



GLOUCESTERSHIRE SAFEGUARDING ADULTS BOARD

**SAFEGUARDING ADULTS REVIEW
Re. KH**

Independent Reviewer:

Brendan Clifford

Date: December 2016

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1.0 INTRODUCTORY SUMMARY

- 1.1 “*Nobody did anything wrong... And yet...*”
- 1.2 These were the words of a senior leader from amongst the partners of the Gloucestershire Safeguarding Adults Board (GSAB) when reflecting on the experience of KH when interviewed for this Safeguarding Adults Review (SAR).
- 1.3 The senior leader was reflecting not just on KH’s experience, but also the way in which the care agencies who had had contact with KH and his family members during 2015 had responded and acted during that year.
- 1.4 The senior leader was also reflecting on the role of the family, who had witnessed a deteriorating situation, and what their actions were during 2015.
- 1.5 The sad outcome was that KH, a resident of Gloucestershire where people enjoy some of the “*best health in the country*”¹ was found to have acquired some of the worst pressure sores seen by care staff when he was admitted to hospital in December 2015.
- 1.6 A number of possible causes for this were considered, including KH’s own neglect of himself; possible neglect by others, family and public sector agencies; KH’s mental capacity; and the consequences of hoarding.
- 1.7 Thankfully, KH has survived the very difficult experience he encountered leading up to his hospital admission when he was not expected to survive 48 hours.
- 1.8 Nevertheless, the words used by the senior leader cited above, express the anguish and bafflement felt by the GSAB partners, staff who had had contact with KH, as well as his own family and KH himself, about his experience. Naturally, the GSAB was concerned that as a local person, KH a citizen of Gloucestershire, could have got into a situation which resulted in his hospital admission.
- 1.9 The GSAB wanted to reflect and learn from these events.
- 1.10 It is important to state at the outset that the author of this Report – an Independent Reviewer commissioned by GSAB to lead the learning on the event – does not believe that it is clear that any single or collective action or decision taken by agencies or other individuals connected to KH would have avoided KH’s deterioration in health during 2015.
- 1.11 The situation was much more complex, as is outlined in this Report.
- 1.12 The episode has resulted in rich learning for the GSAB and individual practitioners. This is leading to change which should minimise the possibility of such a series of events occurring to another Gloucestershire person.

¹ Gloucestershire County Council Adult Social Care Local Account 2014/15 p.7

2.0 SAFEGUARDING ADULTS REVIEWS & GLOUCESTERSHIRE SAFEGUARDING ADULTS BOARD

- 2.1 In early 2016, the GSAB decided to commission a Safeguarding Adults Review (SAR) in respect of the circumstances attached to the experience during 2015 of a person resident in the Board's area, KH.
- 2.2 Building on previously developed practice, a statutory basis for SARs was established as part of the core functions of a Safeguarding Adults Board (SAB) in the Care Act 2014.² Drawing on this framework, the GSAB established their own criteria through which decision-making about whether or not to conduct a SAR was to be completed.³ These included:
- To determine if there are lessons to be learnt from the case about the way local professionals and agencies worked together
 - To review the effectiveness of the safeguarding adults policy and protocols
 - To inform and improve local inter-agency safeguarding practice
- 2.3 As such, SARs emphasise learning to improve practice. They are not inquiries into how an adult died or suffered injury or who is culpable. In other words, SARs may consider harm experienced by a person and not just the worst instance of harm - a death.
- 2.4 Happily, KH did not die as a result of his experience as was feared on his admission to hospital late in 2015. Nevertheless, the GSAB believed that the circumstances were such that a SAR would be useful so as to learn from an experience which might be described as a "near miss."
- 2.5 Terms of Reference (attached as Appendix 1) were developed and agreed with an external Independent Reviewer commissioned to lead the Review. A specific intention of the GSAB was to trial a "systems approach" in the methodology. (See Appendix 2)
- 2.6 It was clarified at the SAR set-up phase that no disciplinary action had been taken against any employee involved in the scenario.
- 2.7 Concern for quality of care at the point of KH's hospital admission resulted in two Serious Incident Requiring Investigation (SIRI) – one in respect of Occupational Therapy and one in respect of Community Nursing. The content of these SIRI's has contributed to this SAR through interviews held with the relevant agencies.
- 2.8 Once the SAR was initiated, GSAB partners who were involved in KH's care provided chronologies for their service area / team.

² *The Care Act 2014*, Section 44 & *Care Act guidance* 14.136 at <https://www.gov.uk/guidance/care-and-support-statutory-guidance/safeguarding>

³ <http://www.gloucestershire.gov.uk/gsab/article/110171/Multi-Agency-Safeguarding-Policy-and-Procedures--supporting-guidance>

- 2.9 The Independent Reviewer conducted 21 one-to-one interviews between May-June. This included a meeting with KH himself as well as a separate one with his eldest (adult) child. The Independent Reviewer was not able to meet KH's two younger (adult) children nor the private landlord of KH's tenancy.
- 2.10 Two group events in June and July brought colleagues together to focus firstly on challenge and secondly, on learning from the events. Attendees were members of the GSAB SAR sub-group and staff members involved in KH's care.
- 2.11 Following consideration by the GSAB SAR sub-group, the final version of this report was presented to the GSAB in November 2016.
- 2.12 The Independent Reviewer was provided with information as requested throughout and noted the positive approach of partners who participated in the SAR process.
- 2.13 It is important to note that in terms of overall process, the findings of the SAR must be published in the SAB Annual Report and GSAB must act on the findings of the SAR.⁴
- 2.14 The GSAB were also clear that they sought recommendations which were as "SMART" (specific, measurable, achievable, relevant and time-bound) as possible.
- 2.15 The Independent Reviewer was also keen to ensure that learning could be incorporated into on-going GSAB improvement plans.

