Safeguarding Adults Review for Susan

2024

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1. Summary of events leading to the SAR referral

1.1 On 02 October 2022, following witnessed fall out of bed, Susan was admitted to hospital. Susan was reported as having refused to eat or drink for the previous two days. She presented as hypothermic and hypoglycaemic. She was transferred to the Intensive Care Unit due to metabolic acidosis secondary to no oral intake. Susan subsequently died in hospital on 05 October 2022.

1.2 The S42 enquiry commenced prior to her death, concluded following her death. This substantiated the concern that Susan had neglected herself, and also raised concerns regarding the consistency of agency communication and collaboration to keep her safe.

1.3 Susan had experienced mental health and physical health issues which significantly impacted her quality of life for over a decade.

- chronic and recurrent depression (diagnosed 2001)
- morbid obesity (diagnosed 2008)
- sleep apnoea syndrome (diagnosed 2008),
- type II diabetes mellitus (diagnosed 2011),
- atrial fibrillation and heart failure (diagnosed 2021)
- Chronic Kidney Disease (diagnosed 2022)

1.4 Susan was well known by the GP practice due to her multiple medical problems. Susan was erratic in how she cared for herself and managed her medication. She frequently did not attend appointments or answer the phone when health professionals tried to contact her. The GP reported that Susan's mental health had an impact on how she managed her physical health, particularly once she was diagnosed with diabetes.

1.5 In March 2020, when the Covid-19 pandemic commenced, Susan continued to work in a public facing role and had the infection in May 2020, which left her with shortness of breath for a while. During the pandemic, Susan became worried about leaving her home. She had periods of sickness and was stressed due to job instability.

1.6 In August 2021, her son's partner raised concerns with the GP that Susan was not coping, not eating, drinking, washing or dressing. During this time the GP made numerous efforts to engage Susan and to identify other support for her, but she would not accept the help.

1.7 In October 2021, the Ambulance service raised a safeguarding concern due to the state of Susan's home, her depression and wanting to die. She was admitted to hospital but declined any help when discharged. In December 2021, the GP

made a referral due to self-neglect, depression, and the risks created by Susan's health conditions. However, Susan declined any support.

1.8 Concerns continued into 2022, with numerous attendances at the Emergency department, whilst primary care attempted to offer social prescribing to Susan. A further safeguarding referral was made in March 2022 due to the home being cluttered, Susan not taking her medication, eating or drinking. However, she continued to refuse any help.

1.9 Then in July 2022, Susan was admitted to hospital following an unwitnessed fall. She remained in hospital for three weeks. By this time her wider family had become increasingly concerned about Susan's welfare. Her brother wrote to Adult Social Care to raise concerns. These concerns were shared with the hospital and a S42 enquiry was commenced at the beginning of August 2022. In mid-August 2022, Susan was discharged having been reported to decline any social support or mental health intervention.

1.10 Once she was back at home, there were continuing concerns about Susan in the community and efforts made to engage her to support her health care, without success. Meanwhile, her family continued to raise concerns with agencies about her health and wellbeing. The s42 enquiry continued into September 2022, with Adult Social Care trying to contact Susan without success. Before the enquiry was concluded, Susan died in October 2022 following a fall at home.

2 SAR Decision Making

2.1 A Safeguarding Adults Board (SAB) must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the Local Authority has been meeting any of those needs) if:

a) There is reasonable cause for concern about how the SAB, members of it, or other persons with relevant functions worked together to safeguard the adult, and
b) Condition 1 or 2 is met:

Condition 1 is met if:

a) The adult has died, and
b) The SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew or suspected the abuse or neglect before the adult died).

Condition 2 is met if:

a) The adult is still alive, and

b) The SAB knows or suspects that the adult has experienced serious abuse or neglect.

2.2 The SAR referral was received on 29/06/2023 from Essex Adult Social Care. Scoping information was requested from agencies, but there was a delay in bringing the case to the SAR committee for discussion due to an increased number of referrals and SARs being managed.

2.3 A SAR referral was made to the SAB and was discussed by the SAR committee on 24/10/2023 and further information was requested. Subsequently, the report was discussed on 23/11/2023. The SAR committee agreed that it had enough information to make a decision and concluded that the case did not meet the criteria for a mandatory SAR under s44 of the Care Act 2014. There was consideration as to whether to commission a discretionary SAR. There was a view that this would not elicit further learning following the S42 enquiry. It was noted that there was a live SAR underway for another individual relating to issues of self-neglect, mental capacity and acceptance/compliance with medical interventions. The SAR committee agreed that once that SAR was completed, to ask the author of that review to compare Susan's circumstances with the learning identified from the SAR.

2.4 The decision of the SAR subcommittee was considered by the Independent Chair on 11 January 2024. The outcome of this was that the Chair requested that a discretionary SAR be commissioned in relation to Susan's death to enable lawful access to information from every agency involved with her care.

3 Methodology

3.1 A systems approach has been applied to consider the findings from the review and identify the wider learning to be taken forward by the ESAB and its partners.

