based on the significant impact of serious harm on both the individual and the increased pressure on services. Although Robert's drinking was not the initial reason for his engagement with services, it is likely that it affected his physical and mental health and his motivation for self-care. It was known that Robert did not cook for himself and relied on pot noodles and sandwiches, which, combined with alcohol use, could lead to poor nutrition and potential malnutrition. The Blue Light Project provides tips and techniques for 'Identification and Brief Advice' for alcohol users by general workers, advocating for a multi-agency and holistic approach to foster self-belief. Locally, there are now greater additional assertive outreach harm reduction opportunities the Commissioned Substance Misuse services and a local charity for homeless. Ignoring the issue implies that drinking is acceptable. This therefore leads to learning.

Effective/Good Practice:

- Those who came into contact with Robert understood that he was a dependent drinker and offered referrals to alcohol misuse services

Learning:

- Identification and brief advice regarding the impact of alcohol may be beneficial to those who are change resistant drinkers.
- Denial of alcohol being a problem may be a façade for ambivalence to internal conflict regarding change.
- Ignoring the issues of dependent drinking implies drinking is acceptable.
- A holistic and multi-agency approach is required to reduce harms from excessive alcohol use.
- Use of assertive outreach offers within the locality can offer services support with harm reduction

Physical Health and Mental Health/Capacity

5.9. Robert was known to be HIV positive with a diagnosis back as far as 1997. On speaking with the Blood Borne Virus Specialist Nurse, the author discerned that Robert engaged well with their service, attended most appointments over the years since his diagnosis which were usually six monthly. Robert was compliant with his treatment and if he had not got his medication for any reason, he would immediately get in touch with the service in order to get access to more as soon as possible. Robert's family member identified, that having seen several of his friends and indeed his partner die over the years from AIDs, Robert's engagement and compliance was "fear driven". The service has noted that their patient group are now becoming older and that they need to recognise associated frailty and other issues that they feel they are not expert in and will reflect on tis in their team.

5.10. Robert also suffered from COPD. The GP practice had difficulties engaging with Robert in respect of his COPD. His annual reviews were not attended despite multiple efforts from the GP practice. It is noted that the only treatment that Robert was on was an inhaler which suggests that the disease was not having a significant impact on him. Robert continued to smoke which would have had a negative impact on his lung condition.

5.11. As discussed in the previous section, the level of alcohol that Robert was drinking during the timeframe of the review was likely to have impacted on several of Robert's body systems. We also know that Robert was not eating a good balanced diet. Records suggest that Robert also suffered for Irritable Bowel Syndrome and brittle bones.

5.12. Robert's GP practice appeared to know him well and were responsive to his needs, visiting him at home on at least two occasions during the review period and following up on his physical and mental health needs.

5.13. Robert developed bladder and bowel incontinence and was duly referred to the Bladder and Bowel Service, as previously mentioned. He agreed to the referral and participated in the home visit and assessment. It was believed that his incontinence was related to his alcohol use rather than any mechanical issues. However, Robert declined the offer of a commode, which would have made managing his toilet needs easier.

5.14. The impact of Robert's self-neglect on his physical health will be discussed in a later section. Overall, it seems that Robert did seek help and support for his physical health and engaged with hospital services, largely agreeing to hospital admissions when necessary. This behaviour is somewhat atypical for individuals who self-neglect, as they often neglect their physical health as well. However, it is evident that Robert did not recognise his alcohol consumption as a contributing factor to his increasing frailty and other developing conditions, such as swollen and ulcerated legs and decreased mobility.

5.15. With regards to Robert's mental health, it is recorded and shared by the family member that Robert had some significant low periods in his life and at times had been depressed and suicidal. This was attributed to the previously discussed trauma. During the timeframe of the review, Robert did not state that he had any suicidal ideation or that he was depressed. Robert had believed that he was declining cognitively and that he had anxiety as a result.

