Mr C Safeguarding Adult Review (SAR)

Calderdale Safeguarding Adult Board Response

1.0 Introduction:

This document sets out the formal response of the Calderdale Safeguarding Adult Board (CSAB) to the findings and learning identified through the Safeguarding Adult Review (SAR) it commissioned following the death of an 81 year old man who will be referred to in this report as Mr C.

It provides key information about the SAR process and its purpose and also gives an overview of how it was conducted and who was involved. Importantly it sets out the learning for the CSAB as the partnership responsible for ensuring that joint working arrangements to protect adults are effective. It also shows how the CSAB partnership will support and monitor the implementation of learning by each of the involved agencies.

All partners who are members of the CSAB have formally accepted the report and endorsed the findings. This response should be read in conjunction with the full Overview Report. These documents seek to demonstrate and support the transparent and objective approach all parties have taken to looking at and learning from death of Mr C.

1.1 SAR Information

The Care Act 2014 requires that SABs must conduct any SARs under Section 44 of the Act. The SAB must arrange for a review of a case relating to an individual if;

a) The person has died and the SAB suspects that the death resulted from abuse or neglect (whether or not the Local Authority had been alerted to the abuse or neglect prior to death); or
b) The person is alive but the SAB knows or suspects that they have experienced serious abuse or neglect; and
c) There is a reasonable cause for concern about how the SAB, its members or other persons involved worked together to safeguard the adult.

Mr C died of natural causes, and although there wasn't a statutory requirement to undertake a Safeguarding Adult Review, the Safeguarding Adults Board chose to do one to identify learning for the future care and safeguarding of adults in Calderdale.

1.2 Background to the Mr C SAR

This review considered the events and circumstances around the death of an 81-year-old man who will be referred to as Mr C. Mr C had health and housing concerns and in early 2019, these housing conditions required immediate action. There was a fire soon after, caused by unsafe cooking which led to Mr C's attendance at A&E for smoke inhalation. The house was assessed to be unsafe and 20 chest freezers containing rotting food were removed.

Emergency accommodation was found and, whilst it was anticipated this was a short-term measure, he ended up staying at care homes for nine months. During this period, further health concerns were identified, and he was given medication for alcohol dependence.

When Mr C returned to his home, professionals again identified concerns over safe cooking and electrical fittings and his poor vision compounded this.

In January 2020, his family raised concerns that Mr C was unable to care for himself and home conditions were again deteriorating. His family raised further concerns in June 2020 to Adult Social Care (ASC) and his GP. He moved to care homes to allow further cleaning of his home, and further concerns over alcohol misuse were identified.

In August Mr C returned to his home, at his request, despite the house being unsafe and the gas and electricity supply having been cut off. Family members and professionals identified a number of risks when visiting.

Shortly afterwards there was a fire at his home, and Mr C was taken to A&E with smoke inhalation from a BBQ in the garden. Professionals described the house as unsafe. In October it was reported that Mr C was using a lit oily rag as a torch.

In October 2020 Mr C died at his home. The cause of his death was Ischaemic Heart Disease. A fire at his house also occurred at the time of his death, although it is recognised that Mr C did not die as a result of that fire.

Throughout the review period professionals considered the mental capacity of Mr C but only in general terms and assumed that he did have capacity as directed by principle 1 of the Mental Capacity Act. The issues of hoarding and self-neglect were central to the involvement of services, which was a challenge given the complexity of the environment that Mr C lived in and his difficulties in accessing services and engaging with professionals and his family.

2.0 Methodology

The CSAB decided that this review would have a panel of senior managers (independent from the case) from local agencies who work with adults, chronologies from each agency written by managers who were independent of the case, consultation events with practitioners and managers who had worked with Mr C, and an Independent Author and Chair: Mr Mark Griffin.

The family were communicated with and engaged in the review and their views can be found later in this report.

The report was guided by terms of reference completed by the Panel. Those terms contained some questions (listed below) set by the CSAB at the beginning of the review process. These questions were addressed by each agency report author and assisted the author in understanding what had happened and why.

1) Was Mental Capacity considered and assessed appropriately when Mr C was making highly risky decisions?
2) Were relevant policies and procedures in place to support this specific situation clear, known by staff, used and effective?
3) How did services respond to safeguarding concerns if Mr C showed reluctance to engage?
4) How were risks and concerns identified, assessed, managed and responded to (including timeliness)?

5) How effectively did agencies work together to share information and respond in a coordinated way at key points?
6) What, if anything, prevented action being taken when concerns were identified?
7) Are there examples of good practice to be highlight?
8) Is there evidence the adult at risk remained the focus for professionals, were his views heard and views of the family?
9) Was there a clear understanding of Self-Neglect, Hoarding and Mental Capacity?
10) Were there any implications or impacts of Covid?
11) What is the impact of poverty in this case?
12) To what extent was previous trauma considered in assessments and interventions?
13) How has learning from previous reviews and incidents improved multi-agency practice?

