Statutory Safeguarding Adults Review

'Tony'

Overview Report

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1. Introduction

1.1. This Safeguarding Adult Review (SAR) concerns self-neglect of "Tony" (a pseudonym chosen by his family) who had a long history of mental ill health (Schizophrenia). Tony was born deaf and had surgery on cataracts at a young age, he remained partially sighted for the rest of his life. Tony lived in Barnsley all his life, apart from an extended stay in a residential deaf school between the ages of 3 – 15. He lived alone in a Council property, managed by Berneslai Homes at the time of his death.

1.2. In November 2023, Tony was found collapsed at a bus-stop and was admitted to hospital. He was severely malnourished and had pressure sores. On admission he required detox treatment for alcohol, though the review did not identify any evidence to suggest that he was a dependent drinker.

1.3. Tony initially responded well to treatment and discharge planning was in place, however he developed pneumonia and died on 13 December 2023 aged 71. Cause of death is listed as 1a) Pneumonia b) Malnutrition 2) Congestive cardiac failure, Alcohol excess.

1.4. A coroner's enquiry has been opened and adjourned. The coroner is aware of this review. Tony's brother and sister have been contacted and their views are contained within it.

1.5. This SAR explores how agencies worked together with Tony in the years preceding his admission to hospital. It does not include his stay in hospital or the period after his death.

2 Summary of the Learning Points from the Practitioner event

Summary of Learning Points

i The review identified the importance of assessing the impact of sensory impairments on an adult's ability to obtain the necessary services

ii The review highlighted the absence of robust multi - agency risk assessments and information sharing, particularly when safeguarding concerns were identified

iii The review also highlighted the need to consider templates for S42 planning meetings to support attendance of all relevant organisations

iv The review identified the need to consider executive functioning when working with adults who were unable to address personal risks

v Services must consider what reasonable adjustments are required to enable people with disabilities to access services. Evidence that Tony may not have understood letters sent out in written English.

vi The review highlighted those individual workers, and their organisations knew little of the relationships Tony had with family and friends, though these were clearly of importance to him.

3. Context of Safeguarding Adults Reviews

3.1 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 because of abuse or neglect and there is cause for concern about how agencies worked together.

3.2. The purpose of SARs is '[to] *promote as to effective learning and improvement action to prevent future deaths or serious harm occurring again.'*

3.3. The SAR was referred by Barnsley Hospital, following his death on ward 21. The SAR criteria were judged to be met because Tony experienced serious harm that was believed to be as a direct consequence of self-neglect. Tony had a diagnosis of Schizophrenia and was deaf from birth. Barnsley Safeguarding Adult Board (BSAB questioned whether agencies had missed earlier opportunities to intervene to support Tony to address the risks he faced.

3.4 Barnsley Safeguarding Adults Board (BSAB) agreed the Board Manager would author the report.

3.5 The Department of Health's six principles for adult safeguarding should be applied across all safeguarding activity. The principles apply to the review as follows:

Empowerment: Understanding how Tony's lived experience was known and how he was involved in his care. Involving family in the review

Prevention: The learning will be used to consider prevention of future harm to others.

Proportionality: Understanding whether least restrictive practice was used; being proportionate in carrying out our review.

Protection: The learning will be used to protect others from harm.

Partnership: Partners will seek to understand how well they worked together and use learning to improve partnership working.

Accountability: Accountability and transparency within the learning process

4. Terms of Reference and Methodology

4.1. Terms of Reference

4.1.1. The specifics areas of enquiry are as follows:

Terms of Reference: Areas of Enquiry

1. How well did your organisation hear and act on the voice of the adult – Tony – when providing his care and support given his communication challenges?
2. Can you evidence risk assessments completed by your organisation? What actions resulted and did they mitigate the risks Tony faced? Did these include any multi-agency action?
3. What role did family and friends play in his life, and did your agency engage with them?
4. Did your organisation make any referrals for other services on Tony's behalf? If so, which, and was support then offered and did he engage with it?
5. How did you manage Tony's non engagement with your organisation. Did you amend your approach to him to improve his engagement? Can you comment on the impact of your approach to working with Tony?
6. Did his non engagement result in discharge from your service?
7. Did you have any concerns about Tony's capacity to make decisions? If yes, did you use the Mental Capacity Act to complete assessments – if yes please detail.
8. Was your organisation involved in safeguarding Tony? Did you raise concerns and/or engage with the S42 enquiry linked to his self-neglect/hoarding? Can you examine the impact of the S42 enquiry on Tony and the effectiveness of the joint working?
9. Evaluating the response to the self-neglect/hoarding risks faced by Tony, do you think your organisation's response was in line with the BSAB self-neglect and hoarding policy and the learning generated from previous cases. Can you identify any good practice or areas for improvement?
10. Did the staff involved in supporting Tony have access to management support and had they completed training around self-neglect and/or hoarding?
11. Did the staff involved with Tony received training or support to use the Mental Capacity Act?
12. What good practice did you identify on both a single agency and multiagency basis?

