Teeswide Safeguarding Adults Board

Adult K

Safeguarding Adult Review

Executive Summary

April 2023

Parminder Sahota
Independent Reviewer

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Preface

The Independent Reviewer and Review Panel would like to thank Adult K and their close relative for supporting and contributing to this procedure and extend their gratitude for their assistance.

A multi-agency Safeguarding Adult Review (SAR) is required by law to determine what agencies and individuals could have done differently to avert harm. Organisations must examine what can be known to learn from each case and understand what happened.

The Reviewer would like to thank the panel and individuals who supplied chronologies and materials for their time, cooperation, and understanding.

Section One – The Review Process

Introduction and Agencies Participating in the Review

1.1 This summary describes the steps the Teeswide Safeguarding Adult Board (TSAB) took to review the circumstances leading to a nonfatal fire and the impact of this on one of its residents. The nonfatal fire took place in 2022.

1.2 Adult K survived the fire, lived alone, and communicated regularly with their close relative.

1.3 After the incident, Adult K was admitted to the intensive care unit. After the incident the fire brigade determined that the fire was caused by unintentionally dropping smoking materials.

1.4 Pre and post-incident, Adult K received input from the adult social care and mental health services. They observed dirty dishes, soiled carpets, and discarded cigarette ends in the home.

1.5 The review panel convened for the first time with the chair on 4 November 2022.

1.6 On 14 February 2023, the review panel had its final meeting to conclude the report and its findings.

1.7 The following agencies contributed to the review:

Organisation	Role
Acute Trust	Named Nurse Safeguarding Adults
Fire Brigade	Hub Manager
Integrated Care Board	Designated Nurse for Safeguarding Adults
Local Authority 1	Service Manager
Local Authority 2	Director of Adult and Community Based Services
Mental Health	Named Nurse Safeguarding Adults
Police	Operational Lead for Missing from Home Team
SAB Business Unit	Business Manager
SAB Business Unit	Temporary Safeguarding Adults Project Officer
SAB Business Unit	Administration Officer
P.S Safeguarding LTD	Independent Chair & Author

Independent Reviewer

1.8 Parminder Sahota is an independent author with ten years of experience in domestic abuse and safeguarding. She has worked as a mental health nurse in the NHS for over 20 years. She is the NHS's Director of Safeguarding, Prevent, and Domestic Abuse Lead.

1.9 Parminder Sahota is independent of all agencies involved and had no prior contact with Adult K, their family members, or the TSAB.

Purpose and Terms of Reference: Key Lines of Enquiry

1.10 The review aims to identify lessons learnt from Adult K's case and to implement those lessons to prevent deaths related to safeguarding.

1.11 The critical question to be addressed by the review was:

How have partners collaborated to fulfil their joint responsibility under Section 117 of the Mental Health Act, specifically regarding compliance with the Inter-Agency guidance for Section 117 of the Mental Health Act 1983?

1.12 The supplementary questions to enhance the review included the following questions:

a. What can agencies learn from this case about the efficacy of support and care for individuals hesitant to utilise support services, particularly during the Covid-19 pandemic? Additionally, how did the pandemic affect the staff practices and well-being?
b. How did agencies assess Adult K's capacity, was executive capacity considered, where were the assessments shared, and how did this affect the treatment Adult K received?

c. Was the right strategy employed to engage Adult K?
d. How was the principle of making safeguarding personal implemented? Did agencies involve and consult with Adult K in developing care plans and interventions?
e. Have organisations considered the risk of self-neglect and hoarding? What was the outcome, and was the fire brigade contacted to offer advice and conduct a home fire safety inspection?
f. Were the assessments and decisions made appropriately and timely?

1.13 The panel members and advisors were all chosen by the review panel. The review's time frame was set to April 2021 and 2022. The panel agreed that this time frame accurately reflected the issues and themes discovered during scoping and subsequent communication with agencies.