3.0 INVOLVEMENT

- 3.1 A key feature of the systems approach is involvement of relevant parties.
- 3.2 By the time this SAR began, KH had been discharged from hospital care and in due course he moved to a local authority reablement centre. The GSAB Chair met KH, first of all, to advise KH what was happening and to seek his on-going agreement to the process. The Independent Reviewer subsequently met KH in May 2016 to seek his views about his 2015 experience and the wider outcome. This Report has also been shared with KH who had an opportunity to comment on its content and to agree the way in which the report would be made public. This included the way in which we refer to him as "KH" throughout this Report.
- 3.3 Front-line staff involved with KH were also heavily involved through one-to-one interviews and participation in the Learning Event. Their experience of service-change was a central factor as it was for the senior GSAB leaders seeking to improve care pathways.

⁴ Care Act Guidance *op cit.* para 14.156

4.0 PUBLICATION & STYLE

- 4.1 The GSAB is committed to transparency in the sharing of the content and outcomes of SARs.
- 4.2 This SAR refers to the experience of someone who is still alive and is being re-integrated into community life, therefore, the style and content of the report take account of this. To protect the identity of the person whose experience was the subject of this Review, his name is anonymised through use of initials. These are the initials of his real name. In addition, certain facts of the situation pertaining to the person's health status are withheld from this report, as they are confidential to KH.
- 4.3 The GSAB SAR sub-group have received a copy of the detailed chronology of events showing the actions and reflections of all agencies concerned.
- 4.4 This approach has been discussed and agreed with the GSAB so that the balance between the GSAB's commitment to transparency, on the one hand, and the individual's right to privacy, on the other, are upheld.

5.0 SYSTEMS APPROACH

- 5.1 More indicative detail of the systems approach is included in Appendix 2.
- 5.2 In general, however, this approach is rooted in the response to well-publicised challenges in the children's services arena made by Dame Eileen Munro and the systems approach developed by the Social Care Institute for Excellence. It has been influenced by the development of thinking in other areas such as aviation and health services. Some of the key features of the approach include:
- Seeing people as being part of the system because their behaviour is shaped by systemic influences
 - all possible variables that make up the workplace and influence the efforts of frontline workers in their engagement with people as well as the more tangible factors such as procedures, tools and aids, working conditions, resources and skills; a systems approach also includes issues such as team and organisational cultures.
 - Noting that "heroic workers can achieve good practice in a poorly designed system, but efforts to improve practice will be more effective if the system is redesigned so that it is easier for average workers to do so."
 - supporting an analysis that goes beyond identifying what happened to explain why it did so – recognising that actions or decisions will usually have seemed sensible at the time they were taken, appreciating the views of people from different agencies and professions.⁵

⁵ Adapted from: At a glance 01: Learning together to safeguard children: a 'systems' model for case reviews (January 2012) <http://www.scie.org.uk/children/learningtogether/resources.asp>

6.0 INITIATING EVENTS

- 6.1 As has been indicated, because this report is a public document, it is important to protect the privacy and dignity of the subject of the report, KH in relating and reflecting on the events which have been referred to.
- 6.2 KH was admitted to hospital on the morning of 9th December 2015.
- 6.3 He had been brought there by South West Ambulance Service Trust (SWAST) following a 999 call made by one of KH's adult children.
- 6.4 At the time, KH shared a tenancy to a private landlord in a first floor flat of a three storey residential building with the younger two of his three children.
- 6.5 During the 999 call, KH was reported as unconscious and a "heart attack" was suspected.
- 6.6 On arrival, KH was found by the SWAST team sitting in a chair in the corner of the living room. It was reported that KH was found to have very significant pressure sores. Flies / insects were found flying round the room. The sores observed were very deep, "Grade 4" on the scale used by tissue viability specialists. Maggots had infested the wounds.
- 6.7 SWAST found the flat cluttered in the extreme. Full, black bin-liner type bags blocked much of the floor space.
- 6.8 In response to the difficulties which they were encountering to move KH out of the flat, SWAST followed standard procedure and sought assistance firstly from Gloucestershire Fire and Rescue Service (GFRS) who arrived at the scene shortly afterwards. SWAST and GFRS sought further support from Gloucestershire Constabulary who subsequently arrived at the scene. By this time SWAST believed that KH's health crisis was caused by severe neglect rather than a heart attack.
- 6.9 The SWAST and GFRS teams believed that they could not negotiate safe passage through the flat due to the significant hoarded material and then down the stairs to the ground-floor. A mechanical lifting device – a "Bronto" - was used, therefore, to remove KH safely from the property.
- 6.10 The property was owned by a private landlord. Gloucestershire Constabulary secured the landlord's attendance at the property whilst the emergency services were in attendance.
- 6.11 It is understood that the landlord immediately evicted the two adult children of KH from the property on sight of the condition and the nature of the circumstances leading to KH's removal from the property to hospital.
- 6.12 On successful transfer from his chair and descent to the street, KH was taken to the Hospital Emergency Department. On admission, his prognosis was judged to be extremely poor. Medical and nursing staff did not believe that KH would survive the night.

