



Safeguarding Adults Review Report Mrs Jones (born 1934 – died 2020) & Mr Jones (born 1930)

Confidentiality statement

This report is strictly confidential and must not be disclosed to third parties without discussion and agreement with the WSAB/SAR chair.

The disclosure of information (beyond that which is agreed) will be considered as a breach of the subject's confidentiality and a breach of the confidentiality of the agencies involved.

Overview Report Author: Mark Dalton.
March 2020

Contents

1. Introduction.....	3
2. Review Process	3
3. Brief Synopsis of Events	4
First Hospital Admission.	4
Support in the Community – February – July 2019.....	6
Second Hospital Admission – July 2019.	8
4. Analysis.....	8
Role of the Police.	8
Role of the GP.....	9
Role of Social Care.....	10
5. Practice Issues.....	11
Use of Mental Capacity Act.....	11
Working with Self Neglect.	12
Failure to Attend Appointments.	15
Advocacy.....	16
Acknowledgement of concerns voiced by neighbours.	16
6. Findings.	17
7. Recommendations.....	18

1. Introduction

1.1 Mr and Mrs Jones were an elderly couple who had been resident in a South Worcestershire town for approximately 12 years. For most of that time they lived quietly and self-sufficiently, enjoyed their retirement and have cared for each other. The couple had no children or no known relatives to support them or advocate on their behalf. There is no evidence of any individual holding a Power of Attorney for either of them. The only support for the couple was from neighbours.

1.2 Until January 2019 they were not known to any services in Worcestershire apart from their GP. Deteriorating physical and mental health had affected their ability to care for themselves and each other. Material standards in the home declined which also adversely affected their health.

1.3 The couple had always politely declined help and as far as possible they avoided services which were offered to them. Neighbours and Health Professionals from the GP's Practice remained concerned and events reached a crisis point when Mrs Jones had a fall in January 2019. As a result, agencies became aware of the home conditions and how the couple had been living.

1.4 Agencies worked to maintain the couple at home, however their attempts were somewhat thwarted by the reluctance of Mr and Mrs Jones to accept help. A further crisis arose in July 2019 when following a further fall Mrs Jones was admitted to Hospital. Mr Jones was also admitted due to concern about his ability to care for himself and several conditions associated with self-neglect. Mr Jones was eventually discharged home after a little over two weeks. Mrs Jones was discharged into Residential Care where she remained until she died in April 2020.

1.5 Currently Mr Jones lives alone in the family home and is in receipt of daily Home Care support.

2. Review Process

2.1 This Review was initiated when a Safeguarding Adults referral was raised on 2nd August 2019 by the Worcestershire Health Care NHS Trust regarding how agencies worked together to support the couple.

2.2 This Safeguarding Adult Review is being held in accordance with the Worcestershire Safeguarding Adults Board Safeguarding Adults

Review Protocol Criteria **1**. This states that *"The Worcestershire Safeguarding Adults Board must arrange for there to be a Review if the statutory criteria prescribed in section 44 of the Care Act 2014 are met. Statutory Guidance on these criteria is provided in Chapter 14 of the Care and Support Statutory Guidance, at paragraphs 14.133 and 14.134. Therefore, the Board **must** undertake a Safeguarding Adults Review under the following circumstances.*

- *There is reasonable cause for concern about how WSAB members or other agencies providing services, worked together to safeguard an adult,*

and

- *the adult has died, and WSAB 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.)*

or

- *The adult is still alive, and WSAB knows or suspects that the adult has experienced serious abuse or neglect."*

2.3 The Worcestershire Safeguarding Adults Board decided to undertake a proportionate review using the SILP (Significant Incident Learning Process) methodology to engage frontline practitioners in analysing the circumstances leading to this Review. Agencies who knew the subjects of this Review were also required to provide an Independent Management Review (IMR) following the attached terms of reference. (see appendix 1)

2.4 When this review was commissioned Mrs Jones was still alive and living in Residential Care. The Covid 19 pandemic meant that the completion of this Review was delayed by several months and sadly Mrs Jones died before the Review was completed.