4.1.2. The scope period for this review focused primarily on the four years pre-dating Tony's death but referenced key relationships and events that dated back to 2003.

4.2. Methodology

4.2.1 This Safeguarding Adults Review combined agency reports with a learning event for practitioners who had been directly involved with Tony. This aimed to explore underlying factors including individual interactions and wider system factors that support or create barriers to good practice.

4.2.2. Including the views of family are key to understanding the adult in a holistic way. Contact was made with Tony's sister and brother and their views are included in the report.

4.2.3. A pseudonym has been used to protect Tony and his family's privacy and dignity. Tony was chosen by his family. Dates and places have been deliberately generalised.

4.2.4. The role of the contributing agencies is outlined in the table below:

Participating Agencies and Context of Involvement

Barnsley Hospital NHS Foundation Trust (BHNFT)

Tony received support via the Emergency Department and was offered support via the fracture clinic but did not attend. He was admitted in November 2023.

Barnsley Metropolitan Borough Council – Adult Social Care (BMBC)

BMBC ASC received Safeguarding adults' referrals in addition to a request for a social care assessment

Berneslai Homes (BH)

Provided 2 tenancies to Tony. Both in the Goldthorpe area

Department Work and Pensions

Tony was in receipt of a state pension and Personal Independence Payments.

GP Practice

Tony had been registered with BHF Goldthorpe practice since his birth.

Rotherham, Doncaster, and South Humber NHS Trust (RDASH). SY wide specialist service for deaf adults

Tony had received support from the specialist service for over 25 years. The current postholder had worked with him for 14 years

Safer Neighbourhood Services (BMBC)

Tony was referred on 5 occasions during 2023 due to concerns about the number of cats and kittens and the risks to his property as he left windows open to facilitate cats entry/exit from his home

South Yorkshire Fire and Rescue

Support to manage risks of smoking/hearing impairment from 2014 – 2022. Entry refused on two occasions. Flame retardant bedding refused. Hard of hearing fire equipment installed but Tony did not "plug it in."

South Yorkshire Police SYP

There are two adult protection investigations and two criminal damage investigations. These were following differing reports from various sources including a RDASH worker and neighbours. The incident reported by Tony was closed due to evidential difficulties.

South West Yorkshire Partnership Foundation Trust (SWYPFT) – Mental Health Services

Tony was supported by SWYPFT (Enhanced Care Team) from January 2003 to his death in December 2023. In the period 2020 – 2023 he had two care coordinators.

4.3. Review Timeline

Safeguarding Adults Reviews should be completed '*within 6 months of initiating it, unless there are good reasons for a longer period being required'*. The SAR took six months from point of commissioning until its conclusion.

4.4. Structure of Report

The report is structured as follows:

- Section 5 provides Tony's background and key events relating to agencies' involvement with him.
- Section 6 gives analysis and learning.
- Section 7 reviews terms of reference
- Section 8 evidence of good practice
- Section 9 What's changed
- Section 10 provides the views of family.
- Section 11 makes recommendations for the BSAB and its partner agencies.

5. Tony: His Background and Key Events Relevant to This Review

5.1. Tony was a man of white British heritage who died at the age of 71. Tony had lived, alone, in Barnsley for all his adult life. He had two siblings, neither lived locally, and several aunts and uncles who lived in Barnsley. He had support from neighbours, but he had a history of "falling out" with people, often without any obvious rationale. The death of his mum severely impacted on his mental health, compounded by his refusal to take his medication and his increased use of alcohol. Tony remained at home with his father after his mum's death, however the relationship was not positive. When his father re-married Tony did not accept this, his father secured alternative housing in a Berneslai homes property before he sold the home and emigrated.

5.2. Tony attended a specialist residential school, in Doncaster, between the ages of 3 and 15. Family believe that he had experienced trauma, but this was never investigated. Tony was reluctant to engage with the deaf community, despite the isolation that resulted from this

choice. His deafness, combined with his visual impairment impacted on his ability to read and understand letters.