- 6.13 The medical assessment noted the extensive pressure areas (Grade 3-4 pressure damage) and skin damage to KH due to contact with urine and faeces and KH's other health issues. A referral was made to the Tissue Viability Nurse and the hospital Safeguarding Lead Nurse.
- 6.14 Safeguarding referrals were made by the Hospital and GFRS and a Safeguarding Meeting was convened in a timely manner where partners shared relevant information. It will be a re-assurance to the GSAB that in the view of the Independent Reviewer, response by agencies at this stage was sound in a couple of respects. Firstly, the Hospital logged the incident on their "Datix" system which created an alert with regard to quality of care which prompted internal NHS investigation. Secondly, a safeguarding meeting was convened with senior staff in attendance to review the circumstances and decide on next steps.
- 6.15 Gloucestershire Constabulary took action to clarify if a crime had been committed. They reflected on possible offences under either the Section 44 of the *Mental Capacity Act 2005* or Section 20 of the *Criminal Justice and Courts Act 2015* with the crime of "wilful neglect" in mind. However, Gloucestershire Constabulary decided that there was not sufficient grounds to submit a file of evidence for consideration by the Crown Prosecution Service. It appeared clear to Officers that the adult children with whom KH lived had simply done what they thought was correct. There did not appear to be any issue of clear intent to harm.
- 6.16 Whilst in Hospital, KH made progress and responded to the expert care provided and was transferred to an appropriate ward a few days after admission. He remained an in-patient until he was deemed fit enough to be transferred to a rehabilitation hospital for further care. KH continued to make progress and was transferred to a community based rehabilitation unit where he continues to make further progress.

7.0 THE EVENTS – 2015 Background

- 7.1 KH had moved to Gloucestershire to settle with various members of his family in the area in about 2010. He found some work on arrival but his family noticed that he began to experience some difficulty in walking. Over time, KH was observed as firstly, beginning to stoop, then he began to use a walking stick and then, in due course, a walking frame or rollator.
- 7.2 As his condition worsened, according to a family member, KH had not wanted to bother a GP with his growing difficulties. Eventually he did do so and a GP visited him at home in 2014. The state of the home was something of a concern to the GP at the time. KH was encouraged to keep moving but this created a dilemma for KH who experienced pain when moving. Medical investigations were initiated to rule out other causes. However, they were unsuccessful at the time due to factors such as KH discharging himself from hospital where he had been admitted for investigations to take place.

- 7.3 The eldest of KH's grown children became a less frequent visitor to KH from the beginning of 2015 due to a variety of pressures. He was concerned by the condition of the property at that time and had assisted KH in managing the difficulties KH faced with the landlord and NHS Services. Offers were made to KH from his family and a friend to move elsewhere but KH refused.
- 7.4 It was around this time when, according to his own account, KH *"switched off."* He had appeared to others to *"give up over the last couple of years"* and it was as if KH *"didn't care."* It was thought that KH must have been *"fed-up because he couldn't walk."*
- 7.5 The impact of a developing disability may be considered to be a challenging experience for anyone and it is hard to assess what this meant for KH. This was the time that KH began to experience symptoms sometimes associated with lack of physical movement. KH attended the GP Practice a couple of times in early January 2015 for tests and was seen in person by a GP when leg oedema, skin breakdown on buttock and incontinence were noted, amongst other issues. GP records indicate that a referral was made to the Community Nurses for pressure sores and skin care. A wheelchair application was also sent and changes were made to medication following review.
- 7.6 Written and verbal sources reports in the Chronologies provided by the GP and the Gloucestershire Care Services NHST use two terms - "pressure sores" and "pressure areas" – to describe the appearance of KH's skin at the time. They are different phrases which may be understood in slightly different ways and which would prompt different actions. The Community Nursing service understood that KH had "pressure areas" which might not be deemed as in need of attention as urgently as "pressure sores" and so their response was not as immediate as it may have been had they heard that "pressure sores" needed attention.
- 7.7 Around this time, the chronology shows that agencies had to start making numerous changes to their records of the mobile number by which they might contact KH. There were relatively frequent changes of number during 2015. This made contact with KH difficult. Agencies could sometimes only communicate through KH's relatives. This meant that agencies could not always "see" KH as well as they might have needed. A participant at the GSAB Learning Event held on 14th July, asked *"When did we stop hearing KH's view and start deferring to [his adult children?]"* This is a key point throughout the following description and analysis. Agencies appeared to balance a presumption of mental capacity with concern for his presentation to them at various points through 2015.
- 7.8 There were also changes in the organisational arrangements between the GP Practice and the Community Nursing service around this time: specific Community Nurses were no longer allocated to specific GP practices and changed access arrangements for the Information Technology system used – called "SystemOne" – were perceived as confusing. Permissions to access

various “levels” within the system had changed in late 2014. This resulted in more restricted access for Community Nurses to GP information, for instance. It’s possible that outcomes for KH may have been better if the permissions to access the system had remained for both the GP and the Community Nurses, but this cannot be conclusively demonstrated. The agencies are clearly aware of the issues about sharing information systems and work has been on-going during 2015 to address these challenges.

