KINGSTON SAFEGUARDING ADULTS BOARD RESPONSE TO THE DAVID SAFEGUARDING ADULTS REVIEW

The Kingston Safeguarding Adults Board (KSAB) members offer their condolences to David's family and friends. David had multiple physical and mental health problems which led to him becoming increasingly debilitated and unable to care for himself.

David's death was discussed at an extra-ordinary meeting of the Safeguarding Adults Review sub-group in November 2022, and I subsequently approved their recommendation to commission a mandatory safeguarding adults review under section 44 Care Act 2014.

The KSAB would like to thank the independent reviewer for a thorough review. There was good analysis of how agencies, across Kingston, worked with David. The report challenges the KSAB and its partner agencies to consider how to make some key improvements to how to safeguard people, with care and support needs, who are cared for in their own homes.

The KSAB will continue to promote the work of the Kingston Vulnerable Adult Multi-Agency Panel (KVAMA) to facilitate reflective thinking about how to best offer support to those individuals with a complexity of needs, who are at high risk of harm.

The KSAB will focus on the 'Safe Care at Home' report to identify areas of focus to gain assurance that those with care and support needs, and their informal carers, are effectively supported in safeguarding themselves.

The KSAB has plans in place to review the effectiveness of the self-neglect guidance in helping agencies to work with individuals. This will include checking on how well practitioners are able to understand the decision-making abilities of the individuals to whom they are offering support. Additionally, the KSAB will seek to ensure that the guidance includes a toolkit to help practitioners to seek to establish why a person is neglecting themselves.

The progress of the learning from this review, and the impact on safeguarding in Kingston, will be set out in the Annual Report for 2024-25.

Nicola Brownjohn
Independent Chair Kingston Safeguarding Adults Board

26 September 2024

Summary Learning Report based on Safeguarding Adults Review "David"

About the Reviewer

This Safeguarding Adults Review has been led by Eliot Smith, an Independent Health and Social Care Consultant who has no previous involvement with this case, or prior connection to the Safeguarding Adults Board, or partner agencies.

INTRODUCTION

The case of David was considered at an extra-ordinary meeting of the Safeguarding Adults Review sub-group, and their recommendation for Safeguarding Adults Review was approved by the Chair of Kingston Safeguarding Adults Board. This Review is a 'mandatory review' under section 44 Care Act 2014.

The purpose of a Safeguarding Adults Review (SAR) is not to hold any organisation or individual to account, but to determine what the relevant agencies and individuals involved in this case might have done differently that could have prevented David's death. It is to enable members of the Safeguarding Adults Board to:

- Establish whether there are lessons to be learnt from the circumstances of the case about, for example, the way in which local professionals and agencies work together to safeguard adults at risk.
- Review the effectiveness of procedures and their application (both multi-agency and those of organisations).
- Inform and improve local inter-agency practice by acting on learning (developing best practice) in order to reduce the likelihood of similar harm occurring again.
- Bring together and analyse the findings of the various reports from agencies in order to make recommendations for future action.

Background

This case concerns David, a White British man aged between 65 and 74 years-old with long term mental and physical health issues. David died during an admission to hospital having been admitted in a poor physical state. Concerns about self-neglect were identified during the admission. David had been known to services for several years, receiving an Adult Social Care funded care package, community nursing and frequently presenting at the Emergency Department. There were numerous referrals to community mental health

services, but David was not accepted due to his reluctance to engage with psychological-therapeutic interventions.

Specific terms of reference

Specific terms of reference provide structure to the collection, organisation, and management of evidence and data gathered for the review. Following the initial scoping of the circumstances of David's death, a number of key practice themes were identified.

1. Case management and coordination: How effective were assessment, care planning, review and intervention processes at ensuring mental and physical health needs were met in the context of coexisting conditions?
2. Multi-agency Safeguarding: How effective were safeguarding activities, including concerns raised, safeguarding enquiry and how this was managed, and how each agency viewed risk in relation to self-neglect?
3. Mental Capacity: How did agencies address the issues of mental capacity, autonomy and freedom of choice?
4. Decision Making in the context of Self neglect: What frameworks are in place to support practice? What frameworks were or could have been applied?

FINDINGS

Finding 1: Multi-agency processes and panels

Underlying issue
There was a general lack of awareness of David's dependent personality disorder and what this meant for the management of his co-existing physical and mental health needs. David's physical health and social care needs, and his mental health needs were assessed and considered separately. In safeguarding and multi-agency work there was a failure to gain mental health expertise to support analysis of the interdependence between physical and mental health and impact on self-neglect and vulnerability to abuse.

