Leicester
Safeguarding
Adults Board

WORKING IN PARTNERSHIP
TO KEEP ADULTS SAFE

SAFEGUARDING ADULTS REVIEW
Rosey

2022

Executive Summary

1. Introduction

1.1 The Care Act 2014 requires Safeguarding Adults Boards (SABs) to arrange a Safeguarding Adults Review (SAR) if an adult (for whom safeguarding duties apply) dies or experiences serious harm as a result of abuse or neglect and there is cause for concern about how agencies worked together. The purpose of a SAR is promote effective learning and improvement actions to prevent future deaths or serious harm occurring again.

2 Rosey and background to this Review

2.1 Rosey was born in 1964. She was described by her siblings as fun loving and well liked. She had an interesting and responsible job but was made redundant in 2001. Rosey's mother, who Rosey described as her "soul mate", died in 2000 and after this Rosey experienced mental health problems and was diagnosed with schizophrenia.

2.2 Rosey had four hospital admissions under the Mental Health Act 1983 in 2001, 2008 and 2010. During these episodes Rosey showed symptoms of psychosis, such as delusional beliefs and hallucinations.

2.3 From 2016 a community psychiatric nurse (CPN) visited Rosey every three weeks at home to administer her anti-psychotic medication. In June 2016 Rosey was self-isolating and withdrawn. She lacked motivation culminating in poor self-care, disengagement from her family and clinical staff, and lack of engagement in social activity. Rosey's CPN referred her to adult social care for a social care assessment. The assessment concluded that Rosey did not have care and support needs because she was independent with all aspects of daily living.

2.4 Over the following four years Rosey's self-neglect fluctuated but generally increased as her home became ever-more cluttered, and her lack of self-care and poor hygiene intensified.

2.5 Over those four years Rosey indicated her fear of cancer to practitioners. For example, Rosey said "If I have cancer, I don't want to know about it".

2.6 A CPN offered to refer Rosey for another care and support needs assessment, but Rosey refused. The CPN openly discussed self-neglect with Rosey, but this seemed to prompt Rosey to disengage with the CPN, for example, by not allowing the CPN into her home.

2.7 In October 2020 Rosey did not answer visits from the CPNs, so on 20/10/20 the Police called at Rosey's flat. The Police issued a Public Protection Notice (PPN) to the adult safeguarding hub and notified adult social care because they were concerned with the state of Rosey's home and felt that she needed more care.

2.8 On 10/11/20 Rosey's CPN and a social worker attended Rosey's home but could not get a response. A warrant was obtained to enter Rosey's property.

On the evening of 11/11/20 the Approved Mental Health Professional (AMHP), doctors, police and Rosey's family met at Rosey's property. Rosey was found collapsed, an ambulance was called, and Rosey was admitted to hospital. On admission, Rosey was found to have late-stage breast cancer and was referred to palliative care. Rosey subsequently died on 24/11/20. Her death certificate listed the causes of death as pneumonia and breast cancer.

3. Review methodology

3.1 A study was made of both the research and practice evidence that provides insight and guidance when working with someone in Rosey's situation: self-neglecting and with whom services found it difficult to engage. Rosey's circumstances and the research and practice evidence, together with relevant legislation and legislative guidance, were systematically analysed and used as a lens to explore and reflect on what facilitates good practice and what presents barriers to effective working. During the Review the independent SAR author facilitated meetings to gather information and to identify and promote learning.

4 Conclusions

4.1 Working with people who self-neglect

4.2 Rosey was recognised as self-neglecting and some approaches made by practitioners were consistent with the self-neglect guidance and research provided by Braye, Preston-Shoot and Orr set out in section 4 of the full report. Despite this, the extent of Rosey's self-neglect was not recognised.

4.3 Future practice could be improved by considering life history and the significance of, and reasons for, self-neglect; how to make the most of moments of motivation; how to practice legal literacy; how and when to practice multi-agency working; how to use of community resources and flexible thinking in engaging with family members.