- 7.9 A Community Nurse made a visit to KH following the GP referral of early January 2015 but could not gain access. The Nurse’s experience in visiting but getting no reply was one experienced by the nursing service again and by other agencies during 2015. It’s important to note that KH did not know that the Community Nurse would be visiting on that day. Given similar experience of other agencies – visiting and getting no reply - during 2015, it cannot be demonstrated conclusively that even if KH had been aware of the visit, he would definitely have been at home.
- 7.10 On arrival at KH’s residence, the Community Nurse noted that there was no buzzer, intercom or manual knocker on the front door. The Community Nurse knocked on the front door, waited for a response and knocked again when none was forthcoming. The Community Nurse tried to contact KH by mobile phone but there was no response. With the need to make numerous other visits that day, and given experience of non-response by patients in other instances, the Community Nurse needed to leave for the next visit. Typically, a Community Nurse in Gloucestershire may have between 12-18 visits to make in a day over a given geographical area to patients with a wide variety of needs requiring different time allocations.
- 7.11 In terms of practice for Community Nurses, the Independent Reviewer understood that it would be unusual for the Nurse to try the back of the property or make contact with neighbours. A health service worker seeking to gain entrance to a property is seen as not something which necessarily should be “advertised” by asking others in the community who may not be aware that a person received visits from a health worker as the person may wish to keep the contact confidential.
- 7.12 In addition, at this stage, it was only a few days since KH had been seen by the GP so it seemed clear at the time that, in terms of risk assessment, another opportunity to meet KH would be available shortly.
- 7.13 For his part, KH recalled contact with the surgery and the need for further treatment.
- 7.14 One of numerous text messages over the coming year was sent to KH by the GP Practice around this time and the Community Nurse left three voicemail messages without response from KH and/or his adult children on the day after the failed visit.
- 7.15 The inability to gain access was reported back to the GP Practice through a telephone call. This would be regarded as standard procedure with the

expectation that if further attempts to make contact were required then the GP Practice would refer again to Community Nurses.

- 7.16 At this stage, known risk factors did not “flag up” concern about KH. Non-attendance at GP appointments may have various reasons and although undesirable, not all patients always attend as arranged.
- 7.17 There was no further Community Nurse involvement until July 2015.
- 7.18 A series of contacts and attempts to make contact between the GP Practice and KH through letter and text followed. Records state that KH himself rang the surgery around this time and appointments were arranged. KH did not attend an arranged GP appointment on the first of these arranged dates but did arrive for the second. Reviews for other areas of health concern were noted to be overdue at this time so a longer appointment was arranged and a reminder text sent.
- 7.19 There was a further short pattern of non-attendance by KH at the surgery despite text reminders. Standard letters concerning his non-attendance were also posted to KH.
- 7.20 These instances show that KH’s non-attendance was seen as part of a regular pattern of behaviour of non-attendance. The behaviour appeared to be seen as part of a longer-term view. In other words, the impression was that KH’s behaviour had always been this way.
- 7.21 KH’s eldest child said that he and KH had both tried to contact the GP Practice to arrange contact as they observed KH’s health deteriorating. From their point of view, they were unsuccessful in getting Community Nurses to visit KH. The fact that one of the adult children with whom KH lived made efforts to contact the GP Practice at this time shows that some concern to act in what might be considered a reasonable way was evidenced. This supports the view eventually taken by the Gloucestershire Constabulary that “wilful neglect” was not applicable in this instance.
- 7.22 Referral to Community Nurses was made again by a GP at the beginning of June. But the chronology does not show that this referral was “received” by the Community Nursing service at the time. In any event, from interviews it was believed that KH remained “open” to the service. This raises the issue of the way in which the information system supports overall monitoring of cases. In other words, if there had been no further planned, professional involvement, then there is an argument that the file should have been “closed” until further intervention was required or asked for. Normally, when the Community Nursing team completed the final episode of care, it was in-putted onto the system with the outcome of the intervention and the reason for closure noted. As KH remained on the team’s case load, he was potentially the team’s responsibility. It is understood that staff within the team did not have individual case loads but the overall case load of 100 patients was shared between a team of 5 staff members. These realities have also been addressed by the leadership team in their review of the information systems

during 2015-16 so that there is greater clarity of responsibility and recording is done in a timely manner.

- 7.23 The fact that KH then attended a subsequent hospital appointment, the outcome of which was communicated by the relevant hospital clinic to the GP, shows that KH's presentation was such that agencies felt some confidence that he was participating in actions to promote his care to some extent. That is, KH was seen to mobilise to some extent even if by now he was using a rollator (or zimmer-frame). However, KH then failed to attend for his next scheduled hospital appointment.
- 7.24 Over a month later, in early June 2015, one of the adult children with whom KH lived called the GP Practice stating that KH was complaining of hip pain. It was also reported that KH's walking frame had broken. An appointment was made to see a GP. KH attended the surgery where he was seen in person.
- 7.25 At this stage, the GP records state that they identified KH as "an adult at risk" and a range of actions were initiated:
- A letter to social services outlining the medical situation and concerns about KH's domestic situation. Evidenced attempts to persuade KH to co-operate with plans were made and KH apparently promised the GP that he would allow access and accept support offered.
 - A referral to Community Nurses was made
 - KH was re-referred to the hospital but KH did not attend a planned X-ray appointment
 - A wheelchair application was also sent.
- 7.26 The chronology states that the Intermediate Care Team Referral Centre tried to contact KH by the mobile numbers which were provided but the numbers either appeared unobtainable or they could get no response. At the point of "triage," (decision-making for next steps in the team,) the relevant manager made the decision for an Occupational Therapy visit.
- 7.27 An Occupational Therapist duly rang the numbers available and left a message on voicemail for KH to return the call but he did not do so. The Occupational Therapist rang again a couple of days later but on this occasion did not leave a message.
- 7.28 Having got no reply on these occasions, the Occupational Therapist discussed the situation with a Social Worker and supervisor. This is an aspect of good practice because colleagues supported one another in coming to a view about the best course of action. It shows that one member of the team did not feel isolated and worked in a supportive environment where colleagues could approach one another for professional support. Moreover, both recognised the complimentary skill-set required from the multi-disciplinary team to respond to complex situations.

