Shropshire Safeguarding Community Partnership

Safeguarding Adult Review

Patrick

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Introduction

Shropshire Safeguarding Community Partnership is a single structure taking on the functions of the Safeguarding Adult Board, Children's Safeguarding and Community Safeguarding Partnerships.

Under Section 44 of the Care Act 2014, the Partnership has a statutory duty to undertake a Safeguarding Adult Review if the following is met:

a) *there is reasonable cause for concern about how the Safeguarding Adult Board, members of it or other persons with relevant functions worked together to safeguard the adult, and*

b) *the adult had died, and the Safeguarding Adult Board knows or suspects that the death resulted from abuse or neglect…, or*

c) *the adult is still alive, and the Safeguarding Adult Board knows or suspects that the adult has experienced serious abuse or neglect.*

The Safeguarding Adult Board may also arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

This review is undertaken under section 44 Care Act (2014) and is a mandatory review.

The purpose of a Safeguarding Adult Review is to determine what the 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 in practice to prevent similar harm occurring again. Reviews should help to achieve understanding for individuals, families and friends of adults who have died or been seriously abused or neglected.

Reviews do not to hold any individual or organisation to account. Other processes exist for that, including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation, such as the Care Quality Commission and the Nursing and Midwifery Council, the Health and Care Professions Council, and the General Medical Council. It is for each agency to consider what action, if any, is required outside this process.

Shropshire Safeguarding Community Partnership will need to examine each of the considerations made by the author, decide which ones it accepts and develop an action plan to address them. Their annual report must state what has been done to act on the findings of this review and/or where it has decided not to act on a finding, why not (Care and Support Act Statutory Guidance, 14.156).

About the author

Sarah Hollinshead-Bland has worked in the area of safeguarding adults since 2001. She has managed operational safeguarding teams in two local authorities and has worked as the Statutory Safeguarding Business Partner for Shropshire Safeguarding Community Partnership until 30th June 2024. This report was written in part during this role and has been completed as an independent Safeguarding Adult Review author.

Context

In his paper for the Journal of Adult Protection 'Human stories about self-neglect: told, untold, untellable and unheard narratives in safeguarding adult reviews'[1], Michael Preston-Shoot suggests that austerity is a partially told or untellable story in Safeguarding Adult Reviews. This is referenced here to demonstrate an understanding of the challenging circumstances that all public services now work in. This is because the human resource capacity is a feature in this review.

The impact of austerity should not be underestimated. BBC News provides the following explanation about what austerity means[2] '*In 2010, the Conservative and Liberal Democrat coalition government embarked on a programme of deep spending cuts and tax increases*. It was aimed at reducing the country's massive deficit (it was spending much more money than it was raising in taxes), after it bailed out banks during the 2008 financial crisis. Since 2010, all public bodies have been required to find significant savings year on year.

About Patrick

Patrick was a 69-year-old, white male who died in hospital on 12th June 2023 of Sarcopenia and Alcoholic Liver Disease. Sarcopenia is the progressive loss of muscle mass that often leads to diminished strength and decreased activity levels, which can then contribute to mobility issues, osteoporosis, falls and fractures. Sarcopenia remains an important clinical problem that affects millions of older adults. Despite its high prevalence, no clear definition has been developed. Causes include declines in hormones and numbers of neuromuscular junctions, increased inflammation, declines in activity, and inadequate nutrition. Interventions for sarcopenia continue to be developed with most emphasis on exercise and nutritional interventions. Sarcopenia is intricately linked with frailty, loss of physical function and the ability to do daily activities, and ultimately a poorer quality of life and even death.

Patrick was well known to his neighbour (who provided a lot of support to him including regularly going shopping); his general practitioner, his social worker and the domiciliary carers that supported him daily, visiting him three times per day.

[1] Human stories about self-neglect told, untold, untellable and unheard narratives in safeguarding adult reviews | Emerald Insight
[2] What is austerity and where could 'eye-watering' cuts fall now? - BBC News

He had a daughter, although Patrick didn't see her very often, he had a picture of her and his two grandchildren in his home.

Patrick often declined help from the carers with tasks like washing and dressing but it was the carers he liked the most that were able to get the best out of him.

Patrick had a stepmother, who had a partner. The carers describe the relationship he had with his stepmother as fractious. He told carers he didn't like her partner in particular, as he only went to Patrick for money.

Patrick had a significant number of health problems including chronic liver disease, osteoporosis, fractured neck of femur, scapula, and ribs, type 2 diabetes and erosive gastritis. Patrick was dependant on alcohol and had a history of Wernicke's encephalopathy. Wernicke's encephalopathy is classed as alcohol related brain damage and often has a sudden onset and is characterised by movement and balance problems, loss of coordination, confusion, disorientation, and abnormal eye movements.

The referral for a Safeguarding Adult Review

The referral for Patrick was made by Shrewsbury and Telford Hospitals NHS Trust on 27th July 2023 once the hospital's Head of Adult Safeguarding became aware of his death.

Their referral form identified the following information:

'*Patrick attended the Royal Shrewsbury Hospital Emergency*

Department on 09.06.2023. Staff identified that he had come in having been found sitting in his armchair for three days and had been drinking alcohol.

He was soiled and unkempt. Patrick was noted to be alcohol dependant. Staff in the unit raised a safeguarding concern [with Shropshire Council's First Point of Contact call centre] in respect of self-neglect. It was raised in his best interests as he lacked capacity to consent at that time to the concern being raised. There was a note on the concern querying a possibility that he had care calls twice a day.

One of the Trust's adult safeguarding team attended the Emergency Department and contacted First Point of Contact and it was identified that his care company and neighbour had raised concerns …… that he was non-compliant with care and had refused General Practitioner input.

The safeguarding nurse contacted Patrick's allocated Social Worker and informed them that at this time he lacked capacity to consent to his care and treatment.

An update [was received] from First Point of Contact on the 09.06.23 which identified that the concern had been screened and would not progress to

safeguarding. [They confirmed that] the information would be shared with Integrated Community Service and his allocated Social Worker.

The safeguarding nurse followed up with a request for a full assessment of his care needs to support safe discharge planning. He was admitted to a medical bed the same day and stayed in the hospital until his death on 12.06.2023.

Agencies that supported Patrick and contributed to this review

The agencies that were involved in this review of the last six months of Patrick's life were:

- Shrewsbury and Telford Hospitals NHS Trust
- A Star Homecare Services
- Hands on Care Homecare Services
- Shropshire Council Adult Social Care; First Point of Contact, Occupational Therapy, Safeguarding, Community Social Work, Emergency Social Work and Integrated Community Service (Hospital Discharge) Teams
- Shropshire Community Health NHS Trust Podiatry; Dietetics, Integrated Community Service, Community Nursing, Rehabilitation, Admission Avoidance
- Shropshire Fire and Rescue Service
- West Midlands Ambulance Service
- Churchmere Medical Practice
- Department for Work and Pensions

Terms of reference and methodology

There is no doubt that a significant number of agencies and teams worked hard to support Patrick and encourage him to accept the help he needed. On August 17th 2023, following a meeting with the relevant organisations, the statutory partners agreed to recommend a Safeguarding Adult Review to the Independent Chair because whilst all agencies were making significant efforts to help Patrick to engage in the services they offered, this was done separately and not together.

Agreement was reached for the author to identify key practice episodes from the information provided by the agencies involved, covering the six months prior to his death and any other significant periods of time identified as part of the information gathering process.

The author has read:

- Agency scoping forms
- The report to the Independent Chair of the partnership recommending a Safeguarding Adult Review

The original intention was to hold a learning event with the practitioners that had supported Patrick during the last 6 months of his life. The purpose was to share the combined chronology and allow them:

- Time to reflect on whether they would've done anything differently knowing more about what information other agencies held.
- A chance to identify additional learning to what was in the report to the Independent Chair of the partnership.

Unfortunately, the practitioner learning event did not go ahead because:

- Not all organisations could release staff because of the nature of their workplace i.e. General Practitioners and Hospitals.
- Not all agencies provided the names and contact information of the individuals who had contact with Patrick.

The author proposed an alternative approach which was for her to:

- Produce a combined chronology
- Identify key practice episodes that would benefit from further exploration
- Hold reflective discussions with staff who worked with Patrick during the key practice episodes to:
    - listen to their reflections
    - find out what was happening at work and personally
    - what hindered and helped their practice

The Managers that attended the decision-making meeting for Adult Services did not notify his community Social Worker that a review was being undertaken until just before she would be unavailable for an extended period. A decision was therefore taken (supported by the author) not to hold a discussion with the Social Worker but to talk to her Team Manager instead.