3. Brief synopsis of events

First Hospital Admission. January 2019

3.1 In mid-January 2019 Mrs Jones was admitted into hospital following a collapse at home. Initially Mr Jones had not called an ambulance, he had sought help from neighbours to put her back to bed. Subsequently he visited their GP Practice and sought advice. As a result, the GP visited the home at midday and called an ambulance after he had assessed Mrs Jones.

3.2 At this time the focus of concern was on Mrs Jones; the ambulance crew had not raised any concerns about Mr Jones and his ability to cope. However, during the in-patient assessment of Mrs Jones, a telephone conversation with Mr Jones suggested that he may also be confused. He was unable to recall his wife falling that day but was able to say she had been on the floor and had been confused for the past five days.

3.3 Mrs Jones was diagnosed with an infection and remained very confused, possibly as a result of the infection. Further assessments and observations took place while Mrs Jones was in Hospital and a picture formed of the couple failing to cope at home due to their neglected physical health needs and an increasing level of confusion and memory loss for both Mr and Mrs Jones.

3.4 At this time there was no formal Carers Assessment of Mr Jones and his ability to undertake the care of his wife. Mrs Jones was deemed medically fit for discharge a little over a week after her admission. Concerns remained about the possibility of undiagnosed dementia and her overall frailty and Mr Jones's ability to cope as he appeared confused.

3.5 In spite of these widely shared concerns amongst all of the professionals who cared for Mrs Jones and had contact with her husband, there was no assessment of Mental Capacity for either of them. There is no evidence in hospital records that an Independent Mental Capacity Advocate (IMCA) ¹ had been considered to advocate on Mrs Jones's behalf given the concerns regarding her capacity and that of her husband. However, these concerns have to be balanced against other considerations, specifically Mrs Jones's state of physical health. She was recovering from an infection which would have had an impact on her cognitive abilities.

3.6 Mrs Jones would eventually be discharged with a Pathway One Package of Care², this entailed four visits per day to support her with her personal care needs and meals. The Hospital policy is that the least restrictive option is always preferred and to promote home discharge whenever possible. The GP was requested to retest her cognitive

¹ The IMCA is a specialist advocate who is appointed to safeguard the rights of individuals assessed as lacking the capacity to make specific decisions in relation to serious medical treatment or changes of accommodation.

² Pathway 1 is one of four care "Pathways" used by the Hospital to describe further assessment and/or treatment when a person is medically fit for discharge. Pathway 1 means to discharge home – in this case with additional support.

function and refer Mrs Jones to the Memory Service. She had also been referred to the Falls Clinic and Age UK.

3.7 The fundamental problem with this plan was the lack of any assessment of Mr Jones's ability to care for his wife between visits and overnight, besides their reluctance to accept help in general. Mr Jones was committed to his wife returning home and there is no doubt that this is what they both wanted, however their ability to care for each other was severely limited by their mental and physical health problems.

[Support in the Community. February – July 2019.](#)

3.8 Indications that supporting Mr and Mrs Jones at home would not be straight forward were apparent even before Mrs Jones was discharged from Hospital. Prior to discharge the Hospital Social Worker had some difficulty in contacting Mr Jones and was unable to do so for several days. Eventually a different Social Worker managed to speak to Mr and Mrs Jones's neighbour who informed them that the house had a broken boiler, no heating and possibly no hot water.

3.9 These details were confirmed by the Team Leader of the Home Care provider. In addition, there were concerns that Mr and Mrs Jones were sleeping downstairs as it was the warmest room in the house and not eating. The Home Care Manager requested an urgent review and a home visit by the GP. They also referred Mr and Mrs Jones to the local area Social Work Team. The GP attempted a visit but Mr and Mrs Jones would not let him in. The GP subsequently made a referral to the Older Adult Mental Health Team requesting an assessment of Mrs Jones's memory in relation to considering a diagnosis of dementia. When the Older Adult Mental Health Team (OAMHT) Worker visited, Mr Jones refused to let them in to assess his wife. The service to Mrs Jones was subsequently cancelled and she was re-referred back to the GP via a standard letter, where it may have been an opportunity to discuss the specific concerns about access and how to engage Mr and Mrs Jones.