5.3. Tony's mental ill health resulted in one detention under the Mental Health Act (1983, amended 2007), he was placed in a specialist unit for adults with communication difficulties in Manchester. His mental health remained relatively stable following discharge due to compliance with regular Depot injections. He did not take any other medication to manage his mental health. He was in Moorlands in 2016, it is not clear if this was a voluntary or statutory detention, however family indicate that this was instigated by Tonys father

5.4. Tony was capable of cooking, shopping, decorating etc. and was able to travel independently within Barnsley and further afield (Wakefield, Doncaster etc.) It is not clear the reason for these trips. He walked for miles and loved being out in the outdoors.

5.5. Tony would nominate people as his "next of kin," often without their knowledge or consent. This role was allocated to his specialist deaf worker on several occasions and had to be revoked.

5.6. Tony was reluctant to engage with new workers and regularly missed appointments for his Depot injections, however they were always administered. He was compliant with workers when he was at home, however he would discourage workers entering the home

5.7. Tony was an animal lover, he had 2 cats for many years. After their death he allowed local strays to use his property via open windows. This very quickly became an issue as they cats had many litters of kittens with significant health issues and the house reflected the lack of cat trays, with large volumes of cat faeces.

5.8. Tony visited the same café and local pub regularly. For many years he received support from "Emily" a neighbour who he visited daily, he then had a disagreement with her and sought support from other neighbours, including "Jane" who was nominated as his next of kin on his admission to hospital in 2023. Tony was asked by both BHNFT staff and the specialist deaf worker if he wanted his sister and brother notifying about his hospital admission. Tony declined this offer.

5.9 Tony first job was in a local bacon factory, furniture manufacturer but was made redundant from both. He worked as a gardener with Barnsley Council and had a positive relationship with his boss, whose death had a negative impact on his mental health. He loved working outdoors, a move to work in greenhouses did not suit him and he was later made redundant and did not work again.

5.9 The following charts key events in agencies' involvement with Tony, leading up to his admission to hospital and his death.

Chronology

Date	Organisation	Intervention
2013 – 14	SWYPFT	Concerns about possible burglaries – Tony refused to make a complaint to the police or improve the security of his home – by closing windows and doors
2014		Concerns raised by sister about Tony's physical presentation. Visit made. Tony unkempt but home reasonable
2014	RDASH	Facilitated 2 police visits regarding two stolen TV and digital box
2014	SYFR	Assessment completed; specialist fire detection equipment provided. Fire retardant bedding refused
2014	RDASH	Another TV loss reported to police. Facilitated home visit with the police
2014	SWYPFT/RDASH	Review by psychiatrist. Tony judged to have capacity to make decisions
2016	SWYPFT	Concerns about home. Tony refused cat flap. Weight loss noted, Tony claimed to be eating well, including visits to café
2016	SYFR/RDASH	Fire alarm working
2018	SYFR	Visit to home. Tony not using fire detection equipment. Agreed to keep it plugged in, in another room
2017 – 2018	SWYPFT	Several visits. Tony at times unkempt but was at times clean/well presented. Confirmed he had clean clothes and a working washing machine
2019	SYFR	Visits attempted. Tony refused entry, would not discuss concerns
2019	SWYPFT	Community matron raises concerns about lack of hygiene
2019	RDASH	Wallet lost, support to obtain new Post Office and Payment cards for utilities
2020	ASC	Referral received from police. Bullying in pub. Tony refused all support. Agreed to continue working with RDASH/Specialist MH Nurse

2020	BHNFT and SWYPFT/RDASH	Fractured foot, support offered by SWYPFT and RDASH to attend fracture clinic. Tony not at home when workers called. Discharged from service Offered help to spay/neuter cats – refused. Damaged TV – Tony refused to report to SYP
2020	GP	Request that Tony be offered a further appointment
2020	RDASH/SWYPFT	Call received from friend- concerns about his physical appearance. SWYPFT informed
2021	SWYPFT	Psychiatrist review – clean and tidy. Home in better condition. Issues with cats remain
2021	Berneslai Homes/SWYPFT	Breach of tenancy linked to cats. Enforcement notice issued
2022	RDASH	Lost money and cards. New ones organised. Tony agreed to leave some money in his home. Refused option of a bank account
2022	RDASH/ASC	Safeguarding concerns raised. Several visits made. Tony not in. Tony did meet with ASC and RDASH – refused all help
2022 – 23	SWYPFT	Ongoing concerns about cats. Professionals meeting
2022	SYFR	Two visits – refused entry.
2023	SWYPFT	Home dirty/Tony unkempt. Weight loss noted, but seen with bags of shopping and he confirmed he was eating
2023	ASC	3 safeguarding referrals received – SYP, Berneslai Homes. Safeguarding enquiry opened and multi-disciplinary meetings held. Tony did not attend. Social worker allocated. 8 visits made with RDASH nurse. Tony still stating he was “fine”
2023	Berneslai Homes	Tenancy support worker allocated. Close work with ASC and RDASH colleagues
2023	RDASH	Tony breathless and “low.” Advised to see GP, offer of support. Refused
2023	BHNFT	Tony admitted to hospital