3.2 This has been undertaken by an independent reviewer with support from a panel comprising representatives from the following agencies:

- Essex Adult Social Care (ASC)
- Mid and South Essex (MSE) Integrated Care Board (ICB)
- Fern House GP Surgery
- Provide Community Interest Company (CIC)
- Essex Partnership University NHS Foundation Trust (EPUT)
- East of England Ambulance Service NHS Trust (EEAST)
- Mid and South Essex NHS Foundation Trust (MSEFT)
- Hertfordshire Partnership University Foundation NHS Trust

3.3 Agencies were requested to provide summaries of their involvement with Susan and a timeline of key events. Agencies were required to participate in a practitioner event and provide additional information as deemed necessary by the reviewer.

4 Scope of Review

4.1 The specific period to be covered, for analysis of practice by the review, will be August 2021 – October 2022. This reflects the point at which Susan's family first raised concerns with professionals until the incident which preceded her death.

4.2 The SAR author will seek to identify findings, set out the analysis, and consider lessons learned and examples of good practice. Where appropriate there will be alignment with other Essex SARs. The final report will include a set of recommendations for action for the ESAB to identify actions to improve practice. The implementation and embedding of the learning will be monitored by ESAB.

5 Key Lines of Enquiry

- Assess the extent, and effectiveness, of agencies to work collaboratively when an individual is known to be self-neglecting.
- Discuss how professionals apply the Mental Capacity Act when there are clear signs of self-neglect, and the impact of this on safeguarding the individual when they are refusing support.
- Consider the impact of the Covid-19 pandemic on how confident individuals with long term care and support needs are in being able to access services safely.
- Review how the hospital discharge process safeguards individuals who decline support when they have a history of self-neglect, mental health and chronic physical issues.
- Evaluate how well agencies worked within the Southend, Essex and Thurrock (SET) Safeguarding Adult Multi-Agency Procedures and single agency policies

6 Parallel investigations

6.1 Susan died in hospital having not recovered from a fall at home, where she was found to be in a poor state of health. A day inquest was held on 10 August 2023. This concluded that Susan's death was caused by:

I a Metabolic acidosis
b Multiple Organ Failure
c Poor intake and Self Neglect

II Congestive Cardiac Failure, Diabetes Mellitus, Depression and Atrial Fibrillation

7 Family Engagement

The independent reviewer met with Susan's family on 19th April 2024, prior to preparing the terms of reference. This enabled the reviewer to hear the views of each family member about Susan's experience. Additionally, the reviewer was able to explain the purpose and parameters of a SAR, and that the process is totally separate from the complaints procedures for agencies working with the SAB.

8 Practitioner Engagement

8.1 The reviewer would like to thank the practitioners who had direct involvement with Susan for their honest reflections at the practitioner event held in July 2024. The focus of the event was to gain an understanding of why workers responded in the way they did. By using this method, the risk of hindsight bias was reduced and enabled the reviewer to see the situation from the worker's perspective and any wider issues in their work during the period in scope.

8.2 Participants at the event were from:

- Essex County Council Adult Social Care
- GP Practice
- Mid and South Essex Integrated Care Board (MSEICB)
- Provide Community Interest Company (CIC)
- Mid and South Essex NHS Foundation Trust (MSEFT)
- Hertfordshire Partnership University Foundation NHS Trust

8.3 The event focused on the key episodes within the timeline. This enabled the reviewer to clarify facts and discuss with practitioners how they worked at the time, along with any changes since Susan's death.

8.4 The findings from the practitioner event are included in the analysis section of this report.

9 What was known about Susan? (Family View)

9.1 Susan was a 64 year old, White British woman who had multiple chronic health conditions. Susan had declined social help over the final two years of her life. She did not always respond to calls from health services but was open to Primary Care staff about how emotionally low she felt and how fearful she was of contracting the coronavirus, once she had become unwell and was unable to

continue working. Yet, she did not indicate to her family that she was fearful of the virus, rather that she was feeling depressed.

9.2 Her family described how Susan's health had deteriorated over the last year or 18 months of her life. They were not clear as to why. Just six weeks prior to her death, her family reported that Susan had given the impression that she was improving. Susan's family described how she had a history of intermittent depression and how she was a complicated person.

9.3 Susan had worked in a commercial, public facing role, even as the Covid-19 pandemic commenced in March 2020. However, she then had a long period off sick, which led to her losing her job, as there was no clear indication of how she could improve enough to return. Her family described how this was the catalyst to her health going rapidly downhill. She spent her days in her home, alone, as her son and his partner were out at work all day.

9.4 Susan was able to order shopping online, but her self-care deteriorated, and she stopped taking her medication. It became increasingly difficult for her family to persuade her to come out of her bedroom. Prior to this, she had been sociable with her family and a small group of friends.

9.5 Susan had numerous attendances at the hospital emergency department. Sometimes her son would call an ambulance, other times Susan would do so herself. Once at the hospital, Susan would often discharge herself. She would wait outside for her son to pick her up, and so the family were not always able to ask hospital staff about her. Susan's son described how, when she was admitted, staff would report that she was fine, yet the family knew she was not fine. The GP would be expected to follow up, but Susan would not pick the phone up.