3.10 A pattern of Mr and Mrs Jones refusing to allow the carer's into the property began to emerge, Mr Jones had previously expressed the wish for his wife to return home from hospital and it was clear he wanted to avoid a Care Home for as long as possible.

3.11 The Older Adult Mental Health Team and Adult Social Services Team share the same office base which makes liaison and case discussion at a less formal level easier. Both services agreed that the priority was overcoming Mr and Mrs Jones's reluctance to accept help

and introduce care rather than provide a diagnostic label. It was agreed that fewer people calling would possibly increase the chance of Mr and Mrs Jones accepting help.

3.12 The professional concerns had reached the level where the Social Worker sought advice from the County Safeguarding Team who advised involving the Police in a joint visit with the Social Worker. Eventually the social work strategy was for the Social Worker to visit with the Police because the concerns had reached the threshold for a Section 42 Safeguarding Inquiry³ (although this information was not shared with the Police at the time). The option of using the Older Adult Mental Health Team manager who as an Approved Mental Health Professional could gain a warrant⁴ to allow Police to gain entry to remove Mrs Jones to a Place of Safety for assessment and care planning was also offered.

3.13 At the time of the joint visit it was apparent that Mr Jones was out in his car, the curtains were drawn and no one answered the door (it should be noted that this was not a planned and agreed "joint visit" as such; where all parties were aware of the reasons behind the visit. The Police were requested to attend the address as the Social Worker was unable to gain access). The Police observed Mrs Jones through a crack in the curtains and having established that she was alive, the Police had no further jurisdiction to enter the house. The Social Worker left a message for Mr Jones explaining what had happened and that they would call again later in the day.

3.14 Subsequently Mr Jones allowed the Social Worker into the home and agreed to a small daily Package of Care (2 calls a day to assist Mrs Jones). After a few weeks Mr Jones informed the Carer that they intended to move away from the area. This prompted a visit from the Care Manager and Social Worker the following day, they noted that Mr Jones looked dishevelled and would not let either the Social Worker or Care Manager into the house, Mrs Jones also refused to see them.

³ The Care Act 2014 (Section 42) requires that each Local Authority must make enquiries, or cause others to do so, if it believes an adult is experiencing, or is at risk of, abuse or neglect. An enquiry should establish whether any action needs to be taken to prevent or stop abuse or neglect, and if so, by whom.

⁴ Section 135 (1) of the Mental Health Act is the power to remove a person from a dwelling if it is considered they have a mental disorder and that they may need care and attention for this. With the agreement of the person, they can be assessed at the dwelling or removed to the place of safety for the assessment to take place there. The process is for the Approved Mental Health Professional to present evidence at a Magistrates Court in order to obtain a warrant which will authorise the Police, an Approved Mental Health Professional and a registered medical practitioner to gain entry to the premises in order for assessment to take place there or for the person to be removed to a place of safety.

Second Hospital Admission – July 2019.

3.15 At the end of July 2019 Mr and Mrs Jones were again admitted into Hospital in circumstances similar to the admission 6 months earlier.

3.16 On this occasion a District Nurse had attempted a home visit and was unable to gain access, they requested support from the Police to undertake a "safe and well" check. Police Officers were in attendance and their presence seemed to have provided a degree of reassurance for Mr and Mrs Jones. They also accepted that the Police calling an Ambulance and allowing themselves to be transported to hospital was the right course of action. Mrs Jones had fallen and had no memory of how she came to be on the floor. Mr Jones had no recollection of eating that day and was also unable to recount how his wife had fallen. In addition, he had leg ulcers, grade 2 pressure damage to his lower back and was unsteady on his feet.

3.17 The full extent of Mr and Mrs Jones's inability to cope was revealed over the next few days as assessments took place. This included concerns about the state of the home as well as their declining mental and physical health.

3.18 Mr Jones was eventually discharged home after a two week stay in hospital with a Package of Care in his own right and ongoing treatment for his leg ulcers. Mrs Jones remained an in-patient for a further 6 weeks and eventually discharged to a specialist Residential Home for further assessment.