Summary of Events

5.10. From 2003 Tony received support from the specialist deaf social work service within RDASH. This was a strong relationship, built on use of British Sign Language (BSL). The current mental health nurse had supported Tony since July 2009

5.11. Tony was largely compliant with support from the enhanced mental health team from **2003** and accepted his Depot injections. He did not engage with his GP; despite being registered with them from birth, he failed to attend multiple appointments and was last seen in August 2022 for routine bloods linked to his mental health medication. He fractured his foot in January 2020 arrangements were made by workers to support him to attend the fracture clinic, however he was not at home when they called. A third appointment was made which he did not attend. The hospital notified the GP who requested a further appointment was made by the fracture clinic, this was not actioned. BHNFT and the GP are asked to examine the reasons for the lack of action to offer a further appointment, Tony's previous actions would suggest that he would not have taken up the appointment?

5.12. **In 2014** SYFR supplied hard of hearing fire detection equipment, however Tony did not plug this in. SYFR identified risks linked to smoking in bed, fire retardant bedding was offered but refused. In **2018,** SYFR moved his deaf hearing equipment into another room and improvements noted. Tony declined flame retardant products, and he refused further referrals. In 2019 a visit was refused and SYFR were informed he was low risk as Berneslai Homes confirmed he had working smoke alarms; this information was shared with his CPN at SWYPFT.

5.13. **Early in 2020** neighbours expressed concerns to mental health workers from SWYPFT about his living conditions and his use of a walking frame and commode and suggested he would benefit from additional support. A referral was made to Adult Social Care, discussions with the specialist worker indicated that Tony was unlikely to accept support and that they would maintain weekly contact with him and contact ASC if Tony would benefit from some support. Tony's support network of neighbours and family were not identified as informal carers and no assessment of their role as carers was completed. In March 2020 concerns were identified about Tony being bullied in the pub and his clothes being burnt. SYP were informed; however, no suspect was identified.

5.14. In the first quarter of **2022,** SWYPFT provided food parcels to Tony as he had no money or food in his property. It is unclear if the lack of money was explored with him?

5.15. Early in **2023** neighbours reported possible thefts from his property to SYP as Tony was leaving windows and/or doors open to enable the cats to enter the property. ASC received a safeguarding referral; however, this was closed and no further action as Tony refused support, and he was receiving support from SWYPFT and RDASH (Specialist deaf

services). The police were unable to progress the enquiry as Tony would not make a complaint and there was limited evidence.

5.16. In May **2023,** Berneslai Homes referred Tony to ASC due to concerns about his unkempt state and the condition of his home due to the large number of cats living in it. ASC opened a safeguarding enquiry, however despite support from the specialist deaf nurse, Tony was reluctant to engage with the allocated social worker who evidenced significant tenacity in working with him to address the welfare issues of the cats. An area of interest to Tony.

5.17. In the autumn of **2023,** SWYPFT noted that Tony was thin, unkempt, and smelly. Wearing the same clothes for many days/weeks. This information was not shared with Adult Social Care to inform assessment using the self-neglect scoring tools.

5.18. In **October 2023,** a joint visit between BH and ASC to address the wellbeing of the cats and to fit a cat flap identified concerns about Tony's finances. BH raised questions about possible financial abuse. A plan was agreed to complete a financial checklist; however, Tony was admitted to hospital before this was completed.

5.19. In **November 2023,** a safeguarding planning meeting was held, Tony's care coordinator at SWYPFT was invited but did not attend. Within a few days of this meeting Tony was admitted to hospital and his home was secured by Berneslai Homes by changing the locks etc. ASC arranged for the cats to be accommodated at local kennels or taken away by the RSPCA, with Tony's agreement. Tony's intention was to have two cats returned to live with him on discharge from hospital.

5.20. Food parcels were provided by adult social care and care coordinator (SWYPFT) on a regular basis, little curiosity about the need for these was evident and organisations were not aware that these were being provided by multiple sources.