A detailed discussion took place with the Team Manager reviewing the teams' practice. During this process, it became clear that there was information missing from their original scoping form as well as a number of inaccuracies. This information has been considered and has informed the review and its findings.

Because of the new information that became known, findings and considerations will also be made about Patrick's experience during the period of time between **23.04.23 and 07.06.23**.

Key practice episode 1, 15.06.22 - 20.11.22

The reason for identifying this period was to explore what work agencies were doing with Patrick and to consider whether interventions were enough to help prevent Patrick's deterioration. Before this time, his carers helped him to get out into his community and he was enjoying swimming.

Summary from chronology
Patrick was known to Adult Social Care during this period but not open to a named Social Worker. Prior to these dates, he had been assessed and a support plan set up resulting in A Star Homecare Services being identified to support him three times a day due to his Wernicke's encephalopathy and other health problems arising from his dependence on alcohol.

On June 14th, 2022, Patrick's stepmother died. It was from this point that carers noticed that Patrick gradually became less engaged with them and he started drinking more. As a result of her death, Patrick had issues to deal with relating to the properties left to him and some complexities around possible estate debts.

Because of Patrick's increased drinking and his reluctance to engage positively with his carers, the agency was struggling to support Patrick during these months and referred him for a reassessment on 21st November 2022.

Findings from chronology
In their paper 'Working with Older Drinkers[3]' Alcohol Research UK state, '*older drinkers are likely to present with a great range and degree of challenges. A one-time brief encounter of 15 minutes or less can reduce non-dependent problem drinking in an older person by more than 20%. However, older people with more complex needs or an extensive history of problem drinking are likely to require more extensive specialist treatment with multiagency support*'. This certainly describes Patrick and the reflection of the Team Manager from Adult Social Care is that had Adult Social Care and the care agency been working more proactively together at this stage, bringing in other agencies as required, it would be reasonable to suggest that Patrick's deterioration could at least have been delayed and possibly been prevented.

Key practice episode 2, 20.12.22 - 11.01.23
This period was identified to explore what actions were being taken since the visit of 20th December (by the social worker and domiciliary care provider) and how the escalating risks (as identified by A Star Homecare Services) reviewed in that meeting were reflected in his support plan.

Another area to explore was whether a stronger, multi-agency approach during that time could have changed the outcome for Patrick.

Summary from the joint chronology
The visit took place as a result of contact between the care agency and Social Worker because of an increase in Patrick's drinking.

Patrick's Social Worker discussed the impact of his drinking with him including identifying what he could contribute to his own support plan.

[3] AlcoholInsight_0085.pdf

She was also following up an earlier referral to the Occupational Therapists and sought their agreement to prioritise him.

Findings from the joint chronology
There was clear evidence of strengths-based practice[4] being encouraged by the community Social Worker. A strengths-based (or asset-based) approach focuses on the individual's strengths (including personal strengths and social and community networks) and not on their deficits. Strengths-based practice is holistic and multidisciplinary and works with the individual to promote their wellbeing.

Although the evidence of this approach was found in Patrick's notes, what was expected of him was not reflected in his support plan and this was not changed following this visit.

A conversation with the Social Worker's Team Manager suggested that support plans are used in Shropshire (as in other local authorities), mainly as a process for commissioning providers, rather than setting out a plan for how the person will be supported by all of those involved including the person. It is not known if this would have made a difference to Patrick, but it would have provided him with a plan to follow and review with the workers who were supporting him. If evaluated with him on a regular basis, it would also have provided him with a way of seeing his own improvements or deterioration.

The Care Act (2014) Factsheet 4: Personalising Care and Support Planning[5] explains that '*The care and support planning process is there to help decide **the best way to meet the person's needs**. It considers a number of different things, such as **what needs the person has**, **what they want to achieve**, **what they can do by themselves** or with the **support they already have**, and what types of care and support might be available to help them in the local area.*

*The local authority must produce a plan that sets out **the detail of what was agreed**. As part of the planning process, the local authority will tell the person about their personal budget. This is the amount of money that the local authority has worked out it will cost to arrange the necessary care and support for that person. This includes any amount that the local authority is going to pay itself towards those costs (which might **range from all, to none of the total**).*

Key practice episode 3, 02.03.23 - 22.04.23
This period was identified to explore what actions led to the unannounced visit by the Social Worker on 14th March and what changed in the plan to support Patrick because of that visit. Again, it was important to explore whether a stronger, multi-agency approach during that time could have changed the outcome for Patrick.

[4] Strengths-based approaches - SCIE
[5] Care Act factsheets - GOV.UK (www.gov.uk)

Summary from the joint chronology
By this point, the Occupational Therapists had seen Patrick at home and referred him to the Tissue Viability Nurse for an assessment. The information was reviewed, and a decision made that Patrick did not need to be seen as his wound seemed to be healing.

The unannounced visit by the Social Worker happened because of the care provider continuing to raise concerns about Patrick's drinking and him not improving. She wanted to get a better view of the provider's concerns. When she visited, she found Patrick had been drinking cider and was under the influence of alcohol but was engaging in conversation.

The Social Worker updated the provider by email, requested they ensure that staff he engages with most are provided and contacted Patrick's Doctor about his weight loss and poor nutrition.

During this time, A Star Homecare Services were withdrawing from the council's framework and wrote letters to service users to advise them of this. This caused Patrick some concerns. Within two weeks, all of their clients had been informed by the company they were remaining in place and no changes were required.

The next day, Patrick was admitted to hospital after another fall.

Summary of the discussions with staff
All but one of the staff spoken to by the author, did not have any direct contact with Patrick. Two were Administrators, one was a Nurse and one a Social Work Team Manager.

After establishing the person's role and their involvement with Patrick during the time period, the focus of the discussions were, understanding what was happening at the time in work and personally, what helps and hinders their practice and what they would change if they could.

A number of issues were raised during the discussions with staff. Although they don't all relate specifically to Patrick's situation, the points raised could have a negative impact on others. They are:

- Agencies working in Health and Social Care are under significant pressure. Examples provided by staff included, not having enough time to read background history to help improve decision making and not having enough practitioners to go out and undertake visits for example, there is sometimes one person to deal with urgent calls and their appointment slots are filled by 10am even though calls continue to come in. Prioritising and rescheduling of appointments based on clinical need is a continuous process.

- There can be a lack of confidence and awareness and sometimes a reluctance in all agencies to call multi-agency meetings due to difficulties historically in agencies refusing to attend. This happens on a regular basis and because of the pressure people are working under, it becomes harder work to use escalation processes to ensure attendance.

- One person said '*we are here as a team between agencies* [to work with individuals]'. However, on exploration of this, it became clear that she thought this wasn't the approach taken by 'the system' but by some individuals.

- In the past, the recording of incidents risk in the DATIX system has been actively discouraged by one manager in Shropshire Community Health NHS Trust. This is no longer the case and is a situation that happened approximately two years ago. The person no longer works for the Trust and is believed to be no longer working in Nursing.

  The issue was raised the person responsible for the DATIX system and a Safety Huddle now takes place every day with a senior member of staff and escalation and referral on is always encouraged.

Findings from the joint chronology and discussions with staff

No written changes were made to Patrick's support plan by either Social Woker during this time despite increasing concerns about his alcohol use and level of self-neglect. However, the approach taken in practice did change to in response to Patrick's changing needs.

The Nurse was confident she would have made the same decision again about Patrick's pressure areas not needing to be seen even having been given information by the author about Patrick's history of self-neglect.

Risks to Patrick were increasing, he was not responding well to some carers and there were at least 5 teams supporting Patrick by this point. Whilst there was communication between agencies, this would have been an ideal point to convene a multi-agency meeting. It would have helped everyone to understand each other's roles and share ideas about what worked well to keep Patrick engaged and responsive to support.

Agencies working together as a team to support an individual does not appear to be a consistent approach in Shropshire.

National guidance and relevant research

What is self-neglect?

The Care and Support Statutory Guidance[6] (updated March 2024) describes self-neglect as 'a wide range of behaviour neglecting to care for one's personal hygiene, health or surroundings and includes behaviour such as hoarding. It should be noted that self-neglect may not prompt a section 42 enquiry. An assessment should be made on a case-by-case basis. A decision on whether a response is required under safeguarding will depend on the adult's ability to protect themselves by controlling their own behaviour. There may come a point when they are no longer able to do this, without external support'.

The guidance also makes clear the importance of engaging with an adult 'to establish what being safe means to them and how that can be best achieved.' In Patrick's situation, all agencies went to great lengths to encourage his engagement with them. An example of this is a domiciliary care provider who tried to allocate carers who got on well with him as they got the best out of him. Patrick responded better to those he had long standing relationships with until his decline after the death of his step mother.

How common is self-neglect?

