Norfolk Safeguarding Adults Board

Safeguarding Adults Review

Executive Summary:

‘Andrew’

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1. Background to the Review

Andrew died, aged 56, in the autumn of 2024. A white British male who lived alone, during the year before his death he experienced five hospital admissions, all but one lasting at least a week. These were occasioned by attacks of vomiting, dizziness, falls, and weakness due to health difficulties relating to Type II diabetes and Andrew's daily alcohol consumption. His living conditions also raised concerns about self-neglect: Andrew seems to have eaten irregularly, with food frequently left to grow mould; he reported sleeping on his sofa to keep warm; and his home environment, particularly kitchen and bathroom, was unsanitary. Several agencies were involved in supporting Andrew, but there was limited joint working to coordinate their efforts.

Safeguarding referrals were raised over this time but did not proceed to a section 42 safeguarding enquiry because Andrew declined help. Two deep cleans were undertaken, but the home environment deteriorated again. Andrew told practitioners he was not able to keep the house heated or to eat well, and accepted certain, limited help with food and practical matters. Other offers of support, such as care packages or post-discharge reablement, were declined either directly or within a few days of commencing.

Andrew had not been in contact with his ex-wife or two adult children since moving from the North to Norfolk fourteen years earlier. He had served in the armed forces earlier in his life, and had worked as a transport manager, but also experienced periods of unemployment and financial difficulties. He was currently not working and rarely left his flat, relying on online deliveries or neighbours to obtain food.

Andrew was advised in July that he should start taking injectable insulin to manage his diabetes but declined. When, in September, an assistant practitioner (AP) from Adult Social Care visited his property and detected no sound or movement from inside, she requested a police welfare check however, based on the information available at the time, the police assessed that the threshold for forced entry was not met. A week later the AP returned and was alarmed by a strong odour emanating through the letterbox. The police attended and entered, to find Andrew dead on the sofa.

2. Key Lines of Enquiry

The SAR was asked to focus on the following lines of enquiry:

- How might professional curiosity have made a difference?
- What efforts were made to engage and build relationships with Andrew?
- What support services are available to those who have served in the armed forces?

- Why wasn't there a coordinated multi-agency response in relation to the concerns about his environment and self-care? If there was, would he have been found and potentially offered support sooner?
- What pathways are in place in Norfolk for people with a dual diagnosis, and why were these not implemented for Andrew?
- What processes are in place in Norfolk for people who decline diabetic medication, and how are their wishes and feelings considered in decision making?
- How did Right Care, Right Person (RCRP) impact on the timeliness of the police response to Andrew?

3. Review Methods

This SAR considered the period between 1 September 2023 and 11 September 2024. The following steps were taken in the course of the review:

a) Review by the independent reviewer of agency records.

b) Initial analysis of chronology and themes by the independent reviewer.

c) The holding of a practitioner event, attended by frontline practitioners who worked with Andrew and senior members of the partner organisations.

d) A telephone discussion with Andrew's son, and additional online discussions with three practitioners not at the learning event.

e) Further analysis by the independent reviewer of themes from the event and discussions, and production of the draft report.

f) Review of the draft report by the SAR panel, partner agency leads, and practitioners.

The agencies that submitted records and/or participated in the practitioner event were:

- East of England Ambulance Service NHS Trust
- Orwell Housing
- South Norfolk and Broadland District Council
- Norfolk and Suffolk NHS Foundation Trust
- Norfolk Constabulary
- GP Surgery
- Change Grow Live (CGL)
- Department of Work and Pensions (DWP)
- Norfolk and Norwich University Hospitals NHS Foundation Trust
- Norfolk Community Health and Care NHS Trust
- Norfolk County Council Adult Social Care
- Norfolk Fire & Rescue Service

4. Findings and Analysis

Professional Curiosity

Practitioners showed professional curiosity in identifying and flagging concerns about Andrew's living conditions, and in trying to investigate what lay behind the self-neglect. At other times however, decisions were reactive and dealt only with immediate concerns, without inquiring more deeply. The initial deep clean was not linked to understanding how the situation arose or planning what actions might be needed to prevent the situation deteriorating again. On the basis of assurances by Andrew that action was not needed, early safeguarding alerts were not pursued without fully considering the reported signs of self-neglect. Later, when recurring patterns of admission, discharge, and refusal of follow-up were becoming apparent, the situation drifted. Although practitioners separately sought to support Andrew and signpost him to appropriate services, the failure of this strategy to result in sustained engagement did not prompt reflection and an attempt to jointly consider other approaches. Instead, unawareness of the whole picture, assumptions about what involvement and monitoring other agencies were undertaking, and caseload pressures exacerbated by insufficiently frequent supervision impeded the exercise of professional curiosity.