- 7.29 The workers agreed to make an unannounced joint visit. When they did so, they were unable to gain access. The next day, further attempts to make contact by phone were made but the two available numbers appeared to be disconnected. The SW rang the GP Surgery to check on the numbers which they had but no other ones were available. A request for the GP to call back was made. A second unannounced joint visit was undertaken but again there was no response.
- 7.30 Various attempts were made to communicate with KH and his sons by the GP Practice and the Social Worker. The nature of these communications (a letter from the GP practice, a record of telephone calls made from the Social Worker) suggest that colleagues might want to consider agreeing what the best form of communication might be. GPs, for instance, appear to use letters as a form of communication to ensure messages are given and received and GP records showed no record / letter of contact from the Social Worker. However, the Social Work record noted the attempts made to achieve direct contact with the GP by telephone and their inability to talk directly to a GP.
- 7.31 Then there was a series of communications and attempted communications between the Intermediate Care Team and KH's adult children. At this point, one of KH's adult children with whom he lived rang the Intermediate Care Team to cancel the planned visit stating that KH "is not feeling well." Then there was a further call to arrange a visit and the Social Worker was able to talk to the adult child who had rung. It is reported that KH's adult child apologised about the postponement of a previous visit and stated that KH "never goes out" due to poor mobility. This was the first reference to KH's inability to go out and after general discussion about KH's needs, a further visit was arranged. Again, in terms of risk assessment, it was arguably not clear to the worker at this stage that there should be any special cause for concern. Many people are unable to leave their own home for any one of a number of reasons and the continued presence of other adults within the household would have been a reassurance.
- 7.32 After another attempt, a further appointment was made for the Social Worker and Occupational Therapist to visit; this one went ahead as they gained access on this occasion and met KH in person.
- 7.33 As a result of the visit, it was noted that KH's legs were extremely swollen and that KH was spending the majority of his time sitting in the chair, including sleeping. The condition of the flat was noted and the apparent lack of motivation by KH's two adult children to clean. Options for re-housing were discussed and the Social Worker left the visit believing that an application for re-housing would be made by the family. Due attention appears to have been given to the adult sons who were both referred to a Community Care Project for education, training and employment advice. An appropriate care plan was drawn up for KH which included the need for Community Nursing visits, a referral for reablement, onward referral for multi-disciplinary team follow-up and equipment was ordered including a profiling bed and mattress.

- 7.34 A few days later, there was confirmation that the bed and mattress had been delivered. The initiation of the reablement service was noted but no access was gained on the first visit. A staff member spoke to one of KH's adult sons who told the worker that KH was at a funeral. A note in the records states the assumption of staff that *"I did not feel that KH was at risk as he had two sons that lived with him."* The Reablement Team describe the throughput and pressures to balance many demands as being *"like air traffic control."* This comment gives a sense of the volume of people to whom the service responds and their need to ensure resources were allocated in the best way. Having continued to try to gain access to see KH unsuccessfully, some days later, the reablement service cancelled the service. It is understood that there was contact with one of KH's adult children about how to contact the service again should KH's needs change. This approach to service closure appears to have been standard practice.
- 7.36 Similarly, Occupational Therapy team tried to make contact about a month after the closure of the reablement service. An Occupational Therapist visited but again no access was gained and a letter was sent to KH. One of KH's adult children responded to this and re-arranged a visit. The worker attended but again got no reply. A second letter was written. Another letter was sent to KH around the same time from the GP Practice about a routine appointment. The Occupational Therapist closed the case after a few months of no contact from KH. This also appears to have been standard practice in the knowledge that – as indicated elsewhere – there are many reasons why a person does not respond to service intervention. Case closure seemed a reasonable action to the worker in this situation.
- 7.37 It does not appear that there was any further contact with KH by public services until his admission to hospital a couple of months later.

8.0 VIEWS OF KH AND HIS FAMILY

- 8.1 *"Switched off"* and *"gave up"* are two phrases used by KH when asked about why things turned out the way they did for him. He used these phrases in connection with the time when he began to be seen as 'disabled' as his mobility became more impaired during 2015. He was conscious of himself as a parent within the household and when he was more able, he had done more of the cleaning and household maintenance. Although one of his adult children received Carers Allowance from the Department for Work and Pensions, KH felt that he had *"put too much on"* this adult child. The issue of personal hygiene and being able to manage bodily functions was a key issue for him and there was a reluctance to seek assistance with this aspect of his needs. According to his own account, KH told no one how he felt and the events of 2015 have become something of *"a blur"* for him.
- 8.2 The Independent Reviewer asked KH if, looking back, he would have done anything differently. KH said that he *"would have kept his appointments up, carried on trying to walk, looked after himself properly as he relied on*

everyone else, he felt resigned that he would not get any better.” KH said that he was not blaming anyone for what happened; “it was all his fault...the only one to blame was [himself;] [he] hadn’t wanted to bother anyone and has now caused more bother to everyone.” KH said that he “kept too much from them.”

