Safeguarding Adult Review

‘David’

Executive Summary

Coventry Safeguarding Adult Board

November 2023

1.0 Introduction

1.1 The subject of this review is David, who was 55 years of age at the time of his death. David was admitted to hospital in mid-July 2021. David lived in a one-bedroom rented flat and had done so for some time. David was a drug user and was very open about the use of heroin and other controlled drugs.

1.2 David had for some months lived in one room in his flat and had not moved from the sofa. When David was admitted to hospital his home conditions were very poor and it was apparent that he had neglected his health and personal care for some time. David was in receipt of low-level package of support, to maximise his independence, but also to ensure that his basic care needs were met.

1.3 Three weeks after being admitted to hospital David died. HM Coroner held an inquest in January 2022. HM Coroner recorded a narrative verdict stating that David died '*due to multifactorial causes which included the deceased drug addiction and self-neglect, agencies involved in his care not escalating issues regarding his living conditions.*'[1]

2.0 Terms of reference:

- To examine the impact of COVID 19 on agencies practice during this review period
- To consider any issues and learning in relation to decision making capacity, working with people who self-neglect, agency information sharing and coordination to improve practice in the future
- To look at the extent to which any available guidance supports practitioners in their decision making, understanding and in working with people who may self-neglect

The review considered the period from June 2020 until David's admission to hospital in July 2021.

3.0 What did we learn?

3.1 Self-neglect

Obvious signs of self-neglect existed in this case for some time. There is no doubt that David's substance misuse impacted on the level of self-neglect. There is no evidence in this case that apart some practical support to clean the address that there was any concerted effort to understand or address the self-neglect. Practice with persons who self-neglect needs to be person centred where practitioners build a rapport and confidence of the person, that they understand the self-neglect including the persons, lived experience, work at the persons pace with confidence, undertake thorough assessments of care and support needs, constantly review the persons mental capacity to make self-care decisions and undertake full risk assessments.

The Care Act 2014 includes self-neglect as a category of abuse, but the statutory guidance acknowledges that self-neglect will not always result in a section 42 enquiry, this will depend on an assessment as to whether the adult is able to protect themselves by controlling their own behaviour. David was deemed at various stages to have mental capacity but this review found that this may well have been impacted by David's lifestyle.

All the guidance on self-neglect recognises that a multi-agency approach is required, this case lacked the coordination and sharing of information by agencies.

3.2 Care Plan

The care provider staff visited David on a twice daily basis and faced considerable challenges. There were often 'associates' of David's at the address. These persons were often involved in substance misuse with David (alcohol and drugs). Whilst there was no evidence that these persons were exerting pressure on David, their presence made supporting David difficult and presented a potential risk to the staff. David was often intoxicated and carers were unable to engage with David. There was a risk to staff from needles, a disposal bin had been provided but was often not used by David and his associates.

The care plan included the care provider supporting David with personal care but it is apparent that the carer was unable to engage David in personal care. At the time David was taken to hospital in July 2021 it was clear that he had not left his sofa for some time. The support plan also requested that the care provider report to the GP where there were concerns regarding David not taking his medication, regarding his overall heath or where his wound dressings were not changed. All these factors existed but there was no direct contact between the care provider and the GP.

3.3 Escalation

The care provider raised concerns with ASC on a number of occasions between Oct 2020 and February 2021. When David was discovered his condition was poor and it is apparent that there had been an acceptance of David's living and health conditions.

Although Adult Social Care did consider and respond to concerns received, they acknowledged no attempts were made to visit David. The care provider felt that their concerns were not effectively addressed but they did not take the opportunity to escalate the concerns. Whilst the care provider was aware of how to escalate concerns within their own organisation, they state they were not aware how safeguarding concerns could be escalated.

3.4 Multi-agency involvement and co-ordination

The safeguarding enquiry was undertaken and considered information from all the agencies involved in the case and also had the benefit of speaking to David before he died. David's involvement was limited due to his health condition. The safeguarding enquiry came to the conclusion that David experienced neglect from a range of services and this review would support that view.

The safeguarding enquiry found that there was a lack of multiagency working and a failure of agencies to recognise the seriousness of the situation and escalate concerns that were not being taken forward.

What is difficult to understand is why professionals did not feel it appropriate to consider self-neglect as an issue and how this should be addressed. There seemed to be an acceptance

of the conditions in which David lived due to his lifestyle choices and no concerted effort to work with him to address these.

The district nursing service was withdrawn from David in June 2020, this was after David had been warned that this would be a likely outcome if he disregarded advice on injecting into his wounds. This would have been an ideal opportunity for consideration of a multi-agency risk plan. This did not happen and in fact there was some confusion as to whether the service had been withdrawn or not. More confusion followed when after the deep clean of David's flat there was an attempt to re-establish the service. The social worker was told that this would have to be achieved through the GP. There is evidence of correspondence being sent but not recorded or actioned by the GP. Another opportunity presented in April 2021, when the dietician made raised a concern about the presence of pressure sores. On this occasion the GP surgery misfiled the information resulting in no action being taken by the GP. This could have presented an opportunity for the withdrawal of the District Nursing Service to the reviewed. Overall the multi-agency communication in this case was poor.

The s42 enquiry made a number of recommendations for various agencies, those recommendations will not be repeated here but the Coventry Safeguarding Adults' Board should seek assurance from the relevant agencies that the identified actions have been addressed.

3.5 Impact of COVID

The first national lockdown due to Covid occurred in March 2020, this impacted on the delivery of all services while they adjusted to ways of working. Much of the interaction with CGL was by telephone. It is recognised that as Covid restrictions and risks lessened it would have been reasonable for this to be reviewed.

4.0 Recommendations

Recommendation 1

The Coventry Safeguarding Adults' Board should promote the use of the West Midlands self-neglect guidance by all agencies.

Recommendation 2

The Coventry Safeguarding Adults' Board should promote the positive use of the stages of the Escalation and resolution of professional differences policy.

Recommendation 3

Coventry Adult Social Care needs to ensure that where domiciliary care providers are engaged in a complex case that there is suitable oversight and support.

Recommendation 4

Consideration should be given by commissioners of domiciliary care to refreshing and re-enforcing the information given on self-neglect and escalation of concerns

Recommendation 5

Coventry and Warwickshire Partnership Trust should review the internal process for withdrawing services to ensure that all relevant agencies involved in the case are fully aware, that the withdrawal is risk assessed and there is a clear route for requests for the service to be re-engaged if appropriate.

Recommendation 6

The Coventry Safeguarding Adults' Board should seek assurance from all the agencies identified in the s42 enquiry as having actions that they have completed them.

Recommendation 7

Coventry Adult Social Care should review the method of prioritising cases for assessment and be confident that cases where there is risk are expedited.

Recommendation 8

Coventry and Warwickshire Integrated Care Board should request GP practices to ensure that their process to review requests for their intervention are viewed by the practice, clinician where appropriate and are effective.