5.16. It became clear that Robert would tell different things to different services. For example, he told the bladder and bowel nurse that he did not want a commode but told the social worker that the nurse was arranging for a commode which he would find useful. Robert also stated that he had not have any support after he had refused to pay for anything other than shopping. These discrepancies were not identified because there was no coordinated agency working around Robert. Therefore, it is unclear whether these issues arose because, as one professional suggested, Robert said what he thought people wanted to hear, or if there was cognitive decline affecting his memory and mental capacity.

5.17. All records indicate that practitioners believed Robert had the mental capacity to make his own lifestyle choices and live as he did. This was never formally tested to determine if Robert maintained functional capacity, meaning he may have appeared to have capacity but did not follow through on what he agreed to. On assessment Robert would often agree the services he needed and furthermore agreed that they would help him and knew that these may need to be paid for. Robert would then often not follow through with what he had agreed to. This could suggest that Robert's

alcohol use was impacting his executive functioning. Studies support this[5], and as discussed during the SAR learning event, it would have been beneficial to consider the impact of Robert's alcohol use on his cognitive functioning. Additionally, it is worth noting that Robert was very concerned about developing cognitive decline and feared dementia. If practitioners had conducted brief interventions regarding alcohol use and informed Robert of the close links between alcohol use, cognitive decline, and increased risk of dementia, it might have prompted him to consider agreeing to help to reduce his alcohol intake.

Effective/Good Practice:

- Services were responsive to Robert's physical health needs
- Practitioners considered Robert's mental capacity

Learning:

- Professionals could apply more curiosity to a person who self neglects but is responsive to health treatment i.e. could be used to start positive conversations.

Safeguarding, Self-neglect and Risk Assessment

5.18. The essential support Robert required was rooted in the safeguarding measures outlined in the local Self Neglect Guidance and pathways[6]. All practitioners acknowledged Robert's self-neglect, with each service offering and trying solutions.

5.19. The SAB has developed extensive resources on self-neglect over time, informed by eight Safeguarding Adult Reviews. The most recent update to the Self-Neglect Guidance occurred just before Robert's death, meaning practitioners would have been using an older version. However, it is important to note that the updates in the newer document were not necessarily relevant to Robert's circumstances.

5.20. The SAB developed a Complex Adult Risk Management (CARM)[7] framework in 2022 that is specifically for those people who may have complex issues, have mental capacity but who cannot be effectively managed though other processes such as Care Act Section 42 Enquiry or Section 9 Assessment and where practitioners may be struggling to prevent risk from escalating.

5.21. With these processes and guidance available, it was for this SAR to understand the barriers to working with Robert collaboratively and effectively to manage and reduce the risk of harm.

[5] Devere, R. (2016). The cognitive consequences of alcohol use. *Practical Neurology*. Available at: https://practicalneurology.com/articles/2016-oct/the-cognitive-consequences-of-alcohol-use [Accessed 6 Dec. 2024].

[6] Worcestershire Safeguarding. (n.d.). *Self-Neglect*. [online] Available at: https://www.safeguardingworcestershire.org.uk/about-us/what-is-safegaurding/who-needs-safeguarding/self-neglect/ [Accessed 11 Dec. 2024].

[7] Worcestershire Safeguarding. (n.d.). *Complex Adult Risk Management (CARM)*. [online] Available at: https://www.safeguardingworcestershire.org.uk/carm-complex-adult-risk-management/ [Accessed 11 Dec. 2024].

5.22. Throughout the review period, every time a service interacted with Robert, they identified his self-neglect and referred him to the Adult Social Care Front Door for assessment and/or safeguarding. In the hospital setting, the social worker referred Robert to the Reablement Team to provide short-term support after his discharge, helping him obtain the necessary assistance and reduce his risk of self-neglect. This shows that practitioners do understand what self-neglect looks like, which does show progress from previous SARs where there was often a lack of understanding of self-neglect.

5.23. On occasions where a referral was made, it was noted that referrals occurred while there was an open case with a social work team. It was determined that Robert had the mental capacity to make decisions about his care and support needs. When speaking with the safeguarding triage team in social care, Robert acknowledged his need for support and agreed to an assessment of those needs.