The Safeguarding Adult Collection[7] is a document to inform people about aspects of safeguarding activity at national, regional and local level. Councils are required to submit information to NHS Digital about their safeguarding activity.

In 2022/23 (the latest published figures), there was a total of 158,555 concluded section 42 enquiries[8] concluded in this financial year.

Self-neglect is 1 of 11 forms of abuse that information is collected about.

The bullet points below compares the numbers of concluded section 42 enquiries about self-neglect.

- Nationally - 15,775 (10%)
- Regionally - 695 (8%)
- In Shropshire - 0 (0%)

This shows that Shropshire appears not to be in line nationally or regionally with undertaking and concluding section 42 enquiries about self-neglect.

A conversation with the Team Manager has confirmed that when safeguarding contacts about self-neglect come into the council's First Point of Contact Team, it is often the case that the person is handed to a community social work team to deal with as an assessment under section 9 of the Care Act (2014). For some individuals, this approach will no doubt work well as long as the lead practitioner has sufficient time and flexibility to build an effective relationship. Where that is successful, the person is responding and any risks relating to self-neglect are reducing, that would

[6] Care and support statutory guidance - GOV.UK (www.gov.uk)

[7] Safeguarding Adults, England, 2022-23 - NHS England Digital

[8] This is a duty on the Local Authority to make enquiries, or have others do so, if an adult may be at risk of abuse or neglect.

be the most proportionate approach to take, demonstrating the application of one of the six safeguarding principles as set out in the Care and Support Guidance ensuring the '*least intrusive response appropriate to the risk presented.'* A consequence of this approach is that, although the Council is working with people who are self-neglecting these self-neglect situations are not picked up in the numbers reported through the Safeguarding Adult Collection as they aren't dealt with as section 42 or other safeguarding enquiries.

The Council is, however, able to identify how many safeguarding concerns are related to self-neglect. Consideration could be given to finding additional ways to demonstrate the prevalence of self-neglect in Shropshire.

The point at which the person is no longer able to function safely without external support and is unable to protect themselves from self-neglect, is when the safeguarding section of the Care Act (2014) should be used.

Tackling self-neglect is not about counting numbers but improving the lives of those affected by it. In making the decision about whether this work should be carried out as a section 42 or other safeguarding enquiry, the following should be taken into account:

- What the person wants
- What the risks of self-neglect are to the person
- Who the best professional is to develop the relationship with the individual affected
- Compliance with the law

Self-neglect and Safeguarding Adult Reviews

The majority of Safeguarding Adult Reviews that have taken place in Shropshire have featured self-neglect. Second National Analysis of Safeguarding Adult Reviews April 2019 and March 2023 by Professor Preston-Shoot found that self-neglect was prevalent in 60% of Safeguarding Adult Reviews.

There are two key repeating themes from the Shropshire reviews which are:

- A lack of the application of the local self-neglect guidance[9] in practice
- No multi-agency meetings convened by any of the agencies involved with the person

This is consistent with the national picture. However, Shropshire are taking action to address this. The Responding to Self-neglect in Shropshire Guidance has been reviewed and new practice tools have been developed to support practitioners when working with people who self-neglect. Weekly workshops have been held to launch the updated guidance and new tools. These have been well attended and the new tools have been well received.

[9] shropshiresafeguardingcommunitypartnership.co.uk/media/2ridjbuu/responding-to-self-neglect-in-shropshire-guidance.pdf

Within that guidance is a section on calling multi-agency meetings and a meeting template. A separate template can also be downloaded from the Shropshire Safeguarding Community Partnership Website. To compliment this a short video on how to organise, hold and chair a multi-agency meeting will also shortly be available.

In July 2019, Alcohol Change UK[10] published a report called 'Learning from tragedies; an analysis of alcohol-related Safeguarding Adult Reviews published in 2017'. Their 'overarching finding was that, perhaps unsurprisingly, most of the adults featured in these reviews had multiple complex needs in addition to alcohol misuse, including mental health problems, chronic physical health conditions, neurological conditions caused by alcohol, self-neglect, exploitation by others, unfit living conditions, and experiences of a past traumatic event such as bereavement and physical or sexual abuse. Many of these factors applied to Patrick.

The report made 10 recommendations in total and the author has identified 3 she considers particularly relevant to Patrick. They are:

- When carrying out Safeguarding Adult Reviews, the team should always have access to and make effective use of independent expertise in alcohol misuse in order to properly assess the role of alcohol in the incident, and to ensure that lessons are effectively learned. This was done as part of this review as the Decision-Making Meeting involved the Assistant Director for Public Health who was also the chair of the Tackling Drug and Alcohol Misuse Group in the Partnership. They will be asked to review this report.

- All professionals working with alcohol-dependent adults should be trained to recognise the complicated role that alcohol plays in adult safeguarding, that 'free choice' is often an unhelpful paradigm, and to avoid stigmatising drinkers

- The commissioning of alcohol services should be carried out in a way that minimises levels of staff turnover and recognises the importance of continuity in supporting people with complex needs.

The lack of effective multi-agency working was identified as a problem in 11 of the reviews they looked at. The report stated,

'*It is clear that, too often, agencies work in silos and fail to effectively share information or coordinate interventions. A number of reviews identify occasions at which a multi-agency meeting would have helped practitioners to share knowledge and make a coordinated plan for the care and support of the adult in question. When a plan of action is made, there is still a need to constantly review and reiterate care plans and risk assessments as new events occur. There is also a need to include all relevant agencies in multi-agency meetings, including alcohol services, even if they are not currently working with the adult*'.

This finding is particularly relevant to Patrick, five years on from the publication of that report.

[10] https://s3.eu-west-2.amazonaws.com/sr-acuk-craft/documents/ACUK_SafeguardingAdultReviews_A4Report_July2019_36pp_WEB-July-2019.pdf

The second national analysis of Safeguarding Adults Reviews[11] *'builds on the findings of the first national analysis, published in 2020, which considered learning from [Safeguarding Adult Reviews] completed between 2017 and 2019. Taken together, the analyses provide a significant knowledge base about adult safeguarding in England across all types of abuse and neglect. They highlight both the shifts that have taken place and the challenges that endure.'*

The report identified that, '*as in the first national analysis, the most experienced type of abuse/neglect overall was 'self-neglect' (affecting 50 per cent of individuals featured in the [reviews]*).' It goes on to state '*comparison between the first and second national analyses shows a marked rise in both self-neglect (from featuring in 45 per cent of [reviews] to now featuring in 60 per cent).'*

'*In the first national analysis 25 per cent of cases featured alcohol dependency, whereas the [second analysis] records 33 per cent featuring substance use, often linked with self-neglect*.' This is certainly the case for Patrick.

The report also identifies which types of abuse is most likely to have occurred by age group concluding that with '*the peak of self-neglect [being] the mid-years between the ages of 41 and 70*.'

It is important for the Partnership to consider how it will use this information and other facts in this report to make changes to practice that will reduce the risk of harm where alcohol use and self-neglect are prevalent in the 41-70 age group.

Alcohol use in England and Wales

In England there are an estimated 602,391 dependent drinkers. Only 18% are receiving treatment.[12] In the same fact sheet, Alcohol Change UK state that alcohol misuse is the biggest risk factor for death, ill-health and disability among 15-49 year-olds in the UK, and the fifth biggest risk factor across all ages. Data also shows that in 2020 there were 8,974 alcohol-specific deaths (around 14 per 100,000 people). This is a 18.6% increase in deaths from 2019.

In document[13] written in 2020 for Alcohol Change UK, Mike Ward and Professor Michael Preston-Shoot identified that withing the group identified as dependant drinkers, '*there is a small group whose chronic drinking, harmful lifestyle and chaotic behaviour pose a significant challenge to services. In particular, this group is unwilling or unable to change.'* They are also clear that '*England and Wales do have legal frameworks which enable professionals to protect chronic dependent drinkers and that professionals should be using those frameworks whenever they are appropriate*.' Their starting point is that '*too often those frameworks are not being used and people are not receiving the help they need*.' This is born out in Patrick's

[11] Second national analysis of safeguarding adult reviews, Final report: Stage 1 analysis (local.gov.uk)

[12] Alcohol statistics | Alcohol Change UK

[13] Safeguarding-guide-final-August-2021.pdf

case as no legal planning meeting took place to consider what legal interventions outside the use of the Care Act (2014), may have been used to intervene particularly when the domiciliary care agencies, Social Workers and health staff were finding it difficult to maintain their engagement with him.

It is noted that the Social Worker initiated and maintained contact with the solicitor dealing with Patrick's stepmother's estate.