3.0 Agency Involvement

The following organisations produced chronologies detailing their involvement with Mr C, critiquing the practice of the professionals involved whilst considering broader contextual issues relating to guidance, systems and processes:

- South West Yorkshire Partnership Foundation Trust. - SWYPFT
- West Yorkshire Police. - WYP
- Calderdale Clinical Commissioning Group. - CCCG
- Calderdale Local Authority Adult Social Care. - ASC
- Calderdale & Huddersfield NHS Foundation Trust. -CHFT
- Local Housing Provider.
- Local General Practitioner.
- West Yorkshire Fire and Rescue Service
- Environmental Health

4.0 SAR Recommendations

1) The Calderdale SAB may wish to review existing and proposed arrangements, including previous learning, to ensure that complex cases including self-neglect are appropriately managed through existing policies and procedures. This should ensure that thresholds and definitions do not present barriers to accessing care and support in hoarding or complex case panels.
2) The Calderdale SAB may want to seek assurance from partners about how and when learning from this and previous reviews will be embedded into practice. Areas of key learning from this review are
3) Developing trusting relationships with people with complex needs through a trauma informed approach.
4) Risk assessments and planning in complex cases.
5) Identifying and responding to self-neglect.
6) Effective multi-agency safeguarding responses including information sharing
7) The Calderdale SAB may wish to improve agencies understanding and application of legal literacy – including the MCA and inherent jurisdiction. This should be extended to include training and learning around executive capacity (recognised locally as executive functioning).

8) The Calderdale SAB may wish to seek assurance that care planning in complex cases and/or self-neglect cases evidence multi-agency planning, effective coordination and communication and outcomes that "improve the wellbeing of the person and prevent serious injury and death of people who self-neglect."
9) The Calderdale SAB may wish to seek clarification about the future of the "one stop shops" and similar hubs.
10) Agencies should look at innovative ways to provide accessible and assertive outreach services within the community to enable service users a known location to access support.
11) Professional curiosity, escalation and challenge processes should be understood and promoted across the partnership.
12) Agencies may wish to ensure that there are appropriate management oversight, audit and supervision processes in place for complex cases. The role and involvement of managers in cases needs focus especially where there are high or escalating risks to the service user and/ or members of the public.

5.0 Response to the learning from the case

Evidence of how it's different now

5.1 Adult Services & Wellbeing (Calderdale Metropolitan Borough of Calderdale)

There are now Practice leads in place to ensure that learning is practice based and each team will have a practice session on a fortnightly basis to embed learning.

Escalation processes are being disseminated to ensure staff understand and are supported in achieving multi-agency working.

Managerial oversight will be focused on with evidence on each case of this.

ASC is currently revamping the front door services to put focus on prevention and early help.

5.2 Health Organisations:

Calderdale and Huddersfield NHS Foundation Trust

- Pilot relating to trauma informed training within the Emergency Departments has taken place and there are discussions about rolling this out trust wide. Safeguarding mandatory training is being reviewed to reflect trauma informed practice.
- Trauma navigator pilot to commence in the Emergency Departments and the project leads are developing trauma pathways
- Promotion of the self-neglect pathways
- Reviewed our training offer regarding the Mental Capacity Act and this has been increased for staff. Bespoke and face to face training will also be re-introduced.
- Non-Concordance flow chart available to support the management of patients who are non-compliant with their care and treatment
- Outreach clinics relating to wound care are operational
- The High Intensity User Group supports the management of patients who are frequent attenders

South West Yorkshire Partnership NHS Foundation Trust

South West Yorkshire Partnership NHS Foundation Trust have incorporated the learning into the mandatory safeguarding training, appropriately shared the information produced by the Calderdale Safeguarding Adult Board and are committed to supporting the recommendations and action plan.

The Trust are actively working towards becoming a Trauma Informed organisation and the Trust lead is working collaboratively across Calderdale with agencies.

West Yorkshire ICB

Through the process of this review, health organisations in Calderdale have contributed to workstreams looking at reviewing and refreshing the self-neglect policy, revisiting escalation procedures, developing professional curiosity and sharing the learning from this SAR.

Health organisations contribute to the delivery of CSAB multi-agency training on the self-neglect policy/protocol used in Calderdale and they have increased commitment to attend and embed this in practice. This training now covers executive capacity and inherent jurisdiction, suitable for both frontline workers as well as managers. All health organisations continue to develop practices around supervision for care planning in complex cases and/or self-neglect cases to evidence multi-agency planning, effective coordination and improved communication.