5.24. The referral would then be transferred to the area social work team in order to undertake a Section 9 assessment. On the times that this was done, Robert agreed to the help that he needed. The first barrier comes in to play here. Robert had above the capital limit for funded care and support, therefore he was signposted to services who could help and support him and then the area team closed the case as there was no longer any active involvement needed.

5.25. On the first occasion within the timeframe, after being discharged from the hospital following a deep clean of his property, adult social care arranged for a care agency to support Robert. He agreed to have the agency's care workers assist with his shopping and provide one hour of weekly cleaning. However, he refused any personal care or additional cleaning services due to costs. This arrangement ended with Robert's next hospital admission. The area social work team had closed the case once the care agency was engaged and Robert reported that it was going well. There was no check back to see how the agency were finding being able put the package of care in place.

5.26. There was a recurring issue where services could not gain access to Robert's house, leading to concerns and the involvement of emergency services on occasions to ensure Robert was safe. Upon gaining access, they often found the house in a severely neglected state, having deteriorated from a previously deep-cleaned condition to being very dirty and messy, with electrical issues and evidence of urine and faeces around the house. Robert himself was found to be very unkempt, and on one occasion, his clothes had to be cut off him. Robert would then be admitted to the hospital, and upon discharge, services would be arranged to support him, including another deep clean.

5.27. Other issues that were addressed over the time period were the faulty electrics. It is of note that it is not clear if a complete safety check was made or if the electrical faults to appliances were repaired individually. The records state that a visiting electrician cut off the plug to the microwave so that it could not be used. Given that the ensuing fire was due to a faulty electrical appliance, it would have been better to have had a complete survey of the electrics within the house. As this had not been offered it is not known if Robert would have agreed to pay for such a survey. It became apparent following further consultation of the report, that there was role here for the private sector housing team from the local authority who may have been able to carry out a health and safety inspection to identify hazards and recommend action or even take enforcement action (had that been appropriate).

5.28. Additional support measures put in place included fitting a key safe to allow professionals access to the house, providing a pendant alarm to alert services if Robert was in difficulty, and conducting an occupational therapy assessment to install an extra handrail for the stairs and toilet aids. The fire service also installed carbon monoxide, heat, and smoke detectors. Some of these items required payment from Robert, which often led to debates about the costs. The family member would insist that Robert must pay these bills, and Robert would usually be persuaded. Practitioners also faced issues with Robert's mobile phone, which was sometimes not working. Robert would explain that it was either being repaired or had been cut off. A family member told the author that Robert might have disconnected his phone to avoid contact with people. The family member also noted that Robert would leave a key in the lock on the inside of the door when he did not want visitors, and it is unclear whether Robert ever had a pendant alarm fitted.

5.29. Following responses to safeguarding referrals, it is possible to see a picture of Robert agreeing to care and support, being assessed under section 9 but not carrying out what he had agreed to, social work closing the case. The recognition of this constant episodic approach described by practitioners in the learning event as a revolving door, became apparent when reviewing the timeline for the SAR.

5.30. At the learning event for the SAR, practitioners identified that they should have recognised that this was increasing the risk each time and that referral to the CARM framework should have been made.

5.31. Those who had made referrals did not use the Escalation Policy when things did not change for Robert. The Police community support officers did try but could not contact anyone in social care, with numbers just ringing out and did not know how to escalate in their own agency. The other person heavily involved with Robert was the Age UK befriender, who did an amazing amount of work in supporting Robert, but as an untrained volunteer, it is not clear that they knew how to escalate.

5.32. The safeguarding team in adult social care did contact the Blood Borne Specialist Nurse to gather information but that nurse only saw Robert in clinic and did not see him in his home environment as the service is clinic-based. The feedback from that service was that Robert was a good attender and that he was compliant with his medication. When the consultant for that service saw Robert and recognised self-neglect concerns, they wrote their concerns in a letter to the GP, rather than contacting their own hospital safeguarding team or making their own referral to adult social care.

5.33. It is not unusual for practitioners to feel stuck and frustrated when working with a person who is self-neglecting and appears to have mental capacity, as highlighted in a learning video by a London Borough SAB that can be accessed via the local SAB website[8].