In the same briefing, they helpfully identify 12 common myths and misconceptions:

1. If someone says they don't have a problem and don't want help, there is nothing we can do.

2. If the person is choosing to live like this, or likes living like this, we can't define them as vulnerable.

3. A person is not vulnerable or self-neglecting if they have mental capacity.

4. Once people are sober, they no longer lack capacity or have care and support needs or lack capacity.

5. If a person has capacity, there is nothing we can do.

6. A person has the right to make unwise decisions.

7. Alcohol dependency is not covered by the Mental Health Act.

8. Mental health services don't need to assess someone if their main problem is alcohol.

9. Assessment is impossible if someone never turn up for their appointments.

10. A person can't be assessed if they are always intoxicated.

11. There is no treatment available for vulnerable dependant drinkers, so people can't be treated under the Mental Health Act.

12. Once someone stops drinking the problems go away, so this isn't a mental health issue.

Some of these misconceptions were evident in the thinking of some of the practitioners that were working with Patrick. The briefing tackles each of the assumptions in detail and consideration could be given by the Partnership to how it could use this information to educate staff and volunteers across Shropshire.

Findings

1. All agencies worked hard with Patrick to support him when he accepted it and to persuade him to accept support when he was refusing it.

2. No agencies walked away from Patrick.

3. All agencies could have organised a multi-agency meeting but did not.

   This would have been particularly important when the risks to Patrick were increasing significantly from 2023. It is not possible to conclude that this would have prevented Patrick's death, but it could have delayed it and improved situation he was living in and improved the factors that were affecting his physical health.

   The teams and agencies involved could also have been clearer about who the lead agency was and that concerns were being acted upon had this been a consideration at the meeting. In the decision-making meeting held on the 17th August, it was clear that some of the information shared, was not known to everyone.

   From discussions with those involved, it became clear that not all information was shared with Patrick's community team Social Worker, who would have been in a good position to pull agencies together to agree a shared plan for moving forwards to reduce the risks faced by Patrick.

4. There was no information in Patrick's records to suggest there was consideration given by Adult Social Care to holding a legal planning meeting to consider what options there may have been for intervention.

5. The West Midlands Ambulance Service's delay in reaching Patrick in January 2023 did have an impact on his immediate health and wellbeing as when he was admitted to hospital he was diagnosed with a fractured scapula (shoulder blade - this is the bone that connects the clavicle to the humerus) and an undisplaced rib fracture. He will have been in pain for longer than he needed to be.

6. Whilst there was often good information sharing between agencies, the lack of information sharing with Adult Social Care from January 2023 was poor on significant occasions. We do not know what impact having this information would have made to Adult Social Care's response to Patrick.

7. The demand on West Midlands Ambulance Service resulting in significant delays in their attendance, is causing harm to individuals. This is evidenced in West Midlands Ambulance Service University NHS Foundation Trust's annual report for 2022/23 and as demonstrated in finding 5. above.

8. The operation of the Memorandum of Understanding that governs the response to gain entry requests, is causing harm to individuals when a second agency cannot attend due to demand affecting them. However, a regulated organisation was in attendance so an alternative approach could have been agreed which would have been better for Patrick.

9. There was no discussion about how best to respond to the safeguarding concerns raised with First Point of Contact before passing Patrick to the community social work team for them to respond. In safeguarding situations, there should be discussions between teams about who is best placed respond to concerns raised to avoid risks increasing.

10. Patrick did not want to receive support from Shropshire's specialist drug and alcohol service, Shropshire Recovery Partnership. Any of the agencies working with Patrick could have used this service for advice and guidance. There is no evidence of this being considered.

11. Patrick didn't go out of the house on his own. There is no information to suggest that where he was getting his alcohol from was considered at an early enough point to put a plan in place with Patrick to manage this.

12. There is no evidence of either the community or hospital Social Workers contacting the specialist Adult Safeguarding Team for advice about how best to work with Patrick or ask that he was responded to within the safeguarding framework. However, the community Social Worker was experienced enough to work with Patrick with guidance from their line manager on a day to day basis as well as in supervision. Safeguarding training is offered to Social Workers.

13. When Patrick came out of hospital in May 2023, his support plan was reduced slightly in terms of hours and the structure was changed even though risks were increasing particularly in relation to Patrick's physical health and needs. This had a significant impact as the two hours that were being spent on shopping and social calls, were removed. This reduction although slight, was not in-line with the view of the community Social Worker who was looking to increase Patrick's support from the care agency.

14. Given what was known about Patrick's escalating drinking and self-neglect, asking Patrick to do on-line shopping was unlikely to have been successful and was an unrealistic expectation of him.

15. At critical points, i.e. from 26th January 2023, information sharing could have been much improved between agencies.

16. There was no evidence of a carer's assessment under section 10 of the Care Act (2014) being offered to Patrick's neighbour who was a significant source of support for him.

17. Shropshire does not appear to be in line nationally or regionally with the number of concluded section 42 enquiries about self-neglect, yet the majority of Safeguarding Adult Reviews in Shropshire feature self-neglect.

    However, it is clear from discussions with the Team Manager and the operational knowledge of the author about practice in Shropshire, that when self-neglect concerns are passed to community social work teams to respond to, it is for a Care Act (2014) assessment and not done within the safeguarding framework offered by the same Act. This means that it is possible that much more is being done to support people experiencing self-neglect than is being reported through the Safeguarding Adult Collection.

    The Care and Support Statutory Guidance makes it clear that '*a decision on whether a response is required under safeguarding will depend on the adult's ability to protect themselves by controlling their own behaviour. There may come a point when they are no longer able to do this, without external support*'. If practice was changed to hand people over to community teams as either a section 42 or 'other' safeguarding enquiry, it will unhide the work already being undertaken. This approach would also be more compliant with the duty to undertake a section 42 enquiry when a person:

    - *has needs for care and support (whether or not the local authority is meeting any of those needs)* - It was clear that Patrick had care and support needs

    - *is experiencing, or at risk of, abuse or neglect* - Patrick was experiencing self-neglect which is one of the forms of abuse identified in the Care and Support Statutory Guidance

    - *as a result of those care and support needs is unable to protect themselves from either the risk of, or the experience of abuse or neglect* - Patrick was not able to protect himself from self-neglect and this was evidenced by the increasing risks to his physical and mental health

18. There were many examples of good practice found in most agencies that work with Patrick and these can be found in appendix 3.

Considerations for Shropshire Community Health NHS Trust

1. Promote the use of the DATIX system through the daily Safety Huddle to ensure all managers understand the importance of reporting incidents and risks via the DATIX system[14] and are actively promoting the use of the system in their teams.

[14] 10866.pdf (shropscommunityhealth.nhs.uk)

Considerations for Shropshire Council

1. Maintain consistency with the person's community Social Worker when there is a hospital admission rather than transferring to the Integrated Community Services Social Worker. This is particularly important for the person being supported and to provide consistency for other organisations involved with the person.

2. Ensure that when safeguarding concerns are reported and present, there is a handover discussion between teams to agree which teams is best placed to work with the individual affected by abuse or neglect.

3. Support plans should include what the person is going to do to contribute to meeting their own needs. This would help to demonstrate a strengths-based approach throughout the assessment process.

4. Ensure that the Integrated Community Service understand they could have agreed additional funding for a week to assess Patrick's mobility needs and manage the risks he faced.

Considerations for Shropshire Safeguarding Community Partnership

1. Consider how it will ensure that staff completing scoping forms as part of a statutory review process, understand what is required of them including checking the content of the form with the teams that have been involved with the person before it is submitted.

2. As time progressed Patrick was neglecting his own needs with high impact on his health and wellbeing and he was not protecting himself by controlling his own behaviour and thus he met the criteria section 42 duty. There is no evidence to suggest though, that if the work undertaken by the Community Social work team had been classified as a section 42 it would have changed the outcome for Patrick. However, it would have been counted in the Safeguarding Adult Collection as a section 42 enquiry. Consideration could be given to the current process of capturing s42 enquiries.

3. Reflect on why multi-agency meetings weren't arranged in Patrick's and others' situations and as a result of this, consider what can be done differently to improve the understanding and workload capacity of front-line staff and their managers to increase the chances of regular multi-agency meetings being held.

Any actions agreed as a result of this consideration need to be different from those identified in previous Safeguarding Adults Reviews as they haven't achieved the level of change expected.

4. Consider how it will use this information and other facts in this report to make changes to practice that will reduce the risk of harm where alcohol use and self-neglect are prevalent in the 41-70 age group. For example, the statutory agencies could each identify the people they are working with where self-neglect and alcohol use are the key issues in this age group. Partners could then:
    - share this information between them to identify who is common to each agency
    - using the Working with Risk Document, assess the risks with and facing each person
    - identify which agency will lead working with the person
    - convene multi-agency meeting and action plans with the aim of reducing the risks faced by the person

5. It is important to demonstrate that learning from Patrick's and previous local and national case reviews, has been implemented. Counting multi-agency meetings about people who self-neglect is part of doing that as well as finding a way to demonstrate the effectiveness of the meetings in reducing risk.