9.6 Susan's family reported to the reviewer that they were struggling in their grief for Susan as there were gaps in them being able to understand why she died in such poor circumstances.

9.7 The family reported the following questions to the reviewer. It is hoped that these have been covered within the terms of reference for this review, where appropriate, as the reviewer explained the purpose of a SAR.

- Why were alarm bells not raised when the GP asked ASC for support, as well as the family letter expressing concerns?
- Why were agencies not joined up?
- Did anyone really try to help Susan?

10 Key Episodes between August 2021 and October 2022

Key Episode 1: August 2021: Family raising health and welfare concerns
• On the 25th August 2021 GP received message from Susan's son's partner who was concerned about Susan's eating and drinking habits and informed GP that she had not washed or dressed so there were concerns about her general wellbeing. • Social Prescriber attempted to contact Susan as there was no consent to speak to Son's partner regarding Susan's medical information. • There was no response from Susan despite several attempts to contact and a voice message was left that should things stay the same she needs to speak to the GP and call the surgery for an appointment. • August 2021 the Talking Therapies (IAPT) Service discharged Susan due to their inability to make contact with her. • September 2021 Susan seen face to face by Primary Care Advanced Nurse Practitioner, nothing was found to be abnormal. • September 2021, GP spoke with Susan on telephone for a depression review, she reports that she was largely the same and had been triggered by her mother's ill health and agoraphobia, a diabetic review was due at the end of September with the Tier 2 Service. • Susan said she had been swapping her medications over and GP advised the risks of this and referred her to a new service at the time called the Emotional Wellbeing Service (commissioned by CCG) as well as a re-referral to Talking Therapies (IAPT). • GP gave crisis and suicide prevention advice and signed her off work for an additional month with a review planned for after this • September 2021- son's partner reported to GP that Susan was not eating or drinking and there was cat mess everywhere. Few days later Susan did not attend diabetic appointment.
Key Episode 2: October 2021 – March 2022 Safeguarding concerns
• In October 2021, the Ambulance service raised a safeguarding concern due to the state of Susan's home, her depression and wanting to die. • She was admitted to hospital but declined any help when discharged. • In December 2021, the GP made a referral due to self-neglect, depression, and the risks created by Susan's health conditions. However, Susan declined any support.

• Concerns continued into 2022, with numerous attendances at the Emergency department, whilst primary care attempted to offer social prescribing to Susan. • A further safeguarding referral was made in March 2022 due to the home being cluttered, Susan not taking her medication, eating or drinking. • However, she continued to refuse any help.
Key Episode 3: July-August 2022: Admission to hospital
• Susan was admitted to hospital following an unwitnessed fall. • She remained in hospital for three weeks. • By this time her wider family had become increasingly concerned about Susan's welfare. Her brother wrote to Adult Social Care to raise concerns. • These concerns were shared with the hospital and a S42 enquiry was commenced at the beginning of August 2022. • In mid-August 2022, Susan was discharged having been reported to decline any social support or mental health intervention.
Key Episode 4: September – October 2022: Back in community, agencies unable to engage Susan
• There were continuing concerns about Susan in the community and efforts made to engage her to support her health care, without success. • Meanwhile, her family continued to raise concerns with agencies about her health and wellbeing. • The s42 enquiry was allocated in September 2022, with Adult Social Care trying to contact Susan without success.

11 Analysis focusing on the KLOEs

11.1 To build on the learning from the Anne SAR, which had some similar themes.

11.1.1 SAR Anne identified a need to improve how mental capacity assessments are undertaken when there is fluctuating capacity due to illness. In Susan's case, she had multiple physical illnesses, as well as mental health issues. She was open about her low mood at times. In July, when she was admitted to hospital, this was due to serious dehydration which would have had an impact on her ability to think clearly about her decisions. However, this did not appear to be

taken into account by practitioners when Susan was making the decision to refuse any support at home.

11.1.2 It is crucial that practitioners are supported to implement the Mental Capacity Act in a more efficient manner. It seemed to be, for Susan, a blanket consideration that she could make a decision, without considering the impact of significant health conditions. If this had been done, then there could have been conversations with Susan and her family to fully understand her wishes, and her comprehension of her health situation.

11.1.3 SAR Anne recommended that there be strengthened assessments in relation to potential self-neglect and for this to include historical information. In Susan's case, she was well known to services. However, again, there was insufficient consideration of the information gathered over time. This was evident when Susan was discharged from hospital, more than once, without support despite reports of self-neglect and no one in the home being able to help.

11.2 Assess the extent, and the effectiveness, of agencies to work collaboratively when an individual is known to be self-neglecting

11.2.1 In Susan's case, there was evidence that she was neglecting herself from August 2021, when her family raised concerns with the GP. The reports were that Susan was not washing or dressing as well as having poor drinking and eating habits. By September 2021, there was additional information that there was cat mess everywhere. The GP appropriately started on actions to follow up on the information and managed to speak with Susan. Susan was able to explain that she was struggling due to her mother's il health and was experiencing agoraphobia. The GP referred her to Talking Therapies, but this was ended due to Susan's 'non-engagement.'

