SAR Anthony and Mary

Cornwall and Isles of Scilly Safeguarding Adults Board (CIOS SAB) commissioned this safeguarding adult review in August 2021. This followed Anthony's death from acute alcohol toxicity. His mother had died three months previously following a terminal illness. Anthony had returned to Cornwall to live with his mother after he had been signed off work due to his alcohol misuse. He had also been diagnosed in with Guillain-Barré syndrome, a disorder of the immune system. The symptoms include ataxic gait, neuropathy and confusion, very similar to those of long term alcohol use and Wernicke's encephalopathy and might have contributed to his low mood. He had also been diagnosed with depressed mood with psychotic features prior to returning to Cornwall.

Whilst living with his mother Anthony was admitted to hospital on several occasions due to his alcohol use where he was subject to deprivation of liberty safeguards (DOLS) due to his fluctuating capacity, being then discharged back into the community. Several safeguarding concerns were raised by agencies in relation to self-neglect; these referrals were triaged to the Adult Social Care (ASC) locality team for assessment. Safeguarding concerns were also raised regarding Anthony's relationship with his mother and concerns that his behaviours could have placed her at risk of abuse and/or neglect. His alcohol use and self-neglect became more excessive following his mother's death. He died at home aged 47.

Key lines of enquiry for the review focused on how services worked together with Mary and Anthony to meet their needs and address adult safeguarding concerns. This included a focus on mental capacity assessments, hospital discharge planning, understanding of family relationships, and outcomes regarding referrals for care and support assessments, for mental health and substance misuse intervention, and of safeguarding adult concerns.

Analysis drew on chronologies and management reviews of the involvement of different services and agencies, on the contributions of practitioners, operational managers and senior leaders at two learning events, and the reflections of members of the panel supporting the independent reviewer. Analysis was organised around an established evidence-base for working effectively with people who self-neglect, which focuses on direct practice, the team around the person, organisational support and governance.

Identified learning

Good practice was noticeable, for example in safety planning by district nurses with Mary, the support offered by a substance misuse practitioner, and the referrals by several agencies of adult safeguarding concerns. Included in the terms of reference was review of how agencies worked with Mary to address her ill-health and to meet her care and support needs. Healthcare practitioners across several medical disciplines, and across primary and secondary care, worked diligently and together in order to address her physical ill-health. There were also attempts to persuade her to accept care and support assessments and a care package that would help her with activities of daily living. Her reluctance to accept social care support could have been explored more fully and is one aspect of learning that also applies to how practitioners worked with Anthony, namely *the expression of concerned curiosity*. Mary's mental health might also have received more attention than it did, other than in moments of crisis.

One feature that increased complexity was the relationship between Mary and Anthony. The views of Mary and Anthony's extended family network were not sought and yet might have provided useful insights into the relationship between mother and son. Whilst it might well have proved difficult to do so, it does not appear that the relationship between them was explored in any great detail. Rather, assumptions appear to have been made about who was at risk and about their willingness and ability to provide care and support. This highlights learning, namely *the importance of thinking family*, and remembering *the duty to offer carer assessments*.

The review was also commissioned to explore multi-agency approaches, processes and systems when assessing Anthony's mental capacity. It has highlighted the importance of recognising the impact of prolonged alcohol misuse on executive functioning and therefore of *including executive functioning in mental capacity assessments*. The review has also identified the need to ensure that practitioners have an *accurate understanding of the five principles within the Mental Capacity Act 2005*.

This links to the question of *legal literacy*. The provision in Section 11 Care Act 2014 does not appear to have been considered when Mary and/or Anthony declined the offer of care and support assessments. There might also be continued misunderstanding of provisions in the Data Protection Act 2018, namely when the law does permit information to be shared without consent, and when, within the context of the right to private and family life, discretion can be exercised to ask family members, for example, about what they know that might help services to reflect on how to engage.

The review was commissioned to explore how Anthony engaged with services, and how agencies engaged with him. Anthony does appear to have engaged with his GP and also with mental health and substance misuse services prior to his return to Cornwall. Not all of that information might have been available to practitioners and services in Cornwall. This highlights *the importance of information-sharing* when individuals move. Anthony's engagement with practitioners, and with mental health services in particular, appears to have become more intermittent. It would have been useful to have considered whether he was unwilling or unable to engage, which is another feature of *concerned curiosity*, and whether reliance on self-referral and on attendance at appointments at times and in locations determined by services was the most helpful approach. There is learning here about persistence, about home visits and about assertive outreach. The learning for *services is to reflect on how they engage*.