6. Consider a multi-agency review of the Memorandum of Understanding that governs the emergency services' response to gain entry requests. The review should be undertaken by the three emergency services and be followed by a period of consultation with the following partners as a minimum; adult services commissioners, social workers, health providers and regulated domiciliary care providers.

7. The agencies who had not shared information about Patrick with relevant partners should consider what action (informal or otherwise) should be taken with the staff responsible to improve their practice in this area.

8. Consider all professionals working with alcohol-dependent adults being trained by Shropshire Recovery Partnership to recognise the complicated role that alcohol plays in adult safeguarding, that 'free choice' is often an unhelpful description of complex, individualised circumstances, and to avoid stigmatising drinkers. Consideration could be given by the Partnership to how it could use the information in Safeguarding Vulnerable Dependant Drinkers to educate staff and volunteers across Shropshire and include when working with problem drinkers, for the case manager to identify who is supplying the alcohol on behalf of the person to see what action may be required.

9. Consider developing a set of standards for referring between agencies to include; the name and contact details of referrers, the history of the person and the reason for the referral.

Combined Chronology
Patrick

Date of event / significance	Description
2011	Patrick was admitted to hospital for alcohol withdrawal.
2017	Patrick was identified as having decompensated liver disease which is an acute deterioration of liver function. His liver function was normal in 2022. Patrick had his support plan set up during this year and his provider was Healthcare Support Services until A Star Homecare Services took over.
01.04.19	A Star Homecare Services began supporting Patrick in April 2019. They knew of his Wernicke's encephalopathy since approximately 2010. Patrick was not drinking at that time, so no issues were identified. They never met his daughter or any other family members. The care package (funded by Shropshire Council) was two 30-minute calls a day and one bathing call and a shopping call each week.
18.11.2019	An extra social call to go swimming (or any other activities Patrick wanted to do) had been added to his support package. As a result of pleading with Patrick by the Manager of A Star Homecare Services, there was a short period where he started to do a little more for himself, but this did not last.
21.11.2022	In November 2022, a referral for a reassessment was received into the Adult Social Care Team. Patrick was allocated to a social worker on the same day.
22.11.22	There was an arrangement made to visit Patrick with the provider to review his support plan on 27.11.22.
27.11.22	During the review visit, A Star Homecare Services told the Social Worker that Patrick's alcohol consumption had increased due to the death of his stepmother. During the visit, the following areas were discussed:

	• Loss of his stepmother • Increased alcohol intake • Recent falls • Concerns about his inherited estate and the pressure this caused him • Social prescribing which he declined • Referral for a medication and occupational therapy review which he accepted
29.11.22	The Social Worker emailed the General Practitioner to request clinical oversight of his drinking and undertake a medication review as Patrick was not able to state when his last medication review was. Her concerns were about his increased alcohol intake and the impact on his medication. She detailed what she thought his alcohol intake to be. The Social Worker arranged to see Patrick again on 8th December.
30.11.22	The Social Worker referred Patrick to Occupational Therapy due to there being a high step between his kitchen and living area. A Star Homecare Services noted that he fell on 5th November misjudging the distance between these steps. The Social Worker updated the provider about the referrals made and explained her commitment to continue to work with Patrick.
08.12.22	Patrick cancelled the meeting with the Social Worker because his solicitor was visiting. It was re-arranged for the next day. The care agency found Patrick drunk at 9am and had food in his fridge dated October 2022. The manager of A Star Homecare Services told the Social Worker she was going to raise a safeguarding concern about self-neglect that day.
09.12.22	First Point of Contact documented on case notes and the outcome of the contact from the provider about their self-neglect concerns was that it was to be allocated for review by the Social Worker to follow the self-neglect guidance and consider assessing Patrick's capacity. The Social Worker was off sick that day, so the visit did not take place.
13.12.22	The Social Worker telephoned the provider manager and apologised for being off and being unable to support the planned visit. The Manager said she thought he had not grieved for his stepmum and that drinking and taking CBD oil was how he was coping with

	the situation. She also explained Patrick was not engaging at present and didn't want to go out with the carer. The Social Worker advised her that she felt the environment itself was not very suitable long term for him due to his mobility and alcoholism but he would need to make decisions about this. The Manager was confident he wouldn't want to move. The Social Worker re-arranged to visit Patrick with the agency on 20.12.23.
19.12.22	Occupational Therapy referral was passed to the team waiting list.
20.12.22	The social work home visit took place as planned with A Star Homecare Service. The notes state there was a discussion with Patrick about: • out of date food • falls and mobility • increased alcohol intake • reduced nutritional intake • not engaging in personal hygiene support Patrick stated he was 'experimenting with the food to see how long it would take to go off'. His Adult Social Care notes also stated that there were discussions with his community Social Worker about the impact of his alcohol consumption on him. The following was agreed as a result of the meeting: • Patrick would continue to engage with his Social Worker • Social Worker to speak with the Financial Assessments Team • Patrick to try to increase engagement with personal hygiene (although notes stated 'did not appear unkempt' on the visit) His support plan was not changed at this point.
10.01.23	Patrick's community Social Worker emailed the Occupational Therapists to ask them to prioritise Patrick's referral which was agreed.
17.01.23	The Social Worker telephoned the solicitor involved in Patrick's stepmother's estate. He told her that the estate had been neglected for the past couple of years. He said that there was a lot to sort out involving many properties which have all been left to Patrick and that Patrick wanted to pass it all onto his daughter.
18.01.23	The care provider and Social Worker met at Patrick's home. The provider Manager suggested to her she didn't feel he had capacity about some things now as he was drinking more.

26.01.23	When Patrick fell on 26th January 2023, A Star Homecare Service couldn't get into his property, so they had to call Shropshire Fire and Rescue Service to gain entry. The response to these requests is governed by a Memorandum of Understanding between the three emergency services about gaining entry in properties. Shropshire Fire and Rescue Service mobilise the gain entry request on the understanding that either the Police or Ambulance Service attend, so that once they gain entry part of the request is fulfilled, the other emergency service takes the lead. On this occasion neither West Mercia Police or West Midlands Ambulance Service were able to attend straight away, so the Fire and Rescue Service did not attend in accordance with the protocol. Patrick waited over the elected time due to increased demand, for a category 3 ambulance. The ambulance arrived at 14:13pm. He was assessed and had sustained a shoulder injury from a fall the previous day and was taken to the Royal Shrewsbury Hospital for further treatment. He could be seen through the window by both the carer and the crew on their arrival and was said to be alert and displaying no signs of confusion. The carer told the crew that Patrick had been witnessed to have had 3 falls and it was on the third fall that Patrick seemed to be in discomfort due to hitting his arm. Patrick's vital signs suggested there were no immediate clinical concerns. West Midlands Ambulance Service are of the view that the delay in reaching Patrick did not have an impact on his health. They stated that if there was less demand within the ambulance service on this day, Patrick may have had fewer falls. Shropshire Fire and Rescue Service arrived at Patrick's address at 14.40pm and conducted the gain entry request. The Fire Service handed over to the Ambulance service and left at 15.01pm. Patrick was bought into the Emergency Department at 16.56hrs by ambulance. Initial notes identified that Patrick had a package of care in place at home but had fallen resulting in a shoulder injury. It was noted he had been drinking. The Initial Safeguarding and Domestic Abuse Screening Tool of the hospital was completed but did not identify any concerns at that stage. Body maps noted his skin and pressure areas were intact. Patrick was diagnosed with a fractured scapula (shoulder blade - this is the bone that connects the clavicle to the humerus) and an undisplaced rib fracture. A follow up appointment was made with the fracture clinic, and he was discharged to Bridgnorth Hospital.