5.34. This SAR has identified several other barriers to supporting Robert. The first is the self-funding element. Each time Robert was referred to the area social work team and agreed to an assessment, he would agree to support and was then directed to follow up on services that he had been signposted to. Since Robert would be paying for these services and the social worker was not required to apply for funding, the case was closed more quickly than it would be for a person who was not self-funding. When the author observed that this appeared to be inequitable because a

[8] https://www.safeguardingworcestershire.org.uk/about-us/what-is-safegaurding/who-needs-safeguarding/self-neglect/ https://www.youtube.com/watch?v=ZEXrczADeKo&t=155s

person not funding their care would receive social worker input for a longer period, it was explained that due to time pressures on services, cases where no ongoing involvement was required were closed. Thus, self-funding is associated with time resource constraints, leading to cases being closed immediately after assessment, which can be recognised as a barrier. Nevertheless, this case suggests that follow-up face-to-face contact or regular updates from a frequent visitor should be conducted to assess risk reduction and to maintain a careful observation of Robert's ability to implement his plans, given that there were few improvements.

5.35. A recent SAR in Derbyshire[9], highlights a number of similar features to this current SAR. Importantly for the author, a recommendation made within that SAR was that the local authority adult social care should review their policy regarding charging. This was of keen interest as the author had felt that not paying for care and/or services was a key factor to Robert's lack of engagement and it had also been so in the Derbyshire SAR. The scenario was exactly the same. Initially, early discussions within Worcestershire and other research did not identify that waiving in this type of case was possible. On further research with the Derbyshire SAB, the author was given access to the full recommendation and actions set against it which had been completed. In essence this indicates that there are possibilities for local protocols for waiving charges in some circumstances, where to do so means that significant harm and death may be avoided. This will be used to support the recommendations for this review linked into the CARM and Self Neglect Guideline, although there are no guarantees that there will a similar process possible in Worcestershire as each local authority prioritises services via local needs assessments.

5.36. Another barrier was that mostly services were working and offering support alone. As stated previously there was some communication but no real multi agency working or collaboration. Most research about what works when working with those who are self-neglecting would suggest that it is only by multiagency working and collaboration that risk of self-neglect may be reduced. This is again highlighted on the SAB web page in the London Borough video.

5.37. Another potential barrier in this case, which was fortunately avoided through some very good practice, is the importance of building trusting relationships. Robert trusted the Age UK befriender, the Blood borne virus specialist nurse and the PCSOs. Whilst these people were contacted by social care, their relationship with Robert was not used in order to progress Robert's self-care and ongoing support that he required within a multi-agency framework (CARM). The GP also appeared to be trusted by Robert; the PCSO's contacted the GP on two occasions and on one of those, carried out a joint visit. It can be seen therefore that there was some really good practice with the building of relationships with Robert by several services. This would have been a good foundation to build on to work with Robert to motivate change.

5.38. What this section is pointing to is that there was a potential to work differently. It appears that the greatest barrier though was Robert's display of 'disguised compliance'. This is a term that has been used in safeguarding children for many years but equally applies to safeguarding adults. By Robert appearing to agree to assessments and ongoing support and stating that he would make changes, he gave practitioners the impression that things would improve, was not a complex case and therefore did not consider the need to more multi agency working and the need for escalation and referral to

[9] https://www.derbyshiresab.org.uk/site-elements/documents/pdf/safeguarding-adult-review-sar22a-learning-brief-william.pdf

CARM. Robert's family member and the PCSOs who worked with him stated that Robert could be persuaded by insistence to take actions, but this was not known or used within a multi-agency framework in order to establish change.

5.39. In the long-term disguised compliance increases risk as the pattern of behaviours are not seen as cumulating. Each time a deep clean was undertaken, and Robert agreed to help, what was not recognised was that in fact the issues were getting worse each time and the risk was becoming greater with cumulative risk not recognised.

5.40. When this was discussed within the learning event, there were practitioners who had not heard of the term, but when it was discussed, it was recognised as a feature. In some cases of disguised compliance there is a deliberate attempt to put a block to practitioners working with a person or taking further action. In Robert's case this was not clear and appeared to be more akin to him not wanting to pay for services. It is not clear if there was a proactive attempt to challenge Robert's perception regarding his self-neglecting behaviours or the risk of serious harm or death that his lifestyle was putting him at.