Engagement and Relationship-building

Two housing officers and Andrew's disability employment advisor (DEA) developed positive working relationships with him by showing flexibility and offering practical assistance. Andrew shared only a limited amount about himself and his background. What he did say suggests that he felt embarrassment at his difficulties coping, and this may have played a part in his disengagement from much support. Knowledge about Andrew was held piecemeal among practitioners in different services; while his DEA knew about his time in the armed forces and the evident pride he took in it, this was unfortunately not known by housing or social care who might otherwise have used it as a point of connection, a way of partially shifting the focus from Andrew's problems to his achievements, and a route to engaging him with suitable support.

Support Available to ex-Armed Forces Members

The DEA sought support for Andrew from the SSAFA (Soldiers', Sailors', and Airmen's Families Association) charity when he expressed interest in moving. As other key services were unaware of Andrew's military background, further sources of support went unexplored. These could potentially include: Op COURAGE, the community mental health service which focuses on veterans; the Armed Forces veteran friendly GP accreditation scheme; and voluntary sector organisations and national programmes designed to support ex-armed forces members with dependent drinking. The learning event identified value in raising wider awareness of these initiatives among practitioners.

Coordinated Multi-agency Response

There were attempts at joint working, such as a proposed joint visit by the housing officers and the social care AP. This did not ultimately happen, and efforts by health, housing, and social care proceeded largely in parallel. This reflects the general difficulties practitioners experience in identifying and contacting the appropriate person in other agencies and getting feedback on referrals. The challenges of engaging Andrew in any sustained way with support meant that there was a pressing need to share relevant information, plan, and consolidate efforts, in order to streamline offers of support for Andrew. A clear lead practitioner was never identified to coordinate the work, because the cumulative level of risk was not fully recognised across all agencies involved. An alternative source of multi-disciplinary advice would have been Norfolk's Early Help Hub, but this too was not considered.

The AP's efforts to meet with Andrew were frustrated partly by his non-response, but also by his hospital admissions and her resulting uncertainty over when he could be found at home. Exploring the possibilities for closer communication between the hospital and Adult Social Care might have reduced the confusion over his whereabouts and allowed Andrew's contact preferences to be explored while he was contactable there.

The DEA's referral to Adult Social Care was not actioned apparently because Andrew appeared not to be registered with a GP. The practitioner event identified a need for Adult Social Care and partner agencies to work with the Department for Work and Pensions (DWP) to ensure DWP colleagues' identification of risks affecting adults at risk are embedded clearly within local safeguarding pathways.

An issue raised at the practitioner event was the challenges IT systems can present for inter-agency information sharing. There has been progress towards shared care systems linking social care and GP records, but at the time of Andrew's case this did not include district nursing, which may have contributed to difficulties in communication when Andrew refused insulin and was referred back to the specialist hospital team.

Pathways to Support People with Dependent Drinking

Medical practitioners discussed his alcohol use with Andrew, and its implications for his health. Andrew was referred to CGL on at least two occasions but declined support. He denied being dependent on alcohol, but at one point described alcohol and cigarettes as his 'only joy in life.' Sustained engagement with Andrew to identify and build motivation, possibly through services addressing the needs of ex-armed forces members or social prescribing routes, would likely have been needed for him to engage with CGL.

Mental capacity assessment can be complex with people showing dependent drinking. Although housing raised concerns about Andrew's fluctuating capacity to make decisions about his care, it is not clear that this was formally assessed in the

community, as some of the difficulties he had in implementing self-care might have warranted.

At the practitioners' event, attendees noted the challenges they all faced in supporting people with dependent drinking who are ambivalent about or reject support. They identified that many of them would find interprofessional training on this subject valuable.