5.21. Despite initial improvement in Tony's condition and plans to discharge him to a "step down bed" prior to returning to his home; Tony sadly developed pneumonia and died in hospital on 13 December 2023

5. Analysis and Learning

The following section provides analysis of the events, grouped under two episodes:

1. Opportunities for Earlier Intervention – 2020 – 2023
2. Review of safeguarding response 2023

6.1. Opportunities for earlier intervention: 2020 to 2023

6.1.1. Tony was a very private man, who struggled engaging with new workers though he maintained strong social contacts with many friends and neighbours who offered him both practical and emotional support. Tony regularly refused support from workers, directly or indirectly (by not being at home when visits had been agreed)

Recommendation 1 – All organisations identify and record social support networks and consider use of the Group around the Person model to engage them in managing risks

6.1.2. Tony required food parcels on multiple occasions, however he was receiving a state pension and Personal Independence Payments that were drawn out in full when he visited the post office on a weekly basis. Tony did not have a bank account and had prepayment cards for this gas and electricity, this often did not meet his needs, though his habit of leaving doors and windows open would have increased the cost of keeping the property warm.

Tony informed workers he had lost his wallet and because he withdrew all his weekly money this meant he had no disposable income. Professional curiosity about finances when evidence of self-neglect and the need for food parcels would have been helpful to exclude financial abuse and/or to identify alternative options for Tony to manage his money as he was in receipt of full benefits totalling £1200 per month. Tony's family indicated that he was in significant debt when he died and question how workers were not aware of this?

Recommendation 2 – Organisations record and explore, known or suspected changes in financial circumstances to identify possible financial abuse and to support alternative money management options.

6.1.3. Tony's insistence that things would not occur again or "it will be all right" were often misplaced as concerns were raised that men had been seen leaving his property with household items, including a TV on more than one occasion, however it is unclear if they were invited into his home? Workers could have explored this belief and how he could have protected himself more robustly or considered if this was an area where he may have struggled to make decisions.

Recommendation 3 – Workers are supported to hold difficult and challenging conversations with adults and record these to evidence that all reasonable steps have been taken to reduce risk of further harm to the adult.

6.1.4 Tony did not attend his GP and other physical health appointments, evidenced by the discharge from the fracture clinic and physiotherapy services. Given his primary language was British Sign Language (BSL) it is possible that he struggled with letters using written English. Limited evidence of this being explored by workers or a standard offer to review his correspondence; accepting that this may have been refused. Most workers relied on non-verbal communication and writing things down, some organisations used the specialist deaf resource to facilitate communication and one used specialist communication cards.

Recommendation 4 and 4a

4 - Organisations supporting people with communication difficulties/sensory impairments assess the impact of these on the adult's ability to maintain their health and wellbeing and evaluate if their methods of communication are supporting the adult to make choices. Barnsley Hospital share the communication resource pack, developed following Tony's death, with all relevant partners.

4a – Organisations review the support available to workers to facilitate communication with adults, outside of specialist support and identify any improvements to increase accessibility of services to people with sensory impairments.

6.1.5 As Tony was largely compliant with interactions with organisations, communication was often completed using non-verbal and written notes. Tony's ability to build relationships with workers will have been compromised because of using these methods of communication; and it limited workers ability to be curious about his physical and mental health. The specialist resource could not support all interactions between staff and Tony, raising questions about how his care coordinator could assess his mental health at the visits to administer his Depot injections. Tony's last mental health assessment (Care Programme Approach meeting) took place in 2023; however, Tony was not supported by a BSL interpreter or the specialist deaf worker. SWYPFT have acknowledged this is an area of learning and have produced practice guidance and shared with staff. A copy of this will be shared with the Safeguarding Adult's Board.

Recommendation 5- SWYPFT complete a SBAR (Situation, Background, Analysis and Recommendations) to maximise their workers use of BSL advocates in CPA meetings and share the outcomes with Barnsley Safeguarding Adults Board (BSAB)

6.2 Safeguarding episode 2023

6.2.1 The first planning meeting was held in October 2023, not all organisations attended the meeting, though invites were issued, it was clear that Tony was not able to manage the responsibility of all the cats using his home and there was evidence that he was not managing his finances. Tony did not attend the meetings, unclear if he refused? As Tony had significant difficulties in engaging with professionals a specialist advocate may have strengthened his voice in the process.

Recommendation 6 – A list of attendees is created to maximise involvement and failure to attend is escalated to managers

Recommendation 6a – Advocates are always considered when working with adults with communication issues. Specialist BSL advocates can be obtained via ReThink

6.2.2. At the planning meeting in November agreement was reached to install a cat flap to enable Tony to close windows and doors. The RSPCA were engaged to manage the health

needs of the cats. Concerns were logged about Tony's finances and the support worker from Berneslai Homes agreed that he would work with Tony to map his income and expenditure, however Tony was admitted to hospital before this work was completed. Limited evidence of wider risk assessments about Tony's refusal to acknowledge risk or the impact of the hoarding of animals

Recommendation 7 – consider inclusion of hoarding of animals in both the hoarding policy and in local training

6.2.3 At the point Tony was admitted to hospital, his home was secured, and arrangements were made for the welfare of the cats; social care staff visited at weekends to provide food/medical care until the cats were moved into kennels/cattery. Plans for a deep clean of the property were implemented to support his return home.