	The care provider arranged for a key safe to be fitted so they could gain access in future. The key safe was bought by his neighbour and fitted by his stepmother's partner. Adult Social Care has no record of any of the agencies involved sharing this information with them.
27.01.23	Patrick was admitted to Bridgnorth Hospital from Royal Shrewsbury Hospital and was discharged on 31.01.2023. Adult Social Care has no record of this information being shared with them.
06.02.23	Patrick's occupational therapy referral from 30.11.22 was allocated. They emailed the Social Worker and care provider for further information. A telephone call was made to Patrick by the Integrated Community Services (hospital) Team. It was recorded that he had declined equipment on discharge from Bridgnorth Hospital and he informed the team that he had twice daily care in place from a care agency. Patrick declined physiotherapy input but agreed to a home assessment for rails.
12.02.23	Patrick had an appointment at Shrewsbury and Telford Hospitals NHS Trust, for an ultrasound scan on his abdomen but did not attend the appointment. A letter was sent to the referring consultant. No new appointment would be sent without a new referral from a consultant. Adult Social Care has no record of this information being shared with them.
14.02.23	Patrick was seen in the fracture clinic at Shrewsbury and Telford Hospitals NHS Trust following his fractures and he was noted to be making excellent progress and was discharged. Hospital staff did not identify any concerns about self-neglect at this appointment.
17.02.23	A home visit was carried out with the Occupational Therapist and the A Star Homecare Services Manager. The equipment was ordered including a half step and grab rail to help Patrick with his step. The Manager of the care provider emailed Patrick's Social Worker again to express more concern which included sending a picture of all the alcohol Patrick was drinking saying he was no longer showing any signs of improvement. This was the first time that the Social Worker was made aware that Patrick had sustained an injury from falling and a key safe had been fitted.

27.02.23	The Social Worker called the provider manager who raised further concerns about the legal issues putting pressure on him. Concerns included his reduced appetite. The community Social Worker explained the negative impact his Wernicke's encephalopathy would have on his appetite. The Social Worker offered solutions such as exploring an advocate to assist with Patrick's legal concerns. There is no record that this was discussed with Patrick or taken up by him. An unannounced visit by the Social Worker was scheduled for 07/03/2023 at 3pm to get a better picture of the provider manager's concerns and it was agreed she would feedback to the provider, after the visit.
28.02.23	Patrick told the Occupational Therapist that '*the step is helpful and I've used it a few times*.'
02.03.23	The Occupational Therapist referred Patrick to the Tissue Viability Nurse for an assessment.
14.03.23	Patrick's Social Worker made an unannounced visit to him following and as a result of the call to the provider on 27.02.23. Although he was drinking cider and under the influence of alcohol, he was engaging in conversation. An email was sent to the provider the same day to update on the outcome of the visit which was: • The Social Worker was liaising with the GP and • Exploring more access to the community such as mobility aids. The community Social Worker had noted that Patrick had engaged with support from the Occupational Therapist and that equipment was to be provided. She had noted concerns with his engagement with some of the new carers. She emailed the provider to request they ensure that staff he engages with most, are provided. The Social Worker also contacted GP about his weight loss and poor nutrition. It was not clear what changed in the plan to support Patrick because of this visit.
31.03.23	At this time, A Star were withdrawing from the council's framework and wrote letters to service users to advise them of this.

	The community Social Worker made contact with Patrick to reassure him and work through his concerns. He was worried he couldn't afford the carers support and was worried about who he would get as a provider. The Social Worker agreed to follow this up with Patrick the following week.
14.04.23	Follow up letters were sent out to all individuals receiving care from A Star to confirm they were going to continue to support their clients as before and no changes were required.
23.04.23	Patrick's next admission to Shrewsbury and Telford Hospitals NHS Trust happened after an unwitnessed fall and a long lie. A long lie is defined as a prolonged period spent on the floor because a person cannot get up. There were no obvious injuries from the fall, however, 2 pressure sores to his sacrum were noted. Again, the Initial Safeguarding and Domestic Abuse Screening Tool was completed but did not identify any concerns at that stage. On examination, he was clinically dehydrated but otherwise normal. His haemoglobin dropped after two days which resulted in him receiving a blood transfusion. Patrick also had an endoscopy which showed erosive gastritis. No self-neglect was identified although it was noted that Patrick was unkempt. The reasons for his admission were recorded as: • Medical emergency • Erosive gastritis • Bed Sore (not infected) He was admitted to Princess Royal Hospital, ward 11. The notes identify that the Paramedics were concerned about several pressure areas and queried whether Patrick had Sepsis. Adult Social Care has no record of this information being shared with them.
24.04.23	The Social Worker responded to an email from the provider dated 20th April 2023, requesting an update from her and explaining their concerns about Patrick's nails and that he had grown a beard. They asked for her thoughts. She explained she had been out of the office and that she was aware A Star were now staying as a Council provider and could arrange a visit for the following week. The Social Worker explained that in relation to drinking, unless Patrick expressed a desire for help to reduce his intake, we could only continue to monitor and work with Patrick. She also said if there were immediate concerns for his health, to share this with the GP and or 111.

	Email response from Provider (24/04/2024) to advise that Patrick was in Telford hospital after a fall at home and Provider calling an ambulance. The discussion with the Team Manager revealed that the carer had taken Patrick some Magners Cider. It was dealt with by the community Social Worker's Manager but was not recorded.
25.04.23	The Social Worker telephoned ward 11, but there were no discharge plans at this time. The ward said that he would need a detox regime and a blood transfusion that day.
28.04.23	The Manager of A Star Homecare emailed Patrick's Social Worker for an update and to advise they can't keep the package of care open as they aren't being paid.
02.05.23	At 08.54 the community Social Worker emailed the provider to confirm there were no discharge plans in place, they would end the care package and were to close Patrick's case to them. At 11.54 the Social Worker emailed again as Patrick was going to be discharged and she wanted to increase the care package. She also explained that Patrick was going to remain open to her and copied the hospital social work team into the email. At 12.09 the provider replied to say she had closed the care package as it had been so long. She also said she would not be prepared to take on Patrick's care package at present as it would be just another failed discharge. She went on to explain that she was concerned that last night she had a call from Patrick saying that he was at a local pub. Even though she thought this was not the case, she went to the pub to try and find him, but he was not there, he was in hospital at that time. The Social Worker replied to explain who will liaise with her about the care package. Although the provider Manager had expressed her concerns about discharge to Patrick's Social Worker, she had not expressed those concerns to the hospital. A Star Homecare Services was not involved from that point.
03.05.23	A Personal Profile (Care Act Assessment) was completed by a Social Care Practitioner at Royal Shrewsbury Hospital. They spoke to Patrick who stated he was under the financial threshold at that point and stated clearly his wish to return home with carers.

04.05.23	The hospital Social Care Practitioner made a call to Patrick who confirmed he was happy to continue with A Star Homecare Services. The practitioner also recorded that the service was unable to continue.
05.05.23	Patrick was discharged to his home address. Hands on Care Homecare Services began supporting Patrick on this day. The package of care consisted of one carer completing three calls a day providing support with diet and fluids, medication administration and personal care. The agency was aware that he had a poor dietary intake and excessive alcohol intake and was not compliant with carers. An assessment of Patrick's care needs was completed by the Deputy Manager and Senior Carer. Patrick agreed to Hands on Care managing his medication. At that time, he said he did not want assistance with toileting and personal care. Patrick explained to the carers that he had very little appetite and will normally just snack throughout the day. This information was checked out by the carers, but they weren't getting much information out of him. They also noticed a large amount of alcohol by his chair. A Star Homecare Services called and left a voice message on Shropshire's Emergency Social Work team's phoneline. They returned the call and the A Star Manger expressed concerns that he had no care or food in the fridge. A Social Worker from the team checked the record and identified he had a care call due at 6pm that evening. They telephoned Patrick who said he had food, carers and was glad to be home. No further action was taken.
09.05.23	Hands on Care telephoned to speak to the Social Worker. The Integrated Community Service (hospital) duty worker responded. Hands on Care stated there was no food and requested a shopping hour to be added to the package of care. She also stated that Patrick is a smoker and 2 care staff have refused to go in when he is smoking. The duty worker spoke to Patrick on the phone and he said he wouldn't smoke when the carers were there. A grade 3 pressure sore was also reported. The pressure sore was discussed during the decision-making meeting and the agency are not clear about how this grading was arrived at as it is usually a clinical decision. When the District Nurses were contacted by the hospital duty worker, they stated that they had not recently seen Patrick, their records '*last contact from A Star 03/04/2023 with a picture of a pressure sore that was not currently requiring treatment*.'