5.3 Environmental Health:

Following the outcome of the SAR, Environmental Health have reviewed all of the well-established operational practices in relation to complaints and requests for service received regarding poor housing conditions and symptoms of negative householder lifestyles and behaviours. Consequently, Officers subsequently completed further Safeguarding training to enhance understanding of safeguarding principles and practices. Officers also have a commitment to undertaking “trauma-informed” training to assist our understanding regarding hoarding behaviours, when it becomes available.

It is also recognised that Environmental Health staff are integral active participants in the Hoarding Panel and will continue to be. Officers have a commitment to continue working to the principles and practices identified by and within the Hoarding Framework.

Officers accept the findings of the Report and therefore recognise that there was limited intrusion into identifying a clear lead professional agency as part of a co-ordinated multi-agency approach. Officers within Environmental Health therefore have a further commitment to collaborating with partners, with professional curiosity, to identify this. If there isn’t a clear lead, Environmental Health participants will ensure that joint situational awareness is maintained. Officers will seek to ensure that partnership working is maintained or strengthened and that there is joint situational awareness between all agencies.

5.4 West Yorkshire Fire Service

Items from the report have now been embedded into working practises for WYFRS.

Procedure ensuring adjacent houses to hoarded properties are visited and fire safety is offered to the occupants.

As chair of the Hoarding Panel in Calderdale, a more robust and flexible approach to the consideration of cases being brought to members and heard in a multi-agency arena. Primarily, the clutter index reference is being lowered from a level 6 to a level 4. Plans are in motion for this to be reflected in the new framework so that frontline workers are aware of this change and encouraged to highlight concerns. An additional approach has also been introduced at meetings whereby agencies can bring 'cases of note' – concerns can be raised outside of the formal criteria approach and if members of the Panel find necessity in a requirement for work to be completed, then a formal referral will be made.

The above changes have been implemented and working well.

6.0 How the Board will oversee and ensure that the recommendations are acted upon

All the agencies involved are working together to address the review's recommendations. The Safeguarding Adult Board and its partners are working to strengthen the development of trusting relationships with people with multiple, complex needs, with a focus on how we can best engage and support people who have experienced trauma.

Partners are working to ensure that when several organisations are involved in a complex case, the work is joined up and information is shared so that everyone understands how to best meet the individual's needs. This includes making sure that care plans are focussed on the individual at risk, including an understanding of the person's mental capacity.

We will continue to regularly review and monitor progress to ensure all the recommendations are fully implemented.

a) The CSAB partnership will ensure that areas of improvement to joint working practice are reflected in the revision of the Business Plan as appropriate. This will take account of, but not be limited to the robustness of policies, procedures, local guidance, training and the impact of these on front line practice.
b) Progress and impact will be managed through the appropriate CSAB work streams, with the SAR sub group monitoring an overarching action plan.
c) The CSAB and its members will formally and regularly monitor the implementation of the action plan and recommendations in order to ensure progress is being made
d) The CSAB SAR subgroup will maintain a register of all recommendations and require both the CSAB and its partner organisations to report on progress on a regular basis
e) The CSAB multi agency case file audit programme may be revised to reflect the learning from this case to seek assurance about any changes to front line practice or management
f) The CSAB multi agency training programme may be amended to reflect key learning and reported to the Board in annual evaluations
g) The CSAB will review policies and procedures and where necessary update or put in place appropriate amendments or new policies
h) The CSAB, in its annual report, will report on the progress made and the wider impact across partners, to consider whether progress and impact has been enough

i) A Challenge Event will be held after 6 months from the date of publication to test out the sustainability of the changes made as a result of this SAR. Learning from this will be reported to the CSAB.

6.1 Dissemination, implementation and monitoring of impact of learning

The Board and its partners have a number of mechanisms to ensure satisfactory dissemination of learning. Across the safeguarding partnership we have a culture of continuous learning and improvement. This must be sustained, and we will test this through regular monitoring and review. Some examples of how the learning from this review will be promoted and embedded in practice are through training and briefing sessions, newsletters, 7-minute guides, and publication on the website.

7.0 Final Summary from Independent Chair

This tragic case highlights a number of challenges for Safeguarding Partners in caring for adults with complex needs, who choose to live independently and who appear to have mental capacity. We are already, as a Board, working to improve our collective response to those with complex needs by taking a trauma informed approach and providing coordinated support.

Another key feature of this case was hoarding behaviour and the need to work with individuals to address the root cause to reduce or prevent hoarding. Mr C's voice came through loud and clear in this Review; his pain and confusion as he was removed from his home whilst his belongings were cleared are tangible. We are committed as a board through our work with the Hoarding Panel to ensure this is not the experience for others who find themselves in that situation.

Finally, I would like to return to the issue of Mental Capacity and executive functioning. A priority for the Board is ensuring our workforce have a better understanding of Mental Capacity and risk taking behaviours and are therefore able take appropriate and proportionate action to keep people safe.

Marianne Huison
Independent Chair of the Calderdale Safeguarding Adults Board
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