6.2.4. This is briefly summarised against the safeguarding principles:

- Empowerment
  Tony did not appear to have been actively engaged with the safeguarding; however, this may have been his choice as he had a history of non-engagement with services (fracture clinic). It is unclear if he had been informed of the safeguarding concerns?

- Protection
  Tony struggled to accept risk and frequently stated "it won't happen again, or it will be OK." It is unclear if our concerns about his safety were fully understood? He did engage with plans to improve the welfare of the cats and the security of his property.

- Proportionality
  The responses reflected Tony's independence and desire for privacy, however this may have prevented a full assessment of the risks he faced and his ability to manage these. His belief that everything would be "ok" was not supported by his actions to reduce the risks identified in the review. (Loss of wallet, lack of bank account, reliance on neighbours etc). It is unclear if Tony was able to understand the risks and make choices to manage these and whether work around executive functioning would have been beneficial

- Partnership
  Tony had a strong/long term relationship with the specialist deaf workers, this provided stability for him but may have reduced the ability of other workers to develop relationships to explore the risks he faced. Tony's care coordinator was not actively involved in the safeguarding enquiry (S42), despite seeing him on a regular basis to administer his injection and monitor his mental health; it is unclear if this impacted on the quality of the risk assessment and risk management plans.

- Prevention

  Tony's independence and actions impacted on worker's abilities to keep him safe and prevent further harm. The installation of the cat flap enabled him to close windows and doors reducing the risk of further burglaries, however his reluctance to open a bank account left him vulnerable to financial abuse as he carried all his benefits in cash.

- Accountability

  Overall, the partners/workers involved in the S42 communicated effectively, however they were reliant on the specialist service to communicate with Tony. The absence of key partners, including Tony's care coordinator in the S42 enquiry could have been explored and/or escalated.

7. Terms reference and analysis

7.1.1 How well did your organisation hear and act on the voice of the adult – Tony – when and support given his communication challenges?

- Except for the specialist deaf service, communication was limited by the absence of the use of BSL, a reliance on non-verbal and some written exchanges impacted on the quality of the information available to workers. Communication cards were explored with Tony whilst in hospital, but rejected by Tony evidencing his preference for BSL

  Learning - all organisations to evaluate their ability to provide services to adults with sensory impairments if specialist resources are not available within the organisation.

7.1.2 Can you evidence risk assessments completed by your organisation? What actions resulted and did they mitigate the risks Tony faced? Did these include any multi-agency action?

- Organisations, in the large, appear to have assessed risk pertinent to their role but did not collaborate on a multi-agency basis, relying on specialist service to function as an intermediary between organisations. Their role in this space may have benefited Tony, by exposing him to a greater range of organisations over time to build his trust. The 2020 safeguarding concern was not progressed; however a multi-agency risk assessment was completed and it decided that regular input from the specialist deaf service and impending covid lock down would manage the risks Tony faced. The 2023 safeguarding did reduce the risks of burglaries and potentially increased his finances by addressing the growing numbers of cats by joint work with the RSPCA and others.

7.1.3 What role did family and friends play in his life, and did your agency engage with them?

- Tony relied heavily on neighbours and had regular contact with local family members, he appears to have distanced himself from his siblings and he gave organisations details of neighbours as his next of kin instead of a family member. It is difficult to establish how significant these relationships were and if they were beneficial to Tony? Limited evidence of conversations with Tony about why family were not named as his next of kin.
- None of the organisations working with Tony identified these individuals as informal carers and explored their need for a carers assessment

7.1.4 Did your organisation make any referrals for other services on Tony's behalf? If so, which, and was support then offered and did he engage with it?

- Tony regularly refused offers of support to address health concerns. Repeated attempts were made by the specialist services to arrange/attend opticians' appointments; support was offered by two organisations to attend appointments at the fracture clinic that Tony declined by not being at home.

7.1.5 How did you manage Tony's non engagement with your organisation. Did you amend your approach to him to improve his engagement? Can you comment on the impact of your approach to working with Tony?

- Most workers relied on the specialist British Sign Language (BSL) workers to communicate with Tony, however this did not extend to routine contacts to administer his Depot injections or to address the complaints about the condition of his home. On reflection many organisations have committed to improve communication with adults with hearing impairments and other sensory impairments.