	A home visit was conducted by the Integrated Community Services (hospital) Team to assess for pressure relieving equipment. Patrick stated he was unhappy his care provider had changed and that he was on the waiting list for his previous agency. The duty worker asked if it was possible for him to shop online, Patrick stated '*it is too complicated and they don't send what you want*'. The team explained to Patrick that his repose mattress should be on top of his mattress, but Patrick stated that his electric blanket must stay on the bed. Patrick was sat on the correct pressure relief on his chair. Patrick was discharged from the team's caseload.
11.05.23	The manager of Hands on Care Homecare Services received a text message from Patrick's neighbour, stating that Patrick had fallen on the floor and that she was at work and unable to help. She also said she felt Patrick was too dependent on her. The manager arranged to contact emergency services who phoned Patrick. West Midlands Ambulance Service had a 999 call at 19:59pm from the Welsh Ambulance Service as Patrick had fallen. He was called back in line with the service's guidance but there was no answer. A second call back was made at 20:30pm and Patrick was spoken to and confirmed he had got himself up and did not require any medical attention. He also denied any pain or injury. The call was closed as per their policy. There is no record in Adult Social Care that this information was shared with them. A District Nurse home visit to Patrick was carried out to assess his skin damage. He was difficult to engage with but allowed Nurses to examine pressure areas and give advice around pressure relief. A dietician referral was discussed but Patrick declined. He also declined prescription for supplements. The Nurse was able to dress the pressure damage to Patrick's buttocks. There is no record in Adult Social Care that this information was shared with them.
18-25.05.23	During this time, several concerns about increasing risks to Patrick due to his self-neglect, were raised by Hands on Care Homecare Services staff to: • Patrick's doctor regarding weight loss and poor appetite, non-compliance with pressure relief and application of barrier creams during care calls and dehydration. A home visit was requested. A doctor spoke to Patrick, but he

	declined any input, help or visit. His carers were asked to monitor him. • Shropshire Council's First Point of Contact call centre about self-neglect when they discovered faeces all over his bed sheet. They also reported that Patrick had refused to let the carer change the bed despite their best encouragement and that he was becoming increasingly non-compliant with carers. As with the previous referral, it did not progress to a safeguarding concern or enquiry. They had listed significant concerns identifying self-neglect. During the decision-making meeting, the manager explained that there was very little information in Patrick's care notes to evidence what carers had done to try and encourage Patrick to accept the help he needed. A home visit was made by the General Practitioner, and he concluded that Patrick was suffering from low mood and dehydration but had capacity to understand and make decisions about his care and support needs. He was advised to take fluids. A urine sample pot was left for Patrick to provide a sample to rule out any infection. There is no record in Adult Social Care that this information was shared with them.
25.05.23	District Nurses visited Patrick, and said they thought that Patrick now required two carers to help with standing and mobilising. This was communicated to the Integrated Community Service (hospital) Team who said that Patrick may have been having an off day. The Social Worker from Integrated Community Service requested their Therapy Team visit to assess Patrick's mobility and noted that mobility hadn't been raised as a problem by the care provider. The visit resulted in a recommendation that two carers would be beneficial due to Patrick's mobilising needs and wider health to aid circulation and movement during the day. The care package remined unchanged. On the same day, the Community Paramedic visited following referral from the Nurse due to concerns raised about Patrick being stuck in his chair. He was able to mobilise out of chair with minor assistance. A joint visit was conducted later the same day with Integrated Community Services and a Rapid Response Paramedic who assessed Patrick's mobility. At that time, he was sitting better due to the cushions being swapped and he said that the chair was more comfortable.

	His urine was tested which showed a suspected Urinary Tract Infection, and a request was made to the doctor for a course of antibiotics. The General Practitioner has provided evidence that Hands on Care Homecare Services were aware of this but Patrick's medication was not collected by them, so Patrick never received the antibiotics. Later that evening, the doctor had attended his home and requested that he be admitted to hospital, but Patrick refused.
26.05.23	A request was made to the Social Worker by the Integrated Community Services Team to request an increase from one to two carers due to Patrick's variability mobilising during the day as a result of the visit the previous day.
01.06.23	Concerns were raised by Hands on Care Homecare Services to the Integrated Community Services Team regarding a pressure area, Patrick being soaking wet with urine and refusing to change into clean clothes despite the carer's best efforts. No call back was received. For the first three days in June, the agency provided an additional carer (unfunded) to help Patrick stand and receive help washing and dressing. This could not be permanently implemented at the time due to staffing availability and was not always successful. The Manager confirmed that he tried to ensure the carer visiting Patrick was one that he got on with.
02.06.23	The Community Nurse visited but was unable to carry out care as Patrick declined and asked the Nurse if she would leave. There is no record in Adult Social Care that this information was shared with them.
06.06.23	Further concerns were raised to the Integrated Community Service's Therapy Team from the care provider by email. They said Patrick was continuing to self-neglect by refusing help with personal care. His Adult Social Care notes stated *'We have received a phone call this morning from Hands on Care regarding [Patrick] for a mobility assessment however it sounds like he needs a self-neglect and safeguarding [plan] put in place. We assessed this gentleman on 26th May. He has varying mobility due to his alcohol consumption, and this is something we cannot change. His current chair is not suitable for chair raisers, and he had a foam cushion in place. Patrick is declining personal care with care staff and not engaging in transfers, he is soiling himself and is often covered in urine as handed over by care agency. Could this please be looked into*'?

	The notes also said '*I advised that from a social [care] perspective, Patrick would need to be willing to accept the support and if so, I could support to refer to alcohol support services etc. I asked who is buying the alcohol for Patrick and the provider Manager advised it is his neighbour, but she is trying to limit the amount she buys for him to try and reduce his intake but not force him to go into sudden detox shock. [Patrick] is sometimes able to stand on his own but mostly he is needing two to help him and manage his personal care. [The Manger] says that for safety, two carers are needed. [Patrick] is not eating and he has lost a considerable amount of weight but his Doctor has advised that due to being an alcoholic there is little they can do unless Patrick is willing to accept support to detox'.* *I have arranged to visit Patrick on Friday morning and meet with a Senior Carer to speak to him about his ongoing support and the risks he is posing to himself. [The Manager] will look at their rota to see if they can provide two carers*'. The hospital Social Worker telephoned Patrick but he didn't answer. The phone rang out as there was no voicemail facility. There was regular communication with District Nurses but when they visited Patrick, he refused them entry. They confirmed they would try again the next day.
07.06.23	Patrick's neighbour rang Shropshire Council and asked to speak to his Social Worker. The Social Worker rang back and spoke to her. The neighbour expressed concerns about Patrick. His notes included the following record of the discussion, '*[His neighbour] said that she wants to raise concerns about Patrick and advised she has also raised these concerns to the Care Quality Commission. I asked what her concerns were and she advised that one of the carers has told her "the social worker is visiting on Friday so she can see Patrick soiled and wet before she will agree to have two carers helping him, she won't do anything until then". I explained that this is not the case at all and advised that I have spoken to the provider who is looking to see if they can facilitate two carers. [Patrick's neighbour] then said that the carers has also told her "we have asked our Manager for another carer but he won't put one in because they won't get paid". I again advised that I am not aware of what he has told the carer but assured her that if he had a second carer, I would arrange funding for them. I explained that the Manager has told me that they are struggling to find a second carer.* *[Patrick's neighbour] explained that he had been sitting in urine and faeces since last week and "no-one is bothering to help him". I explained that therapy have also been involved and the provider*

	has made contact with the Nurses and Doctor but due to Patrick's alcoholism, he is often declining to engage with care and the carers can only encourage, they cannot physically force him to stand and accept support. She said that she has found Patrick is throwing away all the food they are preparing and he is very underweight. She is concerned that he is not well. I again advised that we cannot force him to eat or drink. *She explained that she is only a friend and neighbour but she has found herself being his only support. He has a daughter who does not have contact or supports in any way. [His neighbour] expressed that she is happy to be his main contact and consented for me to put her number on his contact list*'. The Care Quality Commission raised safeguarding concern about Patrick, following [his neighbour's] call. The Social Worker emailed District Nurses about Patrick's skin, asking for them to see him and requesting a continence assessment. She also discussed the additional carer with the agency, who were not in a position to put another carer in at that point.
08.06.23	The District Nurses attempted to engage with Patrick and attempted to support him to stand but this was unsuccessful. Patrick did not consent to the continence assessment and asked the Nurses to leave. The continence assessment paperwork was sent out to Patrick. His pressure areas were not seen. A dressing was placed on a blister to Patrick's foot. On the same day, an email was received by the Social Worker from the District Nurse confirming they have been in close contact with the care agency and Patrick's Doctor but was unable to provide intervention as Patrick would not engage with alcohol services. The Social Worker stated that the care agency was unable to confirm if they can provide two carers so had re-brokered for a new provider to support as soon as possible. There was a further call to Hands on Care Homecare Service who confirmed they could now do it. The Doctor visited Patrick and concluded that he needed hospital admission. Later that day, a District Nurse attempted to visit Patrick again but on arrival, his neighbour informed Nurses that his doctor had been out today and requested admission to hospital by ambulance. West Midlands Ambulance Service received a 999 call at 13:43 from a District Nurse who was concerned regarding Patrick's self-

	neglect. He was found to be hypotensive and treated with intravenous fluids before transporting him to the Royal Shrewsbury Emergency Department for further assessment. All interventions were considered in line with their guidance, by the service. The is nothing recorded in Patrick's Adult Social Care notes to suggest the ambulance service had been called out to Patrick. When Patrick was brought into the hospital, their triage notes identified "*Patient is alcohol dependent, self-neglecting, very thin, not eating*" Their Initial Safeguarding and Domestic Abuse Screening was completed and identified concerns about self-neglect. Patrick had a significant grade 4 sacral wound which is the most severe type of pressure sore. There was a necrotic blister to his left upper foot. The word necrotic means that tissue around the wound was starting to die. He was also noted to be unkempt. Patrick said to staff that he drinks two bottles of rum per day and is a smoker. He had been sat in his chair for three days not eating and drinking. Nursing records identified "*patient received into Resus in very poor condition, looks physically unkempt, covered in faeces, ingrained dirt. Ungradable pressure sores. …… clinical photographs uploaded".* The initial treatment plan was to treat Patrick for alcohol withdrawal.
09.06.23	The hospital Social Worker had attempted to visit Patrick, but he had been taken into hospital the previous night. First Point of Contact (Shropshire Council's call centre) wrote in Patrick's notes that the Care Quality Commission raised a safeguarding concern on 7th June. The outcome was recorded as 'the social worker is aware, so not raising an Adult Safeguarding referral.'
12.06.23	Patrick was found unresponsive in bed showing no signs of life. The medic that undertook a review of Patrick's care in the hospital after his death, reported that his death may have been preventable had he been treated sooner.