5.41. Another barrier, previously discussed, relates to the assumption by most practitioners that Robert had the mental capacity to make decisions about his lifestyle. Robert's repeated failure to follow through on his commitments during assessments should have raised concerns about his executive functioning. This would have helped distinguish between disguised compliance and a lack of executive function. Additionally, it is important to consider rights-based practice and the autonomy of individuals to make lifestyle choices, as emphasised in the Care Act Safeguarding principles. However, this must be balanced against the risk of harm that such lifestyle choices may pose.

Effective/Good Practice:

- Several practitioners spent time building relationships with Robert, supporting him over and above expectations; Robert trusted them.
- The GP undertook home visits in order to address concerns for Robert's health that were raised by police.

Learning:

- Practitioners benefit from resources available but need time and signposting regularly to these.
- People with care and support needs will benefit when practitioners understand and use escalation protocols.
- Where there are continuing electrical faults within a home, a complete electrical survey should be undertaken, to prevent catastrophic electrical occurrences.
- Working as a single service with those who self-neglect is unlikely to be effective.
- Recognising disguised compliance may identify increasing and cumulative risk.
- Managers, through supervision, may be able to recognise when it is not appropriate to close cases of those who are self-funding their care and support packages.
- Referral to multi agency frameworks with collaborated support plans can improve a person's motivation to change.

6. Summary and Conclusion

6.1. In terms of thinking about the overarching summary and conclusion for this SAR, it is useful to consider Robert in terms of the systems around him to support and protect him. This SAR has considered the good practice and points for future practice at several systemic levels as depicted below.

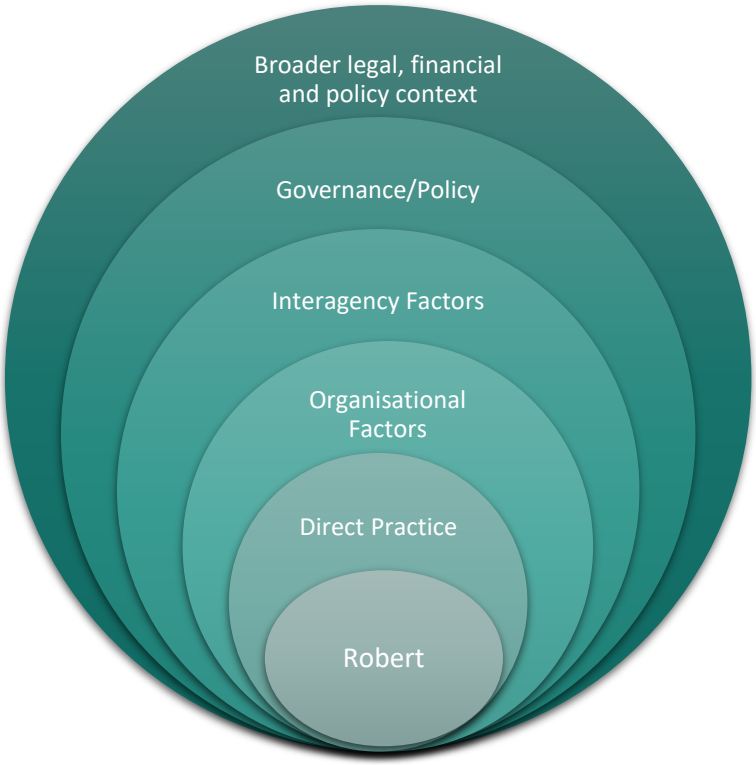

Figure 1. Whole system model from Preston Shoot, M. Shoot (2020) **Adult safeguarding and homelessness A briefing on positive practice** Local Government Association. Pp 8

6.2. The direct practice with Robert was overall very good, with several practitioners exceeding expectations. These instances are highlighted in this report. However, some aspects of the direct practice could have been improved, particularly in verifying whether Robert implemented the actions he committed to following assessments. Being more insistent and assertive with him might have led to more sustained improvements and should have been tested.

