Safeguarding Adult Review
'Anthony'

Overview report

August 2023

Condolences

This Safeguarding Adult Review (SAR) was initiated following the death of Anthony in January 2022. The Lincolnshire Safeguarding Adults Board (LSAB) would like to offer sincere condolences to Anthony's family and all those who knew him and have been affected by his death.

Governance

This SAR was commissioned by the LSAB. An independent author was commissioned for this review. The author was unable to finalise the review and therefore the final version was authored by Dr Amanda Boodhoo.

The author, who commenced the review declared that he had no conflict of interest in completing this review, and that he is independent of the LSAB and partner agencies.

Dr Amanda Boodhoo is the current Independent Chair of the LSAB Significant Incident Review Group – Adults (SIRGA) and is independent of all agencies who provided services to Anthony.

The report has been commissioned by, and written for, the Partnership and overseen by a multi-agency review panel of local senior managers and practitioners from the following agencies:

- United Lincolnshire Hospitals NHS Trust
- Lincolnshire Community Health Services NHS Trust
- Adult Care and Community Wellbeing Service
- East Midlands Ambulance Service
- Lincolnshire Fire and Rescue
- Lincolnshire Police
- Lincolnshire ICB (formerly CCG)
- Lincolnshire Partnership Foundation Trust

The details of the adult and their family, as well as the individuals providing care to them, have been anonymised in accordance with statutory guidance and best practice.

Contents

1.0 Introduction

1.1 The subject of this review is Anthony, who was 63 years of age at the time of his death. He lived with his brother, Ben, at rural farm premises. Anthony was described in agency records at various times as having a learning difficulty or learning disability, these at times are used interchangeably. There were other men living at the farm at various times, who were described variously as relatives, lodgers, or friends.

1.2 In July 2019, Anthony was found having collapsed at the farm and was admitted to hospital. At the time there were concerns over the poor living conditions and self-neglect behaviours being displayed by him. He was admitted to hospital suffering from epididymitis and heart failure. Epididymitis is where a tube (the epididymis) behind the testicles becomes swollen and painful.

Anthony was generally in a poor state of health. He was discharged two weeks later back to his home on the farm.

1.3 In December 2021, an ambulance was called to Anthony's home after he had been found collapsed by his brother. He was admitted to hospital with multiple pressure ulcers, which were infected, gangrene in both feet and other significant comorbidities. Again, concerns regarding Anthony's living conditions and his propensity to neglect himself were raised. He remained in hospital until the end of December 2021, when he was discharged home at his own request. Anthony was to receive care from the district nursing service.

1.4 In mid-January 2022, Anthony was again found collapsed at his home. He was admitted to hospital where he was found to have sepsis, acute kidney failure, gangrene, and neurological failure. Anthony died the day following his admission.

2.0 Why a review

2.1 The purposes of a SAR are to: -

- Learn from cases where there are clear concerns that agencies have not worked together as well as they might and which demonstrate areas of practice that could have been delivered more effectively, and additionally.
- Consider whether or not serious harm experienced by an adult, or group of adults, at risk of abuse or neglect, could have been predicted or prevented, and use that consideration to develop learning that enables the safeguarding adult's partnership in Lincolnshire to improve its services and prevent abuse and neglect in the future.
- Agree how this learning will be acted on, and what is expected to change as a result.
- Identify any issues for multi or single agency policies and procedures.
- Publish a summary report, which is available to the public.

2.2 The SIRGA first considered this case in relation to the referral for a SAR in February 2022. The review group was constituted from agencies with responsibility to make a determination on the necessity of a SAR. At this stage further information was required and a multi-agency chronology was prepared. The case was further discussed by the group in April 2022. After due consideration, the review group unanimously agreed that the case warranted a SAR.

2.3 A SAR panel was formed for this review and developed terms of reference (full details at Appendix A). The agencies identified as being involved in the case provided a report which focused on the key lines of enquiry identified by the terms of reference:

- Were the principles of Making Safeguarding Personal prevalent at all stages of the care and support afforded to Anthony?
- What was known about Anthony's background, his family, and his wider support network?
- What consideration was given to the impact of Anthony's mother's death and the loss of the support that she gave?

- Was self-neglect identified; if so, what was the approach? Was any history of self-neglect considered when undertaking assessments or making decisions? Was the geographical location of Anthony's home and its environment a factor in the self-neglect?
- Were there policies and procedures in place to support practitioners? If so, was there due regard to these? Were they effective and is there a need for any review or amendment?
- Was Anthony diagnosed with a learning disability or learning difficulty? What action was taken to fully understand and support this?
- Was Anthony's mental capacity assessed appropriately at key points?
- Were Anthony's care and support needs appropriately assessed? And, if so, what was the outcome?
- What preventative measures were considered and put in place to support Anthony?
- There were several male persons who featured in Anthony's life, either living at the same address or supporting him.
    - Was the relationship of these people considered or understood?
    - If they were supporting Anthony was the appropriateness of their support considered and was there consideration of carer assessments?
    - Were there any indications or signs of Anthony being exploited?
- What discharge planning was undertaken when Anthony was discharged from hospital in December 2021? Was appropriate consideration given to the history of self-neglect and other risks including tissue viability? Was there a multi-agency approach?
- Were safeguarding concerns identified and appropriately raised? If they were, was there an effective response, which included feedback to the referring agency?
- Was information effectively shared between agencies involved with Anthony? Was there a Team Around the Adult (TAA) referral and was there consideration of a lead professional?
- Was there an impact to Anthony, and the support that he received, from Covid and the associated restrictions?
- Identify any areas of good practice in the case that should be highlighted as positive learning examples. This should go beyond what is organisationally expected.

2.4 All agencies involved were asked to provide staff for a facilitated reflective workshop. This was attended by most agencies and where there was not representation the author spoke to representatives in separate interviews. Professionals engaged particularly well in the workshop and the discussion added value to the review, which is reflected in this report.

2.5 The timeframe considered by the review is from 1st December 2021 to 16th January 2022. Agencies were requested to consider significant events or information outside of this time period which influenced the decisions made during the period in its scope. The timeframe covers the period from the date in December 2021, immediately before Anthony was admitted to hospital due to self-neglect, to the date of his final hospital admission and death in January 2022.

3.0 Background

3.1 Anthony was from a large family; there had been six siblings who had lived with their parents who owned the farm premises. Two brothers died at relatively early ages (42 and 49) and two brothers lived out of the area and lost contact with the family. Anthony and his brother Ben remained living on the farm.

3.2 Both brothers were believed to have been reliant on their mother for support up until she went into residential care in March 2019, where she died in February 2020. There were two men, Colin, and Derek, who provided support to Anthony and his brother. Colin lived on the farm premises, and it is believed that Derek lived close by but had regular contact with Anthony and

his brother. The relationship and role of Colin and Derek has not really been understood by agencies, and they were variously described as ‘uncles’ or ‘friends’ in agency records.

