O1

Safeguarding Adult Review

Background

O1 was a white British man who lived with his wife and his daughter who was known to mental health services. O1 had retired early to help care for his daughter. His wife described him as jolly, outgoing and optimistic but said he could also be short-tempered, aggressive and dependent on alcohol. O1 was the dominant person in the household; no-one in the family was prepared to challenge his views, especially around seeking help.

Concerns were raised in 2014 around self-neglect and hoarding. O1 was reluctant to engage and offers of support were declined. Four years later, a family member contacted Adult Social Care expressing concerns about the state of the home. Advice was given but the concern was not progressed and O1 remained on a waiting list.

In October 2018 O1 was admitted to hospital suffering from pressure ulcers and in a critical state. He was later discharged to a care home due to the state of the family home. In December 2018 O1 discharged himself from the care home and was not seen by agencies until early January 2019. He had been lying on the floor for several weeks and had significant pressure ulcers across multiple areas of his body. O1 was again admitted to hospital and recovered. He moved permanently to a nursing home and died in May 2020 aged 87.

The SAR noted lack of follow up when concerns were raised, missed opportunities for preventative work, risks not being considered.

Recommendations: Safeguarding Referrals and Professional Supervision

- Improved understanding of safeguarding referral processes for GP practices and mental health staff.
- Safeguarding training, highlighting self -neglect, for hospital staff.
- Develop effective ICS governance around understanding safeguarding.
- Ensure clinicians know how to highlight safeguarding concerns.
- All agencies to review and audit safeguarding supervision arrangements.
- Professional Curiosity must be challenged and aired in supervision with time for critical reflection.

Recommendations: Self-neglect

- Improve practice and management of self-neglect across agencies.
- Hospital to: Train staff in mental capacity assessments; Review safeguarding toolkit in respect of self-neglect; Review internal systems for flagging complex or self-neglect cases.
- Mental health NHS Trust to: Implement Self-Neglect Protocol and train all staff; Audit work on self-neglect and effective interagency planning.

Recommendations: Risk, Engagement and Complexity

- Learning across agencies around risk and risk assessing practice and creation of a CSAB single risk management strategy.
- Mental health NHS Trust to: Review patient non-engagement protocols; Fully embed a holistic "Think Family" approach into risk assessment, including family support networks.
- GPs: Robust communication protocols to be implemented with patients at risk; GP Safeguarding Leads to have oversight of monitoring of patients at risk and improvements in application of Mental Capacity Act.
- ASC (all agencies): improvements on escalation of risk, wider legal literacy and implementation of strengths-based practice.

Recommendations: General

- Adult Social Care to: Improve internal communication between teams and external communication with other agencies; Improvements made following key changes implemented in ASC to be reviewed.
- Improved communications between and across all agencies to be audited by CSAB.
- GP registration to be better understood across agencies.
- Improvements to be made in commissioning guidance on discharge summaries and audit; also on commissioning guidance for care homes.

Further thoughts...

- Have joined up strategies across the system.
- Clear and simple guidance for all staff in all agencies on where to get advice.
- Peer Challenge work/events could focus locally on interagency communication.
- Professional safeguarding supervision is so important.
- Making Safeguarding Personal (MSP) and Patient/Person-centred practice means thinking how the person perceives what is happening—and acting accordingly.