1.14 The panel agreed on which agencies must submit a comprehensive chronology and individual management review.

Section Two – Agency Contact and Information Learnt from the Review

2.1 Adult K's first contact with mental health services was in 1989; they were under the mental health service at the time of the fire and subject to Section 117 (S117) aftercare (Mental Health Act 1983)

2.2 Adult K received support from adult social care.

2.3 Safeguarding Adult Concerns

2.4 Adult K received home visits from the mental health service and adult social care.

2.5 During these visits, the practitioners observed fire risks in Adult K's home, including discarded cigarette ends on the floor, empty food boxes, dirty dishes, and black rubbish bags.

2.6 The mental health service discussed the matter with its Safeguarding team and determined that adult social care would raise a formal safeguarding adult concern.

2.7 No safeguarding concern was raised until after the nonfatal fire.

Section Three – Key Issues arising from the Review

3.1 Self-Neglect

3.2 Mental health and adult social care identified and documented concerns regarding Adult K's self-neglect.

3.3 They concluded that this was not a result of Adult K's mental health; nonetheless, neither the explanation nor the difficulties they had due to their lack of self-care were noted. Therefore, it is expected that executive capacity should have been investigated at this stage.

3.4 Hoarding and Clutter

3.6 Adult K was not diagnosed with a hoarding disorder; the kitchen and living room was given a clutter grade of three. When the clutter level reaches or exceeds level four, service users should be encouraged to seek assistance for their hoarding problem. This is also when the Fire Brigade should be notified to conduct a home visit.

3.7 Adult K's home was full of rubbish bags, dirty dishes, rotting foods, and cigarette ends. The visiting practitioners identified fire hazards, but Adult K declined a home fire safety inspection.

3.8 Adult K reported disposing of used toilet paper in the bathroom bin and floor. They were a smoker who smoked in the house.

3.9 Refusing further assistance for domestic duties and the impact of Covid- 19 Pandemic

3.10 Adult K was often assisted in maintaining their house by mental health services and adult social care. Adult K continually refused assistance and indicated they would tackle the problem independently.

3.11 The reviewer hosted a practitioner event where Adult K was described as "proud." A person with a strong sense of personal pride can view accepting offers as an admission of inadequacy or loss. In addition, people may see seeking assistance as an admission of being unable to complete the activity independently.

3.12 Legal Frameworks, Mental Health Act 1983, Care Act 2014, and Mental Capacity Act 2005.

3.13 Adult K was eligible for Section 117 aftercare (Mental Health Act 1983)

3.14 It was evident that Adult K was self-neglecting, as evidenced by the deteriorating condition of their home. Therefore, the assessment of their needs under Section 117 needed to reflect the property's state adequately. If this had occurred, a safeguarding adult concern would have had to be raised.

3.15 The practitioners should have been prompted to assess Adult K's executive capacity by their refusals of aid and claims to care for their property.

3.16 Safeguarding and Making Safeguarding Personal

3.17 Safeguarding was not raised until after the nonfatal fire.

Section Four – Recommendations

Recommendation One: Self-Neglect and Hoarding

4.1 *In January 2022, TSAB relaunched the self-neglect guidance. Several resources on the TSAB website, including the Self-Neglect Policy and Guidance, have already been approved and implemented. In recent years, the Board has exerted considerable effort to help practitioners and promote awareness of self-neglect. The results of multi-agency audits on self-neglect have been shared with the TSAB. TSAB also offers practitioners Self-Neglect training.*

4.2 TSAB should seek assurance on how agencies have promoted TSAB's Self-Neglect Policy and Guidance (and other relevant documents) and how these have been implemented within their respective organisations.

4.3 TSAB should seek assurance that any single agency training on Self-Neglect includes the TSAB's Self-Neglect Policy and Guidance.

4.4 To assist practitioners in identifying and advancing instances, such as referrals for home fire safety checks, environmental health, and, if necessary, escalation to the 'Team around the Individual' panel for additional assistance, agencies should ensure that hoarding is addressed in safeguarding training and that individuals are aware of high-risk items that may increase the risk of fire.