4. Analysis.

Role of the Police.

4.1 The Police were deployed on two occasions during the period under review. On the first occasion - the Section 42 Safeguarding Enquiry - armed Police were deployed as they were the nearest operational unit available. The officers were clearly sensitive about the potential impact their presence would have and played a low key part which ended once they had confirmed that Mrs Jones was alive.

4.2 On the second occasion the Police were called by a Community Nurse for Mr Jones (who had failed to gain access on two separate occasions) and the officers managed the situation without input from

any other agency.⁵ The officers demonstrated skill and sensitivity in gaining access and also encouraging Mr and Mrs Jones to allow the ambulance to take them both to hospital.

4.3 However, the Police Independent Management Report indicates that the Police responded using their inherent professionalism rather than a conscious decision to implement specific Making Safeguarding Personal⁶ guidance. The compassion and empathy shown by the Police Officers is not in question, but a greater awareness of the Adult Safeguarding Policy would be helpful in situations where there were no medical professionals to take over.

Role of the GP.

4.4 The GP Practice played a central role in coordinating services for Mr and Mrs Jones. The Practice has a number of systems in place which should have improved the quality of service to Mr and Mrs Jones. A discussion of Mr and Mrs Jones's needs took place at a regular forum for vulnerable adults within the Practice - this enabled staff to share concerns about the difficulty in engaging Mr and Mrs Jones. When the Practice became aware that Mr Jones had an arduous round trip on public transport to visit the surgery (after his driving licence was revoked), home visits were then offered by way of referral to the Community Nursing Service.

4.5 On several occasions the failure to attend hospital outpatients appointments was symptomatic of Mr and Mrs Jones taking the line of least resistance where they agreed to attend appointments but did not follow these up. The GP Practice offered home visits when they were made aware of these failed appointments.

4.6 Although the care provided by the GP Practice responded to the immediate medical needs of Mr and Mrs Jones, their needs were not analysed to the extent of any clinician considering that they constituted self-neglect as defined in the Self Neglect policy (see below). There was no consideration of a Mental Capacity Assessment even though the concerns within the Practice would have provided the evidence for action.

⁵ The Community Nurses would have had other scheduled appointments and would have been available by phone if required.

⁶ "Making Safeguarding Personal" is an approach to working with people who need protection and safeguarding. It is widely accepted and underpins national and regional guidance including Worcestershire. See [Adult Safeguarding: Multi-agency Policy and Procedures for the Protection of Adults with Care and Support Needs in the West Midlands](#) p10.

Role of Social Care.

4.7 Social Care had no knowledge of Mr and Mrs Jones prior to Mrs Jones's admission into Hospital on the 15th January 2019. The concerns about the degree of confusion shown by Mrs Jones in Hospital, and doubts about Mr Jones ability to care for her, as well as his own health were shared between Hospital and Social Care staff. Additional information about how they coped was provided by the neighbours who visited Mrs Jones in Hospital. This included a report that Mr Jones continued to drive his car but could get lost driving back from the hospital.

4.8 Despite these concerns – and acknowledging the fact that no Mental Capacity Assessment had taken place – the discharge plan was agreed that Mrs Jones should go home and be supported by a Package of Care.

4.9 The failure of the Care Plan proved to be the catalyst for involving the Community Social Work Team. The referral to the Community Social Work Team was for support for both Mr and Mrs Jones in their own right. Lateral checks⁷ also picked up that the GP was concerned about Mr and Mrs Jones's cognitive ability and information about the poor material conditions in the home.

4.10 Rather than prompt action because of a lack of mental capacity, the inability of Mr and Mrs Jones to give informed consent seems to have limited the actions taken. Therefore, the Package of Care was cancelled because Mr and Mrs Jones would not let the Carers in. Similarly, a visit by the Older Adult Mental Health Team led to Mrs Jones also being discharged from the service because Mr Jones denied access.