Processes for People who Decline Diabetic Medication

Reluctance to start using insulin is common. Andrew said when it was raised in hospital that 'he felt he would not be able to manage.' Though he was able to inject successfully under supervision after a week in hospital, these concerns were valid: once back in the community, he refused insulin and wished to continue oral tablets. Andrew's history meant that this could perhaps have been anticipated and planned for. As it was, the community nurses' attempts to seek further support for Andrew went nowhere; identifying Andrew's situation as self-neglect and pursuing the hospital safeguarding route might have helped action to be taken. Andrew's mental capacity was considered by the community nurses, though it is not entirely clear from the information supplied how he weighed the relevant information.

Impact of Right Care, Right Person Policy

The AP's first request for a police welfare check on 4 September was refused, on the grounds that the threshold of 'a real and immediate risk […] of a person being subject to or at risk of serious harm' was not met. The risk indicators known at the time seem to support the police judgement that forced entry for purposes of a welfare check was not clearly warranted, and while there was no sound or movement from within the property, this was not the first time Andrew had not opened the door or failed to answer the phone. The police suggested contacting the ambulance trust instead, but similar thresholds would have applied for them. The key factor is that as a clear care and support plan agreed with Andrew was not in place, there was little to mitigate the risks of him not being found in the event of a health crisis.

On returning one week later, the AP noticed an unusual smell and unopened mail. This time, the criteria for the police to force entry were met. Although there was enough concern to request a welfare check on 4 September, there were no follow-up calls to check on Andrew during the following week until the last visit took place. This points in part to lack of coordination, and assumptions being made that other services were in more regular contact than was in fact the case. Faith that they would be in a position to realise quickly if there was something wrong was therefore misplaced.

5. Recommendations

Recommendation 1: NSAB, through the Self-Neglect and Hoarding subgroup, should promote learning from this SAR among partner agencies to encourage the sharing and escalation of concerns with appropriate agencies (potentially including Fire & Rescue, social care, GP and the housing provider), where a deep clean is proposed for an individual and there are reasons for concern that ongoing self-neglect might prevent the person from sustaining the changes, in recognition that there are frequently deeper reasons for the situation than choices actively made by the individual. The processes in place for arranging a deep clean should be explored to see if a prompt or mechanism can be put in place so that this is considered at the point that the clean takes place (for example, onward referrals for mental health, wellbeing support, psychological support or to other relevant voluntary agencies). (*Professional Curiosity*)

Recommendation 2: Social Care to provide assurance to NSAB that duty teams are sufficiently aware of the non-engagement and self-neglect policies, and what response they should lead to. This assurance to include a deep dive into what the barriers are for staff to access and implement the existing policies and may involve exploration in supervision and/or further audit activity. (*Managing Risk, Uncertainty & Mental Capacity*)

Recommendation 3: The monthly supervision audits instituted in Adult Social Care are a positive step and should continue. If they do not already, the audits should include steps to consider quality as well as quantity of supervision, to ensure that adequate time for reflection is incorporated. Other organisations, such as Orwell Housing and the district nursing service, should consider and confirm to NSAB what support structures are in place, should their teams need advice or opportunities to reflect on self-neglect work. (*Ownership and Accountability: Management Grip*)

Recommendation 4: NSAB, through the Self-Neglect and Hoarding subgroup, should review and update the *Self-neglect and hoarding practitioner guide* to include clear, practice-focused guidance on:

- when the complexity of a situation requires more than one agency to manage it, how to initiate core multi agency working, and how to escalate for more senior engagement in multi-agency planning.

  The review should also incorporate clear guidance on:

- how the language and focus of multi-agency involvement with self-neglect can compound feelings of demoralisation and disengagement; and
- how practitioners can counterbalance this by recognising and working with individual strengths and sources of motivation in a way that supports engagement.

The updated guidance must make clear that, while a strengths-based approach engages with the person in ways that are not *only* problem-focused this should not

mean overlooking or downplaying the very real risks or support needs associated with self-neglect. Instead, it should support practitioners with *addressing* the risks through balanced, professionally curious approaches that encourage hope and self-worth and can lead to sustained engagement.