Appendix 2. Single agency learning

West Midlands Ambulance Service and Shropshire Fire and Rescue Service

The current protocol for gaining entry to a property dictated the response of the services that needed to gain entry to Patrick's home. This document should be reviewed to take into account the clinical or safety risks faced by the person, of any delay on gaining entry.

West Midlands Ambulance Service

Information was not shared with Adult Social Care when they were contacted about Patrick.

On the 22nd April 2023 the WMAS clinicians discussed with Patrick their concerns around his care and his ability to manage independently. They discussed these concerns directly with him and sought his consent to submit a care/welfare concern referral on his behalf, however he declined to consent to the referral so this could not be completed.

On the 8th June 2023 the WMAS clinicians did not make a referral to Adult care but discuss his care package with the carer on scene and they were informed that Patrick had received a care assessment and his calls had been upgraded to two carers attending throughout the day and not one. Additionally, WMAS clinicians also documented their findings in the electronic patient record which was shared with the hospital and Patrick's GP.

Shropshire Fire and Rescue Service

Information was not shared with Adult Social Care when Shropshire Fire and Rescue Service had contact with Patrick.

Shrewsbury and Telford Hospitals NHS Trust

On each admission, Patrick was noted to be alcohol dependent. A referral to the Alcohol Liaison Nurse did not happen. The service has since been to include a formal alcohol detox pathway.

A Star Homecare Services

The Manager of A Star should express concerns about hospital discharges (when relevant) even if a person is no longer in their care. She should also ensure her staff team know to do this.

The Manager of A Star to ensure the agency are aware of and use the Shropshire Safeguarding Community Partnership's escalation document if they think their concerns are not being recognised by other agencies.

They could have arranged a multi-agency meeting to discuss concerns and ensure all agencies were agreeing a plan of action.

The service should reflect on their approach when considering withdrawing from Shropshire Council's provider framework. There should be consultation with the council about the best approach to take to avoid causing worry to their clients.

Hands on Care Homecare Services

There was very little information in Patrick's care notes to evidence what carers had done to try and encourage Patrick to accept the help he needed. This is particularly important when working with people who are refusing care and support.

The Manager of Hands on Care to ensure the agency are aware of and use the Shropshire Safeguarding Community Partnership's escalation document if they think their concerns are not being recognised by other agencies.

They could have arranged a multi-agency meeting to discuss concerns and ensure all agencies were agreeing a plan of action.

Shropshire Council Adult Social Care

There was no reference in the records to the Social Worker considering assessing Patrick's capacity due to his alcohol use, when this was suggested by the care agency and the Adult Safeguarding Team because of a safeguarding concern being raised.

They could have arranged a multi-agency meeting to discuss concerns and ensure all agencies were agreeing a plan of action. This resulted in domiciliary care agencies in particular, thinking nothing was being done when they reported their concerns.

Patrick's written support plan did not change even when risks to him were clearly increasing as were the concerns of other agencies/teams.

The Emergency Social Work Team Social Worker took at face value what Patrick said about having food in the house despite having a call from the care agency that there was no food in the house. The team should consider what if anything, could have been done differently in these circumstances.

The First Point of Contact, Adult Safeguarding Teams and Social Workers could have recognised the number of concerns being raised about self-neglect as a need to undertake a statutory safeguarding enquiry.

Patrick fell down his step between the lounge and the kitchen on 05.11.22. The referral to Occupational Therapy to assess what equipment would support him did not happen until 30.11.22. Patrick's occupational therapy referral was not allocated until 6.02.23 and the equipment he was assessed as needing not ordered until 17.02.23. This is not a timely response given Patrick's history of falling and alcohol use.

Churchmere Medical Practice

The surgery could have communicated with other agencies more effectively about:

- what action they were taking (some agencies thought nothing was being done subsequent to them raising concerns)
- their clinical assessments of Patrick

They could have arranged a multi-agency meeting to discuss concerns and ensure all agencies were agreeing a plan of action.

Shropshire Community Health NHS Trust

It is not evident that Trust staff utilised or made reference to the Trust's Self-Neglect Framework or multi-agency guidance to support them with their decision making and record keeping. It was recognised at the decision-making meeting that Trust staff, could have convened a multi-disciplinary meeting.

More professional curiosity was required of Trust staff about the consequences of not eating enough and drinking too much. There should have been more in-depth discussions about the risk he posed to himself. Although there was a supportive conversation with Patrick about his diet, alternatives and healthier lifestyle changes, these could have been revisited and followed up in more depth.

Appendix 3. Single agency good practice

Shrewsbury and Telford Hospitals NHS Trust

The Initial Safeguarding and Domestic Abuse Screening Tool was completed on each admission resulting in identifying self-neglect when Patrick was admitted in June.

Staff ensured clinical photographs of his skin wounds were recorded and appropriate referrals to the Tissue Viability Nurse and Datix raised.

The Trust's Specialist Safeguarding Nurse attended the Emergency Department to see Patrick and liaised with his social worker and Shropshire Council's First Point of Contact call centre in respect of the concerns about self-neglect.

The Mental Capacity Act and Deprivation of Liberty Safeguards were adhered to including additional capacity assessments being completed in respect of Patrick's ability to consent to his care and treatments.

A Star Homecare Services

A Star maintained their persistence with raising their concerns about increasing risk to Patrick due to his self-neglect. This was despite others saying there was nothing more that could be done as he had capacity.

A Star were providing ad hoc calls (paid for by Patrick) to take him to solicitor appointments.

Carers requested a mental capacity assessment because of Patrick's potential fluctuating capacity due to his alcohol use.

When Shropshire Fire and Rescue Service were called to assist West Mercia Police to gain access to Patrick's home, the manager of A Star stayed with him, chatting with him through the window until emergency services arrived.

Hands on Care Homecare Services

Hands on Care maintained their persistence with raising their concerns about increasing risk to Patrick due to his self-neglect. This was despite others saying there was nothing more that could be done as he had capacity.

For three days in June, Hands on Care provided an additional carer (unfunded) to help Patrick stand and receive help washing and dressing.

Shropshire Council Adult Social Care

Care Act assessments and support plans were in place.

Patrick's community Social Worker spent a lot of time with Patrick during her visits and they were sometimes an hour long. She also maintained her relationship with him over a long period of time.

There was clear evidence of strengths-based practice.

The community Social Worker initiated and maintained contact with Patrick's solicitor.

Patrick's community Social Worker communicated with all agencies involved with Patrick on a regular basis and made referrals when needed.

The Social Workers were responsive to concerns raised by domiciliary care agencies, returning contacts in a timely manner and arranging joint and unannounced visits.

Churchmere Medical Practice

There were two same day visits made by the surgery following concerns raised by Hands on Care.

Shropshire Community Health NHS Trust

A holistic approach was adopted by the teams in the Trust.

There was regular input and attempts to provide clinical interventions even though they were sometimes declined, and all were documented appropriately.

Regular visits were made to review pressure area care and mobility concerns and were documented appropriately.

Concerns were raised appropriately to Patrick's Doctor for example, identifying a suspected urine infection and requesting antibiotics.

Records evidence regular communication with the care agency and Social Worker.

It was identified within the notes that Patrick had capacity to make his own decisions about his clinical care.

Appendix 4. References

working_with_people_who_self-neglect_pt_web.pdf (researchinpractice.org.uk)

Self-neglect at a glance - SCIE

Safeguarding adult reviews: informing and enriching policy and practice on self-neglect (openrepository.com)