3.3 Dating back to 2016 Colin is recorded as having contacted Adult Care Services (ACS) stating that he was the ‘lodger’ and raising concerns that Anthony had debt issues. At this stage Colin stated that Anthony had learning difficulties or a learning disability but was not clear which. A referral was made to Adult Care and Community Wellbeing Service (ACCW). Anthony was seen and it was noted that at this time he appeared well presented and in good health. Anthony was happy for the assessment to take place but felt he did not need support from ACCW. It needs to be acknowledged that this contact was historical, taking place five years prior to Anthony’s death.

3.4 In July 2019, ambulance and fire services were called to Anthony’s address following a report that Anthony had collapsed in his caravan and possibly having been in situ for up to 24 hours. The fire services were called to assist in removing Anthony from the caravan to the ambulance. Anthony was admitted to hospital and treated for epididymitis and heart failure. A referral for a Safe and Well (S&W) check was made by both the ambulance and fire services. The safe and well check is the fire service’s primary home safety intervention method where advice and support are offered. Concerns stated within the referral focused upon the poor living conditions in the caravan where Anthony had been living. There is evidence of ongoing effort by the fire service to undertake the safe and well check. This was achieved in October 2019. It was noted that the main property was in a poor state of repair, with some rooms having no lighting. Specific advice was given to Anthony and his brother regarding the repairs required and planned a follow up visit in six months.

Due to the pandemic, where face to face visits were restricted, this was delayed and took place in January 2022.

3.5 During the hospital stay in July 2019, both Colin and Derek visited Anthony and liaised with agencies. Colin informed the hospital Occupational Therapist (OT) that on discharge from hospital Anthony would be moving to the main house on the farm and that there was planned work to improve the conditions. Anthony had told staff that Colin and Derek supported him but there was not clarity over their role and relationship with Anthony.

3.6 The hospital requested that ACCW undertake an adult care assessment. A Community Care Officer (CCO) attended multi-agency disciplinary meetings (MDTs) on six occasions while Anthony was being cared for on the ward.

These meetings discussed the arrangements being made for Anthony’s discharge. Anthony declined the services of the Lincolnshire Reablement Service (LRS) and any support post his discharge, stating that he could cope and therefore the adult care assessment did not take place. There was conversation regarding Anthony requiring advocacy support to assist him with dealing with his mother’s estate post her death.

3.7 In August 2019, The Court of Protection (CoP) and Appointeeship Team contacted LCC Customer Service Centre. The intention of the referral from the CoP was to provide an advocate to support Anthony with the management of the estate. The outcome of the contact from the CoP was that LCC Customer Service Centre (CSC) requested a needs assessment to consider Anthony’s needs in addition to the support he may need regarding the estate. This is evidence of good practice.

An ACCW Social Worker was allocated the case and visited Anthony. At this time Anthony was being supported by Derek and Anthony invited Derek to be present during the assessment. The Social Worker recorded that there were no concerns regarding this. The hospital had raised concerns regarding Anthony returning to live in his caravan and his ability to mobilise. An Adult Care Assessment was completed, Anthony was supported by Derek during this process.

3.8 Following this, records suggest that Anthony returned from hospital to live in the main house, where he was sleeping in a downstairs room where there was no running water. He had to collect water in bottles. There was work planned to update the central heating in the house. ACCW were aware that Anthony had neglected his physical health in the past, but during the assessment he seemed aware of the need to care for himself. At the end of the assessment Anthony stated he

did not require support as he was managing with the support of Colin and Derek, but he required some help with managing his benefits, so a referral was made to the Wellbeing Team.

3.9 The Wellbeing Team visited Anthony on four subsequent occasions and had no concerns regarding the support being offered by Derek, who was reported as assisting Anthony to attend his medical appointments. Anthony's case was closed to the ACCW in October 2019.

3.10 In September 2019, Anthony was admitted to hospital due to atrial fibrillation. His medication was increased, and he was discharged home. During this admission, Anthony demonstrated the ability to meet his own care needs. Although currently there were concerns in terms of the conditions within the home, the hospital team were not aware of these. There was no evidence of any concerns being raised for Anthony or in relation to the property during this hospital admission. Clearly hospital staff do not have the opportunity to see the patient within their home environment.

3.11 During 2020 and most of 2021, there was limited agency contact with Anthony. Most of the contact was with his community health services or GP for routine appointments. There is evidence that both Colin and Derek continued to support Anthony on some of these appointments.

4.0 Engagement with the family of Anthony

4.1 The Independent Reviewer and LSAB Business Manager had the opportunity to speak with the family and friends of Anthony with whom he was in contact at the time of his death. There have been meetings with the family on two occasions. Their views informed this review. At the second meeting the LSAB Business Manager shared a summary of the report's findings. A further meeting has been planned to share the report in full. The SAR panel were grateful for the family contribution.

5.0 Review time period (1 December 2021 to 16 January 2022)

5.1 On 10th December 2021, an ambulance was called to Anthony's address on a report that he was showing signs of a stroke. He was found by the ambulance crew on the floor, unable to stand and was confused. Anthony was conveyed to hospital. The ambulance staff found the address very cluttered, with bags of rubbish raising a health risk. A safeguarding referral was made by the ambulance service and sent to Adult Social Care (ASC), Fire and the GP.

5.2 On admission to hospital Anthony was described as very unwell with gangrene in both feet and undressed pressure sores. There was evidence of self-neglect with faecal matter and tissues around his wounds. Anthony had been admitted unaccompanied and the hospital made 13 attempts to contact his next of kin. His condition was considered so serious on admission that end-of-life care was planned. After initial treatment, his condition started to improve, and the end-of-life care was stopped.

5.3 ASC received the safeguarding adult concern from the ambulance service. ASC was updated on Anthony's case on a regular basis whilst he was treated in hospital (five occasions).

5.4 During the period Anthony remained in hospital on this occasion there was evidence of appropriate referrals and although no formal MDTs were held there was evidence of multi-agency working to support Anthony's discharge. An MDT may have supported enhanced communication and coordination of actions agreed, including post discharge when referrals had been declined.

5.5 During Anthony's stay in hospital an OT visited the farm home address and deemed that the address was uninhabitable and not suitable for Anthony to be discharged to.

5.6 Anthony's mental capacity was assessed over two separate days whilst he was an inpatient at the hospital. This was completed in two parts, with a day between each discussion to ensure that Anthony's memory and capacity could be properly assessed. This is evidence of good practice. The assessment was to assess Anthony's discharge destination and whether he was able to make informed decisions regarding his care and support needs. It was clear during the second discussion that Anthony recalled the first discussion.

5.7 Anthony was clear that he wished to return to the farm where he previously lived. He felt that he would be supported by his brother and Colin. It was again expressed that there were improvements planned to the accommodation at the farm. Anthony was to be discharged with a catheter and was able to demonstrate that he could manage its care. The outcome of the assessment was that Anthony did have capacity to make decisions regarding his own care and support needs and it was his clear wish to return to his home.

5.8 Anthony was offered and accepted reablement care post his discharge, but the OT deemed that Anthony could not be safely supported at the home address and the situation would not be safe for staff. At this time Ben was offered a carer assessment but declined and although there is no evidence that Colin or Derek were offered a carer assessment it is important to note there was no obligation for them to be offered one and neither Colin nor Derek requested one.