11.2.2 In the following months, concerns grew regarding Susan's welfare, resulting in safeguarding referrals to Adult Social Care (ASC). A key point was in October 2021, when the Ambulance service raised a safeguarding concern due to the state of Susan's home. At this time, Susan was admitted to hospital. However, there was safeguarding activity undertaken in relation to self-neglect. Susan was offered support, but she declined and was discharged from hospital. This was a key point for professionals to come together with Susan and her family to understand her needs and how to support her to safeguard herself.

11.2.3 In December 2021, the GP made a safeguarding referral in relation to Susan's self-neglect, depression and the impact of Susan's health needs. She was admitted to hospital having been found unconscious. She was reported to agree to a mental health referral, but the assessment was that there was no indication of requirement for secondary mental health services. Susan had agreed to this

referral, she was depressed and was struggling to manage her diabetes. There was a decision made to close the safeguarding concern by the ASC Central Triage team as it was deemed that a Care Act assessment would be the best way forward to support Susan to achieve her daily living activities. However, Susan was reported to decline support and so the case was closed. Again, there seemed to be only a conversation with Susan, without the family who were living in the same property. There was no sense of an understanding of why Susan was refusing, or what impact her refusal could have on her longer term wellbeing.

11.2.4 This was a missed opportunity to gather information from the multiple services who knew of Susan, and her family. In January 2022, the GP was concerned enough to discuss Susan at the Multi-Disciplinary Team meeting held within the GP surgery. This included community health professionals and Adult Social Care. Yet, the conclusion was that Susan's capacity and lack of engagement with services was preventing the opportunities to make a real difference to her life. This meeting could have been held under the safeguarding framework to trigger the self-neglect guidance to be enacted. Yet, there does not appear to have been any real consideration of the evidence of self-neglect, or what frameworks and guidance could support the MDT to take proactive action.

11.2.5 In the following months, Susan had numerous attendances to the emergency department. In March 2022, there was another safeguarding referral made, due to the cluttered homes and Susan not taking her medication, eating or drinking. The GP, who made the referral, noted self-neglect and an elevated risk of hospital admission. The response to this was a Reablement assessment which concluded that Susan was independent and had support from her family and friends with cooking and laundry. This did not correlate with the information that the GP had received in the previous seven or eight months from the members of the family who were living in the property. Some support was offered for 6 weeks, but Susan stated that she only needed personal care, as family helped with cooking and laundry. When the provider visited there was no answer at the door. The notes stated that a welfare check was undertaken, and she was safe. However, it is not clear how this was undertaken, and there was some indication that she was in hospital at the time. She certainly was admitted just 2 weeks later for a month. This missed the opportunity to continue the plan for some short term help for when Susan was discharged from hospital. Susan was admitted to hospital for a few weeks but when it came to the discharge plan, there was no communication between the hospital ward and ASC.

11.2.6 In July 2022, Susan had a fall and a further long admission to hospital. The Ambulance crew reported the home to be *'unsanitary, faeces on the floor and all over the bed, dirt and grime all over upstairs, rat runs everywhere.'* By this time, her extended family were concerned and contacted ASC. The concerns

were shared with the hospital and a S42 enquiry was commenced. The hospital also made a safeguarding referral in respect of the reports about the state of the home, and that the family member living in the property no longer wished to provide support for Susan, and Susan was asking for help as she relied on her family member. Yet, Susan was discharged having been reported to decline any social support or mental health intervention. The reports from the ward were that Susan was stating that she was not worried about the state of her home and that her family member did not provide her with any support, and she did not need any help. Apart from this, there is no evidence of any follow up with Susan, or her family, regarding the reports of the state of the home. The family reported that they had deep cleaned the home, but this was not clear from the agencies involved. Significantly, this was at the point where the extended family, and next of kin, had raised concerns with ASC which had been shared with the hospital. Yet, Susan's family were not informed of her discharge from hospital, despite members of the family having been in to the ward to discuss their concerns.

11.2.7 This narrative of Susan's experience demonstrates how agencies were not effectively working together to safeguard an individual who was known to be self-neglecting. The reports of the poor state of the home, came from the Ambulance Service, and somewhat from the family, rather than from those agencies actively working with Susan. The Ambulance service were not present at the practitioner event, as it is difficult to manage the presence of those crew members who witnessed the homes of the individuals subject to a Safeguarding Adults Review. The referrals to ASC following the witnessing of the state of the home, appear to have been made by the hospital rather than the Ambulance service.

11.2.8 In the Anne SAR, it was suggested that concerns raised by the wider community could be undermined in the seriousness of what they had witnessed. Looking at Susan's case, this could also relate to Ambulance crews. The 2nd National SAR analysis identifies the good practice of agencies such as Ambulance Trusts making safeguarding referrals regarding self-neglect.[1] However, in Susan's case, the ambulance crew do not appear to have made direct safeguarding referrals but reported to hospital or GP. These should have been made directly to ensure that the full information was shared. In September 2022, the ambulance crew do not appear to have had access to the previous concerns when they visited and deemed the home state not to meet the criteria for a safeguarding concern and so raised with the GP instead.