4.5 TSAB should consider developing a flowchart on when Self-Neglect issues should be raised as a Safeguarding Concern.

Recommendation Two: Declining Support

4.6 *TSAB has a Professional Challenge Procedure and a Learning Briefing on Professional Challenge and Professional Curiosity. Professional curiosity is not necessarily something that can be taught; thus, it is challenging to achieve assurance. The Multi-Agency Audit tool includes a reference to professional challenge; however, it was deemed unnecessary 50% of the time. Quite often, the professional challenge derives from the audits themselves.*

4.7 TSAB should confirm that organisations have implemented escalation procedures.

4.8 TSAB members to review its escalation processes to support practitioners when service users have declined/refused support despite a high risk of harm in the absence of support.

4.9 TSAB members to assure the board their Mental Capacity Act (2005) training highlights the principle of making "unwise decisions" to encourage positive risk-taking, involving an appropriate and proportional response among practitioners. Senior management should review such cases routinely to ensure support is available for frontline practitioners.

Recommendation Three: Legal Literacy and Safeguarding

4.10 *Adult K was eligible for Section 117 aftercare (Mental Health Act 1983, as amended in 2007) and was subject to Section 42 of the Safeguarding Act (Care Act 2014).*

4.11 The TSAB should seek assurance that a Memorandum of Understanding addressing support from external agencies is in place for Section 117 arrangements. Additionally, multi-agency S117 guidelines and agreements are in place.

4.12 TSAB to seek assurance through its multi-agency audit programme that S117 cases subject to safeguarding are also audited.

4.13 TSAB to design a multi-agency audit to review cases that fall outside of safeguarding, such as a change in the service user's circumstances, an incident, or a matter of concern. This will assure that processes have been followed and identify where referrals are required.

Recommendation Four: Making Safeguarding Personal

4.14 *The Care Act 2014 guidance stipulates that adult safeguarding practice must be person-centred and outcome-focused, with MSP as the recommended safeguarding strategy alongside the other six safeguarding principles. However, Adult K was reportedly a "proud" person, and when they were offered support with deep cleaning, they thought they would have little control over what would be done. Note that the panel accepted that the care Adult K received from Mental Health and Local Authority considered their wishes and views. However, the safeguarding issues were not addressed.*

4.15 TSAB will continue to evaluate MSP outcomes via data returns and seek assurance that agencies consider advocacy, offer advocacy, and have advocates available if requested.

4.16 The Teeswide Safeguarding Adult Board will develop and monitor the recommendations.

Section Five – Conclusions

5.1 This review aims to determine the facts of the nonfatal fire at Adult K's home and the safeguarding followed by the relevant agencies.

5.2 The primary question is Section 117 aftercare. The review determined that although health and social care had signed and finalised the document, it needed more pertinent information about Adult K's needs; it required to appropriately depict the state of Adult K's house in terms of self-neglect.

5.3 Moreover, the exchange of information between agencies needs improvement. Section 117 relies on collaboration to ensure that services collaboratively identify and address areas of concern.

5.4 **Insufficient Professional Curiosity:** Practitioners to have inspected the remainder of Adult K's home; they evaluated the kitchen and living room. A discussion of how Adult K attended to their hygiene should have been explored. In Section 117 needs assessment, neither the impact nor how they would prevent a recurrence were noted nor specified. In addition, the TSAB's guideline on self-neglect has yet to be utilised to assist practitioners in better understanding Adult K's condition or in defining the appropriate support and legal framework.

5.5 **The review could not uncover any instances in which the issue was discussed or escalated to senior management.** Supervision is a forum for practitioners to discuss difficulties and provide high-quality care for their clients/service users. Mental health and adult social care were aware of Adult K's worsening self-care and home situation, and a Safeguarding Adult Enquiry was nevertheless raised (Section 42: Care Act 2014).

5.6 **Mental Capacity and Risk Assessments Not Robust Enough:** The assumption of mental capacity is the first principle of the Mental Capacity Act (2005). However, this review and those conducted by the local authority and mental health found that awareness of executive capacity required improvement.

5.7 Delays in raising safeguarding concerns or commencing Section 42 enquiries.

5.8 **Inadequate decision-making and recordkeeping:** The needs assessment must reflect Adult K's needs or identify self-neglect-related safeguarding concerns.

5.9 Additionally, Adult K's acceptance of services was affected by Covid 19 because they feared developing the disease.

5.10 The learning from the review will be shared with practitioners.