With both Mary and Anthony, several practitioners from different services were involved. There was, however, very limited use of multi-disciplinary and multi-agency meetings, to share information and to agree risk mitigation and contingency plans. Referral to the high risk behaviour panel was appropriate but arguably came too late. Nor were its recommendations implemented. Equally, uncertainty about referral pathways into multi-agency meetings was found. Overall, agencies worked in silos rather than collectively and collaboratively. More work appears to be needed to *embed a multi-agency approach to working with people who self-neglect*. Moreover, no meeting was convened that considered their needs, and the risks involved for Mary and Anthony, together. This is another instance where *thinking family* would have been helpful.

One *transition* that could have prompted a service to consider *convening multi-agency risk management meetings* is *hospital discharge*. Especially where there are repetitive patterns and concern about significant and often escalating risk, this should prompt a review of the approach being taken. This did not happen, especially in Anthony's case when he self-discharged and/or when

deprivation of liberty assessments and procedures were left incomplete. It did not happen when there was concern about whether Mary would be safe at home and how she might manage activities of daily living in a context of possible neglect.

Overall, Anthony's care, support and treatment needs, another key line of enquiry for the review, were ultimately not met. No care and support assessment was completed and none of the referred adult safeguarding concerns resulted in an enquiry or any effective plan to mitigate the evident risks of self-neglect. The decision to triage to case management did not adequately address the local authority's duty to consider what action was necessary to safeguard Anthony (Section 42(2) Care Act 2014). The learning here is about *legal literacy* and *safeguarding literacy*.

It is important to place this review in the context of self-neglect work in Cornwall and the Isles of Scilly. This case was not unique in terms of practitioners' and managers' lived experience of work. Moreover, since 2013 there have been seven reviews where self-neglect has featured, including a thematic review of findings and learning from six of these. Common findings on direct work have focused on engagement, mental capacity assessment, relationship-based work, risk and needs assessments, and thinking family. Common findings on the team around the person have focused on information-sharing, working together, legal literacy and safeguarding literacy, and recording. Common findings on organisational support have focused on supervision, management oversight, staffing levels and resources, and agency culture.

Recommendations

This is not the first SAR completed by the CIOS SAB where self-neglect has featured strongly. The findings are repetitive. A core recommendation is, therefore, that CIOS SAB should conduct regular critically reflective appreciative enquiries or temperature checks with all staff working with cases of self-neglect, using as a basis the evidence-base that now exists for best practice.

In addition to that overriding core recommendation, the CIOS SAB is also recommended to consider the following in order to contribute to this ongoing conversation:

An audit of decision-making regarding referred adult safeguarding concerns where self-neglect features.

Seeking assurance regarding the planned review of the implementation of the dual diagnosis strategy to affirm that mental health and substance misuse providers are working effectively together.

An audit of mental capacity assessments, alongside the provision of opportunities for reflective conversations with practitioners and supervisors/operational managers, to seek assurance about training transfer into practice, with especially a focus on whether the principles within the Mental Capacity Act 2005 are correctly understood and that executive functioning forms part of the focus on whether a person can understand, retain and use or weigh information.

Making contact with NHS England regarding the timely transfer of primary care/GP records, where people move from one location to another and have significant issues.

Appraising the outcomes of the review of the effectiveness of the High Risk Behaviour Panel and of pathways into, and then the convening, management and outcomes of multi-agency risk management meetings.

Engaging in reflective conversations with practitioners and managers in provider services about the challenges involved in assessments and planning when risks arising from substance misuse, mental distress, fluctuating capacity and self-neglect are repetitive and significant. These conversations might include appraising the outcomes of a review of the current prioritisation protocol for response to Deprivation of Liberty Safeguard referrals.

An audit of safeguarding practice that covers in particular thinking family, the provision of carer assessments and the use of concerned curiosity.

The provision of training on legal literacy covering information-sharing, adult safeguarding, mental health in the context of substance misuse, and care and support.

An audit of hospital discharge planning in cases of self-neglect, including where there are repetitive concerns about neglect and domestic abuse, to seek assurance that discharge planning is multi-agency and multi-disciplinary.

Completion of this review has taken longer than the six months recommended in the statutory guidance that accompanies the Care Act 2014. This has been partly the result of the Covid-19 pandemic and other pressures on partner agencies; partly the volume of reviews being undertaken by CIOS SAB. SABs and their partner agencies must have sufficient resource in order to complete Section 44 Care Act 2014 duties. Thus, CIOS SAB is advised to consider a review of how agencies contribute to ensuring that SARs are completed in a timely manner and to disseminating learning as it emerges from the review process as well as subsequently.