- 8.3 KH’s eldest adult child stated something similar. He said that *“it was like (KH) had given up over the last two years and didn’t seem to care any more – ‘like the light went out’.”* KH’s eldest child said that the main issue for KH *“was not being able to walk after being so active.”*
- 8.4 KH’s deteriorating health was difficult for him, obviously, but also for his children. They inevitably looked to KH as their father and responding to KH’s changing health in the best way for all concerned will not have been easy.

9.0 WHAT IS THE LEARNING FROM KH’S EXPERIENCE? ANALYSIS

- 9.1 No one can know if KH’s situation would have been better if different decisions had been made or actions taken by KH himself, his family or workers who met him during 2015. One member of the SAR Sub-group referred to KH’s experience as having been a *“perfect storm”* as KH (appeared to) *“melt into his chair.”*
- 9.2 Nevertheless, using the learning derived from the one-to-one interviews and discussion at the Challenge Event meeting held on 21st June 2016 and the Learning Event on 14th July 2016, the GSAB SAR sub-group, together with the Independent Reviewer, have asked themselves, *“What is the learning from KH’s experience?”*
- 9.2 An “hypothesis testing” approach was taken as part of the systems methodology and ten indicative hypotheses were proposed for debate. The list was “indicative” i.e. more / other hypotheses were justifiable based on the evidence available if attendees wished to suggest them.
- 9.3 **Hindsight bias** - At every stage of the process, the Independent Reviewer has stated to participants that it has been important that all parties don’t apply “hindsight bias.” In other words, consistent with the systems approach, it has been important for all concerned to ask, *“What was the situation like at the time?”* This was important as a number of participants have moved into different roles since the events in which they were involved.
- 9.4 **Limitations of the process** - In addition, many such learning processes may have limitations on the process. For instance:
- although the GSAB has been as speedy as it could have been in deciding to review the learning from these events, some staff on occasion were unable to recall exactly what had happened and in what sequence.
 - The Independent Reviewer hasn’t or couldn’t meet some people whose role in the events may have shed helpful extra light on the analysis.

The two adult children with whom KH lived, for instance, did not wish to be involved in the process and there is no power to force them to do so. In addition, the Independent Reviewer could not meet the private landlord or other, perhaps more distant 'players' in the system such as the pharmacist and Department for Work and Pensions representative.

9.5.1 The hypotheses which were tested included that:

- KH himself, his family and / or friends should have done more or 'raised the alarm' sooner
- there was nothing that any of the services could have reasonably been expected to do any differently. Nobody "did anything wrong."
- Case closures in Occupational Therapy, Community Nursing, and the Reablement Team, did not appear subject to sufficient clinical governance / supervision
- more work is needed on the "Out of contact" framework and approach to DNAs
- communications routes needed to be re-visited across the multi-disciplinary team e.g. with regard to levels of access to information systems
- the role or contribution of mental health services (2gether Trust) did not appear to have been considered when they may have had a role to play
- there may have been an over-optimistic view of how technologies contributed e.g. although texts were sent to KH there was no certainty that he may have read them. Also, no one appeared to have questioned the meaning of the multiple changes of mobile numbers experienced by all agencies
- Recording standards did not appear to be all that they should be.

9.6 The SAR Sub-group were invited to use the proposed hypotheses to generate main areas of learning for the planned Learning Event. The outcome of consideration of the hypotheses were grouped into three main areas which provided the framework for the Learning Event agenda as follows:

- Making it practical: - "keeping the person at the centre"
- Aspects of behaviour of people as patients / service users
- Aspects of professional behaviour

9.7 The Learning Event for practitioners and members from the SAR Sub-group was held on 14th July 2016.

9.8 GOOD PRACTICE

Was noted at the Learning Event, for example:

- GSAB has a series of relevant policies– on neglect, self-neglect, consent and mental capacity, and hoarding, all potentially relevant to this case. It is acknowledged that in themselves those policies appear to be sufficiently robust. Neither the absence or insufficiency of policies could be identified as causes for KH's experience during 2015.
- The Community Nursing Service noted other occasions where the service had been concerned with the well-being of an individual as a result of which they effected an entry to the person's home with the assistance of police colleagues. This showed awareness of risk assessment and ability to act in what was believed to be the best interests of the person. At the Learning Event, the idea of reviewing and itemising the powers of all agencies to effect entrance to a private individual was noted and it was confirmed that the GSAB are already looking into this.
- Leaders in individual agencies did not wait for a review to tackle the need for improved processes, procedures or ways of working in partnership. There has clearly been a vision of multi-disciplinary working in Gloucestershire shown by the development of the Integrated Care Team. Changes in the structure and approach of that team – and perhaps others – were designed to ensure better individual agency accountability and more effective joint-working.
- The GP Practice was exploring ways in which adult safeguarding could be better highlighted within its operations, drawing on learning from the issue of concern in this Review and current practice with regard to children and young people. This is taken up in the Recommendations cf. para. 10.5.
- Developing use of a “Hoarding Scale” approach as part of the Self-Neglect Guidance.
- The response by emergency services leading up to KH's hospital admission was strong, as was the safeguarding response and subsequent actions of the wider partners.
- In the conduct of the Review, some staff had helpfully prepared their own reflections on the experience and determined ways in which they would act differently in future similar scenarios. This was very helpful to the Independent Reviewer and is to be commended.