11.2.9 There is no evidence that a multi-agency meeting to focus on self-neglect, as per the ESAB guidelines/flowchart in place at the time, was arranged by any

[1] 2nd National Analysis part 2 report. p85

practitioner. This could have been called by any of the agencies involved but his does not appear to be understood by agencies, instead, there is an expectation that ASC will lead. Although, the GP did arrange a discussion at the surgery, and this should have been able to be classed under the ESAB guidelines. A recommendation from the Anne SAR was for a review of the ESAB self-neglect guidelines, and this would seem to be endorsed by Susan's experience. If practitioners do not feel able to organise multi-agency meetings, then there needs to be improved guidance and support to enable them to do so.

11.2.10 In Susan's case, there was a report of rat runs, but no evidence that environmental health had been called to undertake a visit.

11.2.11 There should have been a multi-agency meeting held under the ESAB Self-neglect guidance and flowcharts that were in place at the time. This should have included attendance by multiple physical and mental health services, to provide a holistic assessment of Susan's short and longer term needs, and how to provide support. To be successful, in light of Susan's changing narrative and engagement with services, this needed to be undertaken in a joined up way. This would have enabled evaluation of the impact of the different conversations Susan was having with professionals, and the family views.

11.3 Discuss how professionals apply the Mental Capacity Act when there are clear signs of self-neglect, and the impact of this on safeguarding the individual when they are refusing support.

11.3.1 At the practitioner event, there was a clear view that there were no reasons to doubt Susan's capacity to make decisions about her care. This is a recurring theme in SARs nationally. The risk of this is that adults who have significant care and support needs, do not receive help due to them declining, and this being seen as their right to do, despite the overriding evidence that the outcome will not be positive. Additionally, the impact of physical or mental illness on a person's ability to make clear decisions does not appear to be well understood.

11.3.2 The view of capacity seemed to be a barrier to professionals being able to have critical conversations with Susan, as it did in the case of SAR Anne. In that SAR, there was a discussion as to how practitioners could have used gentle questioning to reach the individual. In the same way, for Susan, when in hospital, she was more reachable than when at home, not answering the phone or door. There could have been conversations with her to check what she wanted from her life, and how she could be helped with her health and social care needs. That way, there could have been an honest, constructive challenge to her about her not responding, and, perhaps, she might have agreed to a way forward.

11.3.3 It was known that Susan had mental health issues. The SAR panel discussed how the MCA tends to be used over and above practitioners being able to understand the impact of a person's life, or physical, changes on their mental health.

11.3.4 In December 2021, Susan was seen by the psychiatric liaison team when she was admitted to hospital. This was good practice. Susan was recorded as agreeing to referrals to the Community Mental Health Team (CMHT). However, the CMHT assessed her as not needing secondary mental health support. Had there been the opportunity to work with Susan whilst she was in hospital to establish a relationship with the community mental health service, this might have enabled the relationship to continue once Susan was back home.

11.3.5 When Susan was admitted to hospital again, in July 2022, there was no referral to the Psychiatric Liaison Team. Instead, there was a safeguarding referral, whilst the clinical team viewed Susan as being able to make her own decisions. This was a missed opportunity to work with Susan, and her family, to fully understand how Susan saw her future and how she wanted to be supported. It would have been of benefit to triangulate the safeguarding concerns using both MCA and Mental Health Act lenses.

11.4 Consider the impact of the Covid-19 pandemic on how confident individuals with long term care and support needs are in being able to access services safely.

11.4.1 At the practitioner event, the view was that Susan's deterioration was due to the Covid-19 pandemic, in terms of Susan's fear of being infected, as well as the difficulties for services to perform effectively in accessing homes and having the capacity to deliver a safe service. It is important to note that Susan was not afraid of Covid in the early months and worked on the frontline with the public. However, she then became unwell and was unable to work. Susan gave different responses to professionals and her family as to the impact the Covid-19 pandemic was having on her mental wellbeing.

11.4.2 Susan's situation did worsen during the pandemic. She working in a public facing role which placed her at high risk of infection, but she continued despite that. However, even in the early months of the pandemic, she was reporting feeling down and that people did not care about her. Once she became unwell and was unable to continue her job, she became more isolated.

11.4.3 In 2021, Susan was needing more health input, but the diabetes service was restricted, requiring telephone contacts, as was the talking therapies service,

and the cardiac team. Susan would repeatedly be discharged from community services, due to no response to contact, and then re-referred by the GP.

11.4.4 At the practitioner event, it was clear that services such as the diabetes team made considerable efforts to support Susan. However, practitioners reported that it is difficult when a person is not engaging with the service. Other practitioners reported how it can feel like bombarding the patient when constantly trying to contact them.

11.4.5 This seems to suggest that there is a gap in the system for proactive follow up of those people who do not engage with health services, but who obviously need the support. At the practitioner event, it was explained that the district nursing role has changed from pre pandemic days. Previously, a community matron would have visited homes if there was no response from a patient. However, during the pandemic that remit ceased.