5.9 ACCW made a referral to Age Concern. This referral was recorded as a request for assistance with heating and cleaning the property. This was followed up with a call to Ben who declined the support and stated that he had access to heaters. As Anthony had been assessed as having capacity it would have been good practice to have consulted him regarding the referral.

5.10 The CCO sought advice from the LCC Adult Safeguarding Team regarding concerns that Anthony was making unwise decisions. It was agreed that as it was deemed that Anthony had capacity to make the decision regarding his discharge and care, he therefore could not be prevented from returning home once medically well enough.

5.11 Whilst in hospital the ward staff sought advice from the specialist Learning Disability Nurse. As Anthony did not have a learning disability diagnosis, he did not meet the criteria for this service. The commissioned service does not currently extend to individuals with learning difficulties or autism. A business case is in the process of being developed to expand their service.

5.12 The outcome of the Adult Safeguarding Concern was that it did not meet the criteria for a Section 42 enquiry. It was agreed that Anthony would be discharged on 31st December 2021. There is evidence that the outcome of the Adult Safeguarding Concern was in line with the agencies' policies and procedures. Assessment practice included work to determine whether Anthony had any learning disabilities and whether this impacted on his capacity to make decisions about his care and support needs. There is also evidence of exploration as to whether Anthony understood that this safeguarding concern was raised due to his living conditions and overall presentation. Under the guidance within the Care Act, an enquiry under Section 42 must take place when an adult has care and support needs, is experiencing abuse and/or neglect and as a result of these care and support needs are unable to protect themselves against the abuse and/or neglect. The Local Authority will then have a duty to consider the concerns under a Section 42 enquiry and decide what action, if any, is required to help and protect the adult. In Anthony's case, he was assessed as having capacity to make decisions regarding his care and support needs and demonstrated awareness of the risks of going home and wanted to be home with his brother. He did not have a formal learning disability diagnosis and so did not meet the criteria for a Section 42 enquiry. It was at this point that Anthony was referred to the District Nurses, Wellbeing Team, and Neighbourhood Team as well as Age UK and the Housing Hospital Link Worker and so it was felt that he would still have support around him, despite him making the decision to return to a home in such a poor state of repair.

5.13 The hospital made a referral to the Community Nursing Team (CNT) on the day of the discharge. The referral requested assistance with dressings to Anthony's legs and assistance with his catheter. The referral made no mention of access concerns, infection control measures, safeguarding concerns or any concerns for lone workers attending the address.

Although the hospital referral omitted key information it is important to acknowledge that the discharge happened on a bank holiday, during the pandemic, at a time where there was a national directive to facilitate timely discharges due to bed pressures.

5.14 The first CNT visit was on 2 January 2022; this was undertaken by two staff who recognised the address was isolated. The staff were shown to Anthony by a man presumed to be his brother. Anthony was found to be staying in what was described as a brick-built outhouse. The condition of the building was poor, dirty, and cluttered. There was a halogen heater in the room and

Anthony stated he was warm. As a result of the concerns noted a Case Manager (CM) was requested to visit to assess the concerns.

5.15 The next CNT visit was on 9 January 2022; this was again undertaken by two staff. Anthony was seen and said to be cold to the touch but claimed to be warm enough. There was a heater present, but it was not on, and Anthony stated that it was too expensive to use. At this stage, the CM had not undertaken the review visit and it was planned to take place in a week's time.

5.16 The next visit took place on 13 January 2022; this visit was to remove the catheter. The property felt cold and was unclean. Following the removal of the catheter the nurse had to return later the same day to re-catheterise Anthony. The nurse spoke to the Complex Community Practitioner (CCP) about the poor living conditions. The CCP noted that there was a note on the electronic discharge document that there were safeguarding concerns, but there were no details of these. The nurse recorded that there was no reason to doubt Anthony's mental capacity.

5.17 On 16 January 2022, the CM visited the property with a nurse. There was no response, so they left the property and on returning to the office the CM called the phone number for Anthony. Colin answered the phone and stated that Anthony was unwell. Colin was advised to phone for assistance. CM followed up the call with Colin who informed them that on phoning 999 he had been informed that Anthony was not unwell enough for an ambulance, and that he had not managed to navigate the requests made when he called 111. The CM then called 111 and returned to the property.

5.18 On attending the property the CM and nurse found Anthony in bed in a poor condition, his bed was soiled, and he had chest pains. An ambulance was called. On arrival the ambulance service described Anthony as emaciated, hypothermic, confused, distressed and in pain. Anthony was taken to hospital. The ambulance crew raised a safeguarding concern regarding the condition of Anthony (who they felt had lain in this state for some time), and the condition of the property. The referral was completed with the comment that there was a serious risk of death if Anthony was discharged to the property.

5.19 On arrival in hospital it was established that Anthony had likely multi organ dysfunction syndrome, acute renal failure, neurological failure, cardiovascular failure, respiratory failure, and septic shock. He remained in hospital overnight and died the following day.

6.0 Discussion

This discussion has been structured under the key lines of enquiry identified in the terms of reference for the review.

6.1 Were the principles of Making Safeguarding Personal prevalent at all stages of the care and support afforded to Anthony?

What was known about Anthony's background, his family, and his wider support network?

What consideration was given to the impact of Anthony's mother's death and the loss of the support that she gave?

There were several male persons who featured in Anthony's life, either living at the same address or supporting him.

- Was the relationship between these people considered or understood?
- If they were supporting Anthony was the appropriateness of their support considered and was there consideration of carer assessments?
- Were there any indications or signs of Anthony being exploited?

6.1.1 Making Safeguarding Personal means that safeguarding is:

- Person led
- Outcome focused

- Engages the person and enhances involvement, choice, and control
- Improves quality of life, wellbeing, and safety

Making Safeguarding Personal must not simply be seen in the context of formal safeguarding enquiries as defined in the Care Act as a Section 42 enquiry, but in the whole spectrum of safeguarding activity. See paragraph 14.15 of the Care and support statutory guidance.

The six core principles for safeguarding adults (empowerment, protection, prevention, proportionality, partnership and accountability), as well as the wellbeing principle, are at the heart of Making Safeguarding Personal.

6.1.2 The LSAB has Making Safeguarding Personal embedded within its strategy.

6.1.3 In this case there is evidence of agencies working with Anthony to understand what his wishes were and seeking to fulfil these with Anthony's involvement. On the hospital admissions it was Anthony's clear wish that he return home.

6.1.4 An area which would have assisted all agencies was a greater understanding of Anthony's background and story. It is evident that there was a lack of knowledge across agencies regarding Anthony's circumstances and history. A greater understanding of this would have assisted agencies in providing a more personal approach.

6.1.5 Information provided by agencies demonstrates that there was awareness that Anthony's mother had died and there is evidence that consideration had been given to the impact in terms of support that Anthony may need following her death. In July 2019, the need for an advocate was identified and there was discussion with the CoP. There was exploration with Anthony of support that could be offered. At this time Anthony declined support.