Rationale for change
It is accepted knowledge that physical and mental health are interconnected. Co-existing physical and mental health conditions can lead to complexity and risk. A failure to holistically assess and respond to co-existing physical and mental health problems can make interventions less effective result in missed opportunities to optimise an individual's support. When an individual at risk of abuse and neglect, including self-neglect is not open to specialist mental or physical health services, the relevant expertise must be brought in, so it is not lost to the system. Existing multi agency risk panels provide an opportunity for agencies to work together in an informed and action-based way.

Recommendation
Actions are taken to promote multi-agency panels, ensuring that cases of high-risk and multiple vulnerability are referred and receive the benefit of specialist expertise.

Impact and measurement
The impact of actions to increase the use of safeguarding and/or multi-agency procedures for managing cases of high-risk. Measuring increased awareness and use of guidance and

processes could be an audit of the number of high-risk cases of self-neglect subject to safeguarding or Vulnerable Adult Multi-Agency Panels, including those where specialist expertise was required but not previously available within partnerships.

Finding 2: Missed opportunities in domestic abuse practice

Underlying issue
There were significant vulnerability and risk factors for domestic abuse which were not adequately explored or followed up. This resonates with missed opportunities in a previous Domestic Homicide Review.

Rationale for change
When adults have care and support needs and a dependence on a personally connected carer there may be significant vulnerability and risk factors. It is important that there is synergy across safeguarding and domestic abuse services when address the risks of domestic abuse in vulnerable populations.

Recommendation
The Safeguarding Adults Board and Domestic Abuse Partnership Board should work together to formulate joint actions to address missed opportunities in the case of David and the DHR.

Impact and measurement
A pathway test, or stress test, of the system will reveal areas of strength and improvement. It may be useful to map and test the effectiveness of contact points between specialist safeguarding and domestic abuse services including:

- Early identification and prevention
- Access points
- Initial responses and assessments
- Enquiry decision-making
- Protective interventions and protection planning.

Finding 3: Mental capacity, autonomy, and freedom of choice

Underlying issue

Self-determination, autonomy, and freedom of choice are key concepts in safeguarding. Abuse, neglect, and self-neglect can occur when an individual's autonomy and freedom of choice is impeded – by dependence on others, by the actions of another, emotional distress, mental illness, or even as a result of habitual patterns of behaviours. In many cases of abuse, neglect, and self-neglect, it can be helpful to consider decision-making in its broader context, as a spectrum, rather than the binary determination of 'has' or 'lacks' capacity.

Rationale for change

Understanding how individuals make decisions and identifying potential barriers to autonomy and self-determination can help agencies work more effectively with individuals. A narrow focus on establishing mental capacity can mean that issues of impeded freedom of choice may be overlooked. Professionals working in a safeguarding context should be encouraged to take a broader view of decision-making and mental capacity, considering an adult's level of self-determination, autonomy, and freedom of choice as well as whether they have or lack mental capacity.

Recommendation

Policy, guidance, and training on safeguarding, self-neglect, and mental capacity should be updated to reflect a broader consideration of decision-making styles and ability, and barriers to self-determination, autonomy, and freedom of choice.

Impact and measurement

This finding is intended to introduce, and encourage practitioners to adopt, a broader perspective on decision-making and autonomy in the context of self-neglect. In order to understand practitioner knowledge and awareness following actions, a survey or focus group discussion approach could be used.

Finding 4: Exploring the underlying reasons for Self-neglect

Underlying issue
Despite the high-risk nature of David's self-neglect, there was a missed opportunity to trigger either safeguarding or Vulnerable Adult Multi-Agency Panel processes. By working in isolation and focusing only on the presenting issues, practical interventions offered David some short-term benefit but failed to address the underlying reasons behind his self-neglect. David's physical health continued to decline, and on admission to hospital he was in a very poor state of health.

Rationale for change
Statutory guidance states that many cases of self-neglect will not require a safeguarding enquiry, except where an individual is unable to 'control their behaviours'. High-risk cases that are not appropriate for a safeguarding enquiry could alternatively receive a focused multi-agency response through Vulnerable Adult Multi-Agency (VAMA) processes. Multi-agency processes could provide a forum for agencies, to share knowledge and expertise and to explore underlying reasons for self-neglecting behaviours.

Recommendation
The Board should consider how to raise awareness of the self-neglect guidance and develop practice tools to support exploration of the underlying reasons for self-neglecting behaviours.

Impact and measurement
This finding is intended to raise awareness of the Kingston Safeguarding Adults Board Self Neglect and Hoarding Guidance and Process (KSAB, 2022) and increase the use of practice tools for exploring underlying reasons for self-neglect behaviours. Measuring increased awareness and use of guidance and processes could be achieved through practitioner surveys and tools.

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