11.4.6 Despite several practitioners clearly putting immense effort into trying to engage Susan during the pandemic, there was limited understanding of why she was not responding. It was known that she was in low mood and reported being agoraphobic. This could have prevented her from attending physical appointments or answering the door. Her low mood might have meant that she just did not have the mental energy to answer a phone call. During this time, Susan was found to not be doing her blood tests, needed to manage her diabetes.

11.4.7 By January 2022, Susan's fear of Covid seems to have made a considerable impact on her functioning. She was referred to Talking therapies but did not respond to calls and they discharged her back to the GP. This was at a point when she was considered to need high intensity input. This should have led to a multi-agency meeting to discuss how to get through to Susan. Shortly after, she was taken to hospital the decision of talking therapies. She was seen by the psychiatric liaison team and referred for community mental health (CMHT) input, but this was not considered appropriate by the CMHT. There was some further activity by talking therapies, as the GP had re referred once she was back home. However, this proved unsuccessful in reaching Susan. Therefore, this was another missed opportunity for a multi-agency discussion about how to reach Susan.

11.5 Review how the hospital discharge process safeguards individuals who decline support when they have a history of self-neglect, mental health and chronic physical issues.

11.5.1 At the practitioner event, it was reported that the hospital discharge processes in 2022 were still being impacted by the Covid-19 pandemic in that there were

difficulties in having social workers on the hospital sites. It was reported that now, social workers are integrated within the discharge team. However, the GP reported that there are still similar situations of patients being discharged without a clear plan when they are at risk of harm. The SAR panel explored this and informed the SAR reviewer that there have been no changes in the discharge process since 2020. The Integrated Discharge Team (IDT) is used for the discharge of complex patients. Even though patients such as Susan should be viewed as complex, once they decline a support package, they are not discharged through the IDT. This shows a gap in how individuals with complex needs are supported. Other SARs have highlighted this gap[2]. When there is an individual who is continually declining support, but there have been safeguarding concerns, this should trigger the involvement of the IDT to ensure a safe discharge home.

11.5.2 It was also reported at the practitioner event, that there were mental capacity assessments undertaken prior to Susan being discharged. In August 2022, it was reported that Susan declined all help and said that her son did not help. Yet, it was known that the home was in a poor condition and there was no information that the family, or anyone else, had cleaned the property whilst Susan was in hospital. Given that she had known mental health and chronic physical health needs, it should have been assumed that she would need something to motivate her to be able to help herself. Returning to a clean home, with fresh bedding and meals provided, might have enabled community follow up to assess the sustainability of Susan being able to care for herself.

11.5.3 Hospital admissions should be viewed as an opportunity to have quality conversations with people who are known to have difficulties engaging with services when in the community. This is important to reduce the risk of repeated admissions. In Susan's case, she had numerous attendances at the Emergency Department and several long admissions in a short period of time. She was known to not attend community appointments or answer the phone. The multi-disciplinary team could have come together in the hospital to discuss the options for Susan's care, with her and her family. It might have been difficult during Susan's admissions, due to the Covid-19 pandemic, but this should be considered for inclusion in the SET revised guidance for self-neglect.

'In several cases of severe self-neglect, there was no evident consideration of the suitability and impact of the observed home environment, or how it had descended into such a neglected state. Little was known of what the individuals concerned really thought about their situation and what their desired outcomes were.'[3]

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[2] Sutton SAB (2022) SAR F; KMSAB (2023) SAR Peter; KMSAB (2024) SAR Derek.

[3] 2nd National Analysis part 2 report p35

11.5.4 The 2nd National SAR analysis considers how risk assessments can be inadequate within the context of self-neglect, with a lack of recognition of the interface between self-neglect and health needs.[4]

11.5.5 Apart from the impact of the Covid-19 pandemic, there is no understanding as to why Susan was repeatedly admitted to hospital, and then discharged without a clear plan for her holistic care to prevent readmission. There were differing accounts as to what her wishes were regarding her situation, and to what extent she needed support from her son, who was not able to provide support as he was moving out. There was an account that Susan reported, whilst in hospital, that she was not bothered by the state of her home. This was at a point that there had been reports of rat runs, faeces on the bed and Susan not eating or drinking. This was a woman who was known to be depressed, who had been admitted with dehydration, acute kidney injury and heart failure. and she was subject of a s42 enquiry. Therefore, it is questionable as to why she was discharged from hospital. It was seemingly purely due to her being deemed to have capacity and declining support once she was medically optimised. This appears to have meant that Susan was discharged on pathway 0 (zero) i.e., back to usual residence, with no new or additional health or social care needs.[5] This decision misses the fact that there was a s42 enquiry, yet the discharge plan was not discussed with ASC, and that the home circumstances had changes, with Susan's son reporting that he was not able to help her anymore.