4.11 The allocated Social Worker sought advice from the Council Safeguarding Team due to the pattern of agreeing to and then subsequently refusing support. The initial advice was not to undertake a Section 42 Safeguarding Enquiry but to undertake a “low level” visit with the Police. This advice was overruled by Social Work Managers who gave clear direction that a Section 42 Safeguarding Enquiry should be undertaken, and the Police were available to gain access if necessary. This clarity of decision making was necessary and appropriate - although Police powers of entry were not necessary on this occasion their support was helpful.

⁷ Lateral checks are checks with other Agencies to see whether an individual is known to them.

4.12 Clearly Mr and Mrs Jones were reluctant service users who seemed to have eventually accepted the conclusion that they could no longer cope alone. The social work efforts to work in partnership with individuals with failing capacity was never likely to safeguard them effectively. It should have been apparent that the living conditions were unsustainable and that a health crisis would provoke change.

4.13 Decisions were ostensibly made in Mrs Jones's best interest, but were in the main, based on Mr Jones opinion of his wife's best interests. Mr Jones also had responsibilities as a carer but no formal Carers Assessment was undertaken.

5. Practice Issues.

Use of the Mental Capacity Act.⁸

5.1 A Mental Capacity Assessment (MCA) allows people to express their preferences for care and treatment, and to appoint a trusted person to decide on their behalf should they lack capacity in the future. People can also be provided with an Independent Advocate, who will support them to make decisions in certain situations, such as serious medical treatment or where the individual might have significant restrictions placed on their freedom and rights in their best interests.

5.2 Throughout the period under review there were several occasions, both in Hospital and in the community when both Mr and Mrs Jones were noted to be confused and this may have indicated the need for a formal assessment of their Mental Capacity. The purpose of this would have been to determine if they had capacity to make specific decisions as regarding their care and treatment at that specific time.

5.3 There was some limited consideration of the need for a Mental Capacity Assessment while Mrs Jones was in Hospital but no consideration that an Independent Advocate might be necessary. Mr and Mrs Jones made some instinctive but ultimately ill-informed decisions; the desire to be back in their own home overruled the

⁸ [The Mental Capacity Act 2005](#) is designed to protect and empower people who may lack the mental capacity to make their own decisions about their care and treatment. It applies to people aged 16 and over. It covers decisions about day-to-day things like what to wear or what to buy for the weekly shop, or serious life-changing decisions like whether to move into a care home or have major surgery.

necessity of having an adequate Package of Care in place. In any event they would later prevent the carers from entering the house.

5.4 It must also be considered that Mr and Mrs Jones had parallel but different needs; Mr Jones was able to express his opinion of what was in his own and his wife's best interests, and for many older couples these may seem indivisible. However, it was clearly not in Mrs Jones's best interests to be cared for by her husband when he was incapable of providing the care she needed and obstructed the Care Plan. This is not to suggest any ill will or malicious intent on his part, but it must be recognised that by this time Mr and Mrs Jones had different needs and differing capacity in expressing them.

5.5 Evidence that the confusion was accompanied by a lack of capacity would allow for a formal Best Interests Decision⁹ to have been taken by those involved in the individuals care.

5.6 Every agency which attempted to work with Mr and Mrs Jones had identified concerns about the possible lack of mental capacity. However, the inability to gain access meant that no formal mental capacity assessment could be undertaken.

Working with Self Neglect.¹⁰

5.7 Worcestershire Safeguarding Adults Board has published Multi Agency Self-Neglect Guidance¹¹ which provides advice for practitioners in assessing and working with people who self-neglect. Of necessity the guidance has to encompass a wide range of situations from older people in a gradual state of decline to rough sleepers and people with mental health problems.

5.8 The guidance suggests assessing harm in five key areas:
Physical Wellbeing. The person is likely to need hospitalisation as a result of self-neglect e.g., extensive skin ulcers, dehydration,

⁹ Best Interests is a statutory principle set out in section 4 of the Mental Capacity Act. It states that 'Any act done, or a decision made, under this Act or on behalf of a person who lacks capacity must be done, or made, in his best interests'. Because the Best Interests principle is a statutory principle there is a legal requirement for all Decision Makers to apply it when making decisions on behalf of a person who lacks capacity.