Assurance should be sought by NSAB through partner sign-off and dissemination activity, with consideration given to evaluating practitioner awareness via training uptake, reflective supervision prompts, or themed audit activity, and evidence that guidance has been embedded into other relevant care pathways and processes so that self-neglect is not seen as standalone. (*Professional Curiosity*)

Recommendation 5: NSAB should liaise with Norfolk Armed Forces Covenant Board (NAFCB) to explore if they can contribute to raising awareness among partner organisations of the services and support available to ex-forces members. This potentially aligns well with the NAFCB Action Plan 2024-27, one of the three goals of which is to 'promote greater understanding of the support available to the armed forces community in relation to health and social care services in Norfolk.' NSAB may be able to reinforce the NAFCB's work in this area, most obviously when disseminating the learning from this SAR. (*Fora for Discussion and Information Sharing*)

Recommendation 6: NSAB, through the Self-Neglect and Hoarding subgroup, should reinforce expectations of early and sustained multi-agency coordination where there are several services potentially involved, and there is self-neglect with persistent non-engagement (*even if* contact is still being pursued *and especially* if it is proving elusive) and review how agencies have this embedded within their existing policies and processes.

NSAB should promote the use of Early Help Hubs (EHHs) as an appropriate forum for seeking multi-agency advice regarding difficulties encountered in attempting to engage and support, and for identifying whether other agencies are involved or share the concerns over risk.

The Self-Neglect and Hoarding subgroup will trial and publicise an online community of practice forum, encouraging practitioners to bring self-neglect / hoarding cases they are struggling with for advice and guidance.

NSAB has an expectation that each partner agency will take leadership responsibility for the embedding of these mechanisms in their relevant pathways and practice with a report back to NSAB within 12 months of publication (to include evidence of partner communications, inclusion within relevant practice guidance, and evidence from audit or case-sampling that these mechanisms are being considered and used appropriately in such cases). (*Fora for Discussion and Information Sharing*)

Recommendation 7: When self-neglecting individuals experience repeated hospital admissions and there are ongoing challenges with engagement in the community, closer working is needed between hospitals and other agencies involved, such as social care or housing. Practitioners should consider this in their practice, and NSAB

should facilitate discussions between safeguarding leads in the respective organisations to identify and address potential obstacles, reporting back to NSAB within 6 months of publication. (*Collaborative Working and Decision Making*)

Recommendation 8: Adult Social Care and relevant partner agencies should work with the Department for Work and Pensions (DWP) to ensure that the safeguarding risks identified by DWP colleagues across all roles are recognised, understood, and embedded within local safeguarding pathways to support earlier intervention and improve protection for vulnerable adults. (*Fora for Discussion and Information Sharing*)

Recommendation 9: NSAB should explore whether an interprofessional training workshop, such as was requested at the practitioner event, can be offered to non-specialist practitioners. This might focus primarily on engagement, assessment, mental capacity, and how assertive approaches to dependent drinking can be implemented with self-neglecting individuals, presenting and building on the Blue Light approach.

Because such a workshop can only reach a limited number of participants, key points and practical tips emerging from it should be compiled and shared more widely across the partner organisations as a written and/or audio briefing, or potentially as e-learning. Sustaining the learning can be reinforced by putting it on supervision agendas. Consideration should also be given to identifying, and promoting awareness of, a single point of contact in substance use services, from whom practitioners in other services can seek advice on how to approach a case. (*Managing Risk, Uncertainty & Mental Capacity)*

Recommendation 10: In cases of self-neglect where is reason to anticipate that the person may not continue with the treatment prescribed, sharing a handover or contingency plans with the community nursing team charged with following up should be considered:

- Norfolk's acute hospitals should prepare a report to NSAB to understand the current barriers of information sharing at point of discharge.
- Acute and community hospitals should review current proforma for discharge letters to include any specific concerns that have been identified or remain in relation to self-neglect. Consideration should be given to use of a trigger question to consider the possibility of non-concordance, and / or flow chart setting out how to respond in '*IF x, THEN consider doing y*' format.
- Community health providers should review protocols for safely ceasing involvement and identify support they have available to support community nursing staff in complex and / or safeguarding cases to identify any additional needs. (*Collaborative Working and Decision Making*)

Recommendation 11: Primary care practitioners should consider the possibility that neglect of a diabetic condition may sometimes constitute self-neglect and consider escalating to safeguarding leads if needed so that the relevant needs are

addressed. Practitioners' awareness of their responsibilities should be promoted through the learning from this SAR and reinforced through training, aligned with any changes resulting from Recommendation 10. (*Collaborative Working and Decision Making*)