6.1.6 The importance of agencies gaining an understanding of Anthony's background and story is highlighted during the case progression, where it becomes apparent that there is a lack of knowledge and understanding around those persons who were supporting Anthony. They were variously described as being friends, lodgers, or relatives but there was not a clear picture of their part in Anthony's life. Given the significant role they appeared to play, a better understanding of their involvement in Anthony's life would support professionals in their assessment of risks and protective factors. It was evident at the practitioner reflective event that some professionals had some unease about the relationship and questioned the motivation for providing support, however professionals did not feel able to further explore this as they had no direct evidence of any concern. More information could have been achieved by adopting a more professionally curious approach. The LSAB has developed a Professional Curiosity Resource Pack in December 2022 which will support practitioners in their work.

6.1.7 Whilst there is no evidence that these persons were exploiting Anthony, it would have been reasonable to be more inquisitive regarding their presence and role within Anthony's life. It may have been appropriate to ask why Anthony was living in a quite dilapidated caravan whilst others lived in the main house. It was recorded at various stages that his brother Ben had a learning difficulty, but it is not clear if this was fully explored. Ben was offered a Needs Assessment and Carers Assessment which he declined. Had Ben agreed to these assessments it would have offered an opportunity to gain greater insight into the potential impact of these factors.

6.1.8 For safeguarding, care, and support to be truly personal there needs to be a good understanding of the person being delivered the services and seeing the case from the perspective of the person. For this to happen effectively the person and their circumstances needs to be understood. A clear understanding of Anthony by professionals is not evident in this case.

Recommendation 1
The LSAB to seek assurance from agencies involved in this review that professional curiosity was reflected in their training and the Professional Curiosity Resource Pack has been promoted across their organisation with evidence of impact.

6.2 Was Anthony's mental capacity appropriately assessed at key points?

6.2.1 Anthony was admitted into hospital in July 2019. He had collapsed and both the fire and ambulance service attended to treat him and assist with his conveyance to hospital. Both services subsequently made referrals regarding the poor living conditions in Anthony's caravan and apparent self-neglect. Anthony was offered support from the LRS, which he declined. There is no evidence that at this time there were any concerns over Anthony's mental capacity, although the ACCW assessment recorded that Anthony was vague in giving details on how he would manage. It is relevant that on this admission Anthony stated that he would be supported by Colin and there were to be improvements to the farm living conditions. Records indicate the view that Anthony had the mental capacity to make the decisions around his care and support.

6.2.2 There was a short admission into hospital in September 2019, and again there is no record that Anthony's mental capacity was in doubt and therefore no indication to undertake a mental capacity assessment.

6.2.3 Anthony was admitted into hospital having collapsed again in December 2021, on this occasion he was particularly unwell, and both his living conditions and state of health gave rise to concerns of self-neglect. On admission, Anthony clearly lacked capacity for care and treatment, due to his confused state but it is recorded that this quickly improved.

6.2.4 Anthony had his mental capacity assessed to assist in establishing his discharge destination and whether he was able to make informed decisions on his care and support needs. This assessment took place over two discussions on two separate days, which were a day apart. It was stated in the reflective event for this review that this afforded the opportunity to establish whether there was consistency in the assessment. Anthony was able to recall the first conversation when he was seen on the second occasion. The approach to undertaking the assessment of Anthony's mental capacity was robust and is evidence of good practice.

6.2.5 The review report from the hospital states that there is limited recording, reflection or discussion about self-neglect, his presentation on admission and how he will care for himself. The report from ACCW when dealing with the same assessment records that there was discussion regarding health and safety, who was to support Anthony and whether he would be able to cope with a catheter at home. A 'tell and show' approach was used in relation to the catheter, with Anthony explaining how he could empty it and then demonstrating this to the assessor. This demonstrates good evidence of consideration of executive functioning and is evidence of good practice.

6.2.6 Information was also given to professionals that there was improvement work planned at the farm. This same assertion had been made in 2019 and although there was some evidence of improvements having been made, including the sourcing of heaters, kitchen ware and some maintenance work being completed, there was still significant work to be done to improve the home conditions. There was a potential opportunity to ask whether the improvements to home conditions would ever transpire and how capable Anthony and those who supported him were to bring about this change despite their best stated intention. However, it needs to be acknowledged that Anthony was assessed at this point, as having capacity and in cases where self-neglect is a concern, practitioners are faced with having to make difficult decisions in extremely challenging situations in relation to mental capacity, particularly where an apparently capacious person refuses services.

6.2.7 Staff undertaking the assessment following the admission in December 2021, spoke powerfully at the practitioner reflective event on how they had clear concerns that Anthony's health was at significant risk should he return to his home address. They were very keen that there should be professional focus on Anthony and did their best to achieve this by making referrals (dealt with in more detail in section 5.4). They felt disempowered to take any action as Anthony was deemed to have mental capacity for his care and wished to return to his home. Advice was sought from a Safeguarding Lead within the hospital and the Local Authority, and the advice was that as Anthony had mental capacity and therefore the right to make decisions regarding his care and support and he wished to return home there were no grounds to keep him in hospital against his wishes.

6.2.8 The reflective workshop for this case involved a discussion and provided assurance that that there was a good understanding of mental capacity on the decisional basis, but that professionals would benefit from a greater understanding of executive functioning. Executive function is an umbrella term used to describe a set of mental skills that are controlled by the frontal lobes of the brain. When executive function is impaired, it can inhibit appropriate decision-making and reduce a person's problem-solving abilities.

Executive functioning is part of the capacity assessment and there was no reason to doubt Anthony's capacity at that point; however, the exploration of the reason for Anthony's decision making was not evident which reflects the importance of using professional curiosity in practice. Anthony had lived in his current home for many years, and it needs to be acknowledged that this way of life may have been all he had ever known.

6.2.9 NICE guidance also promotes the assessment of executive capacity. It recommends that assessment should include real world observation of a person's functioning and decision-making ability, with a subsequent discussion to assess whether someone can use and weigh information and understand concerns about risks to their wellbeing. In the care provided to Anthony there is evidence of assessment of executive functioning, examples being, catheter care, not using heating due to cost, not walking to the GP because he gets breathless, which demonstrated that Anthony could apply the theoretical to real world situations and weigh his choices.

6.2.10 The Hospital Trust involved in this case has delivered executive functioning training to a number of relevant staff and stated that it has been well received. Consideration is being given to rolling this out, following some amendments, to other relevant staff and agencies.

Recommendation 2
The LSAB should consider ways of raising awareness to enhance relevant practitioners' knowledge of executive functioning and the importance of exploring choices to further assist them in undertaking holistic mental capacity assessments.

6.3 Was self-neglect identified, if so, what was the approach? Was any history of self-neglect considered when undertaking assessments or making decisions? Was the geographical location of Anthony's home and its environment a factor in the self-neglect?

Were there policies and procedures in place to support practitioners, if so, was there due regard to these? Were they effective and is there a need for any review or amendment?

Was information effectively shared between agencies involved with Anthony, was there a TAA referral and was there consideration of a lead professional?

What preventative measures were considered and put in place to support Anthony?