¹⁰ For definitional purposes self-neglect,

"Includes people, either with or without mental capacity, who demonstrate:

- lack of self-care – neglect of personal hygiene, nutrition, hydration and/or health, thereby endangering safety and wellbeing, and/or
- lack of care of one's environment – squalor and hoarding, and/or
- refusal of services that would mitigate risk of harm." Braye et al (2015)

¹¹ [Guidance for professionals working with people who self-neglect. what can you do and when should you get additional help](#)

malnutrition or untreated / unmanaged health conditions or injuries. Also, where there is a pattern of a person requiring medical treatment for preventable conditions as a direct result of self-neglect.

Emotional Wellbeing. The person is experiencing extreme distress as a result of their inability to manage essential self-care tasks or there is an adverse effect upon their mental health. This also includes distress caused by the person's recognition of a problematic home environment e.g., feelings of shame or being overwhelmed by prospect of tackling problems without support.

Social Functioning. The person is unable to participate in usual activities e.g., home environment makes it impossible for them to have visitors resulting in social isolation or difficulties in maintaining friendships or where poor self-care means they have been excluded from places or services.

Living Environment. The living environment poses significant risk to health e.g., outstanding gas checks, disconnected facilities, structurally unsound property, infestations, treasured possessions are being lost or damaged, pending enforcement under Environmental Health, risk of losing tenancy or essential support services cannot be provided due to risk to workers. Rough sleeping in adverse weather conditions.

Other People. Self-neglect is presenting a significant risk to other people e.g., insanitary living conditions or vermin infestations are affecting neighbouring properties, hoarding or use of unsafe lighting / heating / electrical supply which poses a fire risk to neighbouring properties, or damage is being caused to neighbouring properties due to burst pipes, collapsing walls etc.¹²

5.9 From the information available it would seem that there were concerns in respect of Mr and Mrs Jones in the first four of these categories. No single agency was aware of all of these concerns which may have led to an underestimation of the degree of self-neglect. A Multidisciplinary Team Meeting and more effective liaison between Community and Hospital based services would have helped share an understanding of Mr and Mrs Jones's capacity and the consequences of the choices they made.

¹² [Worcestershire Adults Safeguarding Board. Multi-Agency Self Neglect Guidance.](#) p6.

5.10 Working and supporting people who show a degree of self-neglect can result in conflict between professional values of rights to self-determination and a wider Duty of Care. In the case of Mr and Mrs Jones their self-neglect would seem to have arisen through their previous self-sufficiency and the gradual deterioration in their ability to look after themselves and each other.

5.11 In the absence of any support from wider family, Mr and Mrs Jones relied on neighbours to step in at times of crisis. As Mr and Mrs Jones became increasingly frail, the neighbours correspondingly grew more reluctant to take on the perceived responsibility for their wellbeing. Mrs Jones seems to have shown more mistrust of professionals than her husband and was more fearful of having to leave her home. The difficulty in gaining access to the home (other than times of crisis) prevented Social Care from making a Needs Assessment.

5.12 Mr Jones willingness to accept help has increased since Mrs Jones was admitted into Residential Care. This can probably be attributed to three factors; skilled and supportive intervention from the Community Social Worker, an awareness that he could not continue to care for his wife and a recognition that she was being well looked after and finally the benefits to his own mental and physical health of improved hygiene, regular food and medication.

5.13 In cases where a person with mental capacity refuses support the Self Neglect guidance recommends a collaborative approach between agencies who share concerns:

*“A collaborative approach should be developed. This should include multiagency/professionals and family and community networks. The best person to engage with the adult should be identified. The collaborative approach will provide support to this person and a shared assessment of risk can be completed. A shared assessment of capacity to make decisions on care and treatment can also be undertaken, for example involving the GP to provide a medical perspective. Establishing a relationship in order to spot motivation for change will be a key component of a support plan and initially the aim should be to establish a small measure of agreement, acknowledging what the adult is giving up.”*¹³

5.14 While there was some limited exchange of information and meetings held within the GP Practice, it would have aided recognition

¹³ Worcestershire Adults Safeguarding Board. Multi-Agency Self Neglect Guidance. p13

of the problems self-neglect was causing Mr and Mrs Jones and coordinated further intervention if professionals had worked more closely together.¹⁴

Failure to attend appointments.