11.5.6 Susan had been admitted to hospital due to heart failure, dehydration and acute kidney injury. It would have been reasonable to consider that she would need community follow up to support her to maintain her physical wellbeing, once medically optimised in hospital. Discharge planning should start on admission, and so it should have been well known that Susan's mental health was low, she was subject to a safeguarding investigation, and her home circumstances were changing. She was known to disengage with services once in the community. Therefore, she should have received mental health support whilst in hospital and professionals having clear conversations with her about her long term prognosis and how she would be able to take care of herself.

11.6 Evaluate how well agencies worked within the Southend, Essex and Thurrock (SET) Safeguarding Adult Multi-Agency Procedures and single agency policies.

[4] 2nd National Analysis part 2 report p71
[5] Hospital discharge and community support guidance - GOV.UK (www.gov.uk)

11.6.1 The Essex Safeguarding Adults Board published Hoarding Guidance in 2021[6]. This guidance sets out the types of hoarding and behaviours.

11.6.2 The guidance was reviewed for the SAR Anne and a recommendation was made for a review of the guidance to support practitioners to navigate the challenging area of self-neglect.

11.6.3 In SR Anne, agencies had demonstrated appropriate responses to the reports of hoarding, in taking action to visit the home. For Susan, this does not appear to have been considered. This might have been due to the focus on her acute health needs at the times when the poor state of the home was noted. The GP did raise at an MDT, but this was not conducted under the ESAB self-neglect guidelines/flowchart. There should have been a multi-agency meeting held in respect of Susan given the extent of the concerns regarding self-neglect. Instead, self-neglect seems to have been addressed by ASC separately to the expectations of the guidance.

11.6.4 In SAR Anne there was consideration of how the self-neglecting was addressed against the SET Safeguarding Adult guidelines[7]. Within the guidelines there is a self-neglect flow chart which states the identification of a lead worker is needed when a safeguarding adult concern is raised to undertake a home visit. In Susan's case, a lead professional was not identified. The GP seemed to be the worker who pushed for multi-agency action, but the lead role was not established.

11.6.5 The safeguarding guidelines[8] set out the definitions of self-neglect as:

"There is no single operational definition of self-neglect however, the Care Act makes clear it comes within the statutory definition of abuse or neglect, if the adult concerned has care and support needs and is unable to protect him or herself. The Department of Health (2016) defines self-neglect as, *'… a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding'.*

The Care Act 2014 defines self-neglect as '*…. covers a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding. It should be noted that self-neglect may not prompt a section 42 enquiry. An assessment should be made on a case-by-case basis. A decision on whether a response is required under*

[6] Southend Safeguarding Adults Board, Essex Safeguarding Adults Board, Thurrock Safeguarding Adults Board (December 2021) *Hoarding Guidance*. https://www.essexsab.org.uk/guidance-policies-and-protocols
[7] Southend, Essex & Thurrock (SET) (2023) Safeguarding *Adults Guidelines* Version 9.
[8] Southend, Essex & Thurrock (SET) (2023) Safeguarding *Adults Guidelines* Version 9.

safeguarding will depend on the adult's ability to protect themselves by controlling their own behaviour'.

Self-neglect is when an adult neglects to attend to their basic needs or keep their environment safe to carry out what is seen as usual activities of daily living. It can occur because of mental health issues, personality disorders, substance abuse, dementia, advancing age, social isolation, and cognitive impairment or through personal choice. Self-neglect is an issue that affects people from all backgrounds."[9]

11.6.6 Unlike in SAR Anne, where the person had avoided external interference for more than a decade, Susan did not totally avoid contact. She had been working during the first months of the Covid-19 pandemic, she attended some appointments and would ask for health support. She had been well known by services for over 20 years and had multiple medical diagnoses during that time.

11.6.7 There seemed to be a lack of confidence of practitioners to critically question Susan's decisions to decline help, despite it being very clear that she could not always care for herself. There was a lack of understanding about her living conditions and the role of her family living in the same property, despite there being records of the family reporting that they were not able to help Susan.

12 System learning and recommendations

12.1 Direct practice

12.1.1 The GP reported that, since Susan, their practice has changed in relation to self-neglect. They have a lower threshold for considering self-neglect and to take action.

12.1.2 The ambulance trust was not represented at the practitioner event. This was a gap, in not having any members of actual ambulance crews who witness the home. The ambulance trust was significantly involved with Susan, in that crews were among very few professionals who saw Susan in the home situation and saw her multiple times. Yet they sent their safeguarding concerns to the GP rather than to ASC. It is crucial that those directly witnessing self-neglect are enabled to share their observations with those agencies who can take further action to safeguard the individual. This will help to ensure that the concerns are not minimised by the agencies needing to take action.

[9] Southend, Essex & Thurrock (SET) (2023) Safeguarding *Adults Guidelines* Version 9.

Recommendations

- The Ambulance Trust must review its procedures for making safeguarding referrals when there is self-neglect witnessed. The Trust must also review how it can manage to contribute to practitioner events, preferably with a frontline practitioner.