6.3. Organisational factors that may have impacted the situation were evident when practitioners did not utilise their internal escalation processes after raised concerns failed to lead to effective interventions for Robert's living and self-care conditions. Additionally, there seemed to be pressure to close cases in Adult Social Care when no ongoing intervention was planned. This could be perceived as discriminatory against those who can afford to fund their own care. In this case, it resulted in a lack of follow-up to ensure Robert had implemented what he had agreed to and that the necessary services were in place to support and improve his outcomes.

6.4. Organisational factors may also have been at play where practitioners did not apply any brief interventions related to working with Robert to motivate him to reduce his alcohol intake. It has been noted that the memory loss that he was so concerned with may have been caused by his drinking but there is no evidence that this was discussed with him in any depth. This leads to learning for agencies.

6.5. Interagency factors demonstrated positive practices, though some gaps were identified. Several services collaborated effectively, conducting joint visits, while others used the positive relationship between Robert and the Age UK befriender to support their efforts. What was disappointing was that none of the practitioners involved identified what works best with self-neglect. Practitioners did not test out an understanding of Robert's mental capacity, nor did they consider more collaborative multi agency working using the frameworks that are in place locally to deal with exactly the issues that were presented to them in trying to improve things for Robert.

6.6. From a SAB perspective, it was encouraging to see that the learning from recent SARs related to self-neglect has resulted in the development of high-quality policies, guidance, and frameworks. These resources support services in managing individuals who self-neglect, whether they retain mental capacity, or their capacity is in question despite appearing capable of decision making. The SAB, however, will need to address the element of learning regarding disguised compliance seen in this case.

6.7. The broader legal and policy context was also a factor in this case. The reduction in resources from national policy directly affected Robert, with professionals indicating that there is pressure to close cases when no ongoing intervention is perceived necessary. In this instance, his case was closed because he was self-funding and did not require funding input from Adult Social Care (ASC). Consequently, closing his case resulted in no follow-up to determine if there were improvements based on the services he had committed to engage.

6.8. The understanding of executive functioning, especially in individuals who misuse substances, is not fully addressed by national guidance. Updated guidance on this aspect of the Mental Capacity Act has yet to be implemented, leaving researchers to explore these complexities through journals and case law. This issue is also related to the outer level of the model depicted above.

6.9. This SAR has looked into the barriers to practitioners being able to use best evidence-based practice and has identified several areas where there is new learning and some areas where learning has been repeated from previous SARs and therefore the recommendations will reflect these findings.

7. RECOMMENDATIONS

1. Self-neglect and Complex Adult Risk Management Pathways and Guidance

In evaluating the recommendations required for this SAR, it was determined that most learning areas align with the objectives of the Self-neglect and CARM pathways and resources. During a recent WSAB strategy day, these pathways and their associated guidance were identified as strategic priorities. Consequently, the recommendations will be integrated into this workstream, and must ensure inclusion of the following references:

Self-neglect Guidance:

- Professionals should examine the factors contributing to self-neglect and consider making referrals or conducting further interventions to address trauma-related triggers.

- When an individual has undergone a significant change in their lifestyle, professionals should use professional curiosity to investigate this change and implement appropriate supportive interventions.

- Risk assessments within the home are comprehensive and cover all potential fire hazards such as hoarding, smoking, and poorly maintained gas and electrical appliances. Where the person is a home owner or privately renting , the District Council's Private Sector Housing Team should be involved.

- Utilisation of internal and multi-agency escalation pathways, policies, and guidance.

- Establish clear connections between Self Neglect and CARM pathways.

- Self-funders may self-neglect, therefore equitable pathways should be applied.

- Recognition that those who volunteer in the community may not have a full understanding of self-neglect and its implications. Volunteers may not be reliable in their reporting and accuracy and that professionals should assess for themselves/jointly with a volunteer.