5.15 In the period between Mrs Jones's admission in January 2019 and the couple's admission to hospital in July 2019 they were both invited to Outpatient's appointments at the local Acute Hospital.

5.16 Mr Jones was slightly more willing and able to attend these appointments. Following an initial missed appointment, the Hospital liaised with the GP and Mr Jones did subsequently attend the next appointment offered. During this appointment he was assessed in relation to his leg ulcers and there is evidence in the discharge letter to the GP Practice that concerns were identified in relation to Mr Jones's cognitive state and ability to care for himself.

5.17 Mrs Jones missed two Falls Clinic appointments in April and May 2019. Following her second missed appointment the Consultant Geriatrician wrote to the GP Practice with guidance regarding the issues to be followed up in relation to Mrs Jones's physical health. The letter to the GP did not clarify whether a further Outpatients appointment would be offered, or if an alternative approach should be considered. The reality of their situation was that Mrs Jones was increasingly resistant to leaving the home, and Mr Jones was progressively less able to transport her even if she had been willing to attend.

5.18 Mr and Mrs Jones's inability to attend as Outpatients was further evidence of their self-neglect, any analysis of the reasons for the Outpatients appointments set against the consequences of those issues remaining unaddressed could have raised concerns about self-neglect and what was happening to Mr and Mrs Jones within the home.

5.19 The failure of the Older Adult Mental Health Team (OAMHT) to engage Mrs Jones led to the decision between the Older Adult Mental Health Team and Adult Social Care to concentrate on encouraging Mr and Mrs Jones to accept a level of care as a precursor to a more formal assessment and diagnosis. This was a pragmatic response to a

¹⁴ The structure for this is already in existence; locality neighbourhood take place fortnightly and our multidisciplinary including GP, OAMHT, Community Nursing and Social Care. Mr and Mrs Jones's circumstances could have been referred to the meeting by either the GP or Social Care.

difficult situation, and one where the professionals involved did not want to alienate or distress vulnerable older people. The difficulty of this strategy is deciding when it has run its course and the situation needs to be escalated and more direct action taken. All agencies encountered the same challenges in engaging Mr and Mrs Jones.

Advocacy.

5.20 There is no evidence in either of Mr and Mrs Jones's medical records that an Independent Mental Capacity Advocate (IMCA)¹⁵ was considered or sought for the couple. This may have allowed for a greater understanding of the couple's needs and enhanced communication between the professional involved in planning their care.

5.21 Concerns existed in relation to their living conditions and their ability to cope alone at home unsupported by outside agencies. Mr and Mrs Jones were known to be socially isolated with no children or relatives to support them. In the light of all these circumstances they were appropriate referrals to the Advocacy Service because of their vulnerability and the safeguarding concerns.

5.22 This service would have been particularly relevant at the point of discharge from Hospital. The original plan to introduce day-care was agreed to by Mr Jones as a means of being allowed to return home. It reflected his desire to care for his wife at home and to do this he would agree to virtually anything. The concerns about his failing cognitive ability should have raised concerns about his ability to understand the plan and cooperate with it.

Acknowledgement of concerns voiced by Neighbours.

5.23 Mr and Mrs Jones were fortunate in having good neighbours who took an interest in their welfare and helped out in times of crisis. The neighbours were called upon by Mr Jones to assist him on several occasions when his wife had fallen in their home in both January and July 2019. There is also evidence in the records neighbours expressed their concerns and worries for the couple and their ongoing ability to cope at home given their growing physical and mental health care needs.

¹⁵ [Independent Mental Capacity Advocates](#) safeguard the rights of individuals assessed as lacking the capacity to make specific decisions in relation to serious medical treatment or changes of accommodation. This service was introduced as part of the Mental Capacity Act 2005 and ensures people who have an impairment or disability which results in them being unable to make specific decisions, the right to independent advocacy support and representation. In Worcestershire this service is provided by an independent charity called [Onside](#).