6.3.1 At the points when Anthony required medical intervention due to him being very unwell, there were concerns around self-neglect. However, at other times there were long periods when Anthony appeared to be meeting his own needs without professional support. At the points where there were concerns around self-neglect, agencies were persistent in their efforts to address the concerns. There is evidence of communication and information sharing appropriately taking place between agencies and actions taken include a referral to occupational therapy for a home environment assessment, referral to the wellbeing team for support, exploration around home improvement grants, facilitation of some repairs and fitting of safety equipment. In subsequent assessments the history of self-neglect is recorded and there is evidence of it informing the ongoing assessment process. Anthony lived on a farm in a remote area. The property lacked basic facilities. Anthony had lived in this environment throughout his life and the fact that this is "all he had ever known" is likely to have impacted upon the extent to which he shared the concerns that professionals identified.

6.3.2 Working with persons who self-neglect is more effective where practitioners build a rapport and gain confidence of the person, that they understand the self-neglect including the person's lived experience, work at the person's pace with confidence, undertake thorough assessments of care and support needs, constantly review the person's mental capacity to make self-care decisions

and undertake full risk assessments. A person-centred approach is central to establishing the trust of the person and understanding the reasons for the neglect.

For more information see:

- Working with people who self-neglect (researchinpractice.org.uk)
- Self-neglect and safeguarding adult reviews: towards a model of understanding facilitators and barriers to best practice (openrepository.com)

6.3.3 The Care Act 2014 includes self-neglect as a category of abuse, but the statutory guidance acknowledges that self-neglect will not always result in a Section 42 enquiry; this will depend on an assessment as to whether the adult is able to protect themselves by controlling their own behaviour. See para 14.15 of the Care and Support Statutory Guidance

6.3.4 The Mental Capacity Code of Practice states:

There may be cause for concern if somebody:

- repeatedly makes unwise decisions that put them at significant risk of harm or exploitation or
- makes a particular unwise decision that is obviously irrational or out of character.

These things do not necessarily mean that somebody lacks capacity. But there might be need for further investigation, taking into account the person's past decisions and choices.

6.3.5 These factors have led to Safeguarding Boards developing processes to support those persons who display traits of self-neglect that present a potential risk to themselves or other persons but who are otherwise deemed to have mental capacity. The Safeguarding Boards' guidance is based on research, findings from SARs and good practice. The guidance generally encourages a multi-agency approach, putting in place a support plan to work with the person, having a lead professional to coordinate activity and a pathway for escalation where there continues to be, or there is, increased risk.

6.3.6 The LSAB has both a Hoarding Protocol and Self Neglect Protocol. These, however, were not in place in the period covered by this review. At different times Anthony's property was assessed as level 5 and level 8 on the clutter scale. Being at level 8 would have put the case in the upper tier with a safe and well visit from the fire service and consideration of a notification to the Vulnerable Adult Panel (VAP) and consideration of a TAA.

6.3.7 The LSAB Self-Neglect Protocol acknowledges that a multi-agency approach is key when working with adults who self-neglect. It mentions multi-agency meetings and multi-agency support plans but does not offer guidance as to how these may be achieved. It may be that this guidance would benefit from a pathway for practitioners to follow and from being more explicit on the steps to follow. Some examples also include a suite of documents to support practitioners at the various stages, examples being a template for a self-neglect plan, agenda for a multi-agency meeting and a self-neglect assessment tool.

6.3.8 In reviewing the response by agencies to the needs presented by Anthony there was evidence of persistent attempts to address the concerns around self-neglect. There was ongoing communication between agencies. However, there was no single lead professional identified who could have supported a more coordinated approach.

Across the country, Safeguarding Boards have variously developed processes and protocols to help support adults who have mental capacity but who present as complex cases, often involving self-neglect (VARM – Vulnerable Adults Risk Management, CARM – Complex Adult Risk Management and MARM – Multi-Agency Risk Management). These processes guide professionals on actions available in the complex cases and assist to navigate and escalate concerns where there remains a risk.

The LSAB commissioned a previous SAR (TH19), which was published in 2017. The subject of that SAR had complex needs and there were challenges for services in keeping the person engaged in care. Following this review, work was undertaken by the LSAB, in partnership with the Community Safety Partnership to:

i) Map out the partnership's forums, their roles, and functions relevant to safeguarding adults.

ii) Agree the interface and governance between these partnerships to avoid duplication and make the most effective use of resources.

Part of this work resulted in the TAA initiative being introduced as a pilot. The intention was to support the work of the VAP or similar District Council multi-agency meeting. The role of the VAP, or similar, will continue to ensure a coordinated multi-agency response to complex cases, aiming to provide access to the appropriate accommodation, support, and assistance. However, a Triage Tool, was introduced, with a scoring system with a defined level at which the involvement of the TAA could be considered.

The aim of the TAA is to achieve change where more traditional engagement and intervention methods have not been as successful as anticipated, or change may not have been maintained.

There is evidence of ongoing work within Lincolnshire, to raise awareness of TAA and VAPs, which includes an event, which took place in June 2023. This one-day event brought together over 100 practitioners from the voluntary, statutory, and independent sectors who work with individuals and families with complex needs.

6.3.9 Across Lincolnshire there are seven District Councils, each with their own processes and decision-making bodies. This poses a challenge in implementing a consistent approach. However, Lincolnshire's TAA process which is referenced in the Self Neglect Protocol and on both the Local Authority and Safeguarding Board website, works with what is available in each area. The TAA process is accessed through a referral to the VAP or similar structure. The TAA Standard Operating Procedures state that, 'The Team Around the Adult will support the approach offered through the Vulnerable Adult Panel and work with the particularly complex cases. Usually this is where a more creative approach is required in order to reach out to people in the community and 'go to them,' particularly if they do not wish to engage with services.'

Find out more on Lincolnshire's Team Around the Adult standard operating procedures.

6.3.10 The TAA process is structured around the District Councils. The TAA process is clear that a request for a TAA can be made where there are needs in addition to housing needs. Although Anthony's circumstances may not at face value have appeared to fit the criteria, the TAA define housing needs quite broadly so there can be a less direct link.

6.3.11 The information for TAA is available on both the Local Authority and LSAB websites. Both sites contain the operating procedures as well as clarity on the role of the VAP, including a flow chart, which states "the District Council identify other needs in addition to housing," as the step before the triage tool is used.

The information is supported by a case study and film which involves a person who owned their property.

There is no evidence of Anthony coming to the attention of the VAP or similar, so a request for a TAA was not made.

At the reflective workshop, the staff seeking support for Anthony on his discharge in December 2021 were unaware of the TAA process and their ability to access the VAP in this case. This was discussed at a panel, and it was acknowledged that those attending the workshop may not have known about the TAA as it would not be them making the referrals. The route for staff to report concerns within their organisations was well established and it would not be necessary for these staff to know all of the possible onward referral pathways. The teams these staff referred to would be responsible for making referrals and these team members have a good understanding and links to the VAP via the Neighbourhood teams.