7.1.6 Did you have any concerns about Tony's capacity to make decisions? If yes, did you use the Mental Capacity Act to complete assessments – if yes please detail.

- No organisation identified any reason to question Tony's capacity, however in the context of his self-neglect, hoarding of cats and inability to recognise risk research would suggest that an assessment of his executive functioning may have been beneficial.

7.1.7 Evaluating the response to the self-neglect/hoarding risks faced by Tony, do you think your organisation's response was in line with the BSAB self-neglect and hoarding policy and the learning generated from previous cases. Can you identify any good practice or areas for improvement?

- ASC completed a self-neglect assessment, which indicated a score of 3, which would not generate a S42 response. This did not reflect the hoarding of cats which is not currently included in the policy. Learning from this review will result in changes to the policy to include hoarding of animals.

Tony's inability to address risks was not included in risk assessments, based on the principle of respecting his choices. The self-neglect and/or hoarding policy recommends that we examine the adult's ability to protect themselves when they appear to be making "unwise choices."

A multi-agency assessment of risk would be beneficial when working with adults who self-neglect, when the risks have met the threshold for a safeguarding enquiry. (*Executive dysfunction may be evident when a person gives coherent answers to questions, but it is clear from their actions that they are unable to carry into effect the intentions expressed in those answers. It may also be that there is evidence that the person cannot recall relevant information at the point when they might need to implement a decision that they have considered in the abstract. This will be relevant to assessments of mental capacity as it raises the question as to whether someone can 'understand' and 'use or weigh relevant information' in the moment when a decision needs to be enacted.) From BSAB Self-Neglect and/or Hoarding policy approved January 2024.*

- Training

Staff from ASC, SWYPFT BH and BHNFT all have access to free training via the BSAB training programme (self-neglect and/or hoarding and knowledge and use of the mental capacity act). Training is also delivered within the health partners. Applying learning to practice often requires support via supervision or other management oversight. It may be beneficial for all organisations to consider how they provide opportunities for workers to discuss cases involving self-neglect and/or hoarding to maximise their impact on the risks

7.1.8 Did the staff involved with Tony received training or support to use the Mental Capacity Act

The Mental Capacity Act 2005 should be embedded in all organisations, training is delivered within all organisations and via BSAB multi-agency training offer. Workers often struggle to identify individuals who may struggle with executive functioning and inclusion of this in supervision and multi-disciplinary meetings when working with adults who are self-neglecting and/or hoarding may enable them to hold the necessary conversations with the adult to assess their ability to assess risks and take actions to mitigate these.

7.1.8 What good practice did you identify on both a single agency and multiagency basis?

- See section 8

8 Evidence of Good Practice

8.1 Tenacity and persistence were evident from most organisations who made repeated attempts to engage with Tony to provide support. Adult Social Care's

work outside of work hours to address the welfare of the cats, after Tony's admission to hospital reduced his anxiety about their safety

8.2 SYFR utilised BSL resource within the service to communicate with Tony and have commenced work on development of communication aids for fire crews

8.3 BHNFT engaged the specialist service and after Tony refused use of communication cards and implemented an informal system to enable his medical and nursing needs to be met. BHNFT have since produced a communication pack for use across the hospital

8.4 The specialist service maintained regular contact with Tony, despite covid restrictions. Their willingness to be his main point of contact was helpful to Tony but may have impacted on other organisation's ability to build relationships

8.5 SWYPFT colleagues maintained his mental health in the community by administering his Depot injections, avoiding further admissions to mental health units

8.6 Many workers demonstrated care and compassion by providing food parcels to Tony

9 What's Changed

9.1 ASC have developed a planning meeting template to ensure that all relevant organisations participate in S42 enquiries. They have also committed to cascade the learning within their organisation.

9.2 SYFR have commenced work on a suite of communication aids for fire crews and fire safety coordinators.

9.3 BHNFT have commenced work on communication aids to support nursing staff when BSL is not available.

9.4 SWYPFT complete a SBAR (Situation, Background, Analysis, and Recommendations) to maximise their workers use of BSL advocates in CPA meetings and share the outcomes with Barnsley Safeguarding Adults Board (BSAB)

9.5 A guide to support nonclinical workers to recognise and respond to signs of malnutrition has been approved and published by the Safeguarding Adults Board.

10. Views of Tony's family

10.1 Tony's family acknowledge that Tony would refuse support and help from them and other people, however he had strong relationships with many family members and neighbours and was invited to lots of family events – weddings, birthdays etc. The family recognise that working with Tony would have been challenging but question if the risks he faced were fully understood as most interventions were single agency until the use of safeguarding in 2023.

