East Sussex Safeguarding Adults Board (ESSAB)

Response to the Safeguarding Adult Review regarding

Gwen and Ian

Section 44 of the Care Act 2014 sets out that a Safeguarding Adults Review (SAR) must be carried out for every case in which abuse or neglect is known or suspected, and an adult has died, (including death by suicide), or come to serious harm, and there are concerns about how organisations or professionals worked together to safeguard the adult. The purpose of a SAR, as set out in the Care and Support Statutory Guidance, is to “promote effective learning and improvement action to prevent future deaths or serious harm occurring again”.

As the circumstances of Gwen and Ian and the potential learning were similar, it was decided to undertake a joint review. Both were living at home in circumstances of self-neglect and were residing with family who were experiencing challenges in performing caring roles. There were features of engagement difficulties experienced in limited agency involvement, as well as missed opportunities to respond to presenting needs and risks in a comprehensive and coordinated way.

In 2021, Gwen who was a 95-year-old woman sadly died shortly after her admission to Hospital. In 2022, following a rapid decline in Ian’s mental and physical health, he was admitted to hospital and sadly died the following month.

The ESSAB commissioned this SAR to understand the circumstances leading up to Gwen and Ian’s deaths and to support the identification of strengths and challenges in how agencies worked together to safeguard them.

The Independent Reviewer involved both families and significant others in the review.

The review explored; areas of learning specific to Gwen and Ian’s cases including:

* How health and social care agencies can better meet the needs of adults at risk who have limited interaction with services, when there are concerns about self-neglect and carers needs.
* How effective was multi-agency needs and risk assessment; with a consideration of responding to disengagement, needs assessments, carers assessments, and multi-agency risk assessments and management involving professional curiosity?
* How effective was decision-making in response to safeguarding concerns, when raised by a member of the public, family member or agency?
* How effective was the consideration of mental health, mental capacity, and personalisation?
* How did resources and environmental factors impact on care?

The following information represents our formal response to the key findings, and learning identified in the SAR.

**Practitioner-level risk management:**

**For both Gwen and Ian, there were no multi-agency risk management meetings. This represented a significant missed opportunity (or opportunities) to have developed a coordinated risk management plan to address rapidly increasing self-neglect and carer concerns.**

## Board Response

The review identified that it seems that [The Sussex Multi-agency Procedures to Support Adults who Self-neglect](https://sussexsafeguardingadults.procedures.org.uk/pkoox/sussex-safeguarding-adults-procedures/sussex-multi-agency-procedures-to-support-adults-who-self-neglect) may not be sufficiently embedded in practice across all agencies. Any professional can request and convene a multi-agency meeting under these procedures however, it does not seem to be sufficiently clear from the review findings that agencies are aware of this.

East Sussex SAB, in collaboration with West Sussex SAB and Brighton & Hove SAB, will oversee a review of the pan-Sussex Multi-Agency Self-Neglect Procedures; with a focus on the responsibility of all agencies to trigger practitioner-level risk management meetings when the safeguarding statutory criteria is not met; and with involvement of ASCH to ensure that a safeguarding duty is not missed.

**Needs and carers assessments**

**There was a missed opportunity for Adult Social Care & Health (ASCH) and the GP Practice to have responded to the referral by a neighbour** **in relation to Gwen.** **The referral was not passed to an ASCH care management team to consider a Care Act Section 9 needs assessment, a Section 10 carers assessment, and potentially a self-neglect risk management response (within or outside safeguarding).**

**In Ian’s case there was a missed opportunity for the GP Practice to refer for consideration a Care Act Section 9 needs assessment, a Section 10 carers assessment, and potentially a self-neglect risk management response (within or outside safeguarding).**

**Board Response**

As part of Pan Sussex Self-Neglect Procedures review, ASCH will be considering an audit of front door referral information, screening and recording of self-neglect referrals, including the needs of any identified carers.

It was noted in the review that ASCH were not informed of the concerns relating to Ian until a very late stage.

East Sussex SAB and NHS Sussex ICB will be developing a specific learning briefing for primary care on best practice recommendations, self-neglect referrals and carers assessment in line with a recommendation from the review to improve this area of practice.

**Personalisation**

## The review identified that it was clear that practitioners were sensitive and skilled in communicating with Gwen, Ian, and their family carers. However, there was limited agency involvement, particularly with Gwen, and this will have impacted on the ability of practitioners to develop close, trusting professional relationships. Also, telephone contact was inevitably with their family carers, restricting their voice and adding to their isolation.

## Board Response

The pan-Sussex Multi-Agency Self-Neglect Procedures and accompanying briefings stress the importance of a person-centred and compassionate approach, to building a rapport and trust over time, and to reaching an understanding of the complex causes of self-neglect.

East Sussex SAB partners are to review the provision of information leaflets they publish for members of the public, to ensure that service users, families and the public have clear information on who to contact in the event of concerns about care, as well as what will happen when concerns are raised.

In addition, we will be promoting trauma-informed approaches, professional curiosity & active listening in service user interviews, incorporating this principle within risk management training; including a mapping exercise to identify and learn from good practice across health and social care agencies in Sussex.

**Good practice identified**

SARs are also about promoting good practice and in this case a number of areas were highlighted by the reviewer:

* The GP and Community Nurses were attentive in attempting to engage with Gwen and her daughter. SECAmb Paramedics provided timely and attentive support to Gwen, involving her daughter sensitively in decision-making and in escalating the Safeguarding Adults Concern.
* Ian’s non-attendance for medical appointments were followed up by a GP home visit and a referral for a dementia assessment.
* A Community Psychiatric Nurse (CPN) was proactive in addressing a referral that had not been processed in relation to Ian. Practitioners also had respectful and skilled discussions with his son.

ESSAB fully accept the overall findings and have reflected on lessons learnt from both these tragic cases. We remain committed to seeking assurance with regard to improvement planning across all relevant organisations involved, with progress monitoring being managed by the SAR Subgroup, who are accountable to the East Sussex Safeguarding Adult Board.

There were 6 recommendations that were identified from this review, and these will be developed with partners to ensure that timely learning and changes are implemented to ensure agencies improve the service offered.

East Sussex Safeguarding Adults Board

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