5.24 Due to Mr and Mrs Jones's confusion they could not be relied upon to accurately describe the living conditions at home, the neighbours were able to verify and confirm facts about how the couple were coping. It was the neighbours who were able to highlight concerns about the state of the home such as the absence of heating for the previous 12 months which professionals would not otherwise have known about.

5.25 While some of the conversations between Hospital staff and the neighbours were noted, these conversations tended to be "in passing" allied to the fact that the neighbours had no formal status in relation to Mr and Mrs Jones; they were simply visiting their friends in Hospital. In fact, they were the only source of reliable information about home conditions, but this information was not accorded any particular status (although the local MCA policy includes consulting friends as well as relatives when making best interest decisions). When the information was recorded it was not always passed on to the most appropriate person. This represents something of a missed opportunity. While professional boundaries about sharing information and professionals must be respected, and professionals remain alert to the possibility of exploitation. In this case the information was genuinely useful and would have led to a more realistic and effective discharge plan if it had been appropriately shared.

6. Findings.

6.1 Mr and Mrs Jones were a private couple who did not appear to have wanted to access support in the community. They had relied on close neighbours for informal help but had never approached any statutory or voluntary agencies for assistance as they grew older.

6.2 The desire to remain at home is understandable, but professionals should also consider the negative motivation of anxiety of the alternative, namely Residential Care. Regardless of the reality of the standards of care, the potential loss of independence and self-determination allied with a fear of the unknown may create a real barrier to accepting that an individual is not safe at home. All agencies should consider how they address these worries in vulnerable older people.

6.3 Services found it increasingly challenging to engage effectively with Mr and Mrs Jones as they were committed to maintaining their

independence and being able to live in their own home together for as long as possible. It was perhaps their fear of being separated which underscored their reluctance to engage with helping agencies.

6.4 The practice in this case seems at variance with the policies and guidelines of the Adult Safeguarding Board with regard to both the Mental Capacity Act and Self-Neglect policy.

6.5 Whilst it would seem that training has been delivered to raise awareness of these procedures they are not embedded in practice. There are ethical and practice dilemmas in the implementation of Mental Capacity Assessments where there are problems in gaining access to service users. Unwillingness to engage with professionals may, in some circumstances, be an indication of a lack of mental capacity, yet paradoxically without access there can be no assessment. In addition, the Self-Neglect Policy, which can helpfully define the threshold of where personal choice becomes a safeguarding issue, was not referenced by anyone with regard to Mr and Mrs Jones's circumstances.

6.6 Individually professionals worked with sensitivity and flexibility to meet the needs of Mr and Mrs Jones. This seems to have been with only limited wider consideration of a Multi-Agency approach and without a shared analysis of Mr and Mrs Jones's deteriorating physical and mental health and home environment.

6.7 Responding to the needs of Mr and Mrs Jones as a couple, yet still recognising that they had individual needs that potentially were in conflict was a challenge. While it could be argued that Mr and Mrs Jones's wishes and feelings were ascertained, these conversations did not go beyond their desire to stay at home and be left alone.

6.8 When services fail to engage with individuals it would be useful to have a Multi-Agency discussion of the perceived barriers to engagement, with the aim of understanding why the service offer is not acceptable and what can be done to support their being better able to work with individuals.

Recommendations.

1. Health and Care agencies should ensure there is an understanding of the principle that the person who is directly concerned with an individual at the time a decision about

capacity needs to be made, can make an assessment under the Mental Capacity Act. It may be helpful for agencies to identify experienced workers who can support those undertaking Mental Capacity Assessments.

2. Promote awareness through training and supervision of the requirement to utilise appropriate advocacy, for example, the use of Independent Mental Capacity Advocates. The aim is to enable advocates to support people when they are assessed as lacking capacity to make a best interest decision and do not have family or friends to consult about the decision.
3. WSAB should re-launch the Self-Neglect Policy after it has been reviewed (a scheduled review of the Policy is due in 2021) and when this SAR is published. A short aide memoir should be developed to support practitioners.
4. WSAB to include in the learning briefing about this SAR a reminder to all practitioners that they are able to convene a Multi-Agency Meeting to enable co-ordination of a plan of care and support to meet an individual's needs.