    - SYSTEMS LEARNING CODE Gov/Policy, Direct Practice

CARM

- The Local Authority should explore if a person at significant risk of harm, with capacity, can have essential care charges waived after exhausting all free or self-funded options. This applies to individuals managed through the CARM pathway. Those without capacity should be referred to the court of protection.
    - SYSTEMS LEARNING CODE: Gov/Policy

Work embedding both pathways

- Encourage agencies to ensure that resources related to self-neglect and CARM are accessible across all frontline services.
    - SYSTEMS LEARNING CODE: Org Factors

2. Disguised Compliance

- WSAB should produce a seven-minute (or similar) briefing to help professionals understand the concept of disguised compliance and its root causes.

    - SYSTEMS LEARNING CODE Gov/Policy, Direct Practice

3. Brief interventions by all frontline services for substance use.

- WSAB and the relevant subgroup should consider steps to assist professionals in managing brief interventions for identifying alcohol-related harms and harm reduction in individuals

who do not wish to reduce their drinking. (In this context, Robert was concerned about his memory functioning, but it was not indicated that alcohol could be a contributing factor.) Professionals can seek advice from specialist commissioned services, and guest talks are available.

- SYSTEMS LEARNING CODE Gov/Policy, Org Factors, Direct Practice

APPENDIX ONE

Safeguarding Adults Review
Robert
Terms of Reference and Scope (Redacted for publication)

1. Introduction

A SAB must undertake reviews of serious cases in specified circumstances. Section 44 of the Care Act 2014 sets out the criteria for a Safeguarding Adults Review (SAR):

A SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—

(a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and

(b) condition 1 or 2 is met.

Condition 1 is met if—

(a) the adult has died, and

(b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

Condition 2 is met if—

(a) the adult is still alive, and

(b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

A SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to—

(a) identifying the lessons to be learnt from the adult's case, and

(b) applying those lessons to future cases.

The Care Act Statutory Guidance 2014 states that in the context of SAR's "something can be considered serious abuse or neglect where, for example the individual would have been likely to have died but for an intervention, or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect".

All Safeguarding Adults Reviews will reflect the 6 safeguarding principles as set out in the Care Act and SAB multi-agency procedures. In addition, SARs will:

- Take place within a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and

empowerment of adults, identifying opportunities to draw on what works and promote good practice;

- Be proportionate according to the scale and level of complexity of the issues being examined;
- Be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed;
- Ensure professionals are involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith;
- Ensure families are invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.
- Focus on learning and not blame, recognising the complexity of circumstances professionals were working within;
- Develop an understanding of who did what and the underlying reasons that led individuals and organisations to act as they did;
- Seek to understand practice from the viewpoint of the individuals and organisations involved at the time and identify why things happened;
- Be inclusive of all organisations involved with the adult and their family and ensure information is gathered from frontline practitioners involved in the case;
- Include individual organisational information from Internal Management Reviews / Reports / Chronologies and contribution to panels;
- Make use of relevant research and case evidence to inform the findings of the review;
- Identify what actions are required to develop practice;
- Include the publication of a SAR Report (or executive summary);
- Lead to sustained improvements in practice and have a positive impact on the outcomes for adults.

2. Case Summary

3.1. Robert was a 68-year-old homosexual man of White British origin. His religious beliefs were not known. He lived in his own property, which was a large, terraced property with a shop style frontage. He had lived here for 28 years after moving to the locality where he ran a garden centre.

3.2. Robert had been diagnosed HIV positive in 1997 and had COPD. He had limited mobility and was reported to be isolated. It was known that he was a victim of trauma as a child and that bereavement was a feature of his adult life having lost his partner and sister to cancer.

3.3. Robert was reportedly alcohol dependent but did not want to stop drinking, he was known to services for severe neglect of himself and his property, living in cluttered and unhygienic circumstances. Services offered support but he often declined, especially those that he had to pay for, as his financial circumstances meant that he was above the threshold for support. Electrical maintenance of the property and its appliances were an issue with reports of no electricity supply and faulty/broken appliances.

3.4. The fire service had visited to advise on fire safety and supplied smoke and CO2 detectors.

3.5. On 27th July 2024, a neighbour called the fire service on hearing the alarms sounding but Robert was not responding and despite CPR he was pronounced dead without regaining consciousness.