10.2 Given Tony's smoking habits often resulted in burns to his clothes and skin, combined with his refusal to plug in the fire detection equipment provided by SYFR, they question if another risk assessment should have been completed and the option of wiring the equipment into the mains to remove his choice to unplug it should have been explored?

10.3 Tony's privacy, combined with the inconsistent use of a BSL interpreter by all agencies, impacted on worker's ability to explore some of the "warning flags" with him. They recommend that all organisations provide access to this resource when working with profoundly deaf individuals, especially those at risk of self-neglect

10.4 Tony's choice to nominate a neighbour as his next of kin (NOK) meant they were not informed he was in hospital and were not notified of his death by any worker/organisation and found out about his death via a social media post. This has been very painful for them as they were denied the option of visiting/saying goodbye to him, they accept that they were not listed as his NOK, however, feel very strongly that they should have been notified of his death by the organisations who had their contact details.
The duty of confidentiality continues after a patient has died. Guidance on disclosures after a patient's death is included in Confidentiality: good practice in handling patient information. You should follow a patient's known wishes after their death. (https://www.gmc-uk.org/professional-standards/professional-standards-for-doctors/confidentiality/managing-and-protecting-personal-information)

10.5 Tony's family confirmed that he struggled to manage money, buying multiple toasters, curtains, shoes, etc and storing them in wardrobes and cupboards. They confirm that Tony was in debt with all his utilities and had several county court judgements against him. Given Tony often required food parcels they question the curiosity of workers involved with him about his finances and what he was spending money on and whether he had capacity to make these decisions?

11. Recommendations

Recommendation 1: All relevant organisations identify and record social support networks and consider use of the Group around the Person model to engage them in managing risks

Recommendation 2: Organisations record and explore changes in financial circumstances to identify possible financial abuse and to support alternative money management options.

Recommendation 3: **–** Workers are supported to hold challenging conversations with adults and record these to evidence that all reasonable steps have been taken to reduce risk of further harm to the adult.

Recommendation 4: - Organisations supporting people with communication difficulties/sensory impairments assess the impact of these on the adult's ability to maintain their health and wellbeing and evaluate if their methods of communication are supporting the adult to make choices. Barnsley Hospital share the communication resource pack, developed following Tony's death, with all relevant partners.

Recommendation **4a –** Organisations review the support available to workers to facilitate communication with adults, outside of specialist support and identify any improvements to increase accessibility of services to people with sensory impairments.

Recommendation 5: - SWYPFT to complete an SBAR to ensure that all staff can access BSL resources for adults receiving support from them, who would benefit from this. The outcome of this work will be shared with Barnsley Safeguarding Adults Board (BSAB)

Recommendation 6: - A list of attendees is created to maximise involvement in safeguarding planning and outcome meetings, failure to attend is escalated to managers in line with the BSAB escalation policy

Recommendation 6a: – Advocates are always considered when working with adults with communication issues. Specialist BSL advocates can be obtained via Re-Think

Recommendation 7: - Consider inclusion of hoarding of animals in both the hoarding policy and in local training

Recommendation 8: - Information about support available for unpaid carers (including friends and neighbours) should be cascaded to all staff working with adults in their own homes. (https://www.barnsley.gov.uk/services/adult-social-care/information-for-carers/carers-assessment/)

Recommendation 9: - When a next of kin is nominated, who is not a family member, conversations about family members should be held with the adult at the point of death any organisation with contact details for the family should notify them of the death.

Glossary

ASC- Adult Social Care

BH – Berneslai Homes

BMBC- Barnsley Metropolitan Borough Council

BHNFT- Barnsley Hospital NHS Foundation Trust

BSAB - Barnsley Safeguarding Adult Board

BSL – British Sign Language

CPA – Care Programme Approach- Multi-disciplinary mental health assessment

RDASH – Rotherham, Doncaster, and South Humber NHS foundation Trust (provided specialist MH/Deaf support to Tony)

SAR- Safeguarding Adult Review

SBAR -Situation, Background, Analysis and Recommendations

SWYPFT – South West Yorkshire Partnership Foundation NHS Trust (provided mental health support to Tony)

SYFR – South Yorkshire Fire and Rescue

SYP- South Yorkshire Police

References:

BSAB self-neglect and/or Hoarding policy - https://www.barnsley.gov.uk/media/kgekkobm/sn-and-hoarding-policy-v5-formatted-20231228-copy.pdf

Confidentiality: good practice in handling patient information. (https://www.gmc-uk.org/professional-standards/professional-standards-for-doctors/confidentiality/managing-and-protecting-personal-information)