12.2 Team around the person

12.2.1 In Susan's case, agencies did not effectively come together to make joint decisions about how to support Susan to safeguard herself. It was clear that she was self-neglecting and so the ESAB Self-Neglect guidelines should have been followed. However, she was also extremely difficult to engage with no solutions found, yet it was known that her health issues were deteriorating and that meant that her social care needs would, inevitably, increase. She was a person who was vulnerable. There should have been a multi-agency discussion to evaluate her risks of harm.

12.2.2 The SAR panel discussed how general mental health advice would have been helpful during Susan's admissions. On one occasion there was advice and an onward referral, which was declined. Had this information been considered in the subsequent admissions, there could have been a review of her mental health and the impact that was having on her ability to make decisions.

12.2.3 During the review there were concerns raised by practitioners and managers that there is a gap in how the Integrated Discharge Team (IDT) is able to effectively manage the discharge of patients who decline services, but about whom there are safeguarding or self-neglect concerns. The IDT needs to be provided with the information regarding any safeguarding concerns to inform the decision making and planning for the patient. There should be access to mental health and social care advice to facilitate the safeguarding planning with the patient and their family, to ensure a safe discharge from hospital.

Recommendations

- The Acute Hospital Trusts, Community Health Care and Adult Social Care should review how the Integrated Discharge Teams and other discharge services are managing the discharge of patients about whom there are safeguarding or self-neglect concerns.

- EPUT and their commissioners should review how mental health advice can be provided for multi-disciplinary team meetings in hospital

and GP practices for patients who are having repeat admissions related to self-neglect.

(from SAR Anne)

- There should be a review of the ESAB Self-Neglect Flow Chart and associated Self Neglect Guidance to incorporate fluctuating mental capacity, the consideration of physical health problems, and the need for Mental Capacity Act Assessments to be in place.

- ESAB should seek assurance that the partner organisations who employ staff who are responsible for deploying Mental Capacity Act assessments, are satisfied that those staff are competent to do so, particularly in cases where fluctuating mental capacity might be the case, or where mental capacity may be affected by physical illness.

- Multi-agency discussions must be recorded to show what action will be taken, by whom, when there are escalating concerns about self-neglect.

(from SAR Colin)

- In SAR Colin (unpublished 2024) it was recommended that the ESAB should ensure that a Southend, Essex and Thurrock approach to developing a Multi-Agency Risk Management Framework is in place.

12.3 Organisational support

12.3.1 At the practitioner event, it was reported that ASC have management oversight and responsibilities for closure of cases.

12.3.2 Practitioners were concerned about Susan but did not consider using escalation pathways within their own organisations.

Recommendations

- The agencies named in the SAR must provide assurance to the ESAB on how they ensure that their staff have access to safeguarding supervision and a clear escalation route for concerns that can be owned by senior leaders.

- For ASC, when a S42 enquiry is closed, if risks remain, there should be a plan for how to manage the risks across the multi-agency network.

12.4 SAB governance

12.4.1 This is not the first SAR in Essex to feature self-neglect. It needs to be recognised that difficulties in agencies working together to safeguard a person from self-neglect is a national issue. Nevertheless, the ESAB need to urgently take forward the learning from these SARs to implement solutions to prevent barriers and the bureaucracy of working together articulated by those at the practitioner event

Recommendations
(From SAR Anne)

- The Essex SAB should commission a learning and development programme on a reviewed version of the self-neglect guidance across the multi-agency network. This should include case studies to consider how practitioners identify and assess potential self-neglect and how they can use historical evidence to inform their assessments. There should also be mental and physical health views sought within assessments for potential self-neglect.

Building upon a recommendation from SAR Anne to commission a multi-agency audit of self-neglect cases, Susan's case indicates that:

- The Essex SAB should commission a thematic review of self-neglect cases, featuring MCA and executive functioning, which have been referred to ESAB. The thematic findings should form the basis of a joint work programme between the ESAB leads for ASC and the ICBs to improve the application of the MCA across health and social care in Essex. This programme should incorporate training and toolkits for services. This programme needs to be promoted by commissioners of health and social care to ensure that it is a requirement for services to engage. ESAB should plan for multi-agency audits of self-neglect cases, once ASC and the ICBs have reported on the completion of the MCA programme, to test the impact of the work undertaken.

12.5 National perspective

12.5.1 Other SARs have highlighted the discrepancies in the Discharge to Assess programme.[10][11] This means that people at risk of harm are being discharged on pathway 0 (zero), despite it being clear that they have additional health or social care needs. The application of the mental capacity act in these circumstances needs greater clarity by NHSE and DHSC to ensure that executive functioning is included.

[10] Hospital discharge and community support guidance - GOV.UK (www.gov.uk) accessed 31 July 2024
[11] Sutton SAB (2022) SAR F; KMSAB (2023) SAR Peter; KMSAB (2024) SAR Derek.

Recommendation

- The SAB Chair should raise this SAR at the regional Chairs' network to consider whether the monitoring of the Discharge to Assess process[12] needs to be raised with NHSE to ensure that safeguarding assurances are in place for pathway 0 (zero). There needs to be clarity in the guidance about the application of the Mental Capacity Act when there is a person who is self-neglecting.

[12] Hospital discharge and community support guidance - GOV.UK (www.gov.uk)