9.9 OBSERVATIONS / LEARNING

Two issues discussed in the Learning Event may also give colleagues food for thought in future planning and consideration of content for future care pathway planning or training to support interventions

- Firstly, the “*Village Agents*” model was discussed. It was explained that “*Village Agents*” are identified people within a community who are volunteers but have some training or preparation for a role which makes them more alert to finding ways to respond to any needs or concerns which are drawn to their attention. It is understood that Gloucestershire already has some people in these roles who would be able to share learning on their achievements and role more fully. However, this might be used and extended to promote supportive concern in the community and was noted as a possible initiative for GSAB to encourage.
- Secondly, in terms of interpersonal dynamics with the public where self-neglect or neglect is feature, the Learning Event tried to find an appropriate phrase to describe the behaviours which can be presented in instances of self-neglect or neglect by others such as “*disguised compliance*” or “*passive compliance*” on the part of the person with whom a practitioner is working. Although with some obvious differences, the phrase used in learning from other safeguarding instances “*hidden in plain sight*”⁶ has some resonances in the experience of KH during 2015.

9.10 RESPONSIBILITY

The Independent Reviewer has asserted that nothing in this report negates KH's or his family's responsibility for him, or the responsibility of staff who were involved directly or indirectly in decisions or actions to promote KH's wellbeing and care during 2015. Likewise, so much in the current agenda of asset-based approaches to the person as a citizen or patient relies on the active, positive support / participation of the individual and those around the individual which, if it is absent, may result in more negative experience. At the Learning Event, one of the team reflected the conundrum for many of the role of family, friends and neighbours, when it was asked, “*If not them, who?*” Learning from these difficult instances helps organisations and staff to practise in new ways which are more closely aligned to the positive, asset-based agenda.

10.0 RECOMMENDATIONS

- 10.1 The GSAB sought recommendations which were as “SMART” (Specific, Measurable, Achievable, Relevant and Time-bound) as possible. With this in mind, the following issues are drawn from the analysis activity based on interviews and meetings with GSAB colleagues.
- 10.2. **Issue** – it appears that the statutory responsibilities for private landlords for their tenants are limited to ensuring that the gas connection to the tenancy/property is checked on an annual basis. The experience of tenancy by individuals varies. Those who are tenants of Registered Social Landlords

⁶ <https://www.equalityhumanrights.com/en/inquiries-and-investigations/inquiry-disability-related-harassment/download-disability-related>

can expect to be engaged in a variety of ways so that they co-produce, engage with or consult tenants in a variety of work and responsibilities. It is acknowledged that there may be differences for private landlords. Dilemmas may exist for private landlords about the extent of involvement in the lives of their tenants. But if the assertion that safeguarding is “*everybody’s business*” is to have any meaning, then that maxim applies to private landlords as a cohort, too. In the case of KH, the landlord had seen something of the state of the flat and it is understood that he had commented upon it and had tried to influence change in the situation. It is not inconceivable that if support from statutory services had been sought, it is possible – but not certain - that a more positive outcome for KH might have come about, by the landlord having an awareness of safeguarding and hoarding issues and how to respond. Therefore, it is recommended:

RECOMMENDATION – That GSAB develop a targeted social marketing campaign aimed at raising awareness of private landlords of safeguarding, hoarding, self-neglect and neglect based on the principle that “*Safeguarding is Everybody’s business.*” As suggested at the Learning Event, GSAB may wish to link this to other issues for the local community and work in partnership with the Gloucestershire Safeguarding Children’s Board.

- 10.3 **Issue** – in response to a previous SAR, GSAB developed an “*Out of Contact*” protocol. This could only be a high-level document on behalf of partner agencies in the GSAB. Some staff in the system were not aware of the protocol at the time of the events experienced by KH in 2015. Some individual agencies developed more detailed procedural guidance about non-response to service offers by citizens. There was contrasting evidence provided by interviewees of occurrences where, based on risk assessment, staff did indeed act appropriately to assertively ensure access to individuals about whom they had cause for concern. However, it appears that the events of KH’s 2015 experience have caused the GSAB to ask if the current protocol and approach needs further refinement.

RECOMMENDATION – that GSAB review its “Out of Contact” protocol and individual agency arrangements about non-response to service offers by people, seeking to balance the entitlements of the individual with capacity to make “unwise decisions” with appropriately assertive practice based on dignity and “compassionate persistence.”

- 10.4 **Issue** – The decision-point at case-closure did not seem as rounded as it might be. In comparison to the children’s social care sector where decisions to close cases should be ‘signed-off’ by a manager, the arrangements in the reablement team and occupational therapy appeared to rely on the decision of the individual practitioner. Whilst it is right that standards of individual practice need to meet relevant local or national frameworks, GSAB should reflect on closure processes in relation to local risk assessment

RECOMMENDATION – that GSAB review the case closure decision-point in its partner agencies’ care pathways to ensure that supportive practice frameworks enable practitioners to meet required local and national standards.

- 10.5 **Issue** – At a more general level, the outcome of this review gives an opportunity to link the outcomes to on-going business plans or policies such as communications, risk assessment, risk enablement or specific communications methods such as “*Message In A Bottle*.” This development could encompass reflection on practice challenges of spotting signs in the casework relationship (“*passive or disguised compliance*” or similar descriptor) which might require more assertive practice models to be adopted alongside recognition of a person’s entitlement to make “unwise decisions.” In addition, working across the partnership, the GSAB will be able to support wider models such as the “Village Agent” which are aimed at promoting greater positive community concern for people in the community who may be deemed as vulnerable. In addition, there will be opportunities to build on the good practice being pursued by the GP Practice involved in this Review (cf. para. 9.8) to ensure specific consideration of adult safeguarding issues on the model currently adopted by the Practice for the safeguarding of children through the team meeting structure in the GP Practice environment.