4.4 There was inter-agency coordination, but opportunities for escalation and joint working were not always taken

4.5 Prior to Rosey's death no safeguarding concerns were raised and the Vulnerable Adults Risk Management (VARM) process was not used. Whilst Rosey's CPN did raise increasing concerns to the CMHT's multi-disciplinary team, this was not escalated any further as it was felt that pressuring Rosey or raising concerns with other agencies would lead Rosey to disengage with services.

4.6 A safeguarding enquiry (under s42 of the Care Act 2014) was made, but not until after Rosey's death and therefore it could not make safeguarding personal or apply the six principles of adult safeguarding. Neither Rosey's family nor an advocate were involved as a representative on Rosey's behalf.

4.7 Following receipt of the PPN the approach taken was to work with Rosey consensually, to visit her at a time when she was expecting to receive her

depot injection when it was hoped that she would allow access to her home. This approach led to a delay in assessing and responding to concerns raised in the PPN about Rosey's welfare. A more rapid response to these concerns, prioritising the duty to protect Rosey, who had not been seen since 21/10/20, was required but was not made.

4.8 **There was insufficient attention to Rosey's mental capacity and its interface with Rosey's physical and mental health needs**

4.9 Apart from an assessment of mental capacity during the care and support needs assessment in July 2016, Rosey's mental capacity was assumed rather than fully assessed and Rosey's self-neglect appears to have been accepted as a capacitous decision and as a lifestyle choice. Rosey's mental capacity should have been assessed in the context of her self-neglect (as highlighted in the Mental Capacity Act code of practice). More attention should have been given to whether or not Rosey was able to understand, retain and use and weigh the information relevant in, for example, making decisions to refuse an assessment of needs after July 2016 or to not attend to her personal care. Attention could also have been given to Rosey's executive capacity and functioning, particularly about her personal care.

4.10 It is likely that Rosey's mental health needs meant that she had an impairment of, or disturbance in the functioning of her mind or brain and there may have been a "causative nexus" between this and Rosey's decision making. The predominantly negative symptoms of schizophrenia that Rosey experienced may have reduced her motivation, increased her isolation, reduced her interest in activities and impaired her cognitive abilities. Rosey also appears to have lacked insight into her mental health needs and social anxiety. The effects of schizophrenia and lack of insight should have been considered when assessing the extent to which Rosey could use and weigh relevant information.

4.11 Rosey's mental health needs were responded to with a focus on anti-psychotic medication. However, anxiety and depression also featured in Rosey's life, but Rosey seemed not to recognise that she was depressed and refused to take anti-depressants. Little consideration was given to therapeutic interventions. These may have changed Rosey's view of herself and perhaps reduced her self-neglect, improved her motivation, and may have enabled her to report concerns about her physical health.

4.12 **Rosey's care and support needs**

4.13 There was a lack of recognition during the 2016 assessment of Rosey's care and support needs that although Rosey said that she would, and was physically able to, wash and dress herself and wash clothes and bed linen, her mental health conditions may have prevented her from doing so.

4.14 **There was a lack of involvement with Rosey's family**

4.15 Rosey's wish to not involve her family was respected in accordance and guidance and law but was not considered within the context of her mental

health needs or her mental capacity. According to Rosey's family, relationships had been good but deteriorated as Rosey's mental health declined.

5 Recommendations

5.1 The following recommendations are made at an individual practice, an intra-and inter-agency and a board level. The Leicester Safeguarding Adults Board (LSAB) should create and monitor a multi-agency action plan to implement to implement them.

5.2 **Recommendation 1**: LSAB partner agencies should ensure that there is a process for deciding on which organisation takes the lead on applications to the Court of Protection based on which organisation will be able to apply the Court's determination.

5.3 **Recommendation 2:** Adult Social Care, Leicester Partnership NHS Trust (LPT) and Environmental Health should agree methods to raise multi-agency awareness of, and processes for, using legislation (Care Act, Mental Capacity Act, Human Rights Act, Mental Health Act, environmental health acts etc) to intervene in a timely way to support people who self-neglect and the circumstances and risks which exceed the capability of a single agency, team or individual to manage them on their own and when there is a need to involve other agencies or teams.