3. Decision to hold a Safeguarding Adults Review

3.1. The SAR referral was received from the Fire Service in August 2024. Initial scoping information was gathered, and a Rapid Review meeting was held on 14th October 2024, chaired by an independent Rapid Review Chair. Members of the Case Review Subgroup and invited guests who had been involved with the care of Robert attended. After hearing all of the information It was agreed that the criteria for a mandatory Safeguarding Adults Review were met. It was agreed that the information that had already been gathered alongside some further information and a learning event with professionals would be sufficient to identify multi agency learning. It was therefore agreed that a learning event would be convened, and a Rapid Review Report would be written. The WSAB Independent Chair endorsed that decision.

4. Scope

The review will cover key issues for learning over the last 18 months of his life, which represents a time frame where risk appeared to be escalating.

5. Method

5.1. The Care Act 2014 Statutory Guidance states that the process for undertaking SARs should be determined locally according to the specific circumstances of individual cases. No one model will be applicable for all cases. The focus must be on what needs to happen to achieve understanding, remedial action and, very often, answers for families and friends of adults who have died or been seriously abused or neglected.

5.2. WSAB chose to use a methodology that uses the information gathered and discussed in the Rapid Review meeting and a learning event with professionals to formulate a Rapid Review Report in order that learning could be disseminated promptly.

6. Key Lines of Enquiry to be addressed

Learning will be related to the key learning identified from the Rapid Review Meeting

6.1. Mental Capacity

- To what extent does the Mental Capacity Act support professionals in cases of those who are dependent drinkers**,** who self-neglect and are at risk of harm**.**

6.2. Self-neglect and Safeguarding Pathways

- How well was the impact of self-neglect managed in terms of risk assessment, planning and prevention and protection from harm.
- Consider impact of trauma, bereavement and loneliness on willingness to engage.

6.3. Self-funding and home ownership

- What is in place to protect those who are required to pay for services when they refuse and there is a risk of harm?
- What is in place to ensure the risk of home ownership is not a barrier to ensuring a safe environment to a person at risk of harm and those around them?

6.4. Alcohol Dependency

- How do we understand risk where those who are alcohol dependent do not want to reduce alcohol intake.

6.5. Good Practice

- Ensure examples of good practice are evidenced.

7. Independent Reviewer and Chair

The named independent reviewer commissioned for this Review is **Karen Rees.**

8. Organisations involved with the review:

- County Council Adult Social Care: Area Team and Reablement Team
- Acute Hospitals NHS Trust
- Health and Care NHS Trust
- ICB for GP
- Police
- Ambulance Service
- Fire and Rescue Service
- Homecare Agency

9. Family Involvement

A key part of undertaking a Safeguarding Adults Review is to gather the views of the family and share findings with them prior to finalisation of the report. Contact was made with Robert's family and arrangements were made to include them in the review.

10. Media Reporting

WSAB will prepare a media statement which must not be varied from without the specific authorisation of the Chair of WSAB's approval. During the SAR process any enquiries from the press in relation to the SAR are to be passed to the SAR Manager & WSAB Coordinator.

11. Publishing

It should be noted by all agencies that the SAR report will be published once complete unless it would adversely impact on the adult or the family.

Reference to the adult in the report may be anonymised further prior to publishing. This will be following consultation with the adult/family and time allowed to reflect on how they would like the adult to be referred to.

The media strategy around publishing will be managed by the Community Awareness and Prevention subgroup of the WSAB and communicated to all relevant parties as appropriate

Consideration should be given by all agencies involved in regard to the potential impact publishing may have on their staff and ensure that suitable support is offered, and that staff are aware in advance of the intended publishing date

Whenever appropriate an 'Easy Read' version of the report will be published.

12. Administration

It is essential that all correspondence with identifiable information is sent via secure methods only. This would be via a secure e-mail account. Failure to do so will result in data breach.

The Board Co-ordinator will act as a conduit for all information moving between the Chair, Author and the SAR subgroup.

13. **Confidentiality**

All reports and documentation relating to the SAR are confidential and must be treated as such by all parties. No items should be shared without prior consent from the Rapid Review Independent Author or the SAR Subgroup Chair.