RECOMMENDATION – that the GSAB

- **confirm expectations for communications between agencies e.g. through use of letters/emails between agencies**
- **develop a practical approach to recognising “signs-of-isolation”, “message in a bottle” or something similar and update training content as necessary**
- **improve and develop links into “Village Agent” model**
- **ensure wider and consistent application of consideration of adult safeguarding issues and cases in the GP Practice environment**

APPENDIX 1- Terms of Reference

1. **General** (Gloucestershire Safeguarding Adults Board Adult Case Review Protocol 2014):
 - 1.1 To establish whether there are lessons to be learnt from the circumstances of the case about the way in which local professionals and agencies work together to safeguard adults at risk
 - 1.2 To review the effectiveness of procedures (both multi-agency and those of individual organisations)
 - 1.3 To inform and improve local inter-agency practice benefiting from a systems-type methodology approach.
 - 1.4 To improve practice by acting on learning (developing best practice)
 - 1.5 To prepare or commission a summary report which brings together and analyses the findings of the various reports from agencies in order to make recommendations for future action
2. **Specific:**
 - 2.1 To examine how the circumstances leading up to KH's admission to hospital on 9/12/15 were handled and whether the policies and procedures in place during that time were followed
 - 2.2 To consider whether all opportunities to ensure KH received appropriate care and support within the overall delivery system were identified
 - 2.3 To review the effectiveness of the commissioning, monitoring and inspection of services being provided to KH
 - 2.4 To review whether appropriate and timely assessments of KH's mental capacity to make decisions about his care and treatment were considered
 - 2.5 To review what considerations were given by agencies of the support KH's family may have needed in meeting KH's care and support needs
3. **Reason for the Review**
 - 3.1 This review was commissioned by Gloucestershire Safeguarding Adults Board (GSAB). The subject, KH, lived in private rented property and was cared for by his 2 sons. He was admitted to hospital in a severely neglected and life threatening state.
 - 3.2 The time period covered by the review is 01/01/2015 to 09/12/15. The Terms of Reference set out the particular issues agencies are asked to consider.
4. Overall
 - 4.1 The GSAB wishes to trial a systems-type methodology in its approach to this Review for wider learning within the Gloucestershire safeguarding community.

APPENDIX 2 - What is a systems approach?

The systems approach in social care is rooted in the work led by Professor Eileen Munro and developed in the Social Care Institute for Excellence (SCIE.)⁷ The key features of the approach:

- Have been adapted from the systems approach used in other high risk areas of work, including aviation and health.
- supports an analysis that goes beyond identifying what happened to explain why it did so – recognising that actions or decisions will usually have seemed sensible at the time they were taken.
- involves moving beyond the basic facts of a case and appreciating the views of people from different agencies and professions.
- is a collaborative model for case reviews – those directly involved in the case are centrally and actively involved in the analysis and development of recommendations.
- sees people as being part of the system because their behaviour is shaped by systemic influences
- includes all the possible variables that make up the workplace and influence the efforts of frontline workers in their engagement with people... (from) procedures, tools and aids, working conditions, resources and skills, (to) team and organisational cultures (*and design.*)
- acknowledges that heroic workers can achieve good practice in a poorly designed system, but efforts to improve practice will be more effective if the system is redesigned so that it is easier for average workers to do so.
- helps identify which factors in the work environment support good practice, and which create unsafe conditions in which poor safeguarding practice is more likely.
- provides a way of thinking about front-line practice ... and produces organisational learning that is vital to improving the quality of work with (adults and families) and the ability of services to keep (adults) safe.⁸

⁷ <http://www.scie.org.uk/children/learningtogether/resources.asp>

⁸ Adapted from: *At a glance 01: Learning together to safeguard children: a 'systems' model for case reviews* (January 2012)

APPENDIX 3 – Relevant Resources

- SELF- NEGLECT
 - Suzy Braye, David Orr and Michael Preston-Shoot (2015) *Self-neglect policy and practice: key research messages and other products* via <http://www.scie.org.uk>
 - Social Care Institute for Excellence (2011) *Self-neglect and adult safeguarding* at: <http://www.scie.org.uk/publications/reports/report46.asp>
 - Research in Practice for Adults (2015) Practice Tool - Working with people who self-neglect - <https://www.ripfa.org.uk/>
 - BRAYE, Suzy; ORR, David; PRESTON-SHOOT, Michael (2015) *Serious Case Review findings on the challenges of self-neglect: indicators for good practice* The Journal of Adult Protection Vol 17, Iss 2 pp. 75-87
 - BATES, Peter (2014) *Vile bodies: understanding the neglect of personal hygiene in a sterile society* – NDTi at: <http://www.peterbates.org.uk/library.html>
 - WILFUL NEGLECT
 - Re Edward Hedley – Newcastle SAB (March 2016) <https://www.newcastle.gov.uk/news-story/serious-case-review-concerning-death-edward-hedley> January 2014 Report available at: <http://www.newcastle.gov.uk/social-care-and-health/safeguarding-and-abuse/safeguarding-information-professionals/newcastle-safeguarding-adults-board/safegua>
- HOARDING
 - GFRS – Safety tips re Hoarding
- ON EXECUTIVE CAPACITY
 - *MAKING FINANCIAL DECISIONS - Guidance for Assessing, Supporting and Empowering Specific Decision Making* – Empowerment Matters p56ff at: <https://empowermentmatters.co.uk/>