5.4 **Recommendation 3:** LSAB partner agencies should agree a multi-agency action plan to increase understanding and recognition of self-neglect (including ways of working with people who self-neglect as outlined in this SAR and that self-neglect can be reported as a safeguarding concern). An audit tool should be used across the LSAB agencies to demonstrate that improvements have been made.

5.5 **Recommendation 4:** The VARM guidance should be revised so that the connections between it and adult safeguarding are clear and that action to visit urgently in response to concerns is prioritised over consideration of which process to use and that assertive responses under the duty to protect life are focused on. The use of the clutter rating scale to support and communication about and assessment of the level of hoarding should also be emphasised.

5.6 **Recommendation 5:** LSAB partner agencies should agree a multi-agency action plan aimed at improving the understanding of the practical application of the Mental Capacity Act (i.e. that it requires assessment rather that assertion, that physical and mental health conditions may mean there is an impairment or disturbance in the functioning of the mind or brain, that mental capacity is decision and time-specific, yet should be seen as a video rather than a snapshot, that the Mental Capacity Act does not give the right to make unwise decisions, linkage to self-neglect, use and weighing a decision and executive functioning, etc). An audit tool should be used across the partnership to demonstrate that improvements have been made.

5.7 **Recommendation 6:** ASC should invite representatives from LPT to its monthly multi-agency meetings.

5.8 **Recommendation 7:** The LSAB should lead an analysis of the extent to which the policy, procedural and organisational environment in Leicester fosters effective ways of working with people who self-neglect and ask:

- Do agencies share definitions and understandings of self-neglect?
- Is inter-agency coordination and shared risk-management facilitated by clear referral routes, communication and decision-making systems?
- Is longer-term supportive, relationship-based involvement accepted as a pattern of work
- Does training and supervision challenge and support practitioners to engage with the ethical challenges, legal options, skills and emotions involved in self-neglect practice?
- When services withdraw is there sufficient risk management planning to identify and act upon any self-neglect relapse?

5.9 **Recommendation 8:** ASC should assure itself that safeguarding enquiries are made in a timely manner and, whether the enquiries are made by ASC or delegated to another agency, that they are made with regard to Making Safeguarding Personal.

5.10 **Recommendation 9**: LPT's safeguarding team should work to ensure that specialist interventions such as Assertive Outreach and Occupational Therapy are considered for people experiencing social isolation due to anxiety or negative symptoms of psychosis, lack of occupation and low levels of engagement.

5.11 **Recommendation 10:** Where a self-neglecting individual directs agencies not to contact their family and to exclude them from involvement in their care and support, their mental capacity to make this decision should be assessed.

5.12 **Recommendation 11:** All partner agencies should be sensitive and responsive to the information needs of bereaved families in situations where a relative with care and support needs has died.

5.13 **Recommendation 12:** Ensure that the current shared care agreement with Leicester, Leicestershire and Rutland (LLR) General Practitioners is reviewed and updated as per NICE Quality Standard [QS80], aligning to NICE Clinical guideline [CG178], so that patients with schizophrenia and psychosis whose engagement with services is sporadic or poor, have an agreed care plan as to who and how physical healthcare monitoring will occur annually between LPT and GP's.

5.14 **Recommendation 13:** When people who self-neglect, have mental health needs and live alone do not attend health screening appointments, then whichever practitioner is working with them should encourage attendance and liaise with, for example. the person's GP.

5.15 **Recommendation 14:** GP practices should follow through on proposals to ensure active follow up of patients who do not respond to invitations for health monitoring, for example, breast cancer screening, to explore barriers and encourage greater take up.

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About the reviewer

The review report was written by Patrick Hopkinson, of Apollo Eagle Consulting. Patrick brings an insightful, analytical and impartial approach to Safeguarding Adults Reviews. Patrick has many years’ experience of safeguarding, in health, social care, learning disability and mental health services, both as a senior manager and commissioner. As well as SARs, Patrick develops and delivers safeguarding training and interventions for practitioners and senior leaders, chairs Domestic Homicide Reviews and lectures at the Institute of Psychiatry.