6.3.12 There is evidence of preventative measures being used to try to support Anthony at various stages such as the wellbeing service but most of these were short term and did not form part of a coordinated plan. The TAA or a similar process to support complex cases by bringing a multi-agency and creative approach may have assisted Anthony and his carers and this approach may have been more readily accepted. The challenge of providing effective support and

intervention for adults with complex needs has been identified in the current review and the previous review (TH19).

Recommendation 3
The LSAB should review the guidance given to practitioners on self-neglect and hoarding to ensure the learning from this review is incorporated

Recommendation 4
The LSAB should work with District Councils to gain assurance that practitioners have direct access to information on the process across each district and that these processes are effective for adults with complex needs.

6.4 What discharge planning was undertaken when Anthony was discharged from hospital in December 2021, was appropriate consideration given to the history of self-neglect and other risks including tissue viability? Was there a multiagency approach?

Was there an impact on Anthony, and the support that he received, from Covid and the associated restrictions?

6.4.1 When Anthony was in hospital in 2019 it was noticeable that there were almost daily, six separate MDT meetings which were attended by professionals. During these, the safeguarding referral made by the ambulance service was discussed and what measures were being put in place by Anthony's support network to improve his living conditions. This contrasts with the approach on his admission in December 2021 where, although there was evidence of multi-agency working to support discharge, there is no evidence of formal MDT meetings.

6.4.2 The reasons for the lack of a formal multi-disciplinary approach were explored in both the panel meetings and reflective workshop for this case. The pressures brought about by Covid, and the time of the year contributed to this. Anthony was discharged on 31st December 2021, he was medically fit and wanted to return home. There would have been a pressure for bed space, and this had to be balanced against the reduced capacity that the Christmas and New Year would have presented to all agencies who may have been expected to provide support.

6.4.3 Referrals were made to the Neighbourhood Team, Wellbeing Service and Age Concern but these did not provide the longer-term support that Anthony may have required. This was in part due to Anthony declining services. The request to Age Concern was for a clean of the property and a potential grant for heating. This was resolved with a phone call to Anthony's brother who informed Age Concern that this support was no longer required. Anthony was not spoken to, and the service being declined appears not to have been passed back to the referring agency. Had there been feedback it would have allowed for a review.

6.4.4 The Hospital Trust made a referral to the district nursing service on the day that Anthony was discharged, this was News Year's Eve, and the referral was made by email. The referral requested a home visit for dressings to Anthony's legs and catheter care. There had been no communication between the district nursing service, ACCW or the hospital prior to the discharge. The referral did not contain any information on the safeguarding concerns, previous concerns regarding neglect or any information on concerns regarding staff attending the property alone. This is surprising bearing in mind the OT had previously deemed that the property was not safe for care staff to attend.

6.4.5 The district nursing service had previous contact with Anthony in 2019, where the heart failure nurse had supported him for a short period. There were concerns raised at this time regarding lone staff attending the property, but those concerns do not seem to have been considered when the new referral was made. This information would have assisted those undertaking the more recent referral.

6.4.6 The first District Nurse visit was two days after Anthony's discharge. Immediately there were concerns regarding the environment that Anthony was living in. There were no concerns over his capacity, but he was living in what was described as an outhouse part of the building, which was described as unclean and cluttered. The nurse undertaking the visit was sufficiently concerned to raise the case with a Case Manager (CM). Unfortunately, the referral passed to the CM did not provide any priority and the CM, due to the time of the year and capacity issues, did not become involved until nearly two weeks later.

6.4.7 It was on the visit on 16th January 2022, by the nurse and CM that no response was received. The nurse and CM then displayed tenacity in following the initial no reply at the address, with a phone call and further visit to establish that Anthony was unwell and required urgent medical attention which they facilitated. The district nursing service now have in place daily 'Be Safe' Meetings to discuss cases of concern, the reflective learning event felt that had these meeting been in place at the time of Anthony's discharge the concerns regarding his environment would have been escalated more effectively.

6.4.8 The initial information sharing between the hospital and the district nursing service was not effective as the nursing service was not aware of the previous concerns or the fact that their service was effectively the only service involved in supporting Anthony at this time. This knowledge would also have been assisted by the nursing service exploring their own records, which would have allowed the nursing service to escalate the concerns over the conditions in which they found Anthony more quickly. They were not aware that the OT had previously deemed that the home address was not appropriate for Anthony to be discharged to and that there were safety concerns for the staff attending the address to provide support. This lack of joined up information sharing would have been alleviated by a MDT discharge meeting, with a clear escalation plan should the concerns considered at the time of Anthony's discharge become a reality.

Recommendation 5
United Lincolnshire Hospital NHS Trust should provide assurance that their discharge planning process includes the sharing of all relevant information with community staff if community staff are providing ongoing services. This would include information relating to safeguarding, environment, and access issues.

Recommendation 6
Lincolnshire Community Health Services NHS Trust should provide reassurance to the LSAB that concerns over cases are effectively identified and appropriately escalated in a timely way by the 'Be Safe' meetings

6.5 Was Anthony diagnosed with a learning disability or learning difficulty, what action was taken to fully understand and support this?

6.5.1 The Equality Act 2010 ensures there is consistency in what an organisation does to provide services in a fair environment and comply with the law. This includes all the people who use its services, their family and friends and other members of the public. The protected characteristic of disability includes learning disability.

Read Lincolnshire safeguarding adults board multi-agency safeguarding policy.

6.5.2 At various stages of this case Anthony was described as having a learning disability or learning difficulty. There is no evidence established in this review that indicates that Anthony had a diagnosed learning disability. The very limited information received from the GP would indicate that the only mention of a learning disability was on Anthony's hospital discharge in December 2021.

6.5.3 Around the time of the hospital discharge in December 2021, advice was sought from the specialist Learning Disability Nurse. Although it has been confirmed that advice was given by the Learning Disability Nurse, this is not recorded in the notes by ward staff.

6.5.4 If there is not clarity on whether a person has a disability, agencies will be unable to effectively make the necessary reasonable adjustments. The confusion regarding whether there was a learning disability or learning difficulty required clarification and this would have involved some professional curiosity, and also feeds into the previous discussion of achieving a good understanding of Anthony's history and Making Safeguarding Personal. There is also an important point to be made on the correct use of language. There is a tendency to interchange the use of learning disability and learning difficulty as terms. All professionals should seek to use the correct term, and evidence and record the basis of the use of the term. Otherwise, there is a risk that a term is repeated without basis until it becomes a 'recorded fact' which is difficult to source the origin of.

6.6 Were Anthony's care and support needs appropriately assessed and if so, what was the outcome?

Were safeguarding concerns identified and appropriately raised? If they were, was there an effective response, which included feedback to the referring agency?

6.6.1 When Anthony was admitted to hospital in July 2019, a request was made for ACCW to undertake an Adult Care Assessment. As previously discussed, during the 2019 hospital admission Anthony was very well supported by MDT meetings. During these the assessment was discussed, and Anthony declined an assessment, and it was apparent that he was going to be significantly supported by Colin and Derek. As Anthony declined the assessment one was not required to take place. See para 6.16 of the Care and Support Statutory Guidance.

6.6.2 In September 2019, Anthony was admitted to hospital for an overnight period and the hospital raised concerns about Anthony returning to live at the property in a caravan. ACCW undertook a home visit post discharge and completed a Care Assessment. Anthony was supported by Derek during this assessment. On completion of the assessment Anthony declined support from ACCW, stating that he was adequately supported by Colin and Derek. Anthony was referred to the Wellbeing Team, who supported him with benefit application.

6.6.3 When Anthony was admitted to hospital in December 2021, with very poor health (multiple pressure sores), a safeguarding referral was made by the hospital, who reported the information they had received from the ambulance service. The ambulance service, appropriately, also made a referral regarding self-neglect later on the same day, requesting an assessment of care and support needs, carer package, medicines management, cleaning, and waste removal. The ambulance referral was added to the hospital referral.

The outcome of the concern was that it did not meet the criteria for a Section 42 enquiry. This outcome aligned with the available policy. At this point in time Anthony was assessed to have capacity to make decisions regarding his care and support needs and demonstrated awareness of the risks of going home and wanted to be home with his brother.

In reaching this decision, there were conversations between the hospital worker and safeguarding team which demonstrate that the safeguarding team sought assurance regarding capacity assessment and the planned actions and confirmed that the hospital worker was taking the lead in liaising with relevant agencies to put plans in place for assessment/discharge.

6.6.4 The referrer from the hospital and the hospital safeguarding team were made aware that the referral did not meet the criteria for enquiry under Section 42 on the day of discharge.

However, the previously raised safeguarding concerns were not passed to the district nursing service by the hospital.

6.6.5 There is evidence that Ben (the brother) was offered a carers assessment, which he declined. The information drawn from agencies for this case indicates that Colin and Derek were providing support to Anthony and were viewed as a protective factor.

As discussed earlier in this report, the Local Authority did not owe a duty to provide a carers assessment as neither appeared to have care needs, which is why it was not offered.

Considering their role, both Colin and Derek could have requested carer assessments; however, they did not do this. When spoken to as part of this review Colin stated that had an offer for a carer assessment been made, he would have accepted it.

It is of note that following this feedback from the author, an adult care worker visited Colin and offered a carers assessment. This was declined on the basis that he had no care needs and no caring responsibilities; his needs were medical and were being met.

6.7 Identify any areas of good practice in the case that should be highlighted as positive learning examples. This should go beyond what is organisationally expected.

6.7.1 There are some examples of joined-up working, involving the fire service to visit and assess Anthony's living conditions.

There is evidence of examples of good practice in the approach taken to assess mental capacity.

The OT was clear in their position that Anthony's home was not suitable as a discharge address for Anthony in December 2021 and that it was not a safe environment for staff to attend and administer care.

The district nursing service demonstrated tenacity when they attended Anthony's address but were unable to get a response and their action led to him being admitted to hospital.

7. Actions Already Progressed

7.1 It is important that agencies do not wait until the SAR process has been completed before they identify and make changes to practice, policy, procedure, guidance or training. Other published SARs on similar topics can also be helpful sources of information on changes that can be made. Since Anthony's death the LSAB and partners have carried out a number of initiatives to support practice development:

- A self-neglect working group has been established.
- The self-neglect protocol has been reviewed and updated.
- A multi-agency workshop was held, applying, and testing the Self-Neglect Protocol against the emerging learning from the Anthony SAR
- Further learning from the multi-agency workshop is being used to inform the development of pathways and resources to support practitioners.
- Plans to audit the effective use of the LSAB self-neglect guidance has been included in the revised LSAB Quality Assurance Framework
- Ongoing programme of meetings to further develop the TAA approach.
- TAA conference with over 100 attendees from across the agencies

8. Conclusions

8.1 Self-neglect is a complex, multi-dimensional concept. There is no single standard intervention, and the response needs to be one of flexibility, ensuring a fit with the circumstances of the individual, balanced with risk, safety, and proportionality. In preserving respect for an individual's autonomy, it has to be acknowledged that risk can only be moderated, not eradicated.

The case of Anthony is a sad, but all too familiar, one seen nationally, where professionals are faced with the dilemma of a person having mental capacity, declining services but demonstrating escalating risk to themselves by self-neglecting their health and care. The application of mental capacity law, which emphasises the need to balance paternalism (protecting a person who lacks capacity from harm) against autonomy (allowing the person to make their own decisions) wherever possible poses significant challenges to professionals. This was clearly a challenge that professionals involved in the care of Anthony faced.

When the family and the friends who supported Anthony were spoken to as part of this review, they felt that Anthony should not have been allowed to return home in December 2021, but of course this was Anthony's strong and recorded wish. In undertaking this review, it is important to avoid hindsight bias and recognise the limitations to what can be done when a person has mental capacity to make their own decisions about how they live. In the case of Anthony, professionals needed to find a balance between respecting his autonomy and fulfilling a duty to protect his health and wellbeing. In reviewing the evidence as part of this review, professional decision making was appropriate and there was nothing they could have done to change the outcome. However, the learning that the partnership is in the process of taking forward and which it will need to continue to progress, has the potential to improve the lived experience of individuals with similar experiences to Anthony in the period leading up to their death.

8.2 All evidence and experience indicate that self-neglect and complex cases can only be effectively managed by a coordinated multi-agency approach, relying on good communication and information sharing, a clear and agreed plan, with routes to escalation and a lead professional. For this to happen there needs to be a clear and agreed framework. In Lincolnshire, this could be provided by the TAA but there is a need for clarity on how this approach can be accessed and consistently used. Currently the TAA service is provided by two practitioners and therefore any further development would have resource implications and would require consideration by the partners.

Recommendation 7
The LSAB to receive assurance that partners have considered and agreed the implementation of a framework to be used to respond to cases that are complex, including those individuals where there are concerns regarding self-neglect, who may own their own home, have capacity but make decisions that cause professionals concern regarding their self-neglect. The framework should include an agreed "Self-Neglect Pathway."

9. Recommendations

Recommendation 1

The LSAB to seek assurance from agencies involved in this review that professional curiosity was reflected in their training and the Professional Curiosity Resource Pack has been promoted across their organisation with evidence of impact.

Recommendation 2

The LSAB should raise awareness to enhance relevant practitioners' knowledge of executive functioning and the importance of exploring choices to further assist them in undertaking holistic mental capacity assessments.

Recommendation 3

The LSAB should review the guidance given to practitioners on self-neglect and hoarding to ensure the learning from this review is incorporated.

Recommendation 4

The LSAB should work with District Councils to gain assurance that practitioners have access to information on the process across each district and that these processes are effective for adults with complex needs.

Recommendation 5

United Lincolnshire Hospital NHS Trust should provide assurance that their discharge planning process includes the sharing of all relevant information with community staff if community staff are providing ongoing services. This would include information relating to safeguarding, environment, and access issues.

Recommendation 6

Lincolnshire Community Health Services NHS Trust should provide reassurance to the LSAB that concerns over cases are effectively identified and appropriately escalated in a timely way by the 'Be Safe' meetings.

Recommendation 7

The LSAB to receive assurance that partners have considered and agreed the implementation of a framework to be used to respond to cases that are complex, including those individuals where there are concerns regarding self-neglect, who may own their own home, have capacity but make decisions that cause professionals concern regarding their self-neglect. The framework should include an agreed "Self-Neglect Pathway."

Appendix A – Terms of Reference

Terms of Reference

Safeguarding Adult Review

Anthony

Introduction

A notification for this case was received from Lincolnshire Community Health Services NHS Trust regarding a potential SAR. The notification was discussed at the SIRGA meeting on 10 February 2022 and April 2022, where it was decided that the case met the criteria for a SAR.

Background

Anthony was 63 years of age when he died in hospital. It is believed that Anthony had a learning disability but there is no clear information, at this stage, that this was a diagnosed condition.

In July 2019, Anthony was discovered on the floor of his caravan having collapsed. There was evidence of self-neglect. His living conditions were seen to be very poor, and he had multiple wounds on his body. Anthony was admitted to hospital until August 2019. He was discharged to live in a house on the family farm.

There was, over a period of time, reference to various males who were known to or supported Anthony, these were referred to as his brother, uncle, or friend. Anthony was supported by the Wellbeing Team.

In December 2021, Anthony was again admitted to hospital due to self-neglect. Anthony was admitted with multiple pressure ulcers, lower limb cellulitis and severe sepsis. Anthony was treated in hospital, at the end of December Anthony wished to return home. His mental capacity to make this decision was assessed and it was determined that he had capacity for this. There were concerns at the time of Anthony's discharge from hospital regarding the suitability of the home conditions (no heating or running water). Anthony was discharged to the home address and the case was closed to Adult Care Services.

Anthony was visited on five occasions by community nurses, there were consistent concerns regarding Anthony living in an out-building that was not suitable. The building was cluttered, and Anthony's bedding was soiled.

In January 2022, the address was visited by the ambulance service who raised concerns over the state of the property and whether it was structurally safe. The ambulance service raised a safeguarding concern.

Later in January 2022, Anthony was found by community nurses in his bed in the outhouse, his bed was soiled. It appeared that Anthony had been in this condition for some time. Anthony was conveyed to hospital by ambulance. Anthony was suffering from multi-organ disfunction, septic shock and extensive, scrotal, and lower limb cellulitis. Within 24 hours of hospital admission Anthony died.

Legal Framework

Under Section 44 of the Care Act 2014, Safeguarding Adults Boards must arrange a Safeguarding Adults Review (SAR) when an adult in its area dies as a result of abuse or neglect, whether known or suspected, and there is concern that partner agencies could have worked more effectively to protect the adult.

The Care and Support Statutory Guidance states that SARs should seek to determine what the relevant agencies and individuals involved in the case might have done differently that could have prevented harm or death. This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again. Its purpose is not to hold any individual or organisation to account.

Review Scope

The review will include information in relation to:

Name: Anthony

The timeframe the review will consider is from 1 December 2021 to 16 January 2022. There may be significant events or information outside of this time period which influence the decisions made during the period in its scope. If information is identified, it will be included.

Review Principles

The review will be underpinned by the following principles, as set out in the Care Act 2014 Statutory Guidance.

- there should be a culture of continuous learning and improvement across the organisations that work together to safeguard and promote the wellbeing and empowerment of adults, identifying opportunities to draw on what works and promote good practice.
- the approach taken to reviews should be proportionate according to the scale and level of complexity of the issues being examined.
- reviews of serious cases should be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed.
- professionals should be involved fully in reviews and invited to contribute their perspectives without fear of being blamed for actions they took in good faith.
- families should be invited to contribute to reviews. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.

This review will also follow the approach set out by the SCIE Quality Markers for undertaking SARs.

Of key importance will be the engagement with family members and all organisations involved.

Methodology

The review will be conducted using a blended approach, including:

- A review of all relevant agency information undertaken by a person independent of any of the organisations involved.
- A SAR panel comprised of relevant and nominated senior persons representative of the agencies involved to provide advice and support to the reviewer in regard to local arrangements and existing policies/procedures.
- Early discussions with the family to agree to what extent and how they wish to be involved, and to manage expectations.
- Appropriate involvement of professionals and organisations who were working with the adult so they can contribute their perspectives without fear of being blamed for actions taken in good faith.
- Individual and integrated chronology reports from agencies who were working with the adult.

The methodology will be supported by a Terms of Reference that sets out the focus and scope of the SAR, timeframes within which it will focus, roles, expectations and outcomes required.

Agencies expected to contribute to the SAR process:

- United Lincolnshire Hospitals NHS Trust
- Lincolnshire Community Health Services NHS Trust
- Lincolnshire Adult Care Services
- Age Concern
- East Midlands Ambulance Service
- Lincolnshire Fire and Rescue

- Lincolnshire Police
- Lincolnshire ICB (formerly CCG)
- Lincolnshire Partnership Foundation Trust

Key lines of enquiry

- Were the principles of Making Safeguarding Personal prevalent at all stages of the care and support afforded to Anthony?
- What was known about Anthony's background, his family, and his wider support network?
- What consideration was given to the impact of Anthony's mother's death and the loss of the support that she gave?
- Was self-neglect identified, if so, what was the approach? Was any history of self-neglect considered when undertaking assessments or making decisions? Was the geographical location of Anthony's address and the environment a factor in the self-neglect.
- Were there policies and procedures in place to support practitioners, if so, was there due regard to these? Were they effective and is there a need for any review or amendment?
- Was Anthony diagnosed with a learning disability or learning difficulty, what action was taken to fully understand and support this?
- Was Anthony's mental capacity assessed appropriately and key points?
- Were the care and support needs of Anthony appropriately assessed and if so, what was the outcome?
- What preventative measures were considered and put in place to support Anthony?
- There were a number of male persons who featured in Anthony's life, either living at the same address or supporting him.
    - Was the relationship of these people considered of understood?
    - If they were supporting Anthony was the appropriateness of their support considered and was there consideration of carer assessments?
    - Were there any indications or signs of Anthony being exploited?
- What discharge planning was undertaken when Anthony was discharged from hospital in December 2021, was appropriate consideration given to the history of self-neglect and other risks including tissue viability? Was there a multi-agency approach?
- Were safeguarding concerns identified and appropriately raised? If they were, was there an effective response, which included feedback to the referring agency?
- Was information effectively shared between agencies involved with Anthony, was there a TAA referral and was there consideration of a lead professional?
- Was there an impact to Anthony and the support that he received from Covid and the associated restrictions?
- Identify any areas of good practice in the case that should be highlighted as positive learning examples. This should go beyond what is organisationally expected.

Parallel Processes

HM Coroner has concluded that there will be no inquest in this case. There are currently no other parallel processes.

Publishing

It should be noted by all agencies that the SAR report will be published once complete unless it would adversely impact on the adult or the family.

Reference to the adult in the report may be anonymised further prior to publishing. This will be following consultation with the adult/family and time allowed to reflect on how they would like the adult to be referred to.

Consideration should be given by all agencies involved in regard to the potential impact publishing may have on their staff and ensure that suitable support is offered, and that staff are aware in advance of the intended publishing date.

Whenever appropriate an 